Syllabus & Proceedings Summary

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American Psychiatric Association

2008 Annual Meeting

Washington, DC • May 3–8, 2008

SYLLABUS
AND
SCIENTIFIC PROCEEDINGS

IN SUMMARY FORM

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May 3-8, 2008

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FOREWORD

This book incorporates all abstracts of the *Scientific Proceedings* in *Summary Form* as have been published in previous years as well as information for Continuing Medical Education (CME) purposes.

Readers should note that most abstracts in this syllabus include educational objectives, a list of references, and a summary of each individual paper or session.

We wish to express our appreciation to all of the authors and other session contributors for their cooperation in preparing their materials so far in advance of the meeting. Our special thanks are also extended to the Scientific Program Office staff and the APA Meetings and Conventions Department.

David A. Baron, D.O., *Chairperson*
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Full Texts

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

EMBARGO: News reports or summaries of APA 2008 Annual Meeting presentations contained in these program materials may not be published or broadcast before the local time and date of presentation.

TABLE OF CONTENTS

Foreword ii

CME Requirements iv

Daily Attendance Log v

Paper 1 -Presidential Address 1

Industry-Supported Symposia 3

Scientific and Clinical Report Sessions 46

Symposia 86

Workshops 221

OTHER FORMATS ALPHABETICALLY

Advances in ....APPI Series

Advances in Eating Disorder 301

Advances in Treatment of Psychiatric Disorders 303

Advances in the Treatment of Substance Use Disorder 305

Advances in Medicine 307

Case Conferences 309

Focus Live 310

Forums 312

Lectures 319

Presidential Symposia 326

Small Interactive Sessions 329

Author Index by Format 334

American Psychiatric Association
Continuing Medical Education Requirement

APA Continuing Medical Education Requirement

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

In May 1976, the Board of Trustees endorsed the following standards of participation in CME activities: All APA members in the active practice of psychiatry must participate in at least 150 hours of continuing medical education activities during a three-year reporting period, of which a minimum of 60 hours must be in category 1 CME activities. Category 1 activities are those programs sponsored by organizations accredited for CME and that meet specific standards of needs assessments, planning, professional participation and leadership, and evaluation and other activities which meet the AMA definition of category 1. The 90 hours remaining after the category 1 requirement has been met may be reported in either category 1 or category 2, which includes meetings not designated as category 1, reading, research, self-study projects, consultation, etc. APA members residing outside of the United States are required to participate in 150 hours of CME activities during the three-year reporting period, but are exempt from the categorical requirements.

Obtaining an APA Three-Year Continuing Medical Education Certificate

The APA CME certificates are issued to members upon receipt of a report of CME activities. You may report your activities to the APA in print or electronically using the official APA report form. This form may be obtained from the APA Department of Continuing Medical Education, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209, (703) 907-8661, or on the APA web site at www.psych.org.

Members may also receive the CME certificate by submitting a copy of your current Physician's Recognition Award (PRA) from the American Medical Association to the APA Department of CME at the address listed above.

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

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

DAILY LOG FOR ATTENDANCE AT CME SESSIONS AT THE 161st ANNUAL MEETING MAY 3-8, 2008 ● WASHINGTON, DC

NOTE: This Daily Log can be used keep track of the CME activities you attend while at the Annual Meeting of the American Psychiatric Association, May 3-8, 2008. Members are responsible for keeping their own CME records.

DAY		TITLE OF SESSION		# OF HOURS/CME CATEGORY	
				TOTAL	

Photo courtesy of Sylvia Johnson Photography 2007

Carolyn B. Robinowitz, M.D.

PRESIDENTIAL ADDRESS

OUR VOICE IN ACTION: ADVANCING SCIENCE, CARE, AND THE PROFESSION

The theme for this meeting and for my presidential year emphasizes advocacy for our profession and thus for our patients. The past decade has witnessed a remarkable outpouring of scientific information that has enhanced our understanding of etiology, diagnosis, and treatment. Basic and molecular science and imaging techniques have documented the nature of mental disorders and the impact of treatments, and a host of treatments have been demonstrated to be as effective as treatments for many other medical disorders, while outcome studies have demonstrated the cost-effectiveness of such care. Concurrently, there has been a remarkable increase in public awareness and understanding of mental disorders, and as celebrities and ordinary people alike speak openly about their illness and treatment, we also have experienced a reduction in stigma associated with these disorders.

Yet difficulties persist. Non-discriminatory access to psychiatric care remains a wish, not an actuality, even with the awareness that it is good business practice. Government funding for psychiatric research has decreased in terms of actual dollars spent, and states as well as private entities have provided insufficient funding for acute or chronic care. Our nation's prison system continues to serve as a first line mental health care system. Tragedies such as that at Virginia Tech, or the returning Wounded Warriors from Iraq and Afghanistan increase public awareness, but all too often, the initial outrage or concern is not accompanied by the funds or energy to ensure an integrated system of care. We psychiatrists do have an opportunity to shape the future of our profession and our patients' care. Through our advocacy—speaking with one voice—we can and must speak for those who may be silent or not heard: addressing national, state and local governments and policy makers, the media, health and other mental health professionals, clergy, teachers, and the public. We have an obligation to educate and inform, to state that mental disorders are real, reliably diagnosed, and effectively treated. As professionals, we also have an obligation to continue our own education, to use this new knowledge in caring for our patients, in teaching and mentoring our younger colleagues, and to promote the highest ethical standards in our work. We cannot succeed in isolation; we need a strong APA which engages in advocacy and partners with other organizations, such as the American Medical Association and patient and family advocacy groups to reach policy-makers and opinion shapers. Our learning and work together will benefit our patients and enrich our profession.

SATURDAY, MAY 3, 12:00 PM - 3:30PM

ISS01-PSYCHIATRIC ISSUES IN WOMEN THROUGH THE ADULT LIFE-CYCLE

SUPPORTER: WYETH PHARMACEUTICALS

No. 1A
GENDER DIFFERENCES IN DEPRESSION, ANXIETY AND MOOD DISORDERS: FINDINGS FROM RECENT POPULATION SURVEYS

Kathleen R. Merikangas, Ph.D., Section on Developmental Genetic Epidemiology, National Institute of Mental Health 35 Convent Drive, 1A-201, MSC #3720, Bethesda, MD 20892-3720

SUMMARY:

International epidemiologic studies have consistently yielded higher rates of depression and anxiety disorders in women. However, the patterns of gender differences are not equivalent for all subtypes of disorders and their underlying components. This presentation will present findings from the most recent population-based surveys of adults and children to investigate possible explanations for the female preponderance of mood and anxiety disorders. The stability of sex differences across adulthood in prospective studies will also be described.

No.1B
COGNITION AND MOOD IN PERIMENOPAUSE

Sanjay J. Mathew, M.D., Mount Sinai School of Medicine, Annenberg Building 21st Floor Room 80, New York, NY 10029

SUMMARY:

Women have twice the incidence of major depression compared with men. They are prone to develop episodes of depression during times of reproductive hormonal change at puberty, with use of oral contraceptives, during the premenstrual phase of the menstrual cycle, during postpartum, and during the perimenopause. Central nervous system pathways that mediate mood and cognition are influenced by fluctuations of circulating estrogen during perimenopause. Symptoms are also influenced by other factors, including psychosocial and environmental stresses and supports. Health care for women from perimenopause to postmenopause should include an accurate assessment of cognitive, physical, and emotional symptoms. Despite the fact that hormone replacement therapy has been shown to improve mood, controversy still lingers regarding the safety of this therapeutic modality.

No. 1C
RISK FACTORS FOR PROBLEM DRINKING: IN WOMEN IMPLICATIONS FOR TREATMENT AND PREVENTION

Sharon Wilsnack, Ph.D., Chester Fritz Distinguished Professor, Department of Clinical Neuroscience, University of North Dakota School of Medicine & Health Sciences, P.O. Box 9037, Grand Forks, ND 58202-9037

SUMMARY:

Alcohol abuse and dependence cut across gender, race/ethnicity, and nationality. In general, more men than women are alcohol dependent or have alcohol-related problems, but women are more vulnerable than men both to the acute effects of alcohol and to long-term physical and psychological consequences of alcohol abuse. This presentation will summarize new findings about risk factors for alcohol abuse and dependence in women, including family history, characteristics of employment and intimate relationships, sexual experience, and histories of violence and victimization. Implications of these new findings for prevention, intervention, and treatment of alcohol-use disorders in women will be discussed, and promising approaches to gender-sensitive treatment will be described.

No.1D
POSTPARTUM MOOD DISORDERS: RISK FACTORS AND TREATMENT

Vivien K. Burt, M.D., UCLA Dept. of Psychiatry & Biobehavioral Sciences, UCLA Neuropsychiatric Hospital,760 Westwood Plaza, Los Angeles, CA 90095

SUMMARY:

Many women experience depressive symptoms during the postpartum period, ranging from mild postpartum blues to significant mood disorders such as postpartum depression and postpartum psychosis. The “baby blues” are extremely common, affecting 30% to 75% of new mothers. This form of postpartum mood change is self-limited and requires no specific treatment other than education and support. Puerperal affective illness places the mother at risk for the development of recurrent depression and has also been associated with significant long-term effects on child development and behavior. Therefore, the prompt recognition and efficacious treatment of puerperal mood disorders are essential in order to avoid adverse outcomes for both mother and infant. Psychotherapy or pharmacotherapy may be used alone or in combination to manage postpartum depression.

REFERENCES

1. Wisner KL, Chambers C, Sit DK: Postpartum depression: a major public health problem. JAMA 2006 Dec 6; 296 (21):2616-8.
2. Cohen LS, Soares CN, Vitonis AF, Otto MW, Harlow BL: Risk for new onset of depression during the menopausal transition: the Harvard study of moods and cycles. Arch Gen Psychiatry 2006 Apr; 63(4):385-90.
3. Wiesbeck GA Gender-specific issues in alcoholism - introduction. Arch Womens Ment Health: 2003 Nov; 6(4):223-
4. Schmidt PJ, Roca CA, Bloch M, Rubinow DR. The perimenopause and affective disorders. Semin Reprod Endocrinol. 1997 Feb; 15(1):91-100.

ISS02-COMPREHENSIVE CARE FOR THE LONG-TERM PATIENT WITH SCHIZOPHRENIA: TREATING THE WHOLE PATIENT

SUPPORTER: PFIZER INC.

No. 2A

TOOLS FOR IMPROVING LONG-TERM MEDICAL HEALTH

Peter A. Fahnestock, M.D., Washington State University, 660 S. Euclid, St Louis, MO 63110

SUMMARY:

It is the family members, case managers, and other caregivers who assume the day-to-day responsibility for assisting patients. Their contributions can have a large impact on long-term behaviors, comparable to those of the physician. Consequently, patients, their families, and other community caregivers require education and support to help them achieve long-term well-being. Tools have been created to assist patients and their day-to-day caregivers in making choices that will optimize patients' medical health. These tools include the American Diabetes Association (ADA) toolkit, and specific training modules that are being developed with support from the NIMH and other sources. In this interactive symposium, clinicians will learn how to integrate these resources into long-term treatment planning.

No. 2B

RECOVERY FROM SCHIZOPHRENIA: GOALS AND OUTCOMES FOR AN EMERGING AND ATTAINABLE THERAPEUTIC GOAL

Stephen R. Marder, M.D., UCLA, MI RECC 210A 11301 Wilshire Boulevard, Los Angeles, CA 90073-1003

SUMMARY:

Definitions of recovery and remission vary across professional organizations, practitioners, and researchers. However, there is general agreement that this phase of the illness involves reduced or alleviated psychotic symptoms and improved psychosocial functioning. Patients differ in their goals during the stable phase of treatment. Some individuals may focus on living independently and others may focus on vocational or educational goals. Recently, increasing attention has been paid to the notion of recovery from schizophrenia, and it too has been conceptualized in various ways. Nevertheless, the President's New Freedom Commission on Mental Health has brought recovery to the forefront and offered some guidance as to its definition. Elements of recovery serve as metrics for patient response to treatment and ideally consensus should be reached about specific criteria for patient success. Participants in this symposium will discuss and identify the characteristics of recovery and remission as measures of treatment success. In addition, they will learn methods of how to develop and discuss individualized treatment goals for the patient, the family, and the health care provider.

No. 2C

GENERAL MEDICAL HEALTH IN SCHIZOPHRENIA: IT'S MORE THAN JUST WEIGHT GAIN

John W. Newcomer, M.D., Washington State University, 660 S. Euclid, St. Louis, MO 63110

SUMMARY:

Patients with severe mental illness are at substantially increased vulnerability for a number of medical problems and a relatively high risk for premature death. Many patients do not have access to good medical care or do not take advantage of available services apart from what is required to manage their mental illness. Among the most common medical conditions affecting these patients are those related to cardiometabolic function, which unfortunately can be exacerbated by the adverse effects of some psychotropic medications. Consequently, some portion of the responsibility for medical monitoring and management lies with the psychiatrist, many of whom may feel unequipped to address this role. In this interactive and practice-based symposium, clinicians will learn about the importance of medical management in patients with long-term mental illness and the successful integration of medical monitoring into psychiatric practice. Particular emphasis will be paid to identifying risk factors for common medical conditions and on providing practical tools for clinical management. Finally, the role of psychotropic medications like antipsychotics in increasing or decreasing risk will be reviewed along with recent treatment guidelines.

No. 2D

ACHIEVING RECOVERY: PHARMACOLOGIC AND PSYCHOSOCIAL APPROACHES

Willaim T. Carpenter, M.D., University of Maryland, PO Box 21247, Baltimore, MD 21247

SUMMARY:

Patients with schizophrenia have specific and unique needs over the long term that include symptom remission, relapse prevention, management of long-term treatment-related risk, management of ongoing medical monitoring, and improved psychosocial function. Mental health providers will likely need to play an expanded role in addressing these needs over time, particularly given the relative lack of access to general medical care among severely mentally ill patients. At this juncture, much remains to be learned about how best to individualize treatment goals and how to assess and manage patients with those goals in mind. Mental health providers need to be better equipped with practical tools to achieve remission in patients with schizophrenia. In this interactive and case-based symposium, the faculty will provide examples of treatment plans that incorporate goals of remission and recovery in the management of patients with schizophrenia.

REFERENCES

1. Ahmed M, Osser DN, Boisvert CM, Albert LG, Aslam M: Rationale for emphasis on management over treatment of schizophrenia in clinical practice. Ann Pharmacother 2007; 41:693-695.
2. Newcomer JW. Metabolic considerations in the use of antipsychotic medications: a review of recent evidence J Clin Psychiatry 2007;68 Suppl 1:20-27.
3. Andreasen NC, Carpenter WT, Kane JM, Lasser RA, Marder SR, Weinberger DR: Remission in schizophrenia: proposed criteria and rationale for consensus. Am J Psychiatry 2005;162:441-449.
4. Morken G, Grawe RW, Widen JH. Effects of integrated treatment on antipsychotic medication adherence in a ran-

domized trial in recent onset schizophrenia. J Clin Psychiatry 2007;68:566-571.

ISS03-RECENT ADVANCES IN ALZHEIMER'S DISEASE: EXPERT OPINIONS ON CURRENT AND EMERGING THEORIES

SUPPORTER: FOREST LABORATORIES, INC.

No. 3A
ADVANCES IN DIAGNOSIS ALZHEIMER'S DISEASE

Gary W. Small, M.D., UCLA Semel Insitute for Neuroscience & Human Behavior, Suite 88-201, 760 Westwood Plaza, Los Angeles, CA 90024

SUMMARY:

Many of the recent advances in the diagnosis of Alzheimer's disease (AD) have been in the area of neuroimaging. Structural imaging (computed tomography [CT] or magnetic resonance imaging [MRI]) is a routine component of diagnostic evaluation of dementia. When the differential diagnosis includes AD and frontotemporal dementia (FTD), a flurodeoxyglucose positron emission scan (FDG-PET), which measures regional glucose metabolism, may be useful. Recent studies also suggest the possible use of neuroimaging as a surrogate biomarker of the pathological hallmarks of AD–amyloid plaques and tau neurofibrillary tangles. Plaque and tangle accumulation may be detectable years before clinical AD diagnosis—in the mild cognitive impairment stages—using new in vivo radio labeled detection probes with neuroimaging. There is also an increasing interest for psychiatrists in the value of other imaging markers, such as hippocampal shape and volume and total brain volume, as well as genetic risk measures, such as apolipoprotein E-4 (APOE-4). Additionally, data will soon become available from the nationwide AD neuroimaging initiative (ADNI) launched by the National Institutes of Health in 2006, which will help inform the field about the utility of structural MRI, FDG-PET, and other relevant biomarkers. Neuropsychological testing is not routine but is a topic of discussion for the *Diagnostic and Statistical Manual of Mental Disorders, DSM-V.* More efficient neuropsychological assessment tools may make these informative measures more accessible for practicing psychiatrists. This program will review the recent advances in cutting-edge diagnostic tools that are of immediate interest to AD clinicians and researchers. Advances in the appropriate use of diagnostic tools, particularly imaging techniques, to facilitate early detection of AD in clinical practice, as well as their use as surrogate markers in new drug development will also be discussed.

No. 3B
ADVANCES IN DISEASE MODIFICATION: BAPTISTS VERSUS TAUISTS

Leonard Petrucelli, Ph.D., Mayo Clinic Jacksonville, Department of Neuroscience, 4500 San Pablo Road, Jacksonville, FL 32224

SUMMARY:

The challenges in measuring disease modification in Alzheimer's disease (AD) prevention trials will be highlighted in this presentation along with the novel approaches and trial designs for measuring disease modification in AD. Approaches to disease-modification in AD are being developed with varying degrees of success, based largely on the amyloid precursor protein cleavage pathways. An update on the benefits, disadvantages, and current status of immunotherapies, –secretase inhibitors, ß-secretase inhibitors, and -secretase modulators will be provided. Most notable, late-stage developments in selective amyloid-ß42 (Aß) lowering agents that target altered amyloidogenesis will also be highlighted in this program. A variety of genetic, pathological, and biochemical studies have provided a great deal of evidence that Aß is not simply a disease marker but that it plays a causal role in the development of AD pathology. The differential deposition of various Aß fragments (Aß42, Aß40, and Aß38) in plaques will be discussed. The role of anti-Aß aggregation agents such as glycosaminoglycan mimetics and metal ion chelators that inhibit fibril formation will be elaborated in the context of the amyloid hypothesis of AD. Many investigators believe that tau phosphorylation may represent a more promising therapeutic target than amyloid plaques. The long-standing debate about the primacy of tangles vs plaques in AD pathogenesis has been only partially resolved. In AD, the number and density of NFTs are strongly correlated with the degree of cognitive impairment and aberrant tau phosphorylation and NFTs are thought to play a major role in the pathogenesis of AD. The inter-relationships between Aß and tau and the relative importance of their roles in AD pathology is an active area of research. Current debate on the ß-amyloid plaques (BAPtist) and tau (TAUist) camps will be highlighted in this exciting segment, based on the most current knowledge of the underlying AD pathology.

No. 3C
ADVANCES IN CURRENT ALZHEIMER'S DISEASE TREATMENT GUIDELINES

Peter V. Rabins, M.D., Meyer 279 600 N Wolfe St, Baltimore, MD 21287

SUMMARY:

Practice guidelines for the diagnosis and treatment of Alzheimer's disease (AD) issued by several organizations have recently been revised or are being revised with emphasis on new information. The first American Psychiatric Association (APA) practice guidelines for the treatment of patients with Alzheimer's disease (AD) and other late-life dementias were issued in 1997 when only two cholinesterase inhibitors (ChEIs), tacrine and donepezil, were available for treatment. Since then, two new ChEIs, galantamine and rivastigmine, and one N-methyl-D-aspartate receptor antagonist, memantine, have been approved by the United States Food and Drug Administration (FDA) for the treatment of AD. A guideline watch was issued in April 2006, but a complete second edition of the APA practice guidelines are to be published in August 2007. The American Association of Geriatric Psychiatry issued a position statement in July 2006 emphasizing a set of care principles based on a comprehensive care model for AD that includes available evidence and clinical experience of the leading experts. Similarly, American Academy of Neurology

(AAN) practice guidelines for the management of dementia were issued in May 2001, reaffirmed in October 2003, and AAN is now in the process of developing new dementia guidelines. In light of many recent advances in the treatment of AD and other dementias, there is an immediate educational need for the APA audience to acquire distilled information from these updates in order to provide guideline, level care for AD patients and their caregivers. Key highlights and interpretation of these important guidelines will be discussed in this presentation.

No. 3D

ADVANCES IN SYMPTOMATIC ALZHEIMER'S DISEASE PHARMACOTHERAPY

Brian S. Appleby, M.D. Johns Hopkins Hospital, Depar. of Psychiatry and Behavioural Sciences, Baltimore, MD 21287

SUMMARY:

Recent advances in pharmacotherapy for Alzheimer's disease (AD) underscore the fact that this is a dynamic field in medicine. The essential highlights from recent studies of cholinesterase inhibitors (ChEIs) and memantine will be presented, addressing efficacy and safety in extended clinical trials, switching therapies, combined treatments, comparative analysis between agents, and new indications. Recent extension studies of both ChEI and memantine suggest the beneficial outcomes of continued long-term therapy with these agents. Studies of donepezil in severe dementia have resulted in expansion of its indication to the treatment of severe AD in addition to mild-to-moderate AD. A transdermal formulation of rivastigmine has been FDA approved. Studies of memantine in mild-to-moderate AD patients have showed inconsistent evidence of benefit and did not result in a label expansion beyond moderate-severe AD. Successful management of disturbing behaviors in AD remains the most challenging task for clinicians and a number of novel approaches are evolving with special emphasis on secondary prevention of behavioral disturbances and treatment of harmful acute behaviors. Memantine and ChEIs have shown varying degrees of benefit in improving existing behavioral symptoms as well as preventing the emergence of new symptoms in several clinical trials. The most recent data on antidementia agents and their appropriate use for behavioral disturbances in AD will be highlighted. Published in October 2006, the highly anticipated CATIE-AD study results have highlighted concerns regarding effectiveness in the use of antipsychotics in dementia. Strategies in determining prudent use of these psychotropics in AD will also be described. Finally, a brief primer on the collaborative care model for secondary prevention of neuropsychiatric symptoms in AD will be presented that brings together pharmacological and psychosocial interventions in a comprehensive approach.

REFERENCES

1. Small GW: Diagnostic issues in dementia: neuroimaging as a surrogate marker of disease. J Geriatr Psychiatry Neurol 2006; 19:180-185.
2. Dantoine T, Auriacombe S, Sarazin M, Becker H, Pere JJ, Bourdeix I: Rivastigmine monotherapy and combination therapy with memantine in patients with moderately severe Alzheimer's disease who failed to benefit from previous cholinesterase inhibitor treatment. Int J Clin Pract 2006; 60:110-118
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4. Christensen DD: Alzheimer's disease: Progress in the development of anti-amyloid disease-modifying therapies. CNS Spectr 2007; 12:119-123

ISS04-FIBROMYALGIA: DIAGNOSTIC ADVANCES AND EMERGING PHARMACOLOGIC THERAPIES FOR A COMPLEX, MULTIDIMENSIONAL DISORDER

SUPPORTER: ELI LILLY AND COMPANY

No. 4A

FIBROMYALGIA: THE PATHOPHYSIOLOGY OF DYSFUNCTIONAL PAIN PROCESSING

Daniel J. Clauw, M.D., Division of Rheumatology Associate Dean for Clinical and Translational Research Director, Chronic Pain and Fatigue, Michigan Institute for Clinical and Health Research The University of Michigan,24 Frank Lloyd Wright Drive, P.O. Box 385, Ann Arbor, MI 48106

SUMMARY:

Fibromyalgia is characterized by chronic widespread pain and tenderness (allodynia, hyperalgesia). Patients with fibromyalgia experience pain amplification with both benign and painful types of stimuli including light, heat, touch, cold, chemicals, sights, sounds, and smells. The disorder is thought to arise from multiple factors including genetic factors, stress, and neurotransmitter and neuroendocrine dysfunction. While the pathophysiology of fibromyalgia is not fully understood, accumulating evidence demonstrates that fibromyalgia pain is due to dysfunctional pain processing in the central nervous system (CNS). Patients with fibromyalgia are thought to develop functional changes in the CNS that result in central pain sensitization that is manifested as increased excitability of neurons, enlargement of their receptive fields, reduction in pain threshold, and recruitment of novel afferent inputs. Despite evidence that emphasizes the role of sensory and CNS abnormalities for the chronic pain associated with fibromyalgia, psychosocial factors also play an important role in the development and course of fibromyalgia. These include exposure to negative life events and chronic stress, increased focus on bodily symptoms, and passive pain-coping mechanisms. A recent family study also found that fibromyalgia coaggregates with mood disorders in families suggesting the possibility of shared pathophysiologic factors in fibromyalgia and mood disorders. This presentation will review the pathophysiology of fibromyalgia dysfunctional pain processing and also review the contributions of psychosocial factors.

No. 4B

EFFICACY OF CURRENT THERAPEUTIC INTERVENTIONS FOR FIBROMYALGIA: UNMET CLINICAL NEEDS

Lesley M. Arnold, M.D., Director, Women's Health Research Program, University of Cincinnati Medical Arts Building, 222 Piedmont Avenue, Suite 8200, Cincinnati, OH 45219

SUMMARY:

Fibromyalgia is a common, chronic, and debilitating condition characterized by widespread pain and tenderness and frequently accompanied by fatigue, insomnia, depression, and anxiety. The treatment of fibromyalgia is complex with current evidence advocating a multifaceted approach. The goals of therapy are to improve symptoms, function, and emotional well being. In June 2007, pregabalin became the first treatment approved by the FDA for the treatment of fibromyalgia. Research into other therapies is rapidly expanding treatment options for patients with fibromyalgia. Until recently, tricyclic antidepressants (TCAs) were the most frequently studied medications for fibromyalgia treatment and were shown to provide moderate clinical benefit in the relief of multiple symptoms, with the most consistently observed benefit on sleep attributable to sedative effects of TCAs. Due to concerns about safety and tolerability, newer antidepressants have been widely evaluated for use in fibromyalgia. The selective dual reuptake inhibitors of serotonin and norepinephrine, duloxetine and milnacipran, have been demonstrated in clinical trials to offer significant relief of pain and other symptoms in fibromyalgia as well as improving quality of life and function. Several other medication treatments have also shown promise in the treatment of fibromyalgia, including fluoxetine, gabapentin, tramadol, and pramipexole. In practice, patients often respond to combination of pharmacological treatments, although studies of combination pharmacotherapy are still limited. This presentation will provide an up-to-date review of pharmacological studies and areas of unmet needs and will provide guidelines for a stepwise treatment of fibromyalgia that includes combination therapies, based on available medical evidence.

No. 4C

THE FIBROMYALGIA MYSTERY: DIAGNOSTIC CHALLENGES IN PATIENTS WITH A CONSTELLATION OF SYMPTOMS

Sharon Stanford, M.D., Assistant Professor of Psychiatry and Family Medicine , Medical Arts Building - Suite 8200, 222 Piedmont Avenue, WHRP Treatment Ctr, Cincinnati, OH 45219

SUMMARY:

Fibromyalgia is a chronic and debilitating condition characterized by widespread pain and tenderness affecting approximately 2% of the U.S. adult population. Patients experience both allodynia (pain from a normally non-painful stimulus) and hyperalgesia (inappropriately intense pain from a normally painful stimulus). While chronic pain and tenderness are the defining features of fibromyalgia, patients also exhibit a constellation of symptoms including sleep disturbances, persistent fatigue, irritable bowel syndrome, headache, cognitive or memory impairment, and mood disorders. Diagnosis and treatment are challenging due to the limited understanding of the pathophysiology of fibromyalgia. While diagnosis is made through a combination of history, physical exam, lab findings, and the exclusion of other causes of chronic pain, it takes an estimated 5 years for the average patient to be accurately diagnosed with fibromyalgia, underscoring the need for physician education on recognition, diagnosis, and effective implementation of pain management strategies to help patients cope with this debilitating condition. While fibromyalgia is most often diagnosed in the primary care setting and is the second most commonly diagnosed condition in rheumatology clinics in the United States, psychiatrists often encounter patients with fibromyalgia as they present to psychiatrists with mood disorders and cognitive or memory impairment. Diagnosis is further confounded by overlap with other chronically painful conditions. While diagnostic criteria do exist, they were originally developed for research purposes and need further refinement as understanding of fibromyalgia has evolved. This presentation will review the variety of symptoms present in fibromyalgia, the differential diagnosis, and the diagnostic tools available to psychiatrists.

No. 4D

EMERGING STRATEGIES IN THE MANAGEMENT OF FIBROMYALGIA: A PATHOPHYSIOLOGIC APPROACH TO PHARMACOTHERAPY

Daniel J. Clauw, M.D., Division of Rheumatology Associate Dean for Clinical and Translational Research Director, Chronic Pain and Fatigue, Michigan Institute for Clinical and Health Research The University of Michigan,24 Frank Lloyd Wright Drive, P.O. Box 385, Ann Arbor, MI 48106

SUMMARY

The diagnosis and treatment of fibromyalgia is especially challenging for clinicians due to the limited knowledge of the etiology and poor response to conventional pain treatments. Outcome measures to date have been borrowed from clinical research in pain, rheumatology, neurology, and psychiatry. While these have been helpful to distinguish treatment response in symptoms domains, more work is needed to validate these in fibromyalgia. Due to the multidimensional nature of fibromyalgia, composite response criteria may also be useful to address the effects of treatment across the constellation of symptoms.

In general, abnormalities of pain processing appear to play an important role in fibromyalgia pain. In order to gain a better understanding of the mechanisms involved in the processing of pain associated with fibromyalgia, techniques in neuroimaging such as functional magnetic resonance imaging (fMRI) have been utilized to provide insights into the role of supraspinal mechanisms in pain perception. In addition, imaging studies have provided objective evidence of abnormal central regulation of pain in fibromyalgia. Resting brain blood flow studies have reported mixed findings for several brain regions, whereas decreased thalamic blood flow has been noted by several investigators. Augmented brain responses to both painful and non-painful stimuli that may be influenced by psychological factors have also been reported in studies evaluating the function of the nociceptive system.

This pathophsyiologic approach will lead to a greater understanding of pain-alleviating mechanisms and may ultimately provide direction for the development of more specific treatment approaches. This presentation will highlight that approach, the current data, and demonstrate that further neuroimaging research is warranted.

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3. Mease P: Fibromyalgia syndrome: Review of clinical presentation, pathogenesis, outcome measures, and treatment. J Rheumatology 2005;32(Suppl. 75):6-21.
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ISS05-ADDRESSING UNMET CLINICAL NEEDS IN SEVERE DEPRESSION

SUPPORTER: SANOFI-AVENTIS

No. 5A
ADDRESSING UNMET NEEDS IN PSYCHOTIC DEPRESSION

Alan F. Schatzberg, M.D., Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, 401 Quarry Road, Stanford, CA 94305-5717

SUMMARY:

Psychotic major depression is a severe form of the disorder affecting 15%-18% of patients with major depression and 0.3%-0.8% of the general population. The disorder is characterized clinically by delusions or hallucinations, marked psychomotor disturbance, guilt, and suicidal ideation. Neuropsychological deficits involving poor attention, decreased response inhibition and impaired verbal/visual memory functions are common in the disorder and these appear to reflect abnormalities in prefrontal cortex, cingulate, and hippocampal activity. Patients with the disorder demonstrate significantly elevated cortisol activity as evidenced by high non-suppression rates on the dexamethasone suppression test, very high post-dexamethasone cortisol levels, elevated 24-hr urinary cortisol levels, and elevated nocturnal serum cortisol levels. High cortisol levels correlate with poorer neuropsychological test performance. Historically, treatment for the disorder has revolved around the combination of an atypical antipsychotic with an antidepressant or electroconvulsive therapy (ECT). More recently, combination therapies have shown some efficacy, as have glucocorticoid antagonists. In this interactive symposium, participants will learn to assess patients for psychotic depression and to develop appropriate treatment strategies.

No. 5B
ADDRESSING UNMET NEEDS IN SEVERE DEPRESSION

Charles B. Nemeroff, M.D., Department of Psychiatry & Behavioral Sciences,Emory University School of Medicine, 101 Woodruff Circle Suite 4000, Atlanta, GA 30322

SUMMARY:

Major depressive disorder (MDD) is highly prevalent disorder and represents one of the most burdensome diseases worldwide. Of the approximately 30 million depressed patients worldwide, about one-third have symptoms that can be classified as severe. Severe depression is extremely debilitating and is associated with increased medical morbidity and mortality, reduced quality of life, and significant personal and societal cost. It is often clinically unappreciated that severe depression is in fact relatively responsive to pharmacotherapy. Due to the mulitifactoral etiology of depression with vulnerability being influenced by both environmental and genetic factors, psychiatrists need to be better equipped to assess and identify severe depression as well as how to manage its since successful outcomes may require an arsenal of treatments with numerous mechanisms of action. In this interactive symposium, psychiatrists will learn how to diagnose severe depression and how to measure treatment efficacy. Pharmacologic treatment modalities including SSRIs, TCA, SNRIs, dopamine agonists, antipsychotics, and other novel agents will be compared and contrasted in terms of efficacy and tolerability, both as monotherapy and in combination therapy. The role of non-pharmacologic therapies including psychotherapy, ECT, TMS, DBS, and VNS will be explored as adjuvants to medication management. Strategies for integrated treatment and management will be discussed.

No. 5C
NEUROBIOLOGY OF DEPRESSION

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

SUMMARY:

Major depressive disorder is a prevalent and disabling condition with a heterogeneous presentation and significant individual differences in response to treatment. The heterogeneity of both symptoms and treatment response, coupled with the known derangements to the hypothalamic-pituitary axis, signal transduction abnormalities and altered protein activity strongly support a biological basis for depression. Nevertheless, much remains to be learned about the pathophysiology of depression in general, and the genetic and environmental underpinnings in particular. In this symposium, faculty will review current evidence on the neurobiological basis of depression, with particular evidence on possible genetic contributions and epigenetic regulation. Faculty also will review the results of recent brain imaging studies showing individual differences that may represent genetic variability.

No. 5D
ADDRESSING UNMET NEEDS IN REFRACTORY DEPRESSION

Dwight Evans, M.D., 305 Blookley Hall, 423 Guardian Drive, Philadelpha, PA 19104

SUMMARY:

Treatment-resistant refractory depression (TRD), defined as depression that fails to respond to at least two different medications from two different pharmacological classes, poses a significant challenge for psychiatrists. As many as 30% of patients with major depression do not respond well to the first medication prescribed and up to 75% have recurring symptoms even after treatment. Some 15% of patients with depression do not experience remission even after multiple aggressive

interventions with pharmacotherapy and psychosocial strategies. The challenge of treating patients with TRD is compounded by the lack of consensus on its definition and classification and a paucity of evidence-based medicine to provide guidance. Moreover, many psychiatrists are unfamiliar with the differential diagnosis for TRD in patients with unipolar depression and are unaware of the risk factors for treatment non-response in this population. In this interactive symposium, participants will learn to identify risk factors for treatment resistance and to properly assess and characterize symptoms. Faculty will review pharmacological and psychosocial therapy approaches to managing patients with TRD and how to individualize treatment to optimize outcomes in these difficult to treat patients.

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2. Ohayon MM, Schatzberg AF: Prevalence of depressive episodes with psychotic features in the general population. Am J Psychiatry 2002;159:1855-1861.
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ISS06-PEDIATRIC AND ADOLESCENT ADHD: BACK TO THE BASICS

SUPPORTER: ABBOTT LABORATORIES

No. 6A

OFFICE-BASED PSYCHOSOCIAL INTERVENTIONS FOR ADHD

Aude Henin, Ph.D., Masachusetts General Hospital, Pediatric Psychopharmacology Unit, 185 Alewife Brook Pkwy, Suite 2000, Cambridge, MA 02138, Cambridge, MA 02138

SUMMARY:

While medication is considered the mainstay of treatment for ADHD, the role of behavioral and psychosocial interventions is receiving increased attention. Available evidence indicates that nonpharmacologic approaches to ADHD, by themselves, are not as effective as medication and that the benefit of adding psychosocial interventions to medication regimens is not established. In certain situations, however, the combination of pharmacologic and nonpharmacologic modalities can be synergistic—if, for example, the patient has a less than optimal response to medication, suffers from a comorbid psychiatric disorder (eg, anxiety disorder), or experiences significant stressors that disrupt family life (parental depression or substance abuse, marital problems, significant parent-child conflict). Behavioral therapy alone may be considered when ADHD symptoms are mild with minimal impairment, when the ADHD diagnosis is uncertain, when parents reject medication treatment, or when parents and teachers have marked disagreements about the diagnosis. A growing body of literature is seeking to validate the efficacy of behavioral and psychosocial interventions for ADHD in pediatric patients. Evidence indicates that behavioral parent training may be an effective short-term strategy. Approaches to adolescents may include behavioral techniques, academic interventions, and family therapy. The benefits of other approaches, such as cognitive-behavioral therapy and social skills training for children, are still under investigation. This review will enable the clinician to understand when to initiate nonpharmacologic approaches to ADHD and how to integrate them with medication in a comprehensive treatment plan.

No. 6B

ADHD DIAGNOSIS AND MANAGEMENT: A ROAD MAP TO THE LATEST GUIDELINES

Paul G. Hammerness, M.D., Harvard Medical School, Boston, MA 02115

SUMMARY:

Screening tools and guidelines for diagnosis and management of ADHD proliferate. This presentation will help the busy clinician sort them out. The diagnosis of ADHD relies upon a careful clinical evaluation that includes an assessment for comorbid psychiatric conditions. A myriad of screening tools and symptom rating scales are available; clinicians need to be aware of their practical utility and their limitations. Practitioners also need to know when neuropsychological testing is appropriate—for example, to probe for underlying learning disorders. Guidelines on diagnosis and management come from the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, and American Academy of Pediatrics, as well as international groups. In 2007, AACAP issued an updated Practice Parameter that recommends screening for ADHD as part of every patient's mental health assessment and calls for a "well thought out and comprehensive treatment plan" for all patients diagnosed with ADHD. Meanwhile, new guidelines from the Texas Children's Medication Algorithm Project used a consensus approach to develop guidelines for ADHD management, alone or with comorbid anxiety disorders, major depressive disorder, tic disorders, and aggression. Guidance also comes from the FDA, which is now calling upon clinicians to help families understand the benefits and risks of ADHD medications, including possible cardiovascular events and adverse psychiatric side effects. These considerations require careful screening of patients prior to treatment and diligent monitoring throughout the course of therapy. To fortify the clinician's knowledge in this area, the presentation will cover the Controlled Substances Act and related laws and regulations governing the use of these agents. This session will enable clinicians to understand and implement latest guidelines on ADHD diagnosis and management and to educate parents and patients appropriately.

No. 6C

ADHD TODAY: NEW INSIGHTS INTO CAUSES AND CONSEQUENCES

Stephen V. Faraone, Ph.D., 750 East Adams St, Syracuse, NY 13210

SUMMARY:

Ongoing research is illuminating our understanding of ADHD as a common psychiatric disorder in people of all ages, one with strong genetic and familial origins and characteristic neurobiologic features:

• At least 20 studies provide evidence that gene variants increase susceptibility to ADHD.

• The heritability of ADHD is estimated at 77%.

• Environmental factors such as maternal smoking and childhood lead exposure may also play a role.

• Structural and functional neuroimaging studies show a number of brain regions to be abnormal in individuals with ADHD. While these studies cannot be used to diagnose ADHD, they help articulate its neurobiologic pathways and delineate the response to medication. More is also known about the prevalence of psychiatric comorbidities in ADHD and the far-reaching psychosocial consequences of the disorder, with compelling implications for management. Common pediatric comorbidities include conduct disorder, oppositional defiant disorder, depression, and bipolar disorder.Among adolescents, ADHD is associated with higher rates of school failure, peer rejection, incarceration, and teen pregnancy.ADHD is a risk factor for cigarette smoking8 and substance abuse. Relatively new areas of exploration include the variant (and previously underappreciated) expression of ADHD in girls, and the occurrence and management of ADHD in preschoolers. Untreated, ADHD carries a risk of academic and occupational underachievement and functional impairment across multiple domains, ranging from poor marital, family, and peer relationships to higher rates of motor vehicle accidents, job-related injuries, and addictive/antisocial behaviors. This presentation will summarize the evolving state of knowledge on the nature of ADHD and its lifetime impact.

No. 6C

NEW CHOICES, NEW CHALLENGES: ADVANCES IN ADHD TREATMENT OPTIONS

Timothy E. Wilens, M.D., 55 Fruit Street, YAW 6A, Boston, MA 02114

SUMMARY:

With the clear identification of ADHD and co-occurring psychiatric issues, new strategies for managing these individuals have emerged. The development of new therapeutic agents, formulations, and drug delivery systems has significantly expanded the options for ADHD treatment. These advances include a transdermal (patch) form of methylphenidate, extended-release formulations of amphetamine and methylphenidate, and an amphetamine prodrug designed to limit abuse potential. A new generation of extended-release stimulants in development is expected to relieve symptoms for up to 16 hours. Meanwhile, research offers new insight on the efficacy and safety of atomoxetine, the only non-stimulant currently FDA approved for treating ADHD. A second non-stimulant, an extended-release formulation of the alpha-2A-adrenoceptor agonist guanfacine, awaits FDA approval for treatment of ADHD. Investigations are continuing into the use of agents not FDA approved for ADHD, including antidepressants and nicotinic agonists. Faced with a growing list of therapeutic choices, today's clinician needs guidance in selecting the most appropriate medication for the individual and in determining correct dose parameters, duration of action, and delivery system. Comprehensive management also requires assessment of psychiatric comorbidities and consequent modification of treatment plans. Diligent follow up includes assessing the efficacy of treatment, monitoring side effects, and adjusting dosages and medications to optimize outcomes. Psychoeducation is essential to help the patient and family understand ADHD, its consequences, the management approach, and the importance of adhering to prescribed regimens. This presentation will detail the essential elements of a comprehensive ADHD treatment plan, focused on psychopharmacological intervention, in a way that enhances the clinician's ability to make well-reasoned choices.

REFERENCES

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2. Centers for Disease Control and Prevention. Prevalence of diagnosis and medication treatment for attention-deficit/hyperactivity disorder—United States, 2003. MMWR 2005; 54(34):842-847.
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SUNDAY, MAY 4, 7:30 AM-11:00AM

ISS07-TREATING PATIENTS EARLY: UPDATES ON THE CONTROVERSY

SUPPORTER: ASTRAZENCA PHARMACEUTICALS

No. 7A

DIFFERENTIATING BETWEEN PRODROMAL SCHIZOPHRENIA AND PRODROMAL BIPOLAR DISORDER

Barbara Cornblatt, Ph.D., Zucker Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004

SUMMARY:

The field of prevention of severe psychiatric illness has rapidly grown over the past decade. The basic strategy is to identify vulnerable youngsters during the prodromal phase, when early clinical warning signs are displayed, but frank illness may be prevented. Although schizophrenia has typically been the outcome of interest, focus has been broadened to include bipolar disorder, also a chronic, highly debilitating illness with a presumed developmental course. In the New York Recognition and Prevention (RAP) program, a 30% rate of conversion to psychosis has been found among prodromal subjects (n=225). However, 20% of converted subjects eventually develop a bipolar disorder. There are no baseline differences between subjects prodromal for schizophrenia (P-Sz) vs prodromal for bipolar

(P-BP) disorder, making specific treatments difficult. A new RAP study has now been initiated to directly follow adolescents at risk for bipolar disorder. Early findings suggest that while clinical symptoms overlap substantially, P-BP adolescents display disturbances in temperament (e.g. higher cyclothymia) and circadian rhythm (e.g. sleep disruptions) not found in the pre-schizophrenia prodrome. Thus, there may be a common vulnerability underlying schizophrenia and bipolar disorder, as well as more specific deficits unique to each disorder. Implications of findings for early treatment will be discussed.

No. 7B

EARLY DIAGNOSIS OF SCHIZOPHRENIA

Oliver Freudenreich, M.D., MGH Schizophrenia Program, 25 Staniford Street, 2nd Floor, Boston, MA 02114

SUMMARY:

Patients who present with a first episode of psychosis can pose a variety of problems for physicians, and a diagnosis of schizophrenia is not always made as early as possible. While some morbidity from schizophrenia is probably not modifiable once acute psychosis has occurred, the best management of this stage of illness nevertheless holds the promise of improving long-term outcomes. In this talk, I will discuss how to positively diagnose schizophrenia early in the course of the illness so that appropriate treatment can be implemented in a timely manner. I will specifically focus on the medical differential diagnosis and medical work-up required for a comprehensive, diagnostic assessment, and some initial treatment goals. The talk will argue that the best approach for this patient population might be specialty clinic care augmented by research.

No. 7C

THE PRODROMAL OR ULTRA-HIGH RISK STAGE OF SCHIZOPHRENIA AND RELATED PSYCHOSES: A WINDOW FOR UNDERSTANDING AND INTERVENTION

Patrick McGorry, M.D., University of Melbourne, Parkville, 3052 Australia

SUMMARY:

Most patients who develop a first episode of psychosis and receive a diagnosis of schizophrenia or related psychotic disorder pass through a period of months to years, during which they can objectively be seen to manifest a "need for care," despite the fact that they do not meet current criteria for a *DSM IV* psychotic disorder (though they usually qualify for one or more other diagnoses). We have labeled this stage the prodromal or ultra-high risk (UHR) stage. In recent years it has become possible to study and treat a subset of such patients in specialized clinics and learn more about the neurobiology and risks associated with this stage of illness, as well as the benefits and risks of different forms of treatment. More than six RCTs have now been carried out and a range of neuroimaging and biological investigations as well as naturalistic studies have been conducted. We know that CNS changes of unclear significance actively occur during the transition to psychosis and that novel antipsychotics, CBT, and omega 3 fatty acids can probably all delay transition to first episode psychosis from the UHR state. While much has been learned, there is more that needs to be understood.

No. 7D

MAJOR DEPRESSIVE DISORDER IN YOUTH: NEUROBIOLOGY AND TREATMENT

Kathryn Cullen, M.D., Fairview -University Medical Center, 2450 Riverside Avenue, Minneapolis, MN 55464

SUMMARY:

This presentation will review the current understanding of neurobiological mechanisms underlying major depressive disorder (MDD) in children and adolescents. A working model for neurocircuitry involving fronto-limbic networks has been described in adults, and growing evidence implicates these networks in the pediatric literature. Hypothalamic-pituitary adrenal (HPA) axis dysregulation plays a major role in etiology and pathology of MDD. Clearly, an integration of the neurobiological systems in developmental framework is warranted to achieve an overarching understanding of this disorder. Research conducted at the University of Minnesota is currently exploring the possibility of abnormal development of white matter in the circuits implicated in MDD. Specifically, Diffusion Tensor Imaging MRI techniques are being used in depressed adolescents who are expected to have abnormalities of white matter development in anterior cingulate and amygdala regions as seen in adolescents with other major psychiatric disorders. Additionally, preliminary data assessing salivary cortisol suggests HPA hyperarousal in adolescent girls with MDD. Data are currently being collected to determine correlations between HPA and white matter abnormalities in MDD compared with healthy adolescents. Finally, current recommendations for treatment will be reviewed, with an emphasis on early intervention to prevent serious morbidities.

No. 7E

MEDICATION TREATMENT FOR YOUTH: IS IT THE SAME AS FOR ADULTS?

S. Charles Schulz, M.D., 2450 Riverside Avenue, F282/2A West, Minneapolis, MN 55454

SUMMARY:

Medication treatments for serious psychiatric illnesses, such as schizophrenia, are approved by the FDA after pivotal trials that focus on adults, and the average participant is nearly age 40. To date, pivotal trials have excluded participants under age 18. The previous speakers in this symposium have highlighted the nature of serious psychiatric illness in young people-from assessment to neurobiology. This presentation extends the concerns of practitioners about the science base for efficacy and safety of medication treatment of young people–especially focusing on whether all medications have equal efficacy in youth and whether young people have different sensitivities to medication side effects. To accomplish this goal, recent placebo-controlled trials of antipsychotic medications will be examined and compared. These new trials offer interesting data that contribute to the understanding of how to approach youth with psychotic illnesses.

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ISS08-ADVANCES IN NEUROIMAGING AND GENETICS IN ADHD

SUPPORTER: MCNEIL PEDIATRICS/ORTHO-MCNEIL JANSSEN SCIENTIFIC AFFAIRS, LLC

No. 8A

NEW GENETIC FINDINGS ON THE OVERLAP BETWEEN ADHD AND BPD

Eric Mick, Sc.D., 55 Fruit Street - Warren 705, Boston, MA 02114

SUMMARY:

ADHD and BPD are frequently comorbid in children, and this comorbidity phenotype may be an etiologically distinct familial phenotype. Candidate gene association studies have identified several loci that exert small but significant effects on these two disorders. Variation in the DAT gene (SLC6A3), the site of action of psychostimulants used to treat ADHD, has been associated with susceptibility to both ADHD and BPD. However, this comorbidity has not been systematically assessed in previous SLC6A3 and ADHD association studies, and SLC6A3 has not been examined in children with BPD. A recent family-based association study of SLC6A3 was conducted in 170 bipolar I-affected offspring trios and 315 non-bipolar ADHD-affected offspring trios. A dense set of single nucleotide polymorphism (SNP) markers were chosen from the European population of the International HapMap Project. Results indicated modestly positive association with BPD and the SNP rs40184, but no association with any of the tagged SNPs was observed in non-bipolar ADHD trios. This is the first examination of the association of SLC6A3 and BPD in children. It suggests that an association exists with BPD in children (as in adults), and that this comorbidity may also be an effect modifier of any SLC6A3-ADHD association. These findings implicate DAT function in the clinical presentation and psychopharmacology relevant to ADHD, BPD, and their comorbidity in children. Clinicians should understand the role of DAT function in ADHD, BPD, and their comorbidity in children and the implications for diagnosis and treatment.

No. 8B

NEW FRONTO-CEREBELLAR FINDINGS IN ADHD

Eve, M. Valera, PhD, 1149 Thirteenth Street, Room 265, Charlestown, MA 02129

SUMMARY:

Neuroimaging studies suggest that the neurobiology of ADHD involves structural and functional brain abnormalities in numerous cortical regions. Literature reviews have shown that the most replicated alterations include significantly smaller volumes in the cerebellum, dorsolateral prefrontal cortex, caudate, pallidum, and corpus callosum. A recent meta-analysis found that the greatest volumetric reductions for ADHD children relative to controls were in cerebellar and frontal regions, as well as the splenium, and right caudate. Although there have been only two structural MRI studies in adults, one recently showed that ADHD subjects had significantly smaller frontal volumes in regions involved in attention and executive control. On the whole, these structural findings clearly indicate that there are frontal and cerebellar abnormalities in ADHD brain volumes and that at least some of these abnormalities persist into adulthood. ADHD is also linked with behavioral and neurocognitive dysfunction. However, the neural substrate of cognitive functioning in ADHD adults has been relatively unexamined. In one study using a working memory task, ADHD adults showed significantly decreased activity relative to controls in cerebellar and occipital regions and a trend toward decreased activity in the prefrontal cortex. Also, preliminary results of performance on an internally guided tapping task showed ADHD adults to have decreased activation in the cerebellum relative to controls. These findings suggest that the cerebellum is involved in the pathophysiology of at least some cognitive deficits associated with ADHD. It is important for clinicians to understand how fronto-cerebellar abnormalities may affect behavioral and neurocognitive dysfunction in ADHD.

No. 8C

PHARMACOIMAGING STUDIES OF STIMULANT FORMULATIONS IN ADHD USING POSITRON EMISSION TOMOGRAPHY (PET)

Thomas J . Spencer, M.D., 55 Fruit Street. YAW 6A, Boston, MA 02114

SUMMARY:

DAT is a key regulator of dopamine in the brain. Abnormal DAT binding may contribute to the pathophysiology of ADHD. Both the therapeutic effects and the abuse potential of psychostimulants are associated with occupancy of DAT. One controlled study, for example, measured DAT binding using a highly selective ligand (C-11 altropane) and PET in 47 well-characterized, treatment-naïve, nonsmoking, non-comorbid adults with and without ADHD. Results showed significantly increased DAT binding in the right caudate in ADHD subjects compared with matched control non-ADHD subjects. Many clinicians are concerned that treating ADHD adults with psychostimulants creates a risk for abuse or dependence. The abuse potential of methylphenidate, for example, is related to the drug's capacity to produce a rapid onset of blockade of DAT. Some long-acting formulations of methylphenidate produce a more gradual rise in plasma

methylphenidate concentration, compared with immediate-release methylphenidate. Does this reduce the risk of "likeability" and abuse? To find out, another study randomly assigned 12 healthy adults to receive single doses of immediate-release or osmotic-release methylphenidate to produce equivalent Cmax values. Plasma drug levels, responses to detection/likeability questionnaire items, and DAT occupancies using PET and altropane were obtained at regular intervals. The results showed that osmotic-release methylphenidate was associated with longer time to maximum plasma concentration, longer time to maximum CNS DAT occupancy, and no detection/likeability, compared with immediate-release methylphenidate. Clinicians should understand the key role of DAT in the pathophysiology and pharmacotherapy of ADHD.

No. 8D

A PHARMACOIMAGING STUDY OF OROS-MPH USING FUNCTIONAL MAGNETIC RESONANCE IMAGING (FMRI) IN ADULTS WITH ADHD

George Bush, M.D., Building 149, 13th Street, CNY 9117, Charlestown, MA 02129

SUMMARY:

The neural effects of psychostimulants in treating ADHD are not fully understood. Studies have reported hypofunction and structural and biochemical abnormalities of the daMCC, a brain region that subserves cognition and motor control.A new, randomized, placebo-controlled, 6-week before-and-after fMRI study focused on this region to better understand the neural effects of osmotic-release oral system methylphenidate (OROS-MPH).In the study, 21 ADHD adults were randomized to receive OROS-MPH or placebo, undergoing fMRI twice while performing the Multi-Source Interference Task (MSIT). A validated fMRI task that reliably and robustly activates the cingulo-frontal-parietal cognitive/attention network within individual subjects, the MSIT can be used to identify the cognitive/attention network in normal volunteers and test its integrity in people with neuropsychiatric disorders. Performance and baseline fMRI measures in dorsal anterior midcingulate cortex and other a priori brain regions did not differ between groups. Group comparisons showed a group x scan interaction and t-test confirmation of higher activation within daMCC at six weeks in the OROS-MPH group than the placebo group. Individual volume-of-interest analyses confirmed group-averaged findings, and suggested daMCC activity might be related to clinical response. OROS-MPH also produced higher activation in dorsolateral prefrontal cortex and parietal cortex at six weeks. The investigators concluded that OROS-MPH increased daMCC activation during the MSIT, and may act, in part, by normalizing daMCC hypofunction in ADHD. Clinicians should understand the neural effects of stimulants they prescribe to treat ADHD.

No. 8E

USING MRI TO DISENTANGLE THE COMORBIDITY BETWEEN ADHD AND BPD IN ADULTS

Joseph Biederman, M.D., 55 Fruit Street, YAW 6A, Boston, MA 02114

SUMMARY:

Are ADHD and BPD distinct comorbidities in adults? Or are ADHD symptoms artifacts of BPD? An important new study evaluated the morphometric MRI underpinnings of the comorbidity between adult ADHD and BPD. Whole brain images were collected from subjects 18 to 59 years of age and stratified into four groups based on diagnostic status. Morphometric MRI findings of 31 adults with ADHD plus BPD were then compared with those of 18 adults with BPD only, 26 adults with ADHD only, and 23 healthy adult controls. When BPD alone was associated with a significantly smaller orbital prefrontal cortex and larger right thalamus, this pattern was found in comorbid subjects with ADHD plus BPD. Likewise, when ADHD alone was associated with significantly less neocortical gray matter, less overall frontal lobe and superior prefrontal cortex volumes, a smaller right anterior cingulate cortex, and less cerebellar gray matter, this pattern was found in comorbid subjects with ADHD plus BPD. The syndrome-congruent neuroanatomical findings identified suggest that ADHD and BPD may contribute selectively to brain volume alterations and support the hypothesis that individuals with both disorders are truly comorbid with both conditions. Clinicians should understand that ADHD symptoms in a bipolar adult are not an artifact of BPD, but represent a separate neurobiological disorder with distinct morphological characteristics observable in MRIs. Further, when ADHD and BPD co-occur, each disorder is generally severe, making accurate diagnosis and timely, effective treatment imperative.

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ISS09-RECENT ADVANCES IN THE DIAGNOSIS AND TREATMENT OF FIBROMYALGIA

SUPPORTER: PFIZER INC.

No. 9A

NONPHARMACOLOGIC TREATMENT OF FIBROMYALGIA

Dina Dadabhoy, M.D., Northwest Rheumatology Specialists, 800 Biesterfield Road, Elk Grove Village, Il 60007, Elk Grove Village, IL 60007

SUMMARY:

Nonpharmacologic therapies are an active area of research in fibromyalgia management. As indispensable adjuncts to pharmacologic interventions, nonpharmacologic treatments, such as cognitive-behavioral therapy and exercise, have been shown to help improve symptoms and, to a greater extent, restore function in individuals with fibromyalgia syndrome. In fibromyalgia syndrome, behavioral and neuropsychological factors play an important role in symptom expression and functional decline. Increasing symptoms of chronic pain and fatigue leave individuals with fibromyalgia syndrome isolated and withdrawn with low self-efficacy, an external locus of control, and catastrophizing (feeling negatively about their pain). Focusing on identifying and eliminating maladaptive illness behaviors and increasing coping strategies through cognitive behavioral therapy has an impact in the symptoms and function of individuals with fibromyalgia syndrome. Additionally, recent exercise trials have explored the efficacy of different levels of intensity and methods of exercise. Evidence increasingly supports supervised aerobic programs of low-to-moderate intensity. Compliance continues to be a hurdle but may be mitigated by pool-based programs, which likely have a benefit in mood as well as function. To date, there is little evidence supporting isolated strengthening, stretching, or low-movement exercises such as Qigong, Yoga, and T'ai Chi. Ultimately, the goal is an improved clinical state in a heterogeneous group of individuals; the best therapies will be those tailored to the person. This presentation will review strategies to incorporate behavioral and exercise interventions into the treatment of fibromyalgia patients.

No. 9B

OVERVIEW OF FIBROMYALGIA AND RELATED CONDITIONS

Daniel J. Clauw, M.D., 24 Frank Llyod Wright Dr., PO Box 385, Ann Arbor, MI 48106

SUMMARY:

Fibromyalgia is the second most common rheumatological condition, behind osteoarthritis. Using the strict American College of Rheumatology (ACR) criteria to diagnose this condition, approximately 3%–5% of the United States population and most other countries suffer from this entity. However, it is acknowledged that many individuals with the clinical diagnosis of fibromyalgia do not meet these strict ACR criteria. So these percentages underestimate the true prevalence of this entity. Moreover, fibromyalgia overlaps significantly with other "central" pain syndromes such as irritable bowel syndrome, tension headache, temporomandibular disorder, idiopathic low back pain, as well as some psychiatric disorders such as major depression, OCD, and bipolar disorder. There is agreement that these conditions both share underlying mechanisms, and respond to the same types of treatments, as fibromyalgia. Thus, a sizable proportion of the population has a fibromyalgia-like condition, and a better understanding of fibromyalgia may be helpful in guiding the treatment of many of these individuals.

No. 9C

THE ROLE OF ANTIDEPRESSANTS AS ANALGESICS

David A. Fishbain, M.D., University of Miami, VA Medical Center, 304A Dominion Tower, 1400 N.W. 10th Avenue, Miami, FL 33136

SUMMARY:

Fibromyalgia is a prevalent disease that has major consequences on health care resources and the individual patient. It is a debilitating disorder characterized by chronic, diffuse muscle pain, fatigue, sleep disturbance, depression and skin sensitivity for which pathophysiological mechanisms are difficult to identify and current drug therapies demonstrate limited effectiveness and significant tolerability. Since the late 1970s some studies have indicated that antidepressants may have analgesic properties while others have been in conflict with this hypothesis. Antidepressants, which may improve many important outcomes, are effective in about 40% of individuals. Newer agents of this class, such as duloxetine and milnacipran, show improvement in key fibromyalgia outcomes in about 60% of patients. In a review of 21 controlled trials, 16 involving tricyclic agents, where nine of these 16 studies qualified for a meta-analysis, the largest improvement was associated with measures of sleep quality; the most modest improvement was found in measures of stiffness and tenderness. In another meta-analytic study, antidepressants were efficacious in treating many of the symptoms of fibromyalgia. Patients were more than four times as likely to report overall improvement and reported moderate reductions in individual symptoms, particularly pain. This presentation will review the meta-analytic evidence for antidepressant analgesics, the evidence that some antidepressant groups may have greater analgesic efficacy, discuss analgesic differences among some SNRIs, and establish which components of the analgesic effect is dependent on the antidepressant effect.

No. 9C

PHARMACOLOGIC TREATMENT OF FIBROMYALGIA

Don L. Goldenberg, M.D., Newton-Wellesley Hospital, 2000 Washington St., Suite 304, Newton, MA 02462

SUMMARY:

The pharmacologic management of fibromyalgia (FMS) is based on the evidence that pain in FMS is primarily related to central nervous system (CNS) pain sensitization and inadequate pain inhibition. These are also the hallmarks of related disorders such as chronic low back pain, temporomandibular disorders (TMJ), migraine, and irritable bowel syndrome. Not surprisingly, CNS-active medications have been studied and are the most effective drugs in FMS patients. A number of medications, including low-dose tricyclic antidepressants, serotonin reuptake inhibitors, and dual serotonin-nonrepinephrine reuptake inhibitors, have demonstrated efficacy in randomized, clinical trials. Anti-seizure medications, pregablin and gabepentin, have also been effective. This presentation will discuss that, for the first time, these various FDA-approved medications are being studied very actively in clinical drug trials for the treatment of FMS.

No. 9D
GENETICS OF FIBROMYALGIA

Lesley Arnold, M.D., University of Cincinnati Medical Arts Building, 222 Piedmont Avenue, Suite 8200, Cincinnati, OH 45219

SUMMARY:
A recent controlled family study established that fibromyalgia and reduced pressure pain thresholds strongly aggregate in families, and fibromyalgia coaggregates with major mood disorder in families. These findings have important clinical and theoretical implications, including the possibility that genetic factors are involved in the etiology of fibromyalgia and in pain sensitivity. In addition, mood disorders and fibromyalgia may share some of these inherited factors. Because of the possible involvement of abnormalities of central serotonergic neurotransmission in fibromyalgia, many of the genetic studies of fibromyalgia have focused on the association of fibromyalgia and genetic polymorphisms in serotonin-related genes, such as the T102C polymorphism of the serotonin-2A receptor gene (HTR2A) and the serotonin transporter gene (HTTLPR) regulatory region. In addition to serotonin-related genes, other studies have explored the association of fibromyalgia and genetic polymorphisms in other genes. Dopaminergic neurotransmission may also be altered in fibromyalgia, and a recent study found an association between fibromylagia and the dopamine D4 receptor exon III repeat polymorphism in FM patients. There has been emerging interest in the possible role of catechol-O-methyltransferase (COMT), an enzyme that inactivates catecholamines and catechol-containing drugs, in pain sensitivity. There is a functional polymorphism at codon 158 in the COMT gene that codes the substitution of valine (val) by methionine (met); individuals with the val/val genotype have a three- to fourfold higher activity of the COMT enzyme and reduced pain sensitivity compared with those with the met/met genotype. One study found that the met/met and met/val genotypes together were more frequently represented in fibromyalgia patients. This presentation will review the recent genetic studies of fibromyalgia and explore the impact of this rapidly expanding area of research.

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ISS10-UNLOCKING THE COMBINATION: MOVING TOWARD A BETTER UNDERSTANDING OF MAJOR DEPRESSIVE DISORDER

SUPPORTER: WYETH PHARMACEUTICALS

No. 10A
COMBINING ANTIDEPRESSANTS: IS THERE EVIDENCE FOR SYNERGY?

Craig Nelson, M.D., University of California San Francisco, 401 Parnassus Avenue, PO Box 0984, San Francisco, CA 94143

SUMMARY:
Depression is a common disorder that is frequently resistant to initial treatment. In Sequential Treatment Alternatives to Relieve Depression (STAR*D), only 33% of patients with major depression remitted after a vigorous course of treatment. After two treatments, nearly half the patients failed to remit. Findings like this have led to a search for more effective treatments. One of these strategies is to combine two marketed antidepressants or combination therapy. The rationale is that some agents have different mechanisms of action that may have synergistic effects. Essentially, this means combining agents from different classes. The improved tolerability of second-generation antidepressants has facilitated this approach. The combination of tricyclic antidepressants and monoamine oxidase inhibitors was the first such strategy described but is complicated by serious safety issues. Because combination treatment involves drugs of different classes, the number of combinations is limited. The most popular is the combination of a selective serotonin reuptake inhibitor (SSRI) with the catecholamine reuptake inhibitor bupropion, but the evidence for this combination is lacking placebo-controlled data. The combinations of an SSRI with a norepinephrine reuptake inhibitor or an SSRI with the a-2 antagonist/5-HT2 antagonist mirtazapine are both supported by double-blind, controlled trials but both of these controlled trials were quite small. Combining different SSRIs with similar mechanisms is not considered rational polypharmacy. Because venlafaxine and duloxetine both have relatively greater serotonin than norepinephrine reuptake potency, combining one of these agents with an SSRI is not recommended.. This presentation will review the efficacy, tolerability, and safety issues associated with the common combinations, and issues associated with the administration will be discussed.

No. 10B
THE ROLE OF GLUTAMATE IN MDD NONRESPONSIVE TO STANDARD THERAPIES

Sanacora Gerard, M.D., Yale Medical Group, Connecticut Mental Health Center, Clinical Neuroscience Research Unit, 34 Park Street New Haven, CT 06511

SUMMARY:
Increased awareness of the limitations of existing antidepressant treatments that almost exclusively target the monoaminergic systems provides a strong impetus for the development of novel antidepressant treatments with unique targets of action. Emerging evidence suggests that amino acid neurotransmitter systems (GABA and glutamate) contribute to the pathogenesis, pathophysiology, and treatment of mood disorders. GABAergic involvement in the pathophysiology and treatment of mood disorders is supported by several lines of evidence including: (1) animal studies showing stress-related changes in GABAergic function, (2) the ability of GABA agonists and antagonists

to modulate behavioral models of depression in rodents, (3) GABAergic effects of existing antidepressant medications, (4) evidence of clinical antidepressant efficacy associated with GABAergic drugs, and most convincingly (5) demonstration of GABAergic abnormalities and genetic associations in depressed patients. Supporting evidence for the role of glutamate in the pathophysiology of mood disorders comes from:(1) demonstration of glutamatergic abnormalities in patients with Major Depressive Disorder (MDD), (2) glutamatergic effects of antidepressant and mood stabilizing medications, (3) animal studies showing stress-related changes in glutamatergic function and its possible relationship to the pathophysiology and pathogenesis of MDD, and most recently (4) the effectiveness of glutamate-modulating agents in the treatment of depression. This presentation will briefly highlight some of the clinical and preclinical findings suggesting that amino acid neurotransmitter systems contribute to the pathophysiology of mood disorders. It will then focus on reviewing the results of recent studies examining the clinical efficacy of glutamate-modulating agents such as ketamine and riluzole in TRD.

No. 10C
AUGMENTATION STRATEGIES IN TREATMENT-RESISTANT DEPRESSION

Maurizio Fava, M.D., 15 Parkman Street, WACC-812, Boston, MA 02114

SUMMARY:
The efficacy of antidepressant monotherapy is somewhat limited, particularly in real-world settings. The Sequential Treatment Alternatives to Relieve Depression (STAR*D) trial has shown that treatment with the selective serotonin reuptake inhibitor citalopram in primary and specialty care leads to remission only in one in three patients. When patients with major depressive disorder do not respond adequately to antidepressant treatment, clinicians often add another augmenting compound to the antidepressant regimen, particularly in the event of partial improvement or response. Augmentation strategies appear to be relatively safe and effective approaches to treatment-resistant depression. STAR*D has evaluated the three best-studied augmentation strategies in the literature, namely buspirone, lithium, and T3. STAR* D did not evaluate some of the other augmentation strategies that are frequently used in practice, such as atypical antipsychotic agents, methylfolate, s-adenosyl-methionine, psychostimulants, and modafinil. In particular, atypical antipsychotics have been studied even more extensively as augmentation strategies in resistant depression in the past decade there are several double-blind studies (e.g. aripiprazole; risperidone; olanzapine) to help clinicians make informed choices. This presentation will review the existing literature on augmentation strategies and will examine the pertinent results of STAR*D.

No. 10D
THE ROLE OF PHARMACOGENETICS IN TREATMENT-RESISTANT DEPRESSION

Roy H. Perlis, M.D., 15 Parkman Street WACC 812, Boston, MA 02114

SUMMARY:
Individuals with major depressive disorder (MDD) show wide variation in their response to antidepressant treatment. In addition to the many environmental factors that can contribute to these differences, genetic variation also influences antidepressant treatment response. This variation may contribute to treatment resistance by influencing drug metabolism (pharmacokinetics) as well as pathways by which drugs exert their therapeutic effect (pharmacodynamics). To date, there is little evidence that polymorphisms in cytochrome p450 genes play a large role in treatment resistance. However, multiple genes have now been implicated in antidepressant efficacy as well as tolerability and may thereby contribute to treatment resistance in MDD. This presentation will describe such findings and discuss how identifying these genes could help to elucidate the pathophysiology of treatment-resistant eepression (TRD) itself, and aid in stratifying patients' risk for TRD.

No. 10D
NEUROSTIMULATION APPROACHES TO TREATMENT-RESISTANT DEPRESSION

Sarah Lisanby, M.D., NYS Psychiatric Institute, Room 5214 Unit/Box:21 1051 Riverside Drive, New York, NY 10032, New York, NY 10032

SUMMARY:
Managing patients with treatment-resistant depression remains a challenge for the clinician. Drugs and psychotherapy are inadequate for relieving depressive symptoms in a substantial proportion of depressed patients. Approximately 50% of depressed patients do not respond to a trial of a particular antidepressant, and as many as 20% of patients do not respond to any antidepressant medication. As a result, many patients with major depression are not treated adequately, and some will suffer from chronic, debilitating symptoms. Given that a considerable portion of patients with depression do not respond to or remit during pharmacotherapy, there is increasing interest in nonpharmacologic strategies to treat depressive disorder. For patients with treatment-resistant depression, other therapeutic options must be considered. Neurostimulation is an evolving treatment that holds promise for patients with refractory depression. Neurostimulation is a physical intervention that uses application of either electric current or magnetic field to directly stimulate the brain or central nervous system. The various techniques include electroconvulsive therapy (ECT), repetitive transcranial magnetic stimulation (rTMS), magnetic seizure therapy (MST), vagus nerve stimulation (VNS), and deep brain stimulation (DBS). Although ECT has been in use for several decades, the technique is still being refined and improved. The other neurostimulation treatments are newer and their efficacy will be reviewed.

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ISS11-GENETICS IN PSYCHIATRY: OPPORTUNITIES AND OBSTACLES IN SCHIZOPHRENIA

SUPPORTER: VANDA PHARMACEUTICALS

No.11A

TRANSGENIC MANIPULATIONS OF PUTATIVE SCHIZOPHRENIA SUSCEPTIBILITY GENES: A STRATEGY FOR CLARIFYING LINKAGE/ASSOCIATION SIGNALS AND MOLECULAR PATHWAYS

Tyrone D. Cannon, Departments of Psychiatry and Biobehavioral Sciences and Psychology, UCLA, Los Angeles, CA 90095

SUMMARY:

Progress in identifying genes that contribute to susceptibility to schizophrenia and other psychiatric disorders has been hindered by a number of factors, including non-Mendelian transmission patterns, probable genetic heterogeneity, and an inability to detect premorbid and non-penetrant carriers of predisposing genes. In addition, recent evidence suggests that some susceptibility loci may be shared among conditions traditionally viewed as etiologically distinct. Our approach is based on the notion that schizophrenia and other complex diseases can best be conceptualized as sets of quantitative traits that reflect intermediate states between predisposing genes and symptomatic expression (endophenotypes). We are pursuing a "translational phenomics" strategy to specify the neuroendophenotypic effects of sequence variations in genes associated with schizophrenia and bipolar disorder across the cognitive, anatomical, physiologic, cellular, and molecular levels of analysis and to determine the correspondences between these genotype-phenotype relationships across humans with and at risk for schizophrenia and bipolar illness and mice with experimentally induced alterations of these genes. We demonstrate the merits of this approach in relation to a series of experiments evaluating a transgenic mouse model of the Disrupted in Schizophrenia 1 gene (DISC1) for association with behavioral and neural phenotypes previously seen to be associated with schizophrenia-related haplotypes of DISC1 in humans. Multiple such correspondences have been observed in terms of neurocognition, neuronal morphology, and neuronal physiology. We also discuss how the use of multiple manipulations of the same gene and an inducible transgene platform may facilitate isolating critical regions of genes that will aid in the identification of functional polymorphisms in humans and in the determination of the temporal-developmental and regional-neuroanatomical specificity of these targeted mutations. While most of the examples to be presented pertain to DISC1, work in progress is extending this approach to other putative susceptibility loci, including dysbindin.

No. 11B

NEW APPROACHES TO THE GENETICS OF PSYCHIATRIC DISORDERS

Danielle M. Dick, Ph.D., Virginia Institute for Psychiatric and Behavioral Genetics, Virginia Commonwealth University, Department of Psychiatry, PO Box 980126, Richmond, VA 23298-0126

SUMMARY:

The rapid developments in genomic sequence availability and genotyping capability have provided the impetus for the first comprehensive efforts to link DNA sequence variation with clinical phenomena. To fully appreciate these efforts, it is helpful to understand the terminology, basic methodologies, and the strengths and weaknesses of these novel methods in dissecting complex clinical problems such as psychiatric disease, brain structure and functional impairments, and response to psychotropic drug treatment. In this presentation, we will: (1) review essential terms including single nucleotide polymorphism (SNP), genetic linkage, and case control and family-based association designs, and then move to a discussion of their practical utilization towards understanding the genetics of complex psychiatric disorders, such as schizophrenia; (2) assess the rapidly evolving databases that provide almost daily updates on new human DNA sequence variation, its frequency across populations, and its implication for the development of schizophrenia; and (3) discuss linkage and association analyses that attempt to link genetic variation to clinical manifestations of schizophrenia, including diagnostic issues, symptom domains, and related manifestations of illness including neurocognitive function. At the conclusion of this presentation, we will evaluate emerging developments in the field, including the use of comprehensive association analyses of hundreds of thousands of genetic markers (SNPs), and the prospects for these emerging technologies to identify genes relevant to schizophrenia. Taken together, this presentation should provide an overview of the strategies used to identify genes involved in psychiatric disorders, in order to allow audience participants to critically evaluate this rapidly developing field.

No. 11C

THE PHARMACOGENETICS OF ANTIPSYCHOTIC DRUG RESPONSE

Anil K. Malhotra, M.D., The Zucker Hillside Hospital, Psychiatry Research, 75-59 263rd Street, Glen Oaks, NY 11004

SUMMARY:

Gene mapping and candidate gene association studies are now beginning to identify the first convincing susceptibility genes for schizophrenia including dysbindin (DNTBP1, 6p22), neuregulin 1 (NRG1, 8p12), G72 (13q33), regulator of G-protein signaling 4 (RGS4, 1q23); and catechol-O-methyltransferase (COMT 22q11-13). Despite the success of these initial gene-finding efforts, the implications of these results are less clear. The mechanisms by which these genes predispose to illness development are not known, the specific phenotypes associated with risk genotypes

remain to be determined, and the relationships of disease genes to treatment response (pharmacogenetics) are ongoing lines of investigation. Recent research indicates that pharmacogenetic studies of antipsychotic drug response may be informative and there are now commercially available products to test specific genetic markers putatively associated with drug response. Several groups have identified a relationship between genetic variation in the dopamine D2 receptor gene (DRD2) and clinical response to second-generation antipsychotic drug treatment. Moreover, new phenotypes are being considered including neurocognitive indices, and structural and functional brain imaging measures. These endophenotypic measures may provide greater power to detect the relatively subtle effects of gene variants on the complex phenotype of drug response. Finally, the utilization of drug-induced adverse events such as tardive dyskinesia, clozapine-induced agranulocytosis, and antipsychotic-induced weight gain has shown particular promise In this presentation, we will review the first generation of genetic studies of antipsychotic drug response, examine new pharmacogenetic data from our group and others suggesting replicability of results, and then discuss strategies for utilizing novel genomic approaches such as whole genome association (WGA) in the next generation of antipsychotic pharmacogenetic studies.

No. 11D

CLINICAL PHENOMENOLOGY AND RESPONSE MEASURE IN GENETIC STUDIES

John M. Kane, M.D., The Zucker Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004-1150

SUMMARY:

Individuals with schizophrenia present with a wide range of symptoms. Course of illness and response to treatment vary considerably. At present we are not able to use neuropathological, neurophysiological, or neurochemical findings to establish phenotypic classification. Therefore, we rely on an array of clinical signs and symptoms to establish cases of the illness. The rigor with which patients are assessed and the thoroughness of differential diagnoses varies widely from clinical to research contexts. As we begin to expand our efforts in pharmacogenetics we will more and more attempt to categorize patients in terms of response, time course of response and maintenance of response to a variety of specific treatments. There are no universal criteria by which to categorize patients in terms of clinical response. In addition, there are a variety of pharmacotherapeutic issues such as adherence, dose, bioavailability, metabolism, etc.which can influence treatment response. This presentation will review some of the current strategies to address these issues and suggest needed research for facilitating new methodologic approaches.

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ISS12-TREATMENT OF CHILDREN AND ADOLESCENTS WITH PSYCHIATRIC DISORDERS: THE RISING USE OF ANTIPSYCHOTICS

SUPPORTER: BRISTOL-MYERS SQUIBB COMPANY AND OTSUKA AMERICA PHARMACEUTICAL INC.

No. 12A

ATYPICAL ANTIPSYCHOTICS IN AUTISM SPECTRUM AND DISRUPTIVE BEHAVIOR DISORDERS

Christopher McDougle, M.D., Department of Psychiatry Indiana University School of Medicine, Psychiatry Building – Room A305, 1111 West 10th Street, Indianapolis, IN 46202-4800

SUMMARY:

Autism spectrum disorders (ASD) are neuropsychiatric syndromes that occur in 3.4 of every 1,000 children. Autism is generally characterized by an impairment of social interactions, communication skills, and repetitive patterns of behavior. These core symptoms of ASD are often associated with behavioral symptoms including irritability, aggression, self-injury, and temper tantrums. Optimal clinical management of ASD involves behavioral and pharmacologic strategies; however, there is no clearly effective single treatment option for all ASD symptoms. Pharmacologic agents, such as antipsychotics, are commonly prescribed for the treatment of behavioral symptoms of ASD. Currently, the atypical antipsychotic risperidone is the only FDA-approved agent for the treatment of irritability, aggression, self-injury, and tantrums in autistic children and adolescents. Studies using other atypicals (olanzapine, quetiapine, ziprasidone, or aripiprazole) to treat ASD symptoms show that these medications have some efficacy in reducing certain behavioral symptoms, but like risperidone, they are associated with potentially significant adverse effects. Although these agents show promise for the treatment of many ASD symptoms, there is limited availability of controlled data to guide clinical practice. In addition, despite a lacking evidence base, antipsychotics are being used increasingly for the cluster of aggression, irritability, and behavioral dyscontrol associated with other disorders, such as complicated attention-deficit/hyperactivity disorder, oppositional defiant disorder, and conduct disorder. This presentation will review the current efficacy and safety evidence for the use of atypical antipsychotics in the ASD population. In addition, the use of these agents for symptoms of aggression and behavioral dyscontrol associated with disruptive behavior disorders will be briefly considered.

No. 12B

CHALLENGES IN PHARMACOLOGIC MANAGEMENT OF MAJOR PSYCHIATRIC DISORDERS IN CHILDREN AND ADOLESCENTS: OPTIMIZING TREATMENT

WITH MINIMAL ADVERSE EFFECTS

Christoph U. Correll , M.D., The Zucker Hillside Hospital, Psychiatry Research, 75-59 263rd Street, Glen Oaks, NY 11004

SUMMARY:

Approximately 6-9 million pediatric patients in the United States have a severe psychiatric disorder. The most common pharmacologic agents prescribed for the treatment of major psychiatric disorders, including schizophrenia, bipolar, and severe behavior disorders, in children and adolescents, are the atypical antipsychotics. In adult populations, treatment with atypical antipsychotics has an established efficacy and safety profile. Numerous studies show that select atypical agents have a lower propensity for causing adverse events in adult populations when compared with conventional antipsychotics. However, there are limited data on the efficacy, safety, and tolerability of these pharmacological agents in the treatment and management of major psychiatric disorders in children and adolescents. Reviews of several clinical trials provide evidence suggesting that children and adolescents may be at higher risk for adverse effects such as sedation along with adverse metabolic/endocrine effects such as weight gain and prolactin-related dysfunction. Due to a limited number of controlled trials that specifically address this issue, the evaluation of the long-term neurochemical effects of these agents on the developing brain is unknown optimization of dosing in order to minimize adverse effects is difficult and information required to make the appropriate decisions regarding short- and long-term treatment goals in children and adolescents is lacking. These challenges highlight the significant need for critical appraisal of emerging data supporting the overall effectiveness of antipsychotic medications in order to identify strategies to optimize the efficacy and safety of treating these disorders in children and adolescents.

No. 12C

EARLY RECOGNITION, DIAGNOSIS, AND TREATMENT OF CHILDHOOD-ONSET BIPOLAR DISORDER

Jean Frazier, M.D., Cambridge Health Alliance, Center for Child and Adolescent Development, 1493 Cambridge Street, Cambridge, MA 02139

SUMMARY:

Early warning signs of a major psychiatric illness such as bipolar disorder (BD) include behavioral, emotional, and cognitive disturbances. Recognition of first-episode psychosis in children and adolescents is often delayed, as many of these symptoms resemble other psychiatric disorders. Of the 3.4 million U.S. children and adolescents suffering from depression, it has been suggested that up to third are in fact encountering the early onset of BD. However, due to ongoing development and frequently occuring psychiatric conditions with overlapping symptoms, it can be quite difficult to make an accurate diagnosis of BD in youth. Data from two large studies on childhood- and adolescent-onset BD show substantial rates of illness, significant delays in treatment initiation, and poor long-term outcomes. Additional data support this by reporting an average 16-year delay of first treatment of childhood-onset BD and note that patients with this disorder have increased comorbidities, psychotic episodes, and severity of mania and depression. Early recognition results in early initiation of treatment (pharmacotherapy and psychotherapy), which can lead to improved patient outcomes. Currently, there is promising evidence supporting use of atypical antipsychotics in the treatment of childhood-onset BD. Studies using clozapine, risperidone, olanzapine, and quetiapine have demonstrated significant clinical response in pediatric patients, but treatment is not without considerable adverse effects such as weight gain and somnolence. Newer atypical antipsychotics such as ziprasidone and aripiprazole have demonstrated efficacy and tolerability in adult BD patients, and studies are currently under-way to determine their efficacy and safety in children and adolescents. This presentation will review criteria for making an accurate diagnosis and discuss the applicability of atypical antipsychotics in treating childhood-onset BD with or without the concurrent use of conventional mood stabilizers.

No. 12D

ATYPICAL ANTIPSYCHOTICS IN THE TREATMENT OF YOUTHS WITH EARLY-ONSET SCHIZOPHRENIA

Robert L. Findling, M.D., Department of Psychiatry, University Hospitals Case Medical Center, 11100 Euclid Avenue, Cleveland, OH 44106

SUMMARY:

Schizophrenia affects approximately 1.1% of the adult U.S. population. Childhood and adolescent schizophrenia is less frequent, affecting only about 1 in 40,000 children under the age of 13. However, the rate of onset increases during early teen years and peaks between 15 and 30 years, with an earlier onset in males. Although early-onset (<18 years old) schizophrenia occurs less often than adult-onset schizophrenia, it can be more disabling and is associated with a worse prognosis. Evaluation by a clinician familiar with this patient population is recommended for early, accurate diagnosis and a safe and effective treatment plan. Differentiating between schizophrenia and other disorders such as affective, substance abuse, anxiety, pervasive developmental, and severe personality disorders is confounded by overlapping symptoms including motor restlessness, interpersonal difficulties, affective disturbances, cognitive dysfunction, and symptoms of psychosis. Successful long-term treatment of young patients requires continuous evaluation of symptoms and management of adverse effects such as sedation, metabolic effects including weight gain and hyperglycemia, and endocrine disturbances such as hyperprolactinemia. Atypical antipsychotics have been used with increasing frequency in children and adolescents and clinical evidence suggests that they may be effective treatments for schizophrenia in this age group. Emerging data from controlled studies using clozapine, risperidone, olanzapine, quetiapine, and aripiprazole demonstrate that these agents are promising and may reduce psychotic symptoms in patients with early-onset schizophrenia. Adverse effects observed with some of these pharmacotherapies need to be managed carefully over the long term with weight gain likely being the most troublesome for children and adolescents. A review of the available data on atypical antipsychotic use in early-onset schizophrenia and discussion of the risk-benefit profiles will be presented.

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ISS13-TANGLED UP IN BLUE: OPTIMIZING TREATMENT OF DEPRESSION IN THE PRESENCE OF COMORBIDITIES

SUPPORTER: ELI LILLY AND COMPANY

No. 13A

DEPRESSION, PHYSICAL SYMPTOMS AND PAIN: A ROADMAP FOR PSYCHIATRISTS

John F Greden, M.D., Molecular and Behavioral Neuroscience Institute, University of Michigan Medical Center, Rachel Upjohn Building, 4250 Plymouth Road, Ann Arbor, MI 48109-5763

SUMMARY:

Physical complaints are the norm for patients with depression. The high prevalence of co-occurrences—recently re-confirmed by STAR*D data—creates a huge dilemma for psychiatrists. What do psychiatrists need to know to effectively diagnose and treat? Starting points include early recognition that physical symptoms and pain obscure diagnosis and that the more physical symptoms that are present, the greater the likelihood of depression. Traditional rating scales may be of little aid. Patients with comorbidities achieve remission less frequently. Most patients with lingering symptoms report physical symptoms. Perhaps most importantly, for those with medical and psychiatric comorbidities only 1 in 7 achieves remission with traditional "first-line" monotherapy. For these reasons, the psychiatrist should modify expectations and treatment strategies before starting treatment. More specialized self-screening is warranted. For those with already-documented chronicity and treatment resistance, earlier use of combination treatments or augmenting strategies is warranted. Treatment persistence is mandatory, and optimism justified, since STAR*D data also illustrate that two-thirds of patients can achieve remission with persistence. Selective serotonergic reuptake inhibitors are probably not the optimal "first-line" treatment. The goal of this presentation is to encourage strategies to enhance remission earlier rather than adhering to the approach of pursuing a sequence of clinical changes over many months. Arguably, the time has come for psychiatrists to alter "first-line" treatment selections for patients with co-occurring physical symptoms, pain, and depression.

No. 13B

DEPRESSION: BEATING THE ODDS FOR REMISSION

John Greist, M.D., Healthcare Technology Systems, 7617 Mineral Point Road, Suite 300, Madison, WI 53717

SUMMARY:

Depression is a vitiating illness, afflicting human kind without respect for race, gender, or age. Once begun, depressions often abate, more or less, with the passage of time, only to recur. Beyond distressing symptoms and signs, depression disrupts functioning in important life roles. The highest goal of medicine is always restoration of function even at the cost of side effects as when the surgeon makes a rent in the patient to address the underlying pathology. Depression presents in myriad ways, though usually with recognizable effects on mood, social and occupational functioning, and both physical and emotional symptoms that guide diagnosis and initiation of treatment. We now have many treatments, though none is a panacea. Evidence of efficacy in cohorts of patients from randomized, controlled trials is the best starting point in treatment selection but no guarantee of benefit for individual patients. While symptomatic response is welcome, remission, no mean feat, is required for full restoration of function. What wins through is resolute pursuit and relief of all symptoms and signs. This presentation will review strategies and specific methods of treating symptoms to achieve remission. Anxiety, insomnia, cognitive and psychomotor slippage are proper focuses of treatment without which, enduring restoration of mood and functioning are seldom achieved.

No. 13B

DEPRESSION WITH CO-OCCURING PSYCHIATRIC DISORDERS: RECOGNITION AND MANAGEMENT

James W. Jefferson, M.D., Healthcare Technology Systems, Inc., 7617 Mineral Point Road, Suite 300, Madison, WI 53717

SUMMARY:

In the "real world," clinicians treating major depression disorder (MDD) are usually confronted by the specter of psychiatric comorbidity. They must use antidepressants whose efficacies were established in randomized clinical trials that understandably excluded comorbid contamination. Surveys such as the Epidemiologic Catchment Area (ECA) Study, National Comorbidity Survey (NCS) and its Replication (NCS-R), and the National Epidemiologic Survey on Alcoholism and Related Conditions (NESARC) have confirmed that MDD, more often than not, coexists with other psychiatric disorders. For example, the NCS-R found at least one *DSM-IV* comorbidity in 72% of those with a lifetime diagnosis of MDD (e.g., anxiety disorders 59%, impulse control disorders 30%, substance use disorders 24%). In the STAR*D study, most psychiatric comorbidities were not excluded to better approximate a "real world" setting. Sixty-five percent of patients had at least one such comorbidity and 12.9% had at least four. When faced with depressed patients, clinicians must cast a broad diagnostic net, because failing to incorporate comorbidities into a treatment program will greatly compromise outcome. This presentation will focus on developing effective diagnostic and comprehensive therapeutic strategies for managing depressed patients who carry the additional burden of

psychiatric comorbidity. Attention will be given to exploring shared neurobiological commonalities and their treatment implications.

No. 13C

AT THE CLINICAL CROSSROADS: APPROACHES TO NEGATIVE SYMPTOMS AND COGNITIVE IMPAIRMENT

Maria Muzik, M.D., Women's Perinatal Clinic, Depression Center and Trauma, Stress and Anxiety Research Group (TSARG) University of Michigan, Department of Psychiatry, 4250 Plymouth Rd, Ann Arbor, MI 48109-5765

SUMMARY:

Mood disorders are common in the peripartum, with approximately 10%-15% of women experiencing depression in pregnancy or during the first year postpartum. While in most cases the clinical picture of perinatal depression does not differ from a depressive episode unrelated to childbearing, some authors suggest a unique symptom profile altered by comorbidities, with predominantly anxious features, longer response delay to pharmacotherapy, and need for multipharmacy to achieve response to treatment. Clinical presentation and treatment of depression during the peripartum period also can be complicated by medical comorbidity, and several medical conditions have been related to onset or exacerbation of depression or anxiety in pregnancy or postpartum. Clinicians need to be alert to these comorbidities. Common examples include thyroid illness, gestational diabetes, hyperemesis gravidarum, preeclampsia, and other obstetrical pregnancy outcomes. For example, hypothyroidism in pregnancy has been associated with antenatal and postpartum depression; subclinical hypothyroidism may present with fatigue, constipation, impaired concentration and mood, which are all symptoms mimicking a depressive episode. Other examples for medical comorbidity include gestational diabetes triggering transient antenatal anxiety, and untreated antenatal depression linked to hyperemesis, and preeclampsia. Depressed mothers describe labor as more painful and commonly need more epidural analgesia. Overall, peripartum depression and medical comorbidity are strongly intertwined and bear significant relevance for clinical practice. This presentation will focus on effective diagnostic and therapeutic strategies for managing depressed women who carry additional burden of medical illness during the peripartum period.

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ISS14-MOOD DISTURBANCE IN YOUNGER AND MID-LIFE WOMEN: DEFINING TREATMENT STRATEGIES

SUPPORTER: FOREST LABORATORIES, INC.

No. 14A

BIPOLAR DISORDER IN REPRODUCTIVE AGE WOMEN

Adele Viguera, M.D., Massachusetts General Hospital, Simches Research Building , Floor 2, 185 Cambridge Street, Boston, MA 02114

SUMMARY:

Clinicians face many challenges when treating bipolar disorder in women of childbearing age, particularly those who become pregnant or who are planning to conceive. Pregnancy appears to have neither a "protective" nor "risk-enhancing" effect for women, as recurrence risks in pregnant and nonpregnant women are noted to be similar. Management of bipolar disorder during pregnancy is particularly difficult, as the mainstay of pharmacologic therapy consists of multiple compounds that are known teratogens and others where reproductive safety data are particularly sparse. Sustaining euthymia during pregnancy for bipolar women is particularly critical since relapse of illness during gestation dramatically increases risk for puerperal illness to which these patients are already vulnerable. This presentation will outline available data regarding the course of bipolar disorder during pregnancy as well as new reproductive safety data regarding many agents used to treat the illness, including anticonvulsants and atypical antipsychotics. A more complete understanding of the course of bipolar disorder during pregnancy and reproductive safety of medicines used to treat the illness allows for the most thoughtful collaborative treatment planning between patients and clinicians who prescribe for them.

No. 14B

DEPRESSION DURING THE TRANSITION TO MENOPAUSE: OLD AND NEW TREATMENT OPTIONS

Claudio N. Soares, M.D., 208 Queens Quay W, #2711, Toronto, M5J 2Y5 Canada

SUMMARY:

Recent studies suggest that menopausal transition may be a period of risk for the occurrence of depression (new onset or recurrent). Some have postulated that this increased risk is associated with menopause-related hormonal changes and their impact on central nervous system modulation; after all, depressive symptoms are quite often accompanied by other complaints associated with hormonal dysregulation such as vasomotor symptoms and sleep disturbances. Identifying and treating depression in menopausal women can be challenging, and clinicians must consider the potential impact of pharmacologic treatment agents on other menopause-related symptoms, as well as safety and tolerability profiles of hormonal and nonhormonal strategies. Menopausal hormone therapies (MHT) are effective in managing most menopause-related symptoms, and there is growing evidence that they may be effective in treating depression associated with menopause transition. Despite the fact that estrogens remain a treatment option for menopause-related symptoms, the use/acceptability of MHT has declined considerably in the post-WHI era. Thus, it is important for clinicians to understand the risks and benefits of using nonhormonal therapies for the management of menopausal symptoms, such as antidepressants. This presentation will review the characteristics of these agents, including efficacy/tolerability profile, and impact on other areas such as sleep problems, sexual dysfunction, and comorbid illnesses. Ultimately, treatment strategies should be individualized based on patient-related factors to improve long-term management in this patient population.

No. 14C

MANAGING DEPRESSION DURING THE MENOPAUSE TRANSITION: IS TREATMENT OF HOT FLASHES AND SLEEP DISTURBANCE IMPORTANT?

Hadine Joffe, M.D., Massachusetts General Hospital, Simches Research Building, 185 Cambridge St, Suite 2000, Boston, MA 02114

SUMMARY:

Menopausal symptoms peak during the late perimenopause and early postmenopausal years. Vasomotor symptoms (hot flashes and night sweats) are the primary menopausal symptom. Other symptoms strongly linked to the menopause transition include sleep disturbance and depression. The severity of menopausal symptoms varies markedly between women experiencing a natural or surgical menopause, although women with surgically-induced menopause typically experience more severe and disabling symptoms that significantly interfere with their functioning and quality of life. In some women, vasomotor symptoms can interfere with daily activities and disrupt their sleep. Vasomotor symptoms are also linked to depression in the menopausal transition in some, but not all, studies. Sleep disturbance has been posited as a mediator in the relationship between vasomotor symptoms and depression. However, the relationship between sleep disturbance and depression is complex. Sleep problems can be both a symptom of and a predictor of mood disturbance. The directionality of this relationship has not been worked out in the context of women experiencing depression and vasomotor symptoms during the menopause transition. Decisions about treatment of menopausal symptoms should target those symptoms that are most bothersome to each woman and balance the potential benefits of treatment against potential risks. Estrogen therapies are effective treatments of vasomotor symptoms and associated symptoms in women who do not have a contraindication to estrogen. Antidepressants are effective treatments of depression during the menopausal transition and some have beneficial effects on vasomotor symptoms; however, potential side effects may precipitate or exacerbate symptoms of sexual dysfunction and sleep disturbance. Optimal management of menopausal symptoms should include effective treatments that target each woman's primary symptoms in order to improve overall quality of life.

No. 14D

COURSE AND TREATMENT OF MAJOR DEPRESSION DURING PREGNANCY: WEIGHING THE RISKS

Lee S. Cohen, M.D., 15 Parkman Street, Boston, MA 02114

SUMMARY:

Historically, pregnancy was described as a "protective" state against psychiatric disorders, including major depression. However, there is substantial evidence that pregnancy may be a period of risk for those women who discontinue antidepressant therapy across pregnancy. Depression is estimated to affect 10%–15% of women during pregnancy, and if untreated, has been associated with adverse outcomes including obstetrical and neonatal complications. Risk of depressive relapse during pregnancy must be weighed against potential risks associated with antidepressant treatment during gestation. The last few years have brought a growing number of published reports regarding the safety of antidepressant use during pregnancy, including concerns regarding teratogenicity of these agents, acute neonatal effects, and potential long-term consequences of fetal exposure to these medicines. The relative risks of fetal exposure to medicines used to treat psychiatric illness during pregnancy need to be weighed against the morbidity of untreated maternal illness as physicians and patients collaborate to make treatment decisions about psychotropic drug use during pregnancy.

No. 14E

PMDD: HORMONAL AND NONHORMONAL TREATMENT STRATEGIES

Teri Pearlstein, M.D., Women and Infants Hospital, 101 Dudley Street, Providence, RI 02905-2499

SUMMARY:

The majority of women of childbearing age in the U.S. experience some uncomfortable symptoms related to the premenstrual phase of their cycle, and it is estimated that 5%–8% of these women have symptoms of sufficient severity to be classified as premenstrual dysphoric disorder (PMDD). PMDD is associated with symptoms

such as irritability, anxiety, lethargy, mood swings, sadness, and increased personal conflicts that cause significant functional impairment and impact quality of life. Development of PMDD may be related to multiple interactions, including susceptibility to hormonal changes such as serotonergic dysregulation triggered by cyclic hormonal changes. Pharmacologic treatment modalities include hormonal therapies to suppress ovulation and the selective serotonin reuptake inhibitors (SSRIs) that can be dosed continuously, intermittently during the premenstrual phase, or semi-intermittently with dosage changes throughout the cycle. The SSRIs are effective for managing PMDD symptoms, with benefits and limitations to the various dosing strategies of these agents, including tolerability and risk of side effects as well as treatment adherence. Hormonal therapies such as gonadotropin-releasing hormone agonists have limited utility due to significant long-term risks; however, recent evidence suggests that novel formulations of oral contraceptives containing ethinyl estradiol and drospirenone may be effective in treating PMDD. Other possible treatments include cognitive-behavior therapy, chasteberry, calcium, and anxiolytics. This presentation will review treatment strategies for PMDD, considering the severity and type of symptoms, presence of comorbid conditions, safety and tolerability profiles of agents, as well as agent formulation and need for continuous dosing vs. intermittent dosing.

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ISS15-USING A CHRONIC DISEASE MODEL WHEN MANAGING PATIENTS WITH SEVERE MENTAL ILLNESS

SUPPORTER: ELI LILLY AND COMPANY

No. 15A

MANAGING DEPRESSION IN WOMEN THROUGHOUT THE PHASES OF MENOPAUSE

Mary O'Malley, M.D., Norwalk Hospital Sleep Disorders Center, Norwalk, CT 06856

SUMMARY:

Major depressive disorder affects 21% of women at some point during their lifetime. Depression may be difficult to recognize in some women because its etiology and presentation can change in concert with changes in the hormonal milieu. For example, depressive symptoms occurring around the time of menopause are often associated with vasomotor symptoms that may complicate diagnosis and treatment. Relatively little data are available about the unique aspects of depression during the perimenopausal period, since, until recently, women often were excluded from clinical trials and few studies evaluated the impact of hormonal factors on symptom presentations or response to treatment. As a result, it is not surprising that there is significant inconsistency in how depression is managed in the menopausal woman. Given the health burden of depression in terms of quality of life, reduced productivity, and medical costs, there is an urgent need for psychiatrists to be able to recognize depression in this population and to understand how to weigh potential treatment options in light of other ongoing medical and psychosocial issues. In this symposium, faculty will provide guidance on advancing science, care, and practice for depression in women throughout the menopausal phase.

No. 15B

MAINTENANCE TREATMENT IN PATIENTS WITH SCHIZOPHRENIA

Robert R. Conley, M.D., Maple and Locust Streets, P.O. Box 21247, Baltimore, MD 21228

SUMMARY:

Significant advances have been made in the treatment of schizophrenia, but much remains to be learned. For example, although psychiatrists have become facile at managing the acute manifestations of schizophrenia, there is a need for advanced understanding of how best to manage patients over the long term. The treatment goals for long term care are multiple and complex and are usually not achieved with a single approach. Moreover, people with schizophrenia have significant medical morbidity that must be taken into account in long-term treatment planning. People with schizophrenia are at increased risk for cardiometabolic risks and reduced lifespan. Some antipsychotics and other psychoactive medications can exacerbate these risks.There is increasing interest in developing strategies for balancing efficacy and side effects over the long-term. A number of guidelines for achieving this balance have been put forth. However, psychiatrists still need additional education on how to optimize long-term treatment for their patients and how best to manage the various challenges associated with chronic treatment such as proper treatment selection, dosing, delivery of medication, adherence, and the importance of therapeutic alliance. In this symposium, faculty will advance psychiatrists' understanding of long-term patient management by reviewing state-of-the-art science and discussing its translation into optimized patient care.

No. 15C

THE NEED FOR CHRONIC DISEASE MANAGEMENT IN BIPOLAR DISORDER

Roger McIntyre, M.D., University Health Network, 399 Bathurst St, MP 9-325, Toronto, Ontario M5T 2S8, Canada

SUMMARY:

Bipolar disorder is associated with frequent and potentially severe recurrences that necessitate lifetime treatment in a majority of cases. Over time, patients experience increasing functional disability and up to 15% of patients are severely impaired. Although treatment during an initial acute episode emphasizes symptom control, treatment during the maintenance phase encompasses relapse prevention and mood stabilization. Chronic management is crucial in patients with bipolar disorder; simply responding to each acute crisis is not sufficient. Rather, long-term treatment must take into account not only medical but also psychosocial functioning. Importantly, chronic management of patients with bipolar disorder must take into consideration the known and potential long-term effects of pharmacotherapy and balance these against the need for symptom remission. In this symposium, faculty will review treatment considerations in patients in the maintenance phase of bipolar disorder and will guide psychiatrists in developing appropriate treatment plans. Discussions will focus on the role of anticonvulsants and atypical antipsychotics in the long-term management of bipolar disorder. Psychiatrists will learn to advance science, care, and practice by considering strategies for optimizing efficacy while mitigating side effects.

No. 15D

WHEN SUBSTANCE ABUSE IMPACTS MANAGEMENT IN PATIENTS WITH SCHIZOPHRENIA

Marcia Verduin, M.D., PO Box 250861, Charleston, SC 29425

SUMMARY:

Half of all individuals with schizophrenia have a lifetime prevalence of substance use disorders (SUDs), more than three times the rate of SUDs in the general population. Substance use in schizophrenia poses a treatment challenge for psychiatrists; it is associated with poorer outcome related to low treatment adherence, worse symptom severity, higher propensity for relapse, and more psychosocial difficulties. Despite the well known co-occurrence of SUDs and schizophrenia, dually diagnosed individuals are commonly excluded from clinical trials. Thus, there are relatively few guidelines on how to manage individuals with both schizophrenia and SUDs, and those that do exist are preliminary. Although it has been established that comprehensive treatment strategies that include both psychosocial and medical interventions are required, there is a paucity of data to guide psychiatrists in optimizing treatment. Current data, however, suggest that at least some atypical antipsychotic medications may positively impact SUDs. Faculty in this symposium will review clinical issues in the assessment, diagnosis, and management of individuals with schizophrenia and co-occurring SUDs and will review available data on pharmacotherapeutic interventions, emphasizing a chronic disease management model.

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MONDAY, MAY 5, 6:30 AM- 8:30AM

ISS16-ARE COGNITION, SLEEP AND WAKE DISORDERS CAUSED BY TOO MUCH AROUSAL, TOO LITTLE AROUSAL OR BOTH?

SUPPORTER: TAKEDA PHARMACEUTICALS

No. 16A

WHERE DO INCREASED AROUSAL AND INSOMNIA FALL ALONG THE AROUSAL SPECTRUM?

Daniel J. Buysse, M.D., University of Pittsburgh School of Medicine, Psychiatry, 3811 Ohara St, Room E-1127, Pittsburgh, PA 15213-2593

SUMMARY:

Whether a patient suffers from psychophysiological insomnia involving hyperarousal and conditioned sleep aversion, insomnia due to restless leg syndrome or circadian anomalies, or conditions causing daytime hypoarousal, the end result can be similar: the patient's daytime alertness is compromised. Normally, the circadian rhythm and homeostatic drive, as well as a proper interaction between both, control our sleep/wake cycles and the way we feel. It is therefore not surprising that both are affected when we suffer from insomnia or sleep deprivation. Disturbed sleep/wake patterns can have tremendous negative consequences on people with respect to their efficiency at work, as well as their relationship with family and friends. Environmentally-induced sleep deprivation (e.g., shift-work) as well as disrupted sleep/wake resulting from medical and psychiatric conditions, or the treatment thereof, can lead to executive dysfunction with potentially devastating societal repercussions, such as the Exxon Valdez disaster or the Chernobyl accident. Likewise, that chronic insomnia or "psychiatric insomnia" as seen in bipolar disorder, generalized anxiety disorder, and major depressive disorder, needs to be addressed and treated. "Mild insomnia/arousal", on the other hand, might not be as obvious and could even be controversial to treat; however, it can also lead to cognitive dysfunction. It is important to differentiate between different sleep/wake disorders as they can have important implications on the etiology of psychiatric disorders. Case studies will be used to represent the clinical presentations of insomnia and sleep deprivation and their impact on the outcome of psychiatric disorders.

No. 16B

HOW DO WE BEST TREAT TOO MUCH OR TOO LITTLE AROUSAL?

Leslie P. Lundt, M.D., Foothills Foundation, 223 W State St., Boise, ID 83702-6013

SUMMARY:

Whether the need is to increase the quality or quantity of sleep or to reduce the daytime sleepiness, there are different potential pharmacotherapies available. For excessive daytime sleepiness associated with hypoarousal, caffeine, modafinil, stimulants, and sodium oxybate are some treatment options to achieve normal arousal and help sustain attention. Melatonin and bright-light therapy can be useful treatments in shift workers or patients suffering from circadian-rhythm disorders, and hypnotics are useful to alleviate insomnia. New studies have shown that hyperarousal can result from a hyperactive corticotrophin releasing factor (CRF) similar to that seen in major depression. Thus, the use of antiglucocorticoid agents may become interesting in the treatment of insomnia as well. Choosing the right treatment depends on the disorder/state at stake, but also on the knowledge of the prescribing physician. Current drugs, their mechanism of action and side-effect profile, along with behavioral therapies, will be discussed in terms of different sleep/wake disorders and target populations. Exemplifying which treatment approaches are best for which presentations will be done through the use of case studies. The goal of this presentation is to offer an overview of the current and new treatment approaches with the ultimate endpoint of treating sleepiness and restoring normal functioning during wake time.

No. 16C

WHAT IS SLEEPINESS VERSUS INATTENTIVENESS? CAN THE AROUSAL SPECTRUM ANSWER THIS QUESTION?

Meeta Singh, M.D., Henry Ford Hospital, Sleep Disorders Center, 2799 West Grand Blvd, Detriot, MI 48202

SUMMARY:

Non-restorative sleep, resulting from a medical condition or a life-style situation, will eventually lead to excessive daytime sleepiness. While a good night's sleep can be the cure for a student's all-nighter, it does not work in patients with sleep disorders, and the accumulated sleep debt experienced by these patients will result in compromised daytime alertness. A high percentage of children with attention-deficit/hyperactivity disorder also have obstructive sleep apnea (OSA), and it has been suggested that the psychiatric condition of these children could have been the result of their underlying sleep disturbances as OSA can lead to deficits in memory, learning, and executive function. These examples support the notion that whether the sleepiness is primary or secondary might not be as important as the need to recognize and treat it. However, what if the patient doesn't even know he's sleepy? The same pathways involved in the regulation of sleep are also active in information processing, thus a "mildly sleepy" person might not actually realize that they have cognitive dysfunction as well. While sleepiness can be measured using by the Epworth Sleepiness Scale or the Multiple Sleep Latency Test, executive function is measured using the Stroop Task and the Normal N-back Working Memory Task. Unfortunately, some patients who complain of inattention or mental fatigue might actually not show a difference in any objective tasks, thus appearing "normal." However, in these patients imaging studies will uncover large difference in the dorsolateral prefrontal cortex, an area involved in the regulation of both sleep and executive function. Thus, in some patients, compensatory mechanisms can mask the real issue at hand. But what happens when compensation is insufficient? This talk will cover the spectrum of sleep disorders ranging from narcolepsy, to OSA, to environmentally-induced sleep disturbances and explain how these can lead to cognitive impairments during the day.

No. 16D

INSIGHTS INTO THE NEUROBIOLOGY OF THE AROUSAL SPECTRUM: THE NEUROCIRCUITRY SPANNING STATES FROM "HYPERSOMNIA" TO "HYPERAROUSAL"

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

SUMMARY:

Disorders such as insomnia, narcolepsy, obstructive sleep apnea, and circadian rhythm disorders, normally termed sleep disorders, also impact functioning during the wake time. This symposium will look at the link between sleep/wake disorders and cognitive disorders by introducing the "arousal spectrum."The two extreme states of the spectrum, hyperarousal/insomnia and hypersomnia, are well accepted disorders with efficacious treatments. Ailments along the trajectory connecting both extremes are more intriguing and their treatment can be controversial. For example, can mild sleepiness and mild arousal lead to cognitive dysfunction? And if so, should these states be treated? Increased sleep debt, whether it results from obstructive sleep apnea or shift working, may eventually lead to executive dysfunction. At the same time, the *DSM-IV* criteria of major psychiatric conditions such as major depressive disorder (MDD) and generalized anxiety disorder include "difficulty concentrating or diminished ability to think", i.e. cognitive dysfunction, as one of its diagnostic criteria. Patients with MDD frequently suffer from insomnia and many insomniacs exhibit mild depressive symptoms. Treating the insomnia of a depressed patient not only restores his sleep, but also leadsto better outcome in terms of remission and relapse with regards to the depression. Thus, the question remains, is there a relationship between sleep/wake disorders and cognitive disorders? Is mild hyperarousal already a problem and worth being treated? As sleep circuits overlap with many neurobiological circuits underlying psychiatric disorders, these distinctions become important to delineate. While treatment of sleep/wake disorders is the first step in patient management, a full remission leading to normal arousal and normal executive function should ultimately be attained.

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ISS17-UNDERSTANDING BIPOLAR DISORDER: QUALITY AND CLINICAL CONUNDRUMS

SUPPORTER: PFIZER INC.

No. 17A

COMMUNITY TREATMENT OF BIPOLAR DEPRESSION: SERVICE UTILIZATION AND QUALITY

Alisa Busch, M.D., Harvard Medical School, 180 Longwood Avenue, Boston, MA 02115

SUMMARY:

Prior research has described bipolar disorder quality in usual care. However, there is little information regarding the course and quality of bipolar-depression treatment in usual care settings. We conducted a retrospective analysis of administrative data from a privately insured population diagnosed with bipolar-I depression starting in 1999 (N = 925 persons). Treatment quality was evaluated by using expert guidelines to derive quality measures. Among the 925 persons, there were 1,059 depressed phases identified during the study period and 74% of the phases included antidepressant treatment. Persons with bipolar depression tended to stay in treatment for most of the year (289 mean cumulative days in treatment, sd 92 days). Fifty-seven percent of bipolar-depressed patients received guideline recommended care of an antimanic agent and psychotherapy during acute phase depression treatment. An additional 15% received an antimanic agent in absence of psychotherapy. Nineteen percent received an antidepressant in absence of an antimanic agent (a treatment advised against by expert guidelines). While many patients with bipolar depression remained in treatment much of the year, only slightly more than half received guideline recommended treatment and 20% received treatment explicitly advised against by guidelines.

No. 17B

A HISTORICAL OVERVIEW OF BIPOLAR DISORDER

Ileana Fumero-Perez, M.D., PO Box 19234 , Fernandez Juncos Station, San Juan, PR 00910

SUMMARY:

This presentation reviews bipolar disorder from both a historical and a genetic perspective. The ancient Greek physicians had recognized a relationship between the mental states of depression and mania. Evidence, found in works by Aretaeus of Cappadocia from the first century BC, describes melancholia and mania as two forms of the same disease. In the fourth century, Hippocrates believed that all illness resulted from a biological malfunction. It wasn't until late in the nineteenth century, that a more modern understanding of bipolar disorder was described in France. In the beginning of the twentieth century, Emil Kraepelin introduced the term manic-depressive insanity. This is why many consider him the father of the modern conceptualization of bipolar disorder. Results of more recent follow-up studies have been very compatible with those of studies conducted before the introduction of modern antidepressant and mood-stabilizing treatments. Many of these studies are done in families, twins, and adopted subjects, and provide robust evidence that genetics are a major contributor to the disease. This has had a great impact on our understanding of the disease's pathophysiology and the interaction between genetic and environmental factors involved in its pathogenesis. Other changes during the process of cell differentiation have also been implicated. Epigenetics is the study of modifications in the expression of genes without a change in the underlying DNA sequence. Such changes in gene expression are achieved through the methylation, and other chemical groups that bind to DNA and its associated proteins. Epigenetics has been implicated in complex diseases such as cancer, schizophrenia, bipolar disorder, autism, and systemic lupus erythematosus. Furthermore, epigenetic studies could be relevant to the better understanding of the molecular action of antipsychotic medications. This will very likely result in major improvements to treatment and patient care.

No. 17C

EVIDENCE-BASED TREATMENT OPTIONS FOR BIPOLAR DEPRESSION

Mark Frye, M.D., Mayo Clinic, Rochester, MN 55905

SUMMARY:

Despite the severity of mania, it is clear that when bipolar patients are affectively ill, they are far more likely to be depressed than manic. This is notable both from the standpoint that most of our conventional mood stabilizers, with the exception of lamotrigine, are more effective at treating the manic phase of illness and that many bipolar patients invariably are prescribed conventional antidepressants. As noted in a recent CNN report, antidepressants are the most commonly prescribed medicines in the United States, yet only recently have we systematically evaluated the use of antidepressants in bipolar depression. This talk will review controlled clinical trials, both acute and long-term, in the depressive phase of illness and review how many clinicians in the community approach treatment algorithms for their depressed bipolar patients. In contrast to unipolar depression treatment, an antidepressant response in bipolar depression cannot be at the expense of becoming manic. The ultimate goal will be to allow the best evidence-based medicine guide, not dictate, our practice to maximize outcome in the depressive phase of bipolar disorder.

No. 17D

REDUCING DIAGNOSTIC ERROR: RECOGNITION OF BIPOLAR DEPRESSION PHENOMENOLOGY

Gary Sachs, M.D., Massachusetts General Hospital, 50 Staniford Street, 5th Floor, Boston, MA 02114

SUMMARY:

The diagnosis of patients with bipolar depression remains a challenging issue. Misdiagnosis often results from over-reliance on narrowly focused cross-sectional assessment of patients with current major depression or over-reliance on single symptoms associated with mania. The Affective Disorder Evaluation (ADE) is a modular template designed for routine use in clinical practice, and was used to collect diagnostic information in the Systematic Treatment Enhancement Program for Bipolar Disorder. The ADE includes a bipolarity index that is designed to increase diagnostic confidence by scoring five dimensions of illness: episode characteristics, age of onset, course of illness, Response to treatment, and family history. This presentation will review diagnostic problems encountered in the assessment of bipolar depression and the use of the ADE with bipolarity index. Data from factor analysis and other psychometric studies suggest patients with high bipolarity scores have a better prognosis than subjects with lower scores. Improvements in diagnostic confidence combined with systematic treatment strategies should enhance the management of patients with bipolar depression.

No. 17D

PATHOPHYSIOLOGY OF BIPOLAR DEPRESSION

Terence A. Ketter, M.D., 401 Quarry Rd, Rm 2124, Stanford, CA 94305-5723

SUMMARY:

Bipolar depression has substantial clinical heterogeneity, and thus, presumably, varying pathophysiology. Indeed, no single pathophysiologic theory appears to account for all patients. Nevertheless, a stress-diathesis model appears appropriate, with genetic and/or acquired vulnerabilities interacting with provocative and/or protective environmental factors to yield illness or health. Genetic vulnerability appears related to small effects of multiple genes rather than large effects of a single gene. Potential neurochemical contributors include dysregulation of neurotransmitters (e.g., monoamines and amino acids), hormones (e.g., thyroid, reproductive, and glucocorticoids), and intracellular signaling pathways (e.g., protein kinase C and glycogen synthase kinase-3), and may suggest novel treatment mechanisms (e.g., protein kinase C inhibition). Neuroimaging studies have implicated decreased prefrontal and anterior paralimbic activity. Increased anterior paralimbic subcortical activity has also been seen, consistent with a limbic-cortical dysregulation model of depression, wherein dorsal neocortical hypofunction could occur due to attempts to counteract ventral paralimbic overactivity. Such research may ultimately facilitate targeting novel somatic interventions (e.g., deep brain stimulation). Ongoing studies are needed to realize the clinical potential of our knowledge of pathophysiology to enhance diagnostic accuracy and help better target interventions in patients with bipolar depression.

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ISS18-GENETICS, BRAIN IMAGING, AND PHARMACOLOGY: CLINICAL IMPLICATIONS FOR THERAPEUTIC CHOICES IN PSYCHIATRIC DISORDERS

SUPPORTER: ORGANON, A PART OF SHERING-PLOUGH.

No. 18A

RECEPTOR PHARMACOLOGY, MOLECULAR IMAGING, AND CLINICAL IMPLICATIONS IN SCHIZOPHRENIA

Anissa Abi-Dargham, M.D., New York Presbyterian Hospital, 160 Fort Washington Avenue, New York, NY 10032

SUMMARY:

Current scientific understanding of the neurobiology of schizophrenia from imaging and genetic studies has uncovered molecular targets, which are being used to treat schizophrenia at present and may provide direction for future treatments. This presentation will review those targets and their interrelatedness, discussing the circuitry and systems alterations, how they are interconnected, and how they lead to symptoms. Antipsychotic drugs are the cornerstone of treatment for schizophrenia. First-generation or conventional antipsychotics are high-affinity D2 receptor antagonists that are highly efficacious in reducing positive symptoms, but their use is limited due to adverse neurologic side effects (i.e., extrapyramidal signs, tardive dyskinesia). The next generation or atypical antipsychotics exhibit lower affinity for D2 receptors and greater affinities for serotonin and norepinephrine receptors. These agents are more efficacious in reducing negative symptoms but also have limitations due to metabolic adverse effects (i.e., weight gain, hyperglycemia). Partial agonists with activity at D2 and 5-HT(1A) receptors are also included in this class, but have a better adverse effect profile. Data on the receptor profiles of antipsychotic medications and the relationship to efficacy and side effects will be presented, utilizing evidence from imaging studies on occupancy of D2 and D3 receptors using positron emission tomography (PET) and the high-affinity D2/3 radiotracer [18F]fallypride. This information will provide clinicians with a better understanding of drug receptor pharmacology, allowing them to better predict efficacy and adverse effects for a patient with schizophrenia in order to improve patient adherence and long-term outcomes. In addition, a brief review of the rationale and progress made in the development of treatments for potential novel targets within various neurotransmitter systems, including GABA, glutamate, cannabinoid, and nicotinic systems will be discussed.

No. 18B

CLINICAL IMPLICATIONS OF RECENT GENETICS AND NEUROIMAGING ADVANCES IN BIPOLAR DISORDER

Kiki Chang, Pediatric Bipolar Disorders Program, Division of

Child and Adolescent Psychiatry, Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Palo Alto, CA 94305

SUMMARY:

Bipolar disorder (BD) is a difficult-to-treat disease carrying great morbidity and mortality that typically begins before the age of 18. Early recognition of BD can lead to early initiation of treatment, which may lead to improved quality of life and better outcomes. As early symptoms of BD are relatively nonspecific (e.g., depression, hyperactivity), biological markers of BD, including genetic profiles or neuroimaging findings, would aid in confirming early states of BD. It is estimated that BD has an 80% heritability, as determined by family, twin, and adoption studies. Recent twin studies show that several regions of the genome may play a role in both BD and schizophrenia. Other genes in these regions may contribute solely to the development of bipolar disorder. Certain genetic polymorphisms, of genes such as 5-HTT and BDNF, appear to confer increased risk for BD by their interaction with relevant brain structures. Brain imaging could become an important predictive and diagnostic tool for BD, as specific neurobiological abnormalities have been discovered in both adult and pediatric patients with the disorder. Prefrontal cortical areas may demonstrate abnormalities as bipolar disease progresses through adulthood. Subcortical limbic abnormalities, in areas such as hippocampus and amygdala, may begin earlier in the disorder and serve to be more predictive of disease development. Recent research has also highlighted the effects of treatment on brain function and using genes to predict treatment outcomes. This presentation summarizes the recent advances in the understanding of how genes and neurobiology interact in creating BD and the implications these findings have for diagnosis and treatment of BD across the life span.

No. 18C

SCHIZOPHRENIA: THE CLINICAL IMPORTANCE OF GENETICS AND STRUCTURAL BRAIN IMAGING

Rene S. Kahn, M.D., Department of Psychiatry, Rudolf Magnus Institute for Neuroscience, University Medical Centre, Heidelberglaan 100, Utrecht, 3584 CX

SUMMARY:

Structural brain abnormalities have consistently been found in schizophrenia, and increased familial risk for schizophrenia has been investigated as a contributing factor to these abnormalities. Some brain volume changes are progressive over the course of the illness. Whether these progressive brain volume changes are mediated by genetic or disease-related factors is unknown. Magnetic resonance imaging (MRI) studies of monozygotic twins who have schizophrenia have shown reduced thalamic volumes, when compared with control twins. These abnormalities may be the result of genetic or early environmental factors. Brain abnormalities, most noticeable in the hippocampus, have also been seen in non-psychotic, first-degree relatives of schizophrenia patients. This finding suggests a shared genetic risk. Significant decreases over time in whole brain volume have been observed in schizophrenia patients and their unaffected co-twins as compared with control twins, predominantly due to decreases in cerebral gray matter. Cross-trait/cross twin interactions for whole brain volume change over time have revealed a significant genetic influence. The progressive brain volume loss in patients with schizophrenia is also found in their unaffected co-twins. These findings suggest that the progressive brain volume loss observed in schizophrenia is linked to the genes causing the disorder. Information provided by neuroimaging and genetic studies will help clinicians achieve a greater understanding of the pathophysiology of schizophrenia. This presentation will provide a review of genetic associations, current neuroimaging techniques, and their significance for the practicing psychiatrist.

No. 18D

EFFECTIVE TREATMENT OF BIPOLAR DISORDER: AN ELUSIVE GOAL?

Terence A. Ketter, M.D., Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Stanford, CA 94305

SUMMARY:

Optimal management of bipolar disorder requires considerable skill. Mood stabilizers (with the exception of lamotrigine) and antipsychotics are effective in acute mania; however, bipolar depression is more difficult to treat, and long-term prevention episodes may be even more challenging. Use of traditional antipsychotics has been limited by risks of tardive dyskinesia and exacerbating depression. In contrast, use of atypical antipsychotics (olanzapine, risperidone, quetiapine, ziprasidone, aripiprazole) is increasing, as these agents are less likely to yield tardive dyskinesia, and appear to have a broader therapeutic spectrum. For example, the approved treatments for acute bipolar depression (quetiapine monotherapy, and olanzapine plus fluoxetine combination therapy) include atypical components. An enhanced balance between effects on dopaminergic and serotonergic neurotransmission may account for the improved clinical utility of atypical compared to traditional antipsychotics. Lithium, lamotrigine, olanzapine, and aripiprazole are effective maintenance monotherapies in controlled studies. However, in clinical settings, monotherapy is inadequate for most patients. Efficacy and safety profiles of these long-term treatments must be carefully considered, as some drugs are associated with undesirable side effects such as sedation, weight gain, and metabolic abnormalities. Integrating knowledge of strengths and limitations of treatments and optimally matching these to individual patients is crucial to enhance outcomes.

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ISS19-IS RECOVERY ATTAINABLE

IN SCHIZOPHRENIA? BIOLOGIC, PHARMACOLOGIC AND PSYCHOLOGIC PERSPECTIVES

SUPPORTER: ASTRAZENCA PHARMACEUTICALS

No. 19A

USING RECOVERY PRINCIPLES TO DEFINE TREATMENT GOALS

Alex Kopelowicz, M.D., Associate Professor, Psychiatry and Biobehavioral Sciences , University of California, Los Angeles Neuropsychiatric Institute, 300 Building Medical Plaza, Los Angeles, CA 90095

SUMMARY:

Remission and recovery from schizophrenia were considered theoretically possible, but unrealistic in real-world clinical practice situations. This presentation reviews the changing concepts of remission and recovery in the treatment of schizophrenia. Until recently, the concept of remission had been best developed for affective disorders but more recently have been modified for patients with schizophrenia. This presentation will discuss the criteria for remission, rates of remission in first-episode and persistently ill patient populations, and then how this differs from the recovery concept. Ideas about recovery from schizophrenia have evolved both from concepts derived from the consumer movement and from a psychiatric rehabilitation approach to mental illness. From the former perspective, recovery describes a process in which people regain hope, trust, respect, dignity, and self-efficacy as they strive to make meaning of their lives and determine their life trajectories. From the latter, recovery is a measurable outcome that includes the attainment of symptom remission and restoration of premorbid functioning. Either way, recovery from schizophrenia is very different from ideas of remission or of cure that come from a medical conception of illness. This presentation will discuss the evolving concept of recovery in schizophrenia, critical components for recovery, and the role of treatment models within the framework of recovery as they apply to first-episode schizophrenia as well as patients with persistent illness.

No. 19B

PSYCHOPHARMACOLOGY OF RECOVERY: REDUCING BURDEN OF TREATMENT

John Lauriello, M.D., Department of Psychiatry, University of New Mexico, 2400 Tucker North East, Albuquerque, NM 87131

SUMMARY:

Although pharmacologic treatment of schizophrenia is an essential part of a recovery-oriented treatment plan, patients often have to bear a significant burden from persistent side effects of treatment. The burden of adverse effects of treatment has to be added to the burden from persistent symptoms despite treatment. Fortunately, many of the available antipsychotic agents have markedly different adverse-event profiles, including liability for extrapyramidal symptoms, weight gain, dyslipidemia, sexual dysfunction, sedation, and sleep disturbances. Careful matching of antipsychotic with the medical and psychologic vulnerabilities of the individual patient can greatly reduce the overall burden of treatment. The first-line atypical antipsychotic medications show relatively similar efficacy but can differ greatly in side-effect profiles. Establishing effect and managing side effects are critical to creating a stable platform for a long term recovery. The medication side-effect burden has been shown to be a major contributor to subjective distress and is a critical factor in medication adherence and alliance. In this presentation, we will review the relative side-effect burdens of the newer antipsychotics. We will expand our review of burden to include the benefits and risks of treatment interventions for persistent side effects, including dose changes, complexity of adding adjunctive medications to counteract side effects, risks of "watchful waiting," and the risk of changing antipsychotic medications. Just as it is important to individualize the choice of antipsychotic with the anticipated vulnerability of the individual, the approach to intervention for persistent side effects also needs to consider the range of options, the likelihood of a favorable response, and the risks involved. We will present measures that can be utilized by the working clinician to identify and treat this burden.

No. 19C

WHAT DOES THE NEUROBIOLOGY OF FIRST-EPISODE PSYCHOSIS TELL US ABOUT TREATMENT GOALS FOR RECOVERY?

John A. Sweeney, Ph.D., Neurology and Psychology, Center for Cognitive Medicine University of Illinois at Chicago, Department of Psychiatry Center for Cognitive Medicine (MC913) 912 S. Wood St. Ste. 235, Chicago, IL 60612

SUMMARY:

The Kraeplinian perspective on schizophrenia is that it is a progressive brain disorder. Kraeplin's nomenclature equated schizophrenia with "dementia praecox" (literally "early dementia"), as an irreversible and progressive disorder. The clinical implication of the Kraeplin model is that diagnosis of schizophrenia seriously limits the potential of any treatment intervention to lead to continuous and sustained improvements. Clinical studies of the longitudinal neuroanatomic and neurocognitive course of patients presenting with first-episode psychosis suggest this model may be incorrect. Neuropsychological and neuroimaging studies fail to find robust evidence of decline in brain anatomy or functioning in the follow-up of first-episode cases. These findings raise hope for the ability of interventions to enhance functionality, and are consistent with improvements reported with some long-term psychosocial and pharmacologic treatments of schizophrenia. Recent evidence favors instead a neurodevelopmental basis for schizophrenia, in which early noxious events involving genetic or environmental factors contribute to illness onset. These findings suggest that most of the significant changes to brain and cognition happen before the first psychotic episode, and hence, before clinical presentation. Longitudinal studies of first-episode patients suggest that if illness progression occurs, it is typically less severe than has occurred prior to illness onset. Viewing schizophrenia in early adulthood as a static disease process provides support for the use of recovery-oriented interventions, and that psychosocial or pharmacologic therapy may be able to facilitate a recovery of function. This also suggests recovery approaches being developed for schizophrenia may be useful to address challenges facing patients recently diagnosed with other psychiatric disorders.

No. 19D
PSYCHOPHARMACOLOGY OF RECOVERY: REDUCING THE BURDEN OF DISEASE

Peter J. Weiden, M.D., Psychosis Program, Center for Cognitive Medicine, Department of Psychiatry, University of Illinois at Chicago 912 South Wood Street MC 913, Chicago, IL 60612

SUMMARY:
Mental health systems throughout the United States are attempting to implement recovery-oriented models of care for serious mental illness. While intuitively appealing, a central challenge to implementation in clinical practice has been the absence of a theoretical psychopharmacologic approach to achieving the kinds of outcomes that are consistent with a recovery treatment focus. Many fundamental principles of psychopharmacology of schizophrenia were established in the 1970s and 1980s. At that time, schizophrenia was believed to be a deteriorating illness, and relapse prevention was the primary focus of long-term antipsychotic treatment. In contrast, a recovery approach for long-term antipsychotic treatment is relatively more focused on continued improvements in functional outcomes once stability has been achieved. However, an across-the-board change in treatment philosophy, no matter how appealing, has its own pitfalls, including excessive expectations of outcome, or excessive use of medication additions and changes, without regard to the limitations or risks from these interventions. This presentation will suggest a framework in which a recovery-oriented psychopharmacologic treatment approach can be used in clinical practice. This approach integrates current evidence-based knowledge of pharmacologic outcomes with an individualized treatment plan approach that can be used to make medication choices and decisions in a collaborative way. This approach includes shared risk taking as well as selecting (and matching) of key target symptoms with possible treatment choices. An essential component of this approach is use of continued hierarchical priorities and shared decision making over the challenging and often arduous journey of recovery.

No. 19E
FROM "SUPPORTIVE" TO SYMPTOM REDUCTION: USING COGNITIVE-BEHAVIORAL THERAPY IN SCHIZOPHRENIA

Shanaya Rathod, M.D., Associate Medical Director and Consultant Psychiatrist, Mid Hampshire and Eastleigh TVS Locality Melbury Lodge, Romsey Road, Winchester, SO22 5DG United Kingdom

SUMMARY:
Many patients with schizophrenia will continue to have persistent symptoms despite receiving optimal antipsychotic therapy. Until recently, supportive psychotherapeutic interventions were seen as helpful with patient acceptance and morale, but would not be expected to help in reducing the overall level of symptoms of schizophrenia. The notion that psychotherapeutic interventions could not possibly lead to longstanding symptom improvements has been challenged. There is a growing literature showing that schizophrenia patients receiving cognitive-behavioral therapy (CBT) along with antipsychotic medication will experience a greater reduction in positive, negative, and affective symptoms than patients receiving other therapies or treatment as usual. This body of evidence challenges the notion that symptoms of schizophrenia are immutable and not amenable to change from therapeutic interactions. This presentation will review the evidence for and highlight the role of CBT as a management strategy in the recovery model of schizophrenia.

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ISS20-NOVEL AND CURRENT ANTIDEPRESSANTS: STATE-OF-THE-ART MANAGEMENT OF DEPRESSION

SUPPORTER: NOVARTIS PHARMACEUTICALS CORPORATION

No. 20A
APPROACHES TO IMPROVE OUTCOMES

Andrew A. Nierenberg, M.D., 15 Parkman Street WACC 815, Boston, MA 02114-3117

SUMMARY:
In contrast to patients with major depressive disorder (MDD) observed in tightly controlled, randomized clinical trials, patients with MDD seen in actual clinical settings have less favorable acute and long-term outcomes. Only about a third reach remission and about half of remitters (those who reach a symptom level within the normal range) experience a relapse or recurrence within 1 year. Remitters have a better long-term outcome than responders without remission (e.g., those who have a 50% improvement in baseline symptoms). With a long-term goal of sustaining wellness, clinicians are faced with the daunting task of preventing relapse and protecting from recurrence of MDD episodes. Evidence strongly supports the use of long-term antidepressant treatment, targeted psychotherapies (cognitive-behavioral therapy (CBT), interpersonal therapy (IPT), well-being therapy, and mindfulness-based CBT), or the combination of antidepressants and psychotherapy. Practical tools are available to track changes in depressive symptoms, enhance shared decision making, and provide warning signs for impending mood exacerbation can enhance clinicians' decision

making and encourage measurement-based care (e.g., PHQ-9; QIDS-SR). Psychoeducational websites can also be prescribed to more fully engage patients with MDD and their families (e.g., NIMH, moodandanxiety.org, dbsalliance.org, NAMI). The purpose of this presentation is to review specific data to improve acute and long-term outcomes and provide participants with tools to help their patients sustain remission.

No. 20B

DISEASE BURDEN, UNDERDIAGNOSIS, AND UNDERTREATMENT OF DEPRESSION

Jordan F. Karp, M.D., Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213

SUMMARY:

Major depression is the most common psychiatric disorder; the lifetime prevalence is 17.3%. With the exception of hypertension, depression is more common in primary care than any other condition. Worldwide, major depression affects approximately 121 million individuals. The World Health Organization reported that disability levels and quality of life in primary care patients with chronic conditions like hypertension, diabetes, arthritis, and back pain is greater when depression is comorbid. By the year 2020, depression is projected to reach second in the ranking of disability-adjusted life years for all ages, both sexes. Despite its high prevalence, approximately 50% of psychiatric morbidity is unrecognized in primary care; many of these undiagnosed individuals develop suicidal ideation. Poor detection and under-treatment of depression leads to higher health-care utilization and spending. Much of the cost of depression is not because of treatment costs, but results from absenteeism and reduced productivity at work. Interventions to improve the quality of depression treatment have found that the cost per QALY associated with improved depression care ranges from a low of $2,519 to a high of $49,500. Patients with chronic medical illness (e.g., diabetes, pulmonary and heart disease, arthritis, HIV/AIDS, neurological conditions) and comorbid depression or anxiety, compared with those with chronic medical illnesses alone, report significantly higher numbers of medical symptoms and decreased quality of life even after controlling for severity of the medical disorder. Of particular concern is that when major depressive disorder affects African Americans, fewer than half receive treatment and the condition is often more severe and disabling than in non-Hispanic whites. Progress has been made in access to care, but quality of care is often inconsistent with national treatment guidelines. For example, over 50% of patients treated for depression in general practice stop treatment within three weeks. Given that 45% of patients do not achieve remission with initial drug treatment, the field is poised for innovative approaches to improve diagnosis, access to treatment, and interventions.

No. 20C

A REVIEW OF THE IMPORTANCE AND TREATMENT OF RESIDUAL SYMPTOMS IN DEPRESSION

Matthew A. Menza, M.D., 671 Hoes Lane, D207A, Piscataway, NJ 08836

SUMMARY:

Most patients with depression continue to have symptoms after treatment. These residual symptoms are common and are associated with suboptimal long-term outcomes, such as relapse, disability, and poor quality of life. While is it clear that residual symptoms, as a group, contribute to poor outcomes, individual residual symptoms have received relatively little attention. Recognizing that for clinicians and patients symptom relief is the goal of treatment, we review the evidence that treating individual residual symptoms is both feasible and useful. The most common residual symptoms appear to be insomnia, fatigue, anxiety, sexual dysfunction, lack of motivation, and difficulty with concentration. A converging series of studies suggests that treatment of residual (often treatment-emergent) sexual dysfunction can improve patient outcomes. In addition, a variety of studies have now demonstrated that treatment of insomnia associated with depression is efficacious and may improve patient outcomes. Fatigue may also be treated with augmentation therapy and may improve overall outcomes. Anxiety, motivation, and concentration difficulties may also be targets for augmentation therapy. Depression is a syndrome defined by a variety of symptoms that may reflect dysfunction in different neural circuits. Recent clinical trial data suggest that some residual symptoms can be addressed with pharmacotherapies as well as targeted psychotherapies. When using pharmacotherapy, monotherapy is preferred. However, the clinician may need to target specific symptoms to achieve an optimal outcome for many patients.

No. 20D

NEW ANTIDEPRESSANT MEDICATIONS AND NOVEL MECHANISM OF ACTION

Michael E. Thase, M.D., 3535 Market Street, Room 689, Philadelphia, PA 19104

SUMMARY:

After almost 20 years of continuous growth, the use of antidepressants has generally leveled off and, since 2000, only a handful of new medications have been introduced. Although there are now a large number of relatively safe, well-tolerated, and effective antidepressants available in generic formulations, many people with depression either do not respond to treatment or do not stay on an effective medication for more than a few months. There is, thus, much room for improvement in the treatment of depression and unmet needs for development of new antidepressants include: novel mechanisms of action (which might be effective for patients who do not respond to reuptake inhibitors), earlier onset of benefit, improved effects for common, particularly troubling residual symptoms (i.e., anxiety and insomnia), and better tolerability profiles (e.g., fewer gastrointestinal side effects or less sexual dysfunction). This presentation will highlight recent developments in the area of pharmacotherapy of depression by focusing on drugs that are thought to have novel mechanisms of action, including antagonism of neurokinin (NK), corticotrophin releasing factor (CRF), and various serotonin and norepinephrine receptors, as well as agonists of melatonin receptors. It will be suggested that the next generation of antidepressant medications will be characterized by more highly selective effects that will be useful for specific subgroups of depressed people.

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MT2 receptor agonist with 5-HT2C antagonistic properties, in major depressive disorder. Int J Neuropsychopharmacol. (in press).
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ISS21-SLEEP AND SLEEP DISORDERS ACROSS THE LIFE CYCLE: WHAT PSYCHIATRISTS NEED TO KNOW

SUPPORTER: SEPRACOR, INC.

No. 21A

SLEEP DISORDERS MOST FREQUENTLY SEEN DURING MIDLIFE

Dimitri D. Markov, M.D., Jefferson Sleep Disorders Center, 211 S. Ninth Street, 5th Floor, Philadelphia, PA 19107

SUMMARY:

Sleep disorders are common in psychiatric patients. As psychiatrists, we need to be aware of primary sleep disorders that are associated with midlife phase. The obstructive sleep apnea syndrome comprises symptoms such as nonrefreshing sleep and excessive daytime sleepiness, in association with sleep-disordered breathing. OSAS is common in psychiatric patients. Many psychiatric medications contribute to obesity, and obesity is a known risk factor for sleep-disordered breathing. Untreated OSAS can disrupt sleep, lead to excessive sleepiness, has been associated with worsening of mood disorders, impaired cognitive and executive function, as well as cardiovascular morbidities. Continuous positive airway pressure (CPAP) is the treatment of choice for patients with OSAS. However, due to claustrophobia, some patients do not tolerate CPAP therapy. By addressing patient's anxiety, psychiatrists can help with CPAP compliance. Restless legs syndrome (RLS) is characterized by an irresistible urge to move legs, usually associated with uncomfortable sensations in the legs. RLS symptoms may disrupt sleep, cause insomnia or excessive daytime sleepiness. Periodic limb movements in sleep (PLMS) are stereotyped repetitive movements of legs and arms that occur during sleep. Periodic limb movement disorder (PLMD) is diagnosed in patients with PLMS who present with either insomnia or excessive sleepiness that can not be explained by any other causes. Many patients with RLS are misdiagnosed as having akathisia. Medications that are familiar to psychiatrists, such as tricyclic antidepressants, selective serotonin reuptake inhibitors, and antipsychotics are known to induce or exacerbate RLS and PLMD, while dopaminergic agonists, benzodiazepines, anticonvulsants, and opiates are used to treat RLS and PLMD. Being able to recognize and address RLS is important for psychiatric practice. Both diagnostic and treatment modalities will be discussed.

No. 21B

PARASOMNIAS: THINGS THAT GO "BUMP" IN THE NIGHT

Karl Doghramji, M.D., 211 South Ninth Street, Suite 500, Philadelphia, PA 19107

SUMMARY:

The parasomnias are undesirable behaviors that occur exclusively during the sleep period or that are exacerbated by sleep. They include the disorders which occur in the context of arousals, such as confusional arousals, sleepwalking, sleep talking, and sleep terror; those that occur during REM sleep, such as REM sleep behavior disorder, recurrent sleep paralysis, and nightmare disorder; and those that occur in the context of sleep in general, such as sleep-related dissociative disorders, enuresis, sleep-related hallucinations, and sleep-related eating disorder. Some, such as sleepwalking, are more common in childhood. Others, such as REM sleep behavior disorder, are more common in older age. The fact that parasomnias can be induced by drugs or substances was recently brought to the attention of the medical profession and the public by reports of a possible association between hypnotic use and complex sleep-related behaviors such as sleep-driving, making phone calls, and preparing and eating food while asleep. Nevertheless, they have been reported in the context of almost all psychoactive medications including antidepressants, stimulants, barbiturates, and drugs of abuse. Parasomnias pose risks for their sufferers since they can lead to injury to self and others. Violent behavior during sleep has also led to legal difficulties for parasomnias sufferers. The evaluation of the parasomnias involves the identification of the behaviors, disorders, or substances that trigger these events. Many of the parasomnias can be managed by behavioral intervention, while others necessitate the use of medications.

No. 21C

SLEEP DISORDERS AND THE FEMALE LIFE CYCLE

Mary O'Malley, M.D., Norwalk Hospital Sleep Disorders Center, 34 Maple Street, Norwalk, CT 06856

SUMMARY:

The depth and quality of sleep in women is often measurably better than men. However, for many women, the menstrual cycle brings about monthly swings in their ability to sleep well, or feel rested during the day. Even women who sleep well during their child-bearing years may suffer for years or even decades as peri-menopause turns into menopause with spontaneous wakenings during sleep, with or without vasomotor symptoms. Further, when untreated, these hormone-dependent sleep disorders can gradually evolve into chronic insomnia with fractured, unrestorative sleep, and significant daytime impairment. Women usually expect sleep to be a challenge during pregnancy, but many do not realize primary sleep disorders may develop that can seriously affect fetal outcome as well as maternal health. This presentation will review the important variables that impact sleep in women, and discuss effective treatment strategies and diagnostic tools that may be integrated into psychiatric practice.

No. 21D
THE GOLDEN YEARS? SLEEP AND SLEEP DISORDERS IN LATER LIFE

Milton Erman, M.D., San Diego Center, 10052 Mesa Ridge Court--Suite 101, San Diego, CA 92121

SUMMARY:
Sleep is a dynamic process over the life cycle. "Common knowledge" to the contrary, the amount of sleep that we require for "normal function" does not decrease as we age. Rather, there are changes in sleep depth, quality, and continuity seen as we age, particularly associated with the presence of co morbid medical conditions. Such comorbid medical conditions include (but are not limited to) pain syndromes, depression, nocturia, COPD, cardiac illness, etc. The changes in sleep seen include reductions in sleep efficiency (the percentage of time spent asleep of time spent in bed), increased numbers of awakenings over the course of the night, and greater amounts of time spent asleep outside of nighttime hours (naps in the morning or afternoon, time spent dozing while reading or watching television in the evening, etc.) Specific changes in sleep architecture are usually seen in association with the aging process, beginning with reductions in the amount and density of deep non-dreaming (delta) sleep beginning as early as age 35 and progressing throughout the life cycle, and increases in the amount of "light" stage 1 sleep associated with increased age. These changes seem to occur as a consequence of the natural aging process, but may be intensified as a consequence of the effects of comorbid medical and psychiatric conditions. It is not known whether "healthy aging" reduces the probability that these changes will occur, or whether individuals with better sleep quality are more resistant to the ravages of the aging process. Specific sleep disorders are also seen with increased frequency in older populations. These include sleep apnea, REM sleep behavior disorder, and restless legs syndrome (RLS) and periodic leg movements in sleep (PLMS) all of which have specific diagnostic criteria and unique treatment approaches.

No. 21D
SLEEP AND SLEEP DISORDERS IN CHILDHOOD AND ADOLESCENCE

David N. Neubauer, M.D., Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, Box 151, Baltimore, MD 21224

SUMMARY:
During infancy sleep-wake cycles evolve from a chaotic pattern of random sleep episodes to an established rhythm with a prominence of daytime and evening waking alternating with nighttime sleep. Normally sleep is the deepest, longest, and most consolidated during childhood. However, children and adolescents are vulnerable to a variety of sleep disorders, which may significantly impact daytime functioning and be associated with psychiatric symptomatology. It is estimated that 25% to 40% of children and adolescents experience disordered sleep. This talk will review developmental aspects of normal sleep and will highlight common pediatric sleep disorders. Among these conditions are various insomnia syndromes, disorders of excessive sleepiness, parasomnias, sleep-disordered breathing, and circadian rhythm disorders. Sleep disorders often are unrecognized in pediatric populations for several reasons. Health-care professionals seldom perform routine screening for sleep problems. Children and their parents may not complain of primary sleep-related symptoms, but rather present with the consequences of sleep disturbances. The identification of sleep disorders in pediatric patients is necessary for effective management and because the sleep-related symptoms may indicate underlying psychiatric and medical conditions. An overview of the evaluation and treatment of childhood and adolescent sleep disorders will be presented.

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TUESDAY, MAY 6, 6:30 PM-10:00PM

ISS22-ORGANIZING THE EVIDENCE: OBSESSIVE-COMPULSIVE-RELATED DISORDERS: NEW PERSPECTIVES TOWARD *DSM-V*

SUPPORTER: JAZZ PHARMACEUTICALS, INC.

No. 22A
BRAIN IMAGING IN THE OBSESSIVE-COMPULSIVE SPECTRUM DISORDERS

Stefano Pallanti, M.D., Mount Sinai School of Medicine, 5 East 98th Street, New York, NY 10029

SUMMARY:

There is substantial evidence from structural and functional imaging that obsessive-compulsive disorder (OCD) is mediated by cortico-striatal-thalamic-cortical (CSTC) circuitry. There is also growing interest in the possibility that various OCD symptom dimensions (e.g., washing, hoarding) are mediated by somewhat different components of this CSTC circuitry. An initial hypothesis might then be that CSTC circuitry not only is involved in conditions such as Tourette's disorder, body dysmorphic disorder, and trichotillomania, but also that different components of the CSTC circuitry play a role in each of these conditions. There is additional evidence from molecular imaging and other studies that serotonin, dopamine, and glutamate play a particularly important role in modulating CSTC dysfunction in OCD, and that effective treatments act on these systems. There are few molecular imaging studies of putative OCD spectrum disorders, but such work may also ultimately shed light on similarities and contrasts among these conditions.

No. 22B
NEW TREATMENT DEVELOPMENTS FOR OBSESSIVE- COMPULSIVE AND RELATED DISORDERS

Zohar Joseph, M.D., Division of Psychiatry, Chaim Sheba Medical Center Ramat Gan Tel-Hashomer 52621

SUMMARY:
Obsessive compulsive disorder (OCD) is unique among psychiatric disorders in that only serotonergic medications appear to be therapeutically effective. Noradrenergic tricyclic antidepressants are entirely devoid of anti-obsessive properties; fixed-dose studies suggest that a high dose is needed to attain maximum therapeutic benefit. The concept of OCD may be broadened to include obsessive-compulsive-related disorders (OCRDs), and treatment could be refined accordingly. A classic example is OCD with tic disorder, for which combination treatment using highly potent dopamine blockers and selective serotonin inhibitors is indicated. However, the use of dopamine blockers in OCD is not limited to this subset of patients; dopamine blockers such as risperidone and quetiapine are effective augmentation therapy in treatment-resistant patients. Some of the most severe cases are those in which the family is involved in "helping" the patient. Better instructions to family members about alternative ways to assist the OCD patient, without collaborating with the compulsions, are called for. Unless patients undergo detailed and well-planned cognitive-behavioral therapy, along with careful evaluation and assessment of the family environment, they cannot be considered "resistant." For those patients who are actually resistant, neurosurgery, gamma knife treatment, and, more recently, deep brain stimulation have been proposed, but these should be reserved as a last-resort treatment. With advances in our understanding of the complexity of OCD and OCRDs, it may be possible to tailor treatment to the specific needs of individual patients. Sophisticated pharmacologic interventions and treatment that takes environmental factors into account, along with improvements in diagnostic skills, all provide new hope for this intriguing group of patients with OCD.

No. 22B
ESTABLISHING ENDOPHENOTYPES FOR OBSESSIVE -COMPULSIVE DISORDERS

Naomi Fineberg, M.A., Department of Psychiatry, Queen Elizabeth II Hospital Howlands, Welwyn Garden City Hertfordshire, AL7 4HQ, United Kingdom

SUMMARY:
Neurocognitive or radiologic endophenotypes represent heritable markers of brain dysfunction and more closely represent genetic risk for complex polygenic mental disorders than do overt behaviors. Obsessive-compulsive disorder (OCD) has been linked with a group of purportedly related disorders characterized by difficulties suppressing unwanted behavior. Establishing endophenotypes for obsessive-compulsive related disorders (OCRDs) may clarify the underpinning neurobiology, focus the search for genetic contributions, and indicate new treatment strategies. Such markers should be present in people at risk of developing OCRDs, even in the absence of clinical symptoms. Whereas OCD is characterized by compulsive acts, trichotillomania is considered an impulse-control disorder. Both patient groups showed impaired motor impulse control on the stop-signal task ($P<0.05$), but only OCD patients showed additional impairment on tests of cognitive flexibility (set-shift task) ($P<0.05$). OCD patients with obsessive compulsive personality Disorder (OCPD) were significantly more impaired on the set-shift task than patients without OCPD ($P<0.05$). Thus, different neurocognitive impairments involving inhibitory processes appear to underlie impulsive and compulsive components of these disorders. Deficits in response inhibition and cognitive flexibility were also identified in unaffected first-degree relatives of OCD patients ($P<0.01$). Stop-signal deficits in OCD patients and relatives were associated with reduced gray matter volumes in the fronto-striatal regions involved in impulse control and habit learning. Permutation testing indicated familial effects on variation of these magnetic resonance imaging markers. Thus, structural variation in brain systems related to motor inhibition may represent a radiologic endophenotype associated with genetic risk for OCD.

No. 22C
MUSCLE DYSPHORIA AND ANABOLIC STEROID USE

Philip Seibel, M.D., Mount Sinai School of Medicine, 5 East 98th Street, New York, NY 10029

SUMMARY:
Approximately 1 million Americans—primarily young men, including 4% to 7% of male high school students—have used anabolic androgenic steroids (AAS) to improve athletic performance or personal appearance. The majority of users of AAS use them for physique enhancement. Use of these substances can be attended by psychiatric syndromes such as Major depressive disorder, psychotic behavior, and gggression. In addition, use of AAS may be a symptom of another condition: muscle dysmorphia, or a preoccupation with one's body, viewing it as insufficiently lean or muscular. This body image distortion can be considered a variant of body dysmorphic disorder (BDD) or a reverse form of anorexia. One preliminary investigation comparing males with BDD plus muscle dysmorphia with those

with BDD but without muscle dysmorphia showed similar results for the two groups on many variables, but men with muscle dysmorphia had a higher prevalence of AAS and substance use, were more likely to engage in several compulsive behaviors, and exhibited significantly greater psychopathology in terms of quality of life and suicide attempts. There is limited research describing the relationship between AAS use and muscle dysmorphia, and the phenomenon has received little attention; thus, this is an area in need of scientific development and clinical focus.

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ISS23-UNDERSTANDING THE ENDOCANNABINOID SYSTEM: KEY LINKS BETWEEN MIND, BODY, AND NEUROPSYCHIATRY

SUPPORTER: SANOFI-AVENTIS

No. 23A

THE PSYCHIATRIC PERSPECTIVE: POTENTIAL RELEVANCE TO THE UNMET NEEDS OF PATIENTS WITH PSYCHIATRIC DISORDERS

Dan W. Haupt, M.D., Washington University School of Medicine, Department of Psychiatry, Box 8134, 660 South Euclid Avenue, St. Louis, MO 63110

SUMMARY:

Patients with severe mental illness are at increased risk for metabolic disorders, contributing to their higher cardiovascular mortality rates. This elevated risk is likely related to a combination of factors, including the use of psychotherapeutics, the underlying physiology of psychiatric disorders, and poor lifestyle habits. In addition to increasing risk for cardiovascular disease, weight gain is a significant source of patient poor adherence in bipolar disorder and other psychiatric disorders. Approved medications for the treatment of bipolar disorder and schizophrenia are associated with a range of weight gain liabilities that can increase cardiometabolic risk. Current lifestyle and pharmacotherapeutic interventions for weight control have had very limited success in psychiatric patients because they require high levels of patient adherence, significant lifestyle changes, and/or they are contraindicated in patients receiving antidepressants. These factors present a significant challenge to psychiatrists who must participate in the management of metabolic disorders while ensuring at the same time that patients receive effective treatment for their mental illnesses. Dr. Sachs will present an overview of current and potential future strategies for meeting this challenge, including the possibility that pharmacotherapies directed at the endocannabinoid system will play a role in future therapies. Dr. Haupt will discuss insights into this challenge acquired from his research on the metabolic effects of antipsychotic medications. Improved understanding of the relationship between psychiatric and metabolic disorders in these patients are essential for improving outcomes, and may find application to management of the broader population of patients under treatment for metabolic disorders, such as diabetes or obesity.

No. 23C

THE METABOLIC PERSPECTIVE: CURRENT AND EMERGING THERAPIES FOR METABOLIC DISORDERS: EFFECTS ON MIND AND BODY

Louis Aronne, M.D., Weill Medical College of Cornell University, New York, NY 10021

SUMMARY:

Metabolic disorders such as obesity, diabetes, dyslipidemia, and cardiovascular disease have reached epidemic proportions in the United States and are significant causes of morbidity and mortality. Patients with metabolic disorders often suffer from mood disorders as well, particularly depression. The presence of a mood disorder can raise barriers to patient compliance in the management of metabolic conditions, which rely heavily on long-term lifestyle interventions, such as exercise and diet, and self-care regimens. Pharmacotherapeutic interventions could help overcome these barriers, but current choices are either poorly effective, carry unsafe or unpleasant side effects, or are contra-indicated in patients receiving antidepressants. The endocannabinoid system (ECS) plays a role in regulating aspects of mood as well as many aspects of metabolism, including effects on liver, skeletal muscle, adipose tissue, and pancreatic function. A number of new pharmacotherapies are emerging for metabolic disorders, including some of which target the ECS. This presentation will address the risks and benefits of both current and emerging therapies for metabolic disorders.

No. 23D

THE CARDIOVASCULAR PERSPECTIVE: INFLAMMATION, VISCERAL FAT, AND THE ECS

Jorge Plutzky, M.D., 77 Avenue Louis Pasteur NRB 742D, Boston, MA 02115

SUMMARY:

The accumulation of visceral adipose tissue, also known as central obesity, plays a key role in metabolic syndrome, a constellation of risk factors for cardiovascular disease that includes dyslipidemia, hypertension, and insulin resistance. Central obesity is associated with a state of chronic inflammation, at least in part due to the increased secretion by adipose tissue of adipocytokines such as tumor necrosis factor-alpha, interleukin-6, and plasminogen activator inhibitor-1. The most abundant adipocytokine is adiponectin, which has anti-inflammatory, anti-atherosclerotic, and anti-diabetic properties. Obese patients, particularly those with visceral fat accumulation, have reduced plasma levels of adiponectin. Many clinical studies show that

low adiponectin is closely associated with metabolic diseases, including atherosclerotic cardiovascular diseases, Type II diabetes mellitus, hypertension, and dyslipidemia. The endocannabinoid system has modulatory effects on both inflammation and immune function, and the endocannabinoid receptor blocker rimonabant raises adiponectin levels in humans. These findings suggest that an enhanced understanding of the ECS will shed light on the mechanisms by which central obesity leads to increased risk for cardiovascular disease.

No. 23E

THE ENDOCANNABINOID SYSTEM: IMPACT ON METABOLISM AND MOOD

Stephen Woods, Ph.D., University of Cincinnati Obesity Research Center, Cincinnati, OH 45267

SUMMARY:

The endocannabinoid system (ECS) is a recently discovered system of endogenous, lipid-like signaling molecules that includes two G-protein coupled receptors, CB1 and CB2, and enzymes devoted to synthesis, degradation, and signal termination. By modulating a diverse array of synapse types, endocannabinoids modulate both central nervous system (CNS) and peripheral neurophysiological processes. Within the CNS, the ECS is involved in the regulation of mood, attention, and learning and memory, as well as CNS influences over energy homeostasis. In the periphery, the ECS is involved in the modulation of pain, inflammation and immune processes, as well as many metabolic functions. Energy homeostasis occurs through complex interactions among a number of neuroendocrine pathways that form feedback loops between the brain and peripheral organs and tissues. The ECS modulates these pathways on a number of levels, including CNS effects on food intake, energy expenditure and stress, as well as peripheral effects directly on liver, the gastrointestinal tract, adipose tissue, and skeletal muscle. The ECS system has generated considerable interest for its potential role in a number of disease states, including mood and neurodegenerative disorders, neuropathic pain, addiction, obesity, and diabetes.

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ISS24-SCHIZOPHRENIA: THE COMPLEXITY OF REAL-WORLD CARE

SUPPORTER: JANSSEN PHARMACEUTICA AND RESEARCH

No. 24A

REASONS FOR NON-ADHERENCE AND STRATEGIES FOR IMPROVEMENT IN PATIENTS WITH SCHIZOPHRENIA

Dawn I. Velligan, Ph.D., Division of Schizophrenia and Related Disorders UTHSCSA, Department of Psychiatry MS # 7792, 7703 Floyd Curl Drive, San Antonio, TX 78229

SUMMARY:

The effectiveness of treatment regimens in patients with schizophrenia is often impaired by medication nonadherence. Up to 80% of patients diagnosed with a psychiatric disorder will be non adherent at some point during their treatment. Unidentified problems with adherence for the individuals they are treating may lead physicians to change medications, increase medication dosages, or add concomitant medications unnecessarily. Common reasons for non-adherence include drug-related side effects, lack of insight, misunderstanding of medication instructions, forgetting, and the failure to establish routines that promote appropriate adherence. There are also health service delivery system problems that can contribute to problem adherence. Psychiatrists can simplify a treatment regimen by employing monotherapy whenever possible or switch medications to improve the risk/benefit profile for the individual patient. In addition, use of long-acting injectable antipsychotics can decrease the burden on patients to remember to take medication everyday. Moreover, with injectable medications, the treating physician knows immediately when a dose is missed and can intervene. Psychosocial treatments such as cognitive behavior therapies, which focus on establishing a solid therapeutic alliance, improving motivation for treatment, and teaching problem-solving techniques, can also be very beneficial to patients. Environmental supports such as signs and pill containers with alarms can be used to bypass cognitive problems and increase adherence. Combining multiple intervention strategies (educational, behavioral, and affective) may be the most effective way to improve adherence in patients with schizophrenia. This presentation will review correlates of medication nonadherence, rates of relapse, and methods of measuring adherence. Strategies to increase adherence will also be presented.

No. 24B

UTILIZING MEDICATION AND PSYCHOTHERAPY TO OVERCOME SCHIZOPHRENIA: A PATIENT'S PERSPECTIVE

Elyn R. Saks, J.D., Associate Dean and Orrin B. Evans Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences USC Gould School of Law, 699 Exposition Blvd, 418, Los Angeles, CA 90017

SUMMARY:

Elyn R. Saks is a chaired professor of law and psychiatry, an advanced candidate at a psychoanalytic training institute, and the author of three books and over 30 scholarly articles. She graduated valedictorian of Vanderbilt University, was named a Marshall scholar and studied at Oxford, and received her degree with honors from Yale Law School. Remarkably, Professor Saks has also been diagnosed with paranoid schizophrenia. She has been hospitalized three times, required restraints and seclusion

at times, and was considered to have a poor prognosis. She has decided to come forward with the story of her life and illness. She has recently published a book, The Center Cannot Hold: My Journey Through Madness," which tells the story of her illness, recovery, and ongoing need for treatment to prevent recurrence of psychosis. Professor Saks's talk will describe the experience of schizophrenia, beginning in childhood and adolescence, when she first experienced episodic psychotic symptoms. She will discuss her three psychiatric hospitalizations, the first of which occurred when she was a Marshall Scholar studying at Oxford. Despite numerous psychotic episodes, she was able to complete her studies at Oxford, Yale Law School, and ultimately obtain tenure at the University of Southern California Law School. Her academic speciality area is mental health law, particularly the capacity of the mentally ill to give informed consent for research. Professor Saks will discuss her positive experience with intensive psychoanalytic psychotherapy and her enhanced response to atypical antipsychotic drugs. She will discuss the importance of close and supportive friends and family, the importance of her work to her; and how she has come to terms with having schizophrenia and requiring life, long treatment. Professor Sak's goal in her talk and her books is to give hope to those who suffer from schizophrenia and to increase the understanding of the illness to those who do not.

No. 24C

ACHIEVING OPTIMAL OUTCOME IN SCHIZOPHRENIA

Herbert Y. Meltzer, M.D., Vanderbilt University School of Medicine, 1601 23rd Ave. South, Suite 306, Nashville, TN 37212

SUMMARY:

Outcome in schizophrenia is highly variable, with some patients showing remarkable recovery and others showing severe deterioriation with regard to cognition and reality testing. The results of a new 15-year follow up of patients with schizophrenia showing the dissociation between cognitive outcome and psychopathology will be presented. Broadly speaking, antipsychotic drug treatment, psychosocial support, and psychotherapy are the major elements in achieving the favorable outcome, which Prof Elyn Saks described in this symposium. This talk will focus on the role of antipsychotic drug treatment in achieving improvement in psychosis, complementing the talk of Professor Harvey on the effect of these agents on cognitive impairment, but also note the limitations of all current types of pharmacotherapy. The similarities and differences between typical and atypical antipsychotic drugs will be emphasized. While these two types of agents appear comparable in efficacy for non treatment-resistant patients when appropriate doses are compared, there is strong evidence for the superiority of at least some atypical antipsychotic agents for treatment-resistant patients, when given at a significantly higher dose than is required for non treatment-resistant patients and for an adequate period of time. These considerations help to understand the discrepancies between the general findings in the literature and the recent CATIE and Cutlass trials. Numerous strategies have been employed to augment the efficacy of both typical and atypical antipsychotic drugs, sometimes leading to polypharmacy without apparent benefit to patients. I will review those strategies and discuss several that appear to have some merit. The talk will conclude with a review of new antipsychotic drugs in development and novel augmentation strategies and the need for novel strategies to go beyond typical and atypical antipsychotic drugs.

No. 24D

EVALUATING ALL THE EVIDENCE FOR ANTIPSYCHOTIC EFFICACY: CATIE AND BEYOND

Philip D. Harvey, Ph.D., Professor of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Woodruff Memorial Building, 101 Woodruff Circle, Suite 4000, Atlanta, GA 30032

SUMMARY:

The Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study compared the real-world effectiveness of antipsychotics, including cognition as an outcome. The high discontinuation rate and the low levels of clinical response seen on the part of the patients may raise some questions about the sample selection criteria used. As a result of several of these issues, including the selective randomization of subjects to conventional antipsychotic medications and the low doses that were employed for many agents, CATIE did not provide clinicians with clear answers to what is the most efficacious agent. The cognitive outcomes from the CATIE study appeared counterintuitive, in that olanzapine and risperidone, widely reported previously to have efficacy for cognitive symptoms, were significantly inferior to conventional treatments. In the post-CATIE era, new direct treatments for cognitive abnormalities are being developed. The results of the CATIE trial have also led to an increased sensitivity to the complex issues of dosing for the wide-spectrum treatment of schizophrenia, including the balancing of efficacy, side effects, and cognitive benefits involved in each dose range. There have been several positive developments in terms of treatment of cognitive impairments in schizophrenia, including treatment successes with atypical antipsychotics for the direct treatment of functional disability, successes with cognitive remediation, and improvements in real-world outcomes, and recent positive results from treatment trials with cognitive enhancing agents. The results of these studies are more optimistic than those of CATIE and provide a clear suggestion that disability reduction in schizophrenia is achievable through enhancement of cognitive functioning.

No. 24E

METABOLIC SIDE EFFECTS OF ANTIPSYCHOTIC DRUGS

William V. Bobo, M.D., Department of Psychiatry, Psychiatric Hospital at Vanderbilt, 1601 23rd Avenue South Suite 3035, Nashville, TN 37212

SUMMARY:

First-episode patients with schizophrenia have been shown to have increased resistance to insulin, independent of any drug treatment and lifestyle issues associated with the illness. Some genetic factors shared by schizophrenia and risk for type 2 diabetes mellitus may account for this. Lifestyle issues such as poor diet, lack of exercise, and lack of adequate medical care

lead to a higher incidence of obesity and diabetes mellitus, which may be attributed to insulin resistance. Beyond this, some antipsychotic drugs increase the risk for metabolic complications and cardiovascular disease. While the so-called metabolic syndrome has been emphasized as a way to conceptualize this risk, we will show how the triglyceride/HDL ratio serves as a better indicator of cardiovascular risk. The ability of various antipsychotic drugs to cause adverse metabolic consequences will be highlighted. Recent studies suggest that histamine H1 antagonism, in particular, may contribute to the greater effect of olanzapine and clozapine to cause weight gain. The increasing evidence that weight gain with clozapine and olanzapine, but not other antipsychotic drugs, predicts clinical response will be discussed. Recent controlled studies that evaluate the time course of weight gain, glucose, and lipid changes with the atypical antipsychotic drugs will be reviewed, as will efforts to prevent and reverse the adverse effects of the atypical agents. Switching patients to those atypicals that cause minimal weight gain and lipid changes appears to be an effective strategy that can be done without causing relapse in most patients.

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WEDNESDAY, MAY 7 7:00 AM- 8:30AM

ISS25- PLAQUES & TANGLES: APPLYING GENETICS AND MOLECULAR TARGETS TO UNRAVEL STRATEGIES FOR ALZHEIMER'S DISEASE

SUPPORTER: EISAI

No.25A

MOLECULAR AND GENETIC MARKERS FOR AD: IS THERE A ROLE FOR SCREENING?

Lindsay A Farrer, Ph.D., Boston University School of Medicine Genetics Program L320715 Albany Street, Boston, MA 02118

SUMMARY:

Screening strategies for early detection and interventions have been applied successfully to several cancers as well as diabetes, hypertension, and hypercholesterolemia. However, the question of whether or not to screen for Alzheimer's disease (AD), especially in cognitively healthy people, has been controversial. Currently there exists no simple test or biological markers that detect all early AD pathologies. An ideal biomarker should be related to the neuropathological changes, such as ?-amyloid plaques or neurofibrillary tangles, which are the major changes observed in the AD brain. In addition to improving the diagnosis of AD, biological markers would be valuable in monitoring the progression of the disease and in evaluating the efficacy of therapies. A screening strategy developed from advances in AD genetic research may provide a basis for susceptibility testing. However, sensitivity of genetic screening tests is still under debate, particularly in the area where transitions from normal function, through mild cognitive impairment, to dementia are occurring. In the future, it may be possible to identify high-risk persons with no clinical symptoms years before they would be expected to develop, providing opportunities for early interventions that would delay or prevent the brain damage seen in fully developed AD. Halting or delaying disease progression prior to onset of noticeable symptoms would make a major contribution to the quality of life and continued functioning of patients.

No. 25B

CURRENT TREATMENT STRATEGIES FOR AD

Jacobo E. Mintzer, M.D., 5900 Core Road, Suite 203, N. Charleston, SC 29404

SUMMARY:

In AD, there is a dramatic decrease in cholinergic innervation in the cortex and hippocampus due to the loss of neurons in the basal forebrain. These findings have led to the development of the traditional cholinergic hypothesis, which proposes that the cognitive loss associated with AD is related to decreased cortical cholinergic neurotransmission. Three acetyl cholinesterase inhibitors—galantamine, rivastigmine, and donepezil—are now approved by the FDA and are used for the treatment of mild to moderate AD. All these available agents have shown cognitive benefit over placebo; yet the benefit of these agents in slowing disease progression, delaying nursing home placement, or decreasing mortality remain unknown. Recent innovation in cholinesterase inhibitor include the development of patch (rivastigmine) which have shown comparable efficacy to the solid dosage form but with three times fewer reports of nausea and vomiting. Memantine, a N-methyl-D-aspartate receptor-antagonist, exert its effect in interfering with glutamatergic neuronal excitotoxcitiy. Memantine may be used as monotherapy or in combination with a cholinesterase inhibitor for patients with moderate Alzheimer's disease, and as monotherapy for patients with severe Alzheimer's disease. Long-term follow up of one-year treatment found that memantine to be safe and well-tolerated. Cognitive and behavioral interventions and rehabilitation strategies may be used as an adjunct to pharmacological treatment, especially in the early to moderately advanced stages of disease. Treatment modalities include counseling, psychotherapy (if cognitive functioning is adequate), reality orientation therapy, and behavioral reinforcements as well as cognitive rehabilitation training. During the symposium new information on available treatment and a summary of new upcoming approaches for both cognitive and behvioral symptoms will be discussed.

No. 25C

MOLECULAR MECHANISMS OF NEURODEGENERATIVE DISEASES

*Peter H St George-Hyslop,, Centre for Neurodegenerative Diseases, Rm 119 Tanz Neuroscience Building, 6 Queen's Park Crescent W., Toronto,*Ontario, M5S 3H2

SUMMARY:

Alzheimer's disease is a multifactorial illness with both genetic and non-genetic causes. Recent genetic studies have identified a small number of genes associated with inherited risk for AD (including for instance presenilin 1, presenilin 2, amyloid precursor protein, and apolipoprotein E, and SORL1). These genes account for about half of the total genetic risk for Alzheimer's disease. It is suspected that several other Alzheimer's disease-susceptibility genes exist, and their identification is the subject of ongoing research. Nevertheless, biological studies on the effects of mutations in the four known genes has led to the conclusion that all of these genes cause dysregulation of amyloid precursor protein processing and in particular dysregulation of the handling of a proteolytic derivative termed Abeta. The accumulation of Abeta appears to be an early and initiating event that triggers a series of downstream processes including misprocessing of the tau protein. This cascade ultimately causes neuronal dysfunction and death, and leads to the clinical and pathological features of Alzheimer's disease. Knowledge of this biochemical cascade now provides several potential targets for the development of diagnostics and therapeutics.

No. 25D

CHALLENGES FACED BY PSYCHIATRISTS IN THE MANAGEMENT OF AD: ETHNIC, GENETIC AND ENVIRONMENTAL FACTORS

Jessica L Broadway, M.D., Medical University of South Carolina Geropsychiatry Division, 171 Ashley Avenue, Charleston, SC 29425

SUMMARY:

Of the estimated 4 million individuals with AD in the US, only 60% of probable AD cases are diagnosed, with little more than half of those receiving treatment. One of the possible reasons for this problem is the large role primary care physicians have in adequately diagnosing and referring AD treatment. Diagnosis of AD is difficult and to date no specific diagnostic tests of the disease are available. Some evidence indicates a role for positron emission tomography or single photon emission computed tomography in the diagnosis of AD as well as the use of MRI. Further challenge in the optimal management of AD is the low participation of ethnic minorities in clinical trials. The low participation rate prevents meaningful evaluation of treatment differences among races and ethnic groups.

This presentation will review the challenges faced by psychiatrists to provide optimal management of AD. Strategies to overcome these barriers by incorporating current and emerging treatment paradigms will also be described.

No. 25E

EPIDEMIOLOGY OF AD: UNRAVELING THE TANGLE OF INFORMATION

Richard Mayeux, M.D., Taub Institute for Research of Alzheimer's Disease and the Aging Brain, Columbia University, New York, NY 10032

SUMMARY:

As the US population ages, the prevalence of AD is expected to rise dramatically. Determining the true prevalence and incidence is inexact due to difficulties in definition and detection of the illness. Problems with diagnostic inaccuracy and insidious disease onset influence our ability to observe risk factor association.

Several risk factors have been implicated and include: a family history of Alzheimer-type dementia, cardiovascular disase and head injury. Genetic variants in five genes have also been shown to alter the risk of developing AD. Mutations in the amyloid precursure protein, presenilin 1 and 2 cause early-onset disease, while polymorphic variants in apoliproprotien E and the sortilin receptor, SORL1. However, genetic variation may not totally explain the frequency of this disease. Alternatively, AD may be related to a combination of genetic and environmental risk factors.

The goal of epidemiology is to identify specific genetic and environmental factors involved in AD, determining their relative importance and understanding their interactions in order to prevent and treat the disease.

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ISS26-NOVEL PERSPECTIVES TOWARD A BETTER UNDERSTANDING OF MAJOR DEPRESSIVE DISORDER

SUPPORTER: BRISTOL MYERS SQUIB COMPANY AND OTSUKA AMERICA PHARMACEUTICALS INC.

No. 26A

COMBINING ANTIDEPRESSANTS: IS THERE EVIDENCE FOR SYNERGY?

Craig Nelson, M.D., University of California San Francisco, 401 Parnassus Avenue, PO Box 0984, San Francisco, CA 94143

SUMMARY:

Depression is a common disorder that is frequently resistant to initial treatment. In Sequential Treatment Alternatives to Relieve Depression (STAR*D), only 33% of patients with major

depression remitted after a vigorous course of treatment. After two treatments, nearly half the patients failed to remit. Findings like this have led to a search for more effective treatments. One of these strategies is to combine two marketed antidepressants or combination therapy. The rationale is that some agents have different mechanisms of action that may have synergistic effects. Essentially this means combining agents from different classes. The improved tolerability of second-generation antidepressants has facilitated this approach. The combination of tricyclic antidepressants and monoamine oxidase inhibitors was the first such strategy described, but is complicated by serious safety issues. Because combination treatment involves drugs of different classes, the number of combinations is limited. The most popular is the combination of a selective serotonin reuptake inhibitor (SSRI) with the catecholamine reuptake inhibitor bupropion, but the evidence for this combination is lacking placebo-controlled data. The combinations of an SSRI with a norepinephrine reuptake inhibitor or an SSRI with the a-2 antagonist/5-HT2 antagonist mirtazapine are both supported by double-blind, controlled trials, but both of these controlled trials were quite small. Combining different SSRIs with similar mechanisms is not considered rational polypharmacy. Because venlafaxine and duloxetine both have relatively greater serotonin than norepinephrine reuptake potency, combining one of these agents with an SSRI is not recommended. This presentation will review the efficacy, tolerability, and safety issues associated with the common combinations, and issues associated with the administration will be discussed.

No. 26B

THE ROLE OF GLUTAMATE IN MDD NONRESPONSIVE TO STANDARD THERAPIES

Sanacora Gerard, M.D., Yale Medical Group, Connecticut Mental Health Center, Clinical Neuroscience Research Unit, 34 Park Street New Haven, CT 06511

SUMMARY:

Increased awareness of the limitations of existing antidepressant treatments that almost exclusively target the monoaminergic systems provides a strong impetus for the development of novel antidepressant treatments with unique targets of action. Emerging evidence suggests that amino acid neurotransmitter systems (GABA and glutamate) contribute to the pathogenesis, pathophysiology, and treatment of mood disorders. GABAergic involvement in the pathophysiology and treatment of mood disorders is supported by several lines of evidence including: (1) animal studies showing stress-related changes in GABAergic function, (2) the ability of GABA agonists and antagonists to modulate behavioral models of depression in rodents, (3) GABAergic effects of existing antidepressant medications, (4) evidence of clinical antidepressant efficacy associated with GABAergic drugs, and most convincingly (5) demonstration of GABAergic abnormalities and genetic associations in depressed patients. Supporting evidence for the role of glutamate in the pathophysiology of mood disorders comes from: (1) demonstration of glutamatergic abnormalities in patients with major depressive disorder (MDD), (2) glutamatergic effects of antidepressant and mood stabilizing medications, (3) animal studies showing stress-related changes in glutamatergic function and its possible relationship to the pathophysiology and pathogenesis of MDD, and most recently 4) the effectiveness of glutamate-modulating agents in the treatment of depression. This presentation will briefly highlight some of the clinical and preclinical findings suggesting that amino acid neurotransmitter systems contribute to the pathophysiology of mood disorders. It will then focus on reviewing the results of recent studies examining the clinical efficacy of glutamate-modulating agents such as ketamine and riluzole in TRD.

No. 26C

AUGMENTATION STRATEGIES IN TREATMENT-RESISTANT DEPRESSION

Maurizio Fava, M.D., 15 Parkman Street, WACC-812, Boston, MA 02114

SUMMARY:

The efficacy of antidepressant monotherapy is somewhat limited, particularly in real-world settings. The Sequential Treatment Alternatives to Relieve Depression (STAR*D) trial has shown that treatment with the selective serotonin reuptake inhibitor citalopram in primary and specialty care leads to remission only in one in three patients. When patients with major depressive disorder do not respond adequately to antidepressant treatment, clinicians often add another augmenting compound to the antidepressant regimen, particularly in the event of partial improvement or response. Augmentation strategies appear to be relatively safe and effective approaches to Treatment-Resistant Depression. STAR*D has evaluated the three best-studied augmentation strategies in the literature, namely buspirone, lithium, and T3. STAR* D did not evaluate some of the other augmentation strategies that are frequently used in practice, such as atypical antipsychotic agents, methylfolate, s-adenosyl-methionine, psychostimulants, and modafinil. In particular, atypical antipsychotics have been studied even more extensively as augmentation strategies in resistant depression in the past decade and there are now several double-blind studies (e.g., aripiprazole, risperidone, olanzapine) to help clinicians make informed choices. This presentation will review the existing literature on augmentation strategies and will examine the pertinent results of STAR*D.

No. 26D

THE ROLE OF PHARMACOGENETICS IN TREATMENT-RESISTANT DEPRESSION

Roy H. Perlis, M.D., 15 Parkman Street WACC 812, Boston, MA 02114

SUMMARY:

Individuals with major depressive disorder (MDD) show wide variation in their response to antidepressant treatment. In addition to the many environmental factors that can contribute to these differences, genetic variation also influences antidepressant treatment response. This variation may contribute to treatment resistance by influencing drug metabolism (pharmacokinetics) as well as pathways by which drugs exert their therapeutic effect (pharmacodynamics). To date, there is little evidence that polymorphisms in cytochrome p450 genes play a large role in treatment resistance. However, multiple genes have

now been implicated in antidepressant efficacy as well as tolerability and may thereby contribute to treatment resistance in MDD. This presentation will describe such findings and discuss how identifying these genes could help to elucidate the pathophysiology of treatment-resistant depression (TRD) itself, and aid in stratifying patients' risk for TRD.

No. 26E
NEUROSTIMULATION APPROACHES TO TREATMENT-RESISTANT DEPRESSION

Sarah Lisanby, M.D., NYS Psychiatric Institute, Room 5214 Unit/Box:21 1051 Riverside Drive, New York, NY 10032, New York, NY 10032

SUMMARY:
Managing patients with treatment-resistant depression remains a challenge for the clinician. Drugs and psychotherapy are inadequate for relieving depressive symptoms in a substantial proportion of depressed patients. Approximately 50% of depressed patients do not respond to a trial of a particular antidepressant, and as many as 20% of patients do not respond to any antidepressant medication. As a result, many patients with major depression are not treated adequately, and some will suffer from chronic, debilitating symptoms. Given that a considerable portion of patients with depression do not respond to or remit during pharmacotherapy, there is increasing interest in nonpharmacologic strategies to treat depressive disorder. For patients with treatment-resistant depression, other therapeutic options must be considered. Neurostimulation is an evolving treatment that holds promise for patients with refractory depression. Neurostimulation is a physical intervention that uses application of either electric current or magnetic field to directly stimulate the brain or central nervous system. The various techniques include electroconvulsive therapy (ECT), repetitive transcranial magnetic stimulation (rTMS), magnetic seizure therapy (MST), vagus nerve stimulation (VNS), and deep brain stimulation (DBS). Although ECT has been in use for several decades, the technique is still being refined and improved. The other neurostimulation treatments are newer and their efficacy will be reviewed.

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WEDNESDAY, MAY 7, 6:30 PM-10:00PM

ISS27-INDIVIDUALIZING TREATMENT PLANS FOR TOTAL HEALTH IN PATIENTS WITH BIPOLAR DISORDER
SUPPORTER: ORGANON , A PART OF SCHERING-PLOUGH

No. 27A
LONG-TERM TREATMENT STRATEGIES TAILORED FOR COMORBID PRESENTATIONS

David Kemp, M.D., Bipolar Disorder Research Center, Case Western Reserve University, 11400 Euclid Ave., Suite 200, Cleveland, OH 44106

SUMMARY:
Patients with bipolar disorder often suffer from comorbid psychiatric and general medical illnesses. In fact, the National Comorbidity Survey Replication has identified that the number of patients with three or more comorbid conditions is remarkably higher than comorbidity with only one disorder across the bipolar spectrum. Conditions commonly seen in comorbid presentations of bipolar disorder include substance abuse, anxiety disorders, and disorders of metabolism such as obesity and the metabolic syndrome. Clinical studies suggest that comorbidity in the bipolar population is associated with greater mood disorder severity, including a heightened risk for suicide, lower likelihood of symptomatic remission, and poor functional recovery. Medical hazards extend this risk to include increased mortality from natural causes such as cardiovascular disease. A relative paucity of controlled pharmacotherapy trials conducted across comorbid presentations of bipolar disorder present unique therapeutic challenges for determining the optimal long-term illness management. This presentation will integrate accumulating controlled-trial evidence that addresses maintenance phase treatment outcomes with results from trials that generalize to comorbid presentations of bipolar disorder. Concerns arising from long-term pharmacological treatment will be highlighted, as well as the role of newer agents and strategies employing the use of combination therapies. Emerging evidence intended to narrow the disparities between clinical practice and research settings will be reviewed.

No. 27B
THE IMPORTANCE OF EARLY RECOGNITION AND TREATMENT OF BIPOLAR DISORDER

Karen D. Wagner, M.D., University of Texas Medical Branch, Department of Psychiatry and Behavioral Sciences, 1.302 Rebecca Sealy, 301 University Boulevard, Galveston, TX 77555-0188

SUMMARY:
Recent attention has focused on the importance of early recognition of bipolar disorder in youth. Adults who report an onset of bipolar disorder in childhood have been found to have

more severe mania, more depressive episodes, fewer days well, and more suicide attempts than adults with a later onset of illness. Children with bipolar disorder often have mixed states, long episode duration, and high rates of relapse after recovery from illness. Given the significant impairments in social, academic, and family functioning associated with pediatric bipolar disorder, it is important to identify effective treatments. This presentation will discuss the clinical presentation of bipolar disorder in children, screening instruments that assist in detection, the current status of pharmacological treatments, side effects, a of commonly used psychotropic medications, medication treatment algorithm, and the role of adjunctive psychosocial treatments and support groups for families.

No. 27C

IMPROVING TREATMENT OUTCOMES IN BIPOLAR DISORDER

Robert M. Hirschfeld, M.D., University of Texas Medical Branch, Department of Psychiatry & Behavioral Sciences 1.302 Rebecca Sealy, 301 University Blvd., Galveston, TX 77555-0188

SUMMARY:

Bipolar disorder is a recurrent and sometimes chronic illness involving episodes of depression and mania or hypomania. This complex and multidimensional illness presents particular challenges with regard to treatment and assessing clinical outcomes. The first goal of acute treatment is a positive response. The next goal is remission. Finally, we strive for sustained remission, hopefully full recovery. This presentation will critically evaluate and review response rates, remission rates, and sustained remission rates of treatment options (both pharmacologic and psychosocial) for bipolar mania and depression. Currently the response rate for acute monotherapy for mania is 49% and 59% for combination; and 48% for bipolar depression. The median remission rate for acute monotherapy for mania is 45% and for combination therapy is 51%; and for bipolar depression is 51%. The sustained remission rate is around 35%. Ways to improve the rates are discussed.

No. 27D

EVIDENCE-BASED APPROACHES TO TAILORING INDIVIDUAL TREATMENT PLANS

Terry Ketter, M.D., Stanford University School of Medicine, Department of Psychiatry and Behavioral Sciences, Mail Code 5723 PBS #2200, Stanford, California 94305-5723

SUMMARY:

The substantial interindividual variability in patients with bipolar disorder needs to be considered for optimal treatment planning. Thus, individual characteristics such as age, gender, ethnicity, primary diagnosis (e.g., bipolar I vs. bipolar II disorder), comorbid psychiatric and medical diagnoses, phase of illness, course of illness, therapeutic and adverse prior treatment effects, most recent episode, current interpersonal and occupational stressors and level of function, and patient preferences need to be integrated into treatment plans. Because efficacy data from randomized controlled trials have limited generalizability, they need to be integrated with effectiveness data from randomized controlled trials as well as systematic clinical observations for an evidence-based approach to the substantial challenges of individualizing treatment plans. For example, data indicate that patients with comorbid substance-use disorders, rapid cycling, mixed episodes, and many prior episodes respond less well to lithium than patients lacking these features. Important alternative interventions for such patients include divalproex, carbamazepine, lamotrigine, and atypical antipsychotics. Similarly, patients with severe and highly recurrent bipolar disorder may have poorer responses to intensive cognitive-behavioral therapy than patients lacking these features. In patients receiving naturalistic treatment, residual depressive or manic symptoms appear associated with earlier depressive recurrence, while residual manic symptoms appear associated with earlier manic, hypomanic, or mixed episode recurrence. Medical factors are also important. For instance, patients with obesity experience earlier episode (particularly depressive episode) recurrences during maintenance treatment than those without obesity. Thus, careful integration of individual patient characteristics is necessary to enhance outcomes in patients with bipolar disorder.

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ISS28-ADVANCING SCIENCE AND PRACTICE: MANAGEMENT OF ADHD FROM CHILD TO ADULT: AN INTERACTIVE CASE PRESENTATION

SUPPORTER: SHIRE US, INC.

No. 28A

PUTTING OUR VOICE TO ACTION IN THE MANAGEMENT OF CHILDHOOD ADHD: RECOGNITION, DIAGNOSIS AND MANGEMENT

Aude Henin, Ph.D., Masachusetts General Hospital, Pediatric Psychopharmacology Unit, 185 Alewife Brook Pkwy, Suite 2000, Cambridge, MA 02138

SUMMARY:

ADHD was long thought to be a disorder of childhood, but it is now recognized to affect individuals across the lifespan. Although both children and adults can be diagnosed with ADHD, the clinical presentation varies between the two populations and in both cases, it can be difficult to diagnose. Appropriate diagnosis of ADHD is crucial if rational, evidence-based management strategies are to be applied. In this symposium, faculty will review approaches for recognizing and diagnosing ADHD in children and adults and will describe cutting edge research evidence to aid psychiatrists in treatment planning for these populations.

No. 28B

CASE PRESENTATION:CHILDHOOD ADHD

Richard D'Alli, M.D., DUMC 2096, Durham, NC 27710

SUMMARY:

ADHD is a prevalent problem in children and adolescents, yet it remains difficult to diagnose because of overlapping symptoms with other childhood psychiatric disorders and behavioral problems. In addition, the stigma associated with ADHD may make patients or their parents reluctant to come forward for treatment and may give parents pause about allowing their children to take medication. For patients that do seek treatment, psychostimulants are first-line pharmacotherapy, with demonstrated efficacy and safety. Psychostimulant therapy is associated with an average of 70% improvement in core behavioral symptoms and associated functional impairment. However, a number of practical issues may limit the efficacy of psychostimulants. First, adherence to medication regimens often proves challenging in children. Second, psychostimulants as a class possess substantial pharmacokinetic variability that may lead to unpredictable bioavailability in certain patients. Furthermore, a subset of patients may fail to respond to psychostimulants or have side effects that preclude use. Given the known efficacy and safety of this class of medications for childhood ADHD, the search for solutions to these problems remains active. Newer treatment options such as long-acting or patch preparations as well as non-stimulant medications increase the options clinicians have to optimize outcomes in their patients. In this case-based symposium, faculty will discuss current issues in the identification and diagnosis of ADHD in children and will review state-of-the-art, evidence-based practices for long-term management.

No. 28C

ADULT ADHD: HOW WELL DO WE RECOGNIZE AND MANAGE THE CONDITION?

Joel Young, M.D., 441 S. Livernois, Ste.205, Rochester Hills, MI 48307

SUMMARY:

ADHD is the most prevalent neuropsychiatric disorder in childhood. Sixty percent of these cases persist into adulthood and often go undiagnosed. Although adult patients with ADHD frequently suffer from comorbid psychiatric disorders such as anxiety (9.5%), bipolar disorder (21.2%), and depression (32%), medical and prescription claims data show that less than 2.5% of these patients had a documented diagnosis of ADHD. The consequences of unrecognized ADHD can be severe. These adults experience significantly more career-related difficulties, earn less, and are more often unemployed than the general population. Adult ADHD is a significant, yet treatable, public health problem. Pharmacologic treatment combined with psychotherapy clearly helps to manage the disease, and emerging treatments provide clinicians with more tools to individualize and optimize treatment. This presentation will utilize interactive video case presentations to discuss the latest evidence regarding recognition, diagnosis, and management of adults with ADHD.

No. 28D

WHAT IS THE ROLE OF NON-PHARMACOLOGIC THERAPY IN ADHD?

Scott H. Kollins, Ph.D., 718 Rutherford St., Durham, NC 27705

SUMMARY:

Patients with ADHD can be stabilized with pharmacologic treatment about 60% to 70% of the time. However, drug therapy alone leaves several needs unmet. Response to treatment is not uniform between patients, and it depends on the severity of the underlying disease. Thus, a notable proportion of patients may have ADHD-related residual symptomatology, anxiety, and depression even after initiating pharmacotherapy. Moreover, pharmacotherapy does not modify or optimize the coping mechanisms necessary to deal with deficits in executive functions. Coping mechanisms and adaptive strategies evolve over time as children, teenagers, and adults deal with the particular pressures of their respective environments. To assist patients with ADHD in maximizing the benefits of drug treatment, various models of adapted adjunctive non-pharmacologic therapy have been studied. One study of adults with residual symptoms showed that drug therapy plus modified cognitive-behavior therapy (CBT) was significantly better than drug therapy alone. Cognitive-behavior therapy addressing parenting skills also has been reported to be successful for adult parents with ADHD. This presentation will provide an evidence-based review of the rationale for and applications of non-pharmacologic management in patients with ADHD. Discussion of the age-adapted goals of non-pharmacologic therapy in ADHD and the place of support networks will provide clinicians with the tools needed to optimize outcomes in their patients.

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ISS29-BEYOND PAIN TO "FIBROFOG" AND SLEEP IMPAIRMENTS: IMPLICATIONS FOR NEUROCIRCUITRY AND TREATMENTS IN FIBROMYALGIA

SUPPORTER: PFIZER INC.

No. 29A

MANAGING PAIN SYMPTOMS IN FIBROMYALGIA

Daniel J. Clauw, M.D., Michigan Institute for Clinical and Health Research The University of Michigan, 24 Frank Lloyd Wright Drive, Ann Arbor, MI 48106

SUMMARY:

Pain perception in fibromyalgia is highly variable across patients. In a given day, an individual's pain may fluctuate from nil to extreme discomfort. Given this unstructured pain level, management of pain symptoms can be difficult. Currently pregabalin, an antiepileptic, is the only FDA-approved drug for the treatment of pain in fibromyalgia. Its mechanism of action includes binding to the alpha 2 delta ligand of voltage-gated sodium channels. Other pharmacotherapies are being examined for their efficiency in treating neuropathic pain symptoms. These include milnacipran, which is presently available for treatment of fibromyalgic pain in countries other than the U.S., duoxetine, fluoxetine, citalopram, and paroxetine. This lecture will include information on the commonly studied tricyclic antidepressants, SSRIs, and SNRIs for treatment of pain symptomatology in fibromyalgia. The use of polypharmacy will be introduced, as many patients' symptoms may not be alleviated with monotherapy and may need augmentation to experience more relief. Cognitive-behavioral therapy, mindfulness training, and other alternative therapies will also be discussed. In addition, a patient case will be introduced to further enhance learning of how various drugs may benefit an individual experiencing neuropathic pain.

No. 29B

"FIBROFOG": IDENTIFYING AND TREATING COGNITIVE DYSFUNCTION IN FIBROMYALGIA

Nikhil D. Nihalani, M.D., SUNY Upstate Medical University Syracuse, NY, 713 Harrison St, Syracuse, NY 13210

SUMMARY:

Patients with fibromyalgia often experience cognitive symptoms, including memory impairment and decline of mental clarity. These difficulties have been coined "fibrofog," and can co-exist with dissociation, creating perceived cognitive dysfunction. Fibrofog implies fuzzy, blurred feelings of forgetfulness, including difficulty processing information following conversations, decreased ability to think, and sensory overload. Since normal cognitive function has a tendency to decline with age, it is possible that these symptoms are overlooked in the older fibromyalgia population. Current research indicates an increased need in screening for cognitive dysfunction, though it is noted that memory deficits in these patients may be more related to allocation of attention rather than focal attention. This allocation of attention is not readily tested using today's screening methods. Treatments for the cognitive dysfunction aspect of fibromyalgia are not specific; generally medications used to treat the majority of symptoms will affect the cognitive aspect to a certain degree. Recent findings indicate that treatments commonly used for Alzheimer's and ADHD such as stimulants, modafinil,and buproprion may be beneficial in the treatment of cognitive symptoms. Using a combination of drugs may benefit these patients so that symptoms other than just pain alleviation are ameliorated. This lecture will further discuss the cognitive pathways behind the fibrofog mystery, and will indicate which drugs may be most beneficial in alleviating the sense of fogginess. Future directions for research will be discussed, and a case example will be introduced.

No. 29C

FIBROMYALGIA AND SLEEP IMPAIRMENT: HOW THEY RELATE

Sonia Ancoli-Israel, Ph.D., Department of Psychiatry 116A; VASDHS; 3350 La Jolla Village Drive, San Diego, CA 92161

SUMMARY:

Sleep disturbance is common in fibromyalgia. Common sleep problems reported include sleep apnea, restless legs, periodic limb movements, and fatigue. Restorative sleep is crucial to these patients, as decreases in slow wave sleep can lead to an increased perception of pain and fibrofog. The relationship between fibromyalgia and sleep appears to be reciprocal; the less sleep a patient gets, the more fatigued and pained he/she may feel. On the other hand, the more pain the patient feels may lead to less sleep due to discomfort, creating an unrelenting cycle. In order to break this cycle, treatment must be administered. Common medicinal interventions include antidepressants, though research has indicated that they often have positive short-term effects and may begin to be less effective as time elapses. Cognitive-behavioral therapy (CBT) has shown positive results with fibromyalgia patients complaining of sleep disturbances. In a recent study by Edinger et al. (2005), patients with fibromyalgia expressed an approximately 50% increase in sleep quality when they received CBT versus patients who received only sleep hygiene therapy and usual fibromyalgia treatment. This effect appears to hold fast in several studies, leading researchers to suggest CBT as an augmenting therapy for fibromyalgia that may assist in solving the sleep problems experienced by these patients. This lecture will focus on the relationship between fibromyalgia and sleep, as well as define the best-known treatments for the sleep impairment aspect of fibromyalgia and the role that CBT may play in treatment.

No. 29D

INDICATIONS OF FIBROMYALGIA ORIGIN AND MECHANISMS OF ACTION OF TREATMENT OPTIONS

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

SUMMARY:

There is now a compelling reason to believe that fibromyalgia is a true syndrome that warrants attention and treatment. Current evidence suggests that perceived increases in pain may be due to dysfunctional central pain processing. The ascending nociceptive pathway is modulated by descending inhibitory pathways, which in fibromyalgia may be functioning abnormally. This central sensitization involves nerve activity, receptive fields, and amplified stimulus responses. Serotonin, norepinephrine, and dopamine are involved in the transmission of pain stimuli, such that as neurotransmitters, they can affect the pain pathways. Gene polymorphisms are more likely to exist in fibromylagia than normal controls, which may be due in part to genetic or biological factors. The mechanisms of action behind current treatments include ion channel and monoamine involvement. In cognitive circuitry, neurotransmitters norepinephrine and dopamine are at the forefront of dysfunction, with brain areas such as the dorsolateral prefrontral cortex involved as well. Slow wave sleep is also impaired in fibromyalgia, though treatments are often aimed at pain relief, rather than alleviation of cognitive and sleep comorbidities. This lecture will focus on the pain pathways that may be altered in fibromyalgia patients, as well as distinguish pertinent reasons for clinical trials of 5HT2C antagonists for treatment of all fibromyalgic symptoms.

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2. Clauw, DJ. Journ of Clin Rheum 2007;13(2):102-09.
3. Edinger. JD et al: Arch Int Med 2005;165:2527-35.
4. Lawson. K: Curr Opinion in Invest Drugs 2006;7(7):631-36.
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MONDAY, MAY 5, 11:00 AM - 12:30PM

SCIENTIFIC AND CLINICAL REPORT SESSION 01- FORENSIC PSYCHIATRY

No. 1

PROFILE OF PERPETRATORS WITH IMPULSIVE VIOLENT BEHAVIOR

Rob Brouwers, M.D., Grote Zilverreiger 10, 9648DK Wildervank, Netherlands, Wildervank, Netherlands 9648DK, Karel T.I. Oei, Ph.D., Martin Appelo, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better recognize impulsive violent behavior based on reward-delay and rapid-response impulsivity. The participant will learn the factors associated with impulsive violent behavior and the assessment instruments to detect these factors. In the end, recognition is improved of the profile of perpetrators with impulsive violent behavior.

SUMMARY:

This presentation focuses on the clinical difference between impulsive violent behavior based on reward-delay and rapid-response impulsivity. Self-questionnaire assessment instruments related to the factors associated with impulsive violence found in the literature were completed by 44 perpetrators and 56 persons in a control group. After principal component analysis, perpetrators and the control group members differed on three factor-groups: (1) alcohol, drugs and weapon; (2) verbal intelligence; and (3) impulsivity, arousability, anger, hostility and physical aggression. Closer examination of the perpetrators showed an Impulsive Violent Disorder based on rapid-response impulsivity with the following criteria: (1) violent behavior as a response to a provocation; (2) the violent behavior occurs within a short time span; (3) the level of violence is highly extreme compared to the provocation; (4) there is a logical and less violent alternative available; (5) immediately prior to and during the violence no inner consideration takes place; and (6) important information is missed.

REFERENCES:

1. Kockler TR, Nelson CE, Meloy JR: Characterizing aggressive behavior in a forensic population. Am J of Orthopsychiatry 2006; 76:80-85.
2. Brouwers RC: Impulsive violent behavior. Nijmegen, Wolf Legal Publishers, 2007.

No. 2

THE VALIDITY OF PSYCHIATRIC IMPAIRMENT ASSESSMENT: A COMPARISON OF TWO SYSTEMS IN CLINICAL PRACTICE

Gordon Davies, M.B., 33 Smith Street, Wollongong, Australia 2500

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant should have a greater awareness of: (1) the arbitrary nature of the medicolegal assessment of psychiatric impairment and the lack of an evidence base; and (2) the problems in developing an equitable interval scale and the differing values put by the community on degrees of improvement depending on the severity of impairment.

SUMMARY:

Objective: To compare the outcomes of impairment assessment systems based on the AMA Guides 2nd and 4th editions with each other and with the HoNOS. Method: Psychiatric evaluations using scored modifications of the AMA 2nd edition protocol (in use in the Australian State of Victoria) and of the 4th edition (used in New South Wales) together with ratings on the Health of the Nation Outcome Scale (HoNOS) were carried out on 110 patients who presented with compensable injuries for assessment at a private psychiatric practice. The results of the formal percentage evaluations as well as the raw scores were compared and the relationship of the subscales on each protocol examined. Result: The raw scores were all highly correlated although the percentage estimate of impairment varied substantially and systematically between the systems. The correlations between the subscale scores indicated that there is a substantial overlap between the domains sampled in the 5th edition based system whereas only the behavioral subscale showed such an overlap in the 2nd edition based system. Conclusion: Using the raw scores, it is clear that there is substantial correlation between the scores and with the HoNOS suggesting that they do sample a core concept of impairment. However, the resulting assessed impairment is clearly biased by the arbitrary scoring methods used which, in the case of the AMA 4th edition based scale, transforms a normally distributed set of scores to a set skewed toward low percentages. The internal correlations suggest that apart from the behavior scale the domains sampled by the 2nd edition format are relatively independent, but that those sampled by the 4th edition format have substantial overlap. The merits of alternative scoring systems and the weighting of these in accord with community estimations of varying degrees of disability are reviewed.

REFERENCES:

1. Spieler EA, Barth PS, Burton JF, Himmelstein J, Rudolph L: Recommendations to guide revision of the Guides to the Evaluation of Permanent Impairment. Journal of the American Medical Association 2000 283, 519-523.
2. Nord E, Pinto JL, Richardson J, Menzel P, Ubel P: Incorporating societal concerns for fairness in numerical valuations of health programmes. Health Economics, 1999, 8, 25-39.

No. 3

FATHERS WHO KILL THEIR CHILDREN

Sara West, M.D., Department of Psychiatry, University Hospitals - Case Medical Center, 11100 Euclid Avenue, Cleveland, OH 44106, Susan Hatters Friedman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) recognize the role of paternal filicide in a historical context; (2) identify characteristics common to fathers who kill their children; and (3) compare and contrast maternal and paternal filicide.

SUMMARY:

Objective: Filicide, or the murder of a child by a parent, is unfathomable. Though the majority of the literature focuses on maternal filicide, roughly half of filicidal acts are committed by

fathers. This paper reviews the existing data on paternal filicide with the goal of defining characteristics common among fathers who kill their children. *Methods:* Following Medline searches, 12 pertinent studies that quantitatively and/or qualitatively described paternal filicide were identified. Information presented in the studies was organized into 15 categories. Results: Fathers who killed their children were, on average, in their mid-thirties. The average age of their victims was five years old, and fathers rarely killed newborns. They tended to have multiple victims, including other children and spouses. Sons and daughters were killed in equal numbers. Motives included death related to abuse, related mental illness (including psychosis and depression), and revenge against a spouse. The method was often violent. Suicide following the filicidal act occurred regularly. Filicidal fathers were often unemployed or in low paying jobs. After being convicted for their crimes, filicidal fathers were more frequently incarcerated than placed in forensic hospitals. Conclusions: Given the assortment of men capable of this crime, mental health professionals must be alert to the possibility of filicidal acts in a variety of fathers. They should inquire about thoughts of harming children, partner, and themselves in unstable male patients.

REFERENCES:

1. Bourget D, Gagne P: Paternal filicide in Quebec. J Am Acad Psychiatry Law 2005; 33(3):354-60.
2. Resnick PJ: Child murder by parents: a psychiatric review of filicide. Am J Psychiatry 1970; 126:325-34.

SCIENTIFIC AND CLINICAL REPORT SESSION 02-WOMEN'S AND CHILDREN'S HEALTH

No. 4

OVERVALUATION OF SHAPE AND WEIGHT IN BINGE-EATING DISORDER AND OVERWEIGHT CONTROLS: REFINEMENT OF BED AS A DIAGNOSTIC CONSTRUCT

Carlos Grilo, Ph.D., Yale Psychiatric Research, Yale University School of Medicine, 301 Cedar Street (2nd floor), New Haven, CT 06519, Joshua I. Hrabosky, Psy.D., Marney A. White, Ph.D., Kelly C. Allison, Ph.D., Albert J. Stunkard, M.D., Robin M. Masheb, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the *DSM-IV* diagnostic criteria for binge-eating disorder and to recognize the clinical significance of overvaluation of shape and weight.

SUMMARY:

Objective: Binge eating disorder (BED), a research diagnosis in the *DSM-IV,* is associated with significant psychological and medical problems. Debate continues regarding its nosological status as a psychiatric disorder as opposed to a useful marker for psychopathology. Contention also exists regarding the specific criteria for the BED diagnosis, including whether, like anorexia nervosa and bulimia nervosa, it should be characterized by overvaluation of shape/weight. Method: This study compared features of eating disorders, psychological distress, and weight among overweight BED patients with clinical levels of overvaluation (n=92), BED patients with subclinical levels of overvaluation (n=73), and overweight non-BED patients (n=45). Patients were reliably assessed with semi-structured diagnostic interviews. The Structured Clinical Interview for Axis I Disorders was used to determine diagnostic groupings and the Eating Disorder Examination Interview was used to assess dimensional aspects of eating disorder psychopathology including overvaluation of shape/weight. Results: BED patients categorized with clinical overvaluation reported significantly greater eating-related psychopathology and depression levels than those with subclinical overvaluation. In addition, both BED groups reported significantly greater overall eating-related pathology and depression levels than the overweight comparison group. Significant group differences existed despite similar levels of overweight across the groups and when controlling for group differences in depression levels. Conclusions: Findings suggest that overvaluation of shape/weight is an important distinguishing clinical feature within BED patients as well as between BED and overweight non-binge eaters. Thus, our findings provide further support for the BED research diagnostic construct and make a case for the importance of overvaluation of shape/weight as a diagnostic specifier.

REFERENCES:

1. Hrabosky JI, Masheb RM, White MA, Grilo CM: Overvalu ation of shape and weight in binge eating disorder. J Consult Clin Psychol 2007;75:175-180.
2. Brown TA, Barlow DH: Dimensional versus categorical classification of mental disorders in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders and beyond. J Abn Psychol 2005;114:551-556.

No. 5

ADVERSE EFFECTS ON GESTATIONAL AND NEONATAL OUTCOMES: FROM DEPRESSION OR ANTIDEPRESSANT DRUGS?

Katherine Wisner, M.D., WPIC 3811 O'Hara Street, Pittsburgh, PA 15213

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) differentiate the effects of major depressive disorder from SSRI exposure on pregnancy and birth outcomes; and 2) utilize the results and conclusions from this presentation for risk-benefit decision making for treatment in depressed childbearing women.

SUMMARY:

Objective: We address: (1) Do minor physical anomalies occur with greater frequency in SSRI-exposed with compared infants exposed to depression or to neither drug nor depression?; (2) Are maternal weight gain and premature birth impacted by SSRI exposure; and (3) Are neonatal outcomes less favorable in SSRI-exposed compared with depression-exposed or control infants? *Method:* In a five-year prospective study, women with SSRI exposure during pregnancy were included with two comparison groups: depressed, unmedicated women, and women who were neither medicated nor depressed (N=232). SSRI exposure was confirmed by serum levels. Presence of major depressive disorder (MDD) was assessed with the SCID. Interviews were done

at 20, 30, and 36 weeks. Outcomes were obtained by blind review of delivery records and infant exam at two weeks. *Results:* Smoking and alcohol intake did not differ among groups. Of 68 SSRI exposures, 57 (88%) were solo drugs; the majority took sertraline (40%), followed by fluoxetine (25%), and citalopram (19%). Most (67%) women were treated with SSRI continuously. No major malformations occurred. Neither medication nor MDD exposure was related to minor anomalies. A significantly greater pre-pregnancy mean body mass index was observed in women with MDD (29.7+7.9) vs. controls (25.9+7.2) and SSRI-treated women (26.8+5.5) (p=0.02); however, the proportions of women who gained less than, within, or above pregnancy weight gain guidelines did not differ. Although SSRI-exposed infants were more likely to go to the NICU and have neonatal problems, controlling for gestational age negated these relationships. MDD exposure in utero was not significantly related to any adverse outcome. Survival analyses (gestational time to birth) showed that women who took SSRI continuously were more likely to deliver preterm infants vs. women in other groups (Hazard ratio=3.4, CI=1.3-8.8, p=0.01). *Conclusion:* An increased risk for prematurity is related to in utero SSRI and not MDD exposure.

REFERENCES:

1. Wisner KL, Zarin DA, Holmboe ES, Appelbaum PS, Gelen berg AJ, Leonard HL, Frank E: Risk-benefit decision making for treatment of depression during pregnancy. Am J Psych 157:1933-1940, 2000.
2. Chambers CH, Moses-Kolko EL, Wisner KL, Chambers C, Moses-Kolko E, Wisner KL: Antidepressant use in pregnancy: new concerns, old dilemmas. Expert Review in Neurotherapeutics 7:761-4, 2007.

No. 6

HIGH FREQUENCY OF UNDIAGNOSED COGNITIVE DISORDERS IN INNER-CITY CHILDREN AND ADOLESCENTS HOSPITALIZED FOR DISRUPTIVE BEHAVIOR

Presenters: Mark Smith, M.D., 729 13th Street, NE, Washington, DC 20002, Washington, DC 20002, Sidney Binks, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the importance of diagnosing cognitive disorders in inner-city children and adolescents with disruptive behavior as well as be comfortable in requesting neuropsychological testing in such children and understand the rudiments of cognitive rehabilitation.

SUMMARY:

Objective: cognitive disorders are organic brain disorders usually diagnosed after middle age that affect functions involved in synthesizing information – perception, attention, memory, reasoning, etc. Such impairments can and do occur in children & adolescents and can have deleterious effects on academic & social function. This study measured the frequency of cognitive disorders in inner-city children and adolescents hospitalized for disruptive behavior. *Methods:* 162 inner-city children and adolescents (115 boys, 47 girls; age: 14.06 yrs (6-18); predominant race: 85% african-american, 12% caucasian, 2% hispanic) hospitalized for disruptive behavior underwent K-SADS diagnostic interviews and the Woodcock-Johnson III (W-J III): Tests of Cognitive Ability neuropsychological battery shortly after admission. Positive results of the WJ-III were the existence of a Cognitive Disorder, NOS (DSM-IV 294.9) and whether there were impairments in the following areas: attention, Working Memory, processing speed, language, visuo-spatial, executive functioning, reasoning-abstraction, learning, verbal comprehension/perception/processing, impulsivity/disinhibition. mental retardation diagnoses were made separately from cognitive diagnoses, but both could be diagnosed concurrently. Results: 52% of patients met criteria for cognitive disorder, NOS. Most frequent cognitive impairments were Processing Speed 70%, working memory 42%, attention 30%, language 29%, reasoning-abstraction 13%, learning 18%, verbal comprehension-perception-processing 11%, impulsivity-disinhibition 18%, visuo-spatial 8%, executive functioning 6%. mental retardation or borderline intellectual functioning were present in 46% of patients. Frequent diagnoses: ADHD 83%, ODD 79%, PTSD 46%, depression 43%, anxiety aisorders 43%, bipolar 41%, phobias 41%, Substances 36%, psychosis 32%, conduct disorder 32%, mania 27%, alcohol 14%. *Conclusion:* cognitive disorders in inner-city adolescents may be overlooked without testing.

REFERENCES:

1. Teichner G, Golden CJ, Crum TA, Azrin NH, Donohue B, Van Hasselt VB: Identification of neuropsychological subtypes in a sample of delinquent adolescents. J Psychiatr Res - 2000; 34(2):129-32.
2. Dery M, Toupin J, Pauze R, Mercier H, Fortin L: Neuropsychological characteristics of adolescents with conduct disorder: association with attention-deficit-hyperactivity and aggression. J Abnorm Child Psychol. 1999; 27(3): 225-36.

SCIENTIFIC AND CLINICAL REPORT SESSION 03-PSYCHIATRIC GENETICS

No. 7

GENES, MEMES, AND AN INFECTION MODEL OF MENTAL ILLNESS

Hoyle Leigh, M.D., Department of Psychiatry, Univ. of California, San Francisco-Fresno, 155 N. Fresno St., Fresno, CA 93701

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the role of gene-meme interaction in mental illness and formulate judicious specific and broad-spectrum meme-oriented therapies in conjunction with biological therapies.

SUMMARY:

Objective: To propose a new model of mental illness based on gene-meme interaction through development. *Method:* Memes, like genes, are replicating packets of information. Genes make proteins; memes make thoughts and behaviors. Memes are the result of evolution of the brain capable of imitating, both behavior and the brain state of others through language. Genes interact with environmental stress (which may be both physical and memetic, i.e., has meaning) resulting in vulnerability for mental illness. *Results:* In vulnerable individuals, childhood stress may introduce pathogenic memes (e.g., helplessness) that take up resi-

dence in the brain. Exposure to stress in adulthood may induce a brain state favorable to the proliferation of resident pathogenic memes, which then may overwhelm the brain, resulting in a mental illness. A massive environmental meme infection as in severe trauma may also overwhelm the brain. *Conclusions:* Treatment of mental illness should be both biologic (gene-oriented) and memetic, i.e., detoxifying and neutralizing the toxic memes. Existing psychotherapies may be meme-specific (e.g., cognitive-behavioral therapy) or broad-spectrum anti-meme therapies (e.g., relaxation, meditation). The concept of memes opens up avenues for further development of meme-oriented therapies that may include use of music, rhythm, visual presentations, etc. It also puts into perspective the role of education and critical thinking in prevention of mental illness, and opens up possibilities for novel prevention strategies.

REFERENCES:

1. Dawkins R: The Selfish Gene. Oxford, Oxford University Press, 2006.
2. Aunger R: Darwinizing Culture: The Status of Memetics as a Science. New York, Oxford University Press, 2000.

No. 8

COMBINATORIAL CYP450 GENOTYPING FOR DEPRESSED INPATIENTS

Gualberto Ruano, M.D., Genomas, Inc., 67 Jefferson Street, Hartford, CT 06106, Hartford, CT 06106, John W. Goethe, M.D., Andreas Windemuth, Ph.D., Bonnie L. Szarek, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) list the CYP450 genes relevant to the metabolism of antidepressants; (2) describe the combinatorial prevalence of common alleles leading to drug metabolism deviations from average; and (3) discuss the implications of multi-gene CYP450 genotyping for psychotropic drug management.

SUMMARY:

Objective: To determine in a random sample of inpatients with MDD (1) the proportion with clinically relevant polymorphisms in CYP2D6, 2C9, and 2C19, and (2) the prevalence of combinatorial multi-gene polymorphisms identified. *Methods:* The sample consisted of 150 consecutive, consenting admissions 18 years of age or older, admitted 1/07-3/07 with a clinical diagnosis of MDD. The resulting sample represented 67.4% of all MDD admissions. 61.3% of patients were female, and 65.3% white, 27.3% Latino and 7.3% black. Tag-It™ Mutation Detection assays on the Luminex xMAP system were utilized for DNA typing. Results were classified as "carrier" or "non-carrier" based on presence or absence of gene alleles and as "functional" (normal or ultra-rapid metabolizers) or "deficient" (deficient or null metabolizers). Chi-square, t-tests and descriptive statistics were used for data analysis. *Results:* Carriers were common in CYP2D6 (49.3%, n=74), CYP2C9 (30.7%, n=48) and CYP2C19 (30.7%, n=46). In only 22% of patients (n=33) were all three genes functional. In 49.3% of the sample one gene was deficient (n=74), in 25.3% (n=38) two genes, and in 3.3% of patients (n=5) all three genes were deficient. The 2D6*2A allele, which affects gene expression, was found in 59 patients (39.3%). Four patients were 2D6 ultra-rapid metabolizers. *Conclusions:* Most patients (78%) had deficiencies in at least one gene important in metabolizing many antidepressants. One of every four patients was doubly deficient; one in every 30 was triply deficient. Combinatorial DNA typing of 2D6, 2C9 and 2C19 adds a valuable perspective on patient's drug metabolism capacity. Comprehensive data on CYP450 functional status may play an important role in the selection and dosing of psychiatric medications and contribute to improved compliance and response.

REFERENCES:

1. Vandel P, Talon JM, Haffen E, Sechter D: Pharmacogenetics and drug therapy in psychiatry – the role of the CPY2D6 polymorphism. Curr Pharm Des 13:241-250, 2007.
2. Mulder H, Heerdink ER, van lersel EE, Wilmink FW, Egberts ACG: Prevalence of patients using drugs metabolized by cytochrome P450 2D6 in different populations: a cross-sectional study. Ann Pharmacother 41:408-413, 2007.

No. 9

PHARMACOEPIGENETICS: THERAPEUTIC AND DIAGNOSTIC APPLICATIONS OF CHROMATIN REMODELING AGENTS IN MENTAL ILLNESS

David Gavin, M.D., The Psychiatric Institute, University of Illinois at Chicago, 1601 W. Taylor St., Chicago, IL 60612, Cherise Rosen Ph.D., Saritha Kartan B.S., Kayla Chase B.A., Robert Marvin M.D., Rajiv Sharma M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better understand the mechanisms of epigenetic gene regulation as well as the evidence supporting the role of chromatin remodeling abnormalities theorized to be present in schizophrenia. Participant will be able to artilculate the potential diagnostic and therapeutic applications of agents that alter chromatin structure.

SUMMARY:

A restrictive chromatin state either globally or at specific gene promoters has been implicated in psychiatric disorders including schizophrenia, major depressive disorder, and Fragile X. We recently reported an invivo study in which bipolar and schizophrenic patients were treated with valproic acid, a known chromatin remodeling agent, for four weeks. Schizophrenic patients were significantly less likely to increase their acetylated H3 (acetylH3) (72%) compared with bipolar subjects (360%) ($p<0.04$), possibly indicating that schizophrenia is associated with less plastic chromatin. Since the publication of that study, additional patients have been added with findings consistent with that report (50% vs. 360%; $p<0.04$). We have also found a correlation among schizophrenic subjects between improvement in negative symptoms and increase in acetylH3 ($r=0.619$; $p<0.05$) and negative symptom improvement and increase in GAD67 mRNA ($r=0.639$; $n=11$; $p<0.04$). Furthermore, we have developed a novel method for studying chromatin assembly in clinical subjects. Using primary lymphocyte cultures treated with highly specific chromatin remodeling agents such as Trichostatin A, we have shown that chromatin remodeling directly regulates GAD67, a prototypic schizophrenia candidate gene. In preliminary experiments, using this assay system we have demonstrated that schizophrenic subjects are less able than control subjects to both increase the

fraction of acetylH3 (2% vs 46%) and increase the expression of GAD67 mRNA (-9% vs. 207%). Our findings may indicate that among schizophrenic subjects, or perhaps in a subgroup within this diagnostic category, a restrictive chromatin state may be of pathophysiological significance, and consequently provide a novel therapeutic target. In addition, the use of an invitro assay may provide a clinically useful tool whereby chromatin remodeling can be explored in relation to diagnosis, disease characteristics, treatment response, and medication development.

REFERENCES:

1. Sharma RP, Rosen C, Kartan S, Guidotti A, Costa E, Gray son DR, Chase K: Valproic acid and chromatin remodeling in Schizophreniz and bipolar disorder: preliminary results from a clinical population. Schizophr Res. 2006; 88:227-31.
2. Sharma RP, Grayson DR, Guidotti A, Costa E: Chromatin, DNA methylation and neuron gene regulation the purpose of the package. J Psychiatry Neurosci. 2005; 30:257-63.

SCIENTIFIC AND CLINICAL REPORT SESSION 04- SYMPTOMATIC OUTCOMES OF BORDERLINE PERSONALITY DISORDER

No. 10

PROSPECTIVE PREDICTORS OF SUICIDAL BEHAVIOR IN BORDERLINE PERSONALITY DISORDER

Paul Soloff, M.D., Western Psychiatric Institute and Clinic, 3811 O'Hara St., Pittsburgh, Pa. 15213, Pittsburgh, PA 15213, Paul H. Soloff, M.D., Anthony Fabio, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize clinical and psychosocial risk factors which predict recurrent suicidal behavior in patients with borderline personality disorder.

SUMMARY:

Efforts to identify reliable predictors of suicidal behavior in BPD have been confounded by the marked dimensional heterogeneity of the disorder, frequent comorbidity with other high-risk disorders, debilitating social and vocational consequences of BPD over time. In a prospective study, we assessed the predictive association between risk factors in each of these symptom domains and suicide attempts in 137 BPD subjects followed for 12 months, 18-24 months and 2 – 5 years. The suicide attempt rate was 19% in the first year, 24.8% through the second year. Using Cox regression analyses, the relative risk of suicidal behavior in the first 12 months was increased by co-morbid MDD and poor social adjustment. Outpatient treatment decreased short-term risk. Among 133 subjects completing 18-24 months in the study, the relative risk of a suicide attempt was increased by a psychiatric hospitalization occurring prior to any attempt, and poor social adjustment. Among 122 subjects followed for 2-5 years, increased risk was associated with hospitalization and medication visits prior to any attempt, a suicide attempt in the first year, and a low GAS score at baseline. Long-term risk was decreased by outpatient treatment. Predictors of suicidal behavior in BPD change over time. MDD has a short-term effect on relative risk of suicidal behavior, while poor social adjustment may increase risk in both short- and long- term intervals. Outpatient treatment,which diminishes risk, should focus on both current depression and long-term psychosocial adjustment. Supporting family, work, and social relationships as a long term focus of treatment may diminish suicidal behavior in BPD. This study was supported by NIMH Grant MH 48463 (PHS).

REFERENCES:

1. Black DW, Blum N, Pfohl B, Hale N: Suicidal behavior in borderline personality disorder: Prevalence, risk factors, prediction, and prevention. Journal of Personality Disorders 2004; 18(3):226-239.
2. Soloff PH: Risk factors for suicidal behavior in borderline personality disorder: A review and update. In Borderline Personality Disorder, edited by Zanarini MC, New York, Taylor & Francis, 2005, pp.333-365.

No. 11

THE TEN-YEAR COURSE OF DISSOCIATION REPORTED BY PATIENTS WITH BORDERLINE PERSONALITY DISORDER

Mary Zanarini, Ed.D., McLean Hospital, 115 Mill Street, Belmont, MA 02478, Frances R. Frankenburg, M.D., D. Bradford Reich, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that the long-term course of the dissociative symptoms reported by borderline patients is, for most patients, more benign than previously thought.

SUMMARY:

Objective: The purpose of this study was to assess the severity of dissociation reported by borderline patients over 10 years of prospective follow up. Methods: The Dissociative Experiences Scale (DES)—a 28-item, self-report measure—was administered to 290 borderline inpatients during their index admission. It was also readministered at each of five contiguous two-year follow-up periods. Over 90% of surviving borderline patients participated in all five follow-up assessments. Results: About 26% of patients were found to have high or trauma-level DES scores at baseline (30 or higher), 42% were found to have moderate scores (10-29.9), and 32% had low scores (<10). Over the 10 years of follow up, those in the low DES group retained a mean DES score in the low range. Those in the moderate group had a mean score in the low range by the time of the six-year follow up and those in the high DES group had a mean score in the moderate range by the time of the 4-year follow-up. While 92% of those borderline patients with a high DES score at baseline had a remission of their severe dissociation during the years of follow-up, 33% had a recurrence of a DES score of 30 or higher. In contrast, only a low 5% of those with lower scores at baseline had a new onset of high levels of dissociation over the years of follow-up. Conclusions: The severity of dissociation declines significantly over time for even severely ill borderline patients taken as a whole. However, it remains a recurring problem for about a third of those with DES scores that initially were in the range associated with PTSD or DID.

REFERENCES:

1. Shearer SL: Dissociative phenomena in women with borderline personality disorder. Am J Psychiatry 1994; 151:1324-1328.
2. Zweig-Frank H, Paris J, Guzder J: Dissociation in female patients with borderline and non-borderline personality disorders. J Personal Disord 1994; 8:203-209.

No. 12

PREDICTION OF TIME-TO-ATTAINMENT OF GOOD PSYCHOSOCIAL FUNCTIONING FOR BORDERLINE PATIENTS FOLLOWED PROSPECTIVELY FOR TEN YEARS

Mary Zanarini, Ed.D., McLean Hospital, 115 Mill Street, Belmont, MA 02478, Frances R. Frankenburg, M.D., D. Bradford Reich, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that prediction of the attainment of good psychosocial functioning is multifactorial in nature, primarily involving aspects of competence and temperament.

SUMMARY:

Objective: The purpose of this study was to determine the most clinically relevant baseline predictors of time-to-attainment of good psychosocial functioning among patients with borderline personality disorder (BPD). *Method:* A total of 290 inpatients meeting both DIB-R and DSM-III-R criteria for BPD were assessed during their index admission using a series of semistructured interviews and self-report measures. Psychosocial functioning was reassessed at five contiguous two-year time periods. Survival analytic methods, which controlled for baseline severity of impairment, were used to estimate hazard ratios. *Results:* All told, 50.3% of the borderline patients studied achieved a GAF score of 61 or higher. In terms of time-to-attainment of good psychosocial functioning, 31.7% of the borderline patients who achieved a GAF score of 61 or higher first achieved this score by two-year follow up, an additional 26.8% by four-year follow up, an additional 19.5% by six-year follow-up, an added 13.8% by eight-year follow up, and an added 8% by ten-year follow up. Fifteen variables were found to be significant bivariate predictors of earlier attainment of good psychosocial functioning. Six of these predictors remained significant in multivariate analyses: a good work history as a child or adolescent, a higher IQ, a good premorbid adult work or school history, number of friends during the two years prior to index admission, not having a history of prior hospitalizations, and a lower neuroticism score on the NEO. No measure of childhood adversity or psychopathology was a significant multivariate predictor of the attainment of good psychosocial functioning. *Conclusions:* Competence, temperament, and the absence of chronicity seem to be the best predictors of time-to-attainment of good psychosocial functioning for borderline patients

REFERENCES:

1. McGlashan TH: The Chestnut Lodge follow-up study. III. Long-term outcome of borderline personalities. Arch Gen Psychiatry 1986; 43:20-30.
2. Skodol AE, Gunderson JG, McGlashan TH, Dyck IR, Stout RL, Bender DS, Grilo CM, Shea MT, Zanarini MC, Morey LC, Sanislow CA, Oldham JM: Functional impairment in schizotypal, borderline, avoidant, and obsessive-compulsive personality disorders. Am J Psychiatry 2002; 159:276-283.

SCIENTIFIC AND CLINICAL REPORT SESSION 05-CHEMICAL DEPENDENCY

No. 13

DIFFERENCE IN USING WAIT-AND-SEE STRATEGY BETWEEN NON-CHEMICAL AND CHEMICAL ADDICTIONS ON THE STOP SIGNAL PERFORMANCE

Pinhas Dannon, M.D., Rehovot Community Mental Health & Rehabilitation Clinic, Rehovot, Israel 76449, Semion Kertzman, Katherine Lowengrub, Tali Visne, Anat Aizer, Haim Grenspan, Nina Shliapnikov, Moshe Birger, Moshe Kotler

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the difference behavioral patterns between pathological gamblers and multi substance abusers.

SUMMARY:

Previous studies demonstrated various neuropsychological deficits in pathological gamblers (PGs) and substance dependent/addicted (polysubstance abuse-PSA) patients. There are limited data available on interruptive inhibition ability among PG and PSA patients. The aim of this study is to assess response inhibition functioning in a male population with pathological gambling (N=56; as non-substance-related disorders), with polysubstance abuse (N=58), and healthy subjects (N=43). A stop-signal task was employed as a measure of interruptive inhibition ability. Our results demonstrated that PSA patients performed with significantly more number of the false alarms and misses than PG and controls in stop-signals task. Future studies to investigate neurobiological mechanisms underlying differences on the Stop-signal task performance between PG and PSA patients are necessary to confirm our results.

REFERENCES:

1. Potenza MN: Should addictive disorders include non-substance related conditions? Addiction 2006; 101 (Suppl. 1):142–151.
2. Maddux JF, Desmond DP: Addiction or dependence? Addiction 2000; 95:661–665.

No. 14

CLINICAL ASSESSMENT IN COCAINE ABUSING PATIENTS: ASSOCIATION OF ALEXITHYMIA WITH INADEQUATE PARENTAL ATTACHMENT

Gianmaria Zita, M.D., ASL Città di Milano, Addiction Unit, via delle Forze Armate 381, 20152, Milano, Italy, Milano, Italy 20149, Rosamaria Vitale, Psy.D., Elisa Corvaglia, M.D., Angelo Burato, Cristina Catani, Pierluigi Vigezzi, M.D., Edoardo Cozzolino, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to manage better the assessment of incoming patients with a co-

caine use disorder, including distinguishing subtypes of cocaine addiction and addressing them with different treatment options.

SUMMARY:

Aims: To assess psychological, social, and medical characteristics of incident cocaine patients (pts) in our addiction center from January 2006 to June 2007. Methods: A new protocol for diagnosis and treatment was established. Results: 96 pts, 80 males; mean age 33.9±7yrs; mean abusing time 7yrs (IC95% 5.9-8.5yrs). 83 and 6 pts had dependence and abuse diagnosis respectively; 7 pts didn't meet any DSM-IV criteria. 58.3% were polydrug abusers, mostly alcohol or THC. Affective disorders were the most frequent in Axis I disorder, while borderline and antisocial in axis II disorder. In 20 pts we could not assess the diagnosis. Alexithymia was found in 35.9% out of 78 pts administrated the Toronto Alexithymia Scale. 81 pts were administrated the Parental Bonding Instrument: 59.2% and 51.8% didn't reach cut-off respectively in father and in mother care; high values were found in mother (66.6%) and in father (66.6%) overprotection. Pathological parental attachment was significantly associated with high total alexithymia score (?2test p=.02). depression, obsessive-compulsive and paranoid ideation were the most frequent symptoms occurred in the sample (80 pts) checked for Symptom Checklist-90. Average length of treatment was 168 days (IC95% 138-198 days). Overall retention rate was 41.6%. Average baseline Global Assessment of Functioning (GAF) was 56, while final was 61 (T-test p=.014). Among pts with valid urinary analysis (84.3%) a negative result was found in 88%. Combined treatments were 53%, single treatments 22.9% while 21.8% dropped out before a complete evaluation. Combined and single treatment retention rate were 51.1% and 33.3%. Conclusion: Most of cocaine abusing pts had dual diagnosis. A high percentage of polydrug abusers was found. Combined treatments were effective than single treatments. Strong association between inadequate parental care and high levels of emotional unawareness in cocaine abusing pts is a relevant finding that deserves further investigation.

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No. 15

PATIENT SELECTION AND MATCHING FOR OPIOID MAINTENANCE TREATMENT

Ayman Fareed, M.D., Atlanta VA Medical Center, 1670 Clairmont Road, Decatur, GA 30033, Decatur, GA 30033, Jennifer Casarella, M.D., Richard Amar, M.D., Karen Drexler, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the difference in charateristics for patients maintained on methadone or buprenorphine. Those differences would help in improving patient matching for each medication. Better matching may improve retention in treatment and decrease the rate of drop out.

SUMMARY:

Background: The rationale behind this project is to improve the delivery of clinical services at the Atlanta VA Medical Center opioid agonist treatment program. We compared the characteristics and outcome of treatment for patients maintained on either buprenorphine or methadone at the opioid agonist clinic and the ambulatory outpatient program. We assumed that we would find differences, which will guide better patient matching and selection criteria for each medicine. *Method:* We did a retrospective chart review for 105 patients who were maintained on methadone or buprenorphine between 2003 and 2007. *Results:* Methadone maintained patients who had better retention in (P=0.001), had less number of previous substance abuse treatment (P=0.02), history of being on methadone in the past (P=0.04), and fewer legal problems (P=0.01) than methadone patients who dropped out of treatment. Buprenorphine maintained patients who had better retention were younger (P=0.02). We found borderline association for better retention for buprenorphine patients who were on higher dose (P=0.069) and reported that their drug of choice is prescribed narcotics, not heroin (P=0.066). Patients who had negative urine screen at admission had better retention regardless of the medication (P=0.003 for methadone patients and P=0.001 for buprenorphine patients). *Conclusions:* Based on our chart review we found differences in patients maintained on buprenorphine or methadone, which need further investigations and more research to assist in better patient matching and selection criteria for opioid maintenance treatment.

REFERENCES:

1. A comparison of levomethadyl acetate, buprenorphine, and methadone for opioid dependence. N Engl J Med. 2000 Nov 2; 343(18):1290-7.
2. Predictors of outcome in LAAM, buprenorphine, and methadone treatment for opioid dependence. Exp Clin Psychopharmacol. 2005 Nov; 13(4):293-302.

SCIENTIFIC AND CLINICAL REPORT SESSION 06- CAN EARLY SYMPTOMS PREDICT THE COURSE OF SCHIZOPHRENIA?

No. 16

THE PREDICTIVE VALUE OF FIRST-RANK SYMPTOMS IN PATIENTS WITH SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

Linda Grossman, Ph.D., University of Illinois at Chicago, Department of Psychiatry, Neuropsychiatric Institute, 912 South Wood, Chicago, IL 60612, Cherise Rosen Ph.D., Martin Harrow, Ph.D., Greg Strauss, Ph.D., Megan Butler, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will have greater understanding of the value of Schneiderian First-Rank Symptoms (FRS) as predictors of later psychotic symptoms, functional outcome, and periods of recovery over a 20-year period for patients with schizophrenia and other psychotic disorders.

SUMMARY:

Objective: This study prospectively examined the degree to which Schneiderian First-Rank Symptoms (FRS) predict later psychopathological symptoms, functional outcome, and periods

of recovery over a 20-year period in patients with schizophrenia and other psychotic disorders. *Method:* The Chicago Followup Study prospectively examined 51 subjects with a diagnosis of schizophrenia and 45 subjects with other psychotic disorders at index hospitalization and followed prospectively by six subsequent assessments over the next 20 years. FRS, negative and positive symptoms, psychosocial functioning, global outcome, and periods of recovery, were assessed at each time point. Results: FRS are not exclusive to schizophrenia; however they are less frequent in patients with other psychotic disorders. Rather surprisingly, even after the acute phase, FRS are one of the more frequent types of psychotic experiences in schizophrenia patients. Schizophrenia patients who have FRS at the two year follow up are more likely to exhibit psychosis over the next 20 years. *Conclusions:* FRS are no longer considered pathognomonic for schizophrenia. Although Schneider's classic work remains a useful heuristic tool, FRS should not be used as absolute criteria for diagnosis of schizophrenia. FRS at index hospitalization are predictive of a more severe course of illness. The second year of illness was predictive of course and outcome, regardless of diagnosis. Current data suggest that outcome may be better predicted by specific patterns of symptoms over time than by diagnosis at index hospitalization.

REFERENCES:

1. Silverstein ML,Harrow M: First rank symptoms in the Postacute schizophrenic: A follow-up study. Am J Psychiatry. 1978: 135:12.
2. Nordgaard J, Arnfred SM, Handest P, Parnas J: The diagnostic status of first-rank symptoms. Schizophr Bull. 2007 June 11; [Epub ahead of print].

No. 17

NEGATIVE SYMPTOMS AND THEIR PREDICTORS IN SCHIZOPHRENIA WITHIN THE NORTHERN FINLAND 1966 BIRTH COHORT

Jussi Makinen, Sairaalanrinne 4 gc 24, Oulu, Finland 90220, Jouko Miettunen, Ph.D., E. Jaaskelainen, M.D., Ph.D., J. Veijola, Matti Isohanni, M.D., Ph.D., Hannu Koponen, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the predicting factors of persistent negative symptoms.

SUMMARY:

Background: There is paucity of data concerning the predictive factors and longitudinal course of negative symptoms in schizophrenia. We report the prevalence, persistence, and predicting factors of negative symptoms based on Northern Finland 1966 Birth Cohort. *Method:* The Northern Finland 1966 Birth Cohort is an unselected, general population birth cohort based on 12,058 live-born children. The negative symptoms of subjects with *DSM-III-R* schizophrenia were scrutinized from the hospitalization for the first episode psychosis and evaluated with two methods (n=46). First assessment was conducted using the Operational Criteria Checklist for Psychotic Illness (OCCPI) and for the second time with the PANSS assessment at the 34-year follow up. Data to OCCPI were collected from hospital notes of the first psychotic hospital episode. Several developmental and sociodemographic predictors were analysed for longitudinal variable of negative symptoms. The mean duration of schizophrenia in the sample was approximately ten years. *Results:* A total of 15 subjects (33%) had clinically significant negative symptoms in both measure points and six subjects (13%) had no negative symptoms at all. Normal or low birth weight (Fisher exact test, p=0.04), none or seldom smoking by age 14 (p=0.03), and average or low school performance (p=0.002) were significant early predictors for the stable negative symptoms. *Conclusion:* There data indicate that about one third of schizophrenia patients have persistent negative symptoms. Althought more data are needed concerning factors related to the long-term course of negative symptoms in schizophrenia.

REFERENCES:

1. Kirkpatrick B, Fenton WS, Carpenter WT, Marder SR: The NIMH-MATRICS consensus statement on negative symptoms. Schizophr Bull 2006 ;32:214-9.
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No. 18

NEGATIVE FEATURES OF PSYCHOSIS PRECEDE ONSET OF PSYCHOSIS IN A PROSPECTIVE GENERAL POPULATION SAMPLE OF ADOLESCENTS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand, that prodromal features of psychosis are commonly reported by adolescents in the general population. Negative symptoms may be seen to precede the onset of first-episode psychosis.

SUMMARY:

Purpose of the study: There exists no prospective study ingeneral population exploring symptoms predicting the onset of first episode psychosis. Material and methods: Members (N= 9,215) of the Northern Finland 1986 Birth Cohort, an unselected general population cohort, were invited to participate in a field survey during 2001, at ages of 15-16 years. The study included a 21-item PROD-screen questionnaire screening prodromal symptoms for psychosis for last six months. PROD-screen included nine questions for positive and five questions for negative symptoms. Of the boys, 3,285 (67%) and 3,391 (74%) of the girls completed the PROD-screen questionnaire. The Finnish Hospital Discharge Register was used to find, new cases of hospital treated mental disorders during 2002-2005. Results: Of the subjects 17 (0.3%) were treated due to first-episode psychosis and 95 (1.5%) due to non-psychotic disorder during the follow-up period. Positive symptoms did not associate with the onset of psychosis, but negative symptoms did. 94% of subjects who got psychosis reported negative symptoms. Respective figure for those who were treated for non-psychotic disorder was 48%, and for those "healthy" without psychiatric hospital treatment 46% (Fisher's

exact test: psychosis vs. healthy p<0.001, psychosis vs. non-psychosis p<0.001, and non-psychosis vs. healthy p=0.61). Conclusions and importance of the study: This study may be the only one exploring prospectively in the general population symptoms predicting onset of first-episode psychosis. The findings emphasize the importance of negative symptoms in the development of neuropsychiatric disorder of first episode psychosis. Acknowledgements: The Academy of Finland, the National Institute of Mental Health, the Signe and Ane Gyllenberg Foundation, the Sigrid Juselius Foundation and the Thule Institute, Finland.

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1. Heinimaa M, Salokangas RK, Ristkari T, Plathin M, Huttunen J, Ilonen T, Suomela T, Korkeila J, McGlashan TH: PROD-screen--a screen for prodromal symptoms of psychosis. Int J Methods Psychiatric Res 2003; 12(2): 92-104.
2. Weinberger DR: From neuropathology to neurodevelopment. Lancet 1995; 346: 552-57.

SCIENTIFIC AND CLINICAL REPORT SESSION 07- CLINICAL DILEMMAS IN SCHIZOPHRENIA

No. 19

DECONSTRUCTING FIRST-EPISODE PSYCHOSIS

Cherise Rosen, Ph.D., University of Illinois Medical Center, Department of Psychiatry, 1601 Taylor Street, Suite 489, Chicago, IL 60302, Robert Marvin M.D., James Reilly, Ph.D., Peter Weiden, M.D., John Sweeney, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify differences and similarities of the psychopathological profile at onset in psychotic disorders.

SUMMARY:

Objective: This study compares psychopathological profiles in psychotic patients at onset in persons with schizophrenia (SZ), bipolar (BP), and major depressive disorder (MDD). Method: Patients were recruited from the University of Illinois Medical Center. Patients were assessed medication-free at baseline. Lifetime exposure to psychotropics was less than 16 weeks. Diagnosis was determined using the SCID and consensus case review. The Positive and Negative Syndrome Scale (PANSS) was used to evaluate clinical symptoms: 5-factor scoring included positive, negative, cognitive, excitement, and depression, and cluster analysis of anergia, thought disturbance, activation, paranoia and depression. Results: Of the 72 patients assessed, 33 were diagnosed with SZ, 19 with BP, and 20 with MDD. PANSS 5-factor scores at baseline demonstrated that SZ and BP patients showed more positive symptoms than MDD patients (p<.001) while SZ and MDD patients demonstrated more negative symptoms than BP patients (p=.002). Additionally, SZ patients were significantly more cognitively impaired in relation to patients with BP and MDD (p=.04). Lastly, PANSS cluster scores showed SZ and BP patients exhibited more. Thought disturbance (p<.001) and paranoia (p=.03), and higher a level of anergia (p=.001) compared with patients with MDD. Conclusions: Early data emerging from this study suggests that initial onset of psychotic disorders illustrate considerable overlap in clinical presentation, yet dimensions of pathology can discriminate disorders.

REFERENCES:

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2. Van Os J, Tamminga C: Deconstructing Psychosis. Schizophrenia Bulletin 2007; 861-862.

No. 20

PATHWAYS LEADING TO SUICIDE IN SCHIZOPHRENIA

Antti Alaräisänen, M.B., P.O. Box 5000, 90014 University of Oulu, Oulu, Finland 90230, Johanna Heikkinen, Zuzana Kianickova, M.B., Miettunen Jouko, Ph.D., Räsänen Pirkko, M.D., Ph.D., Matti Isohanni, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand what is currently known about the pathways leading to suicide in schizophrenia.

SUMMARY:

Suicide and suicidal behavior are still major problems when treating schizophrenia. The objective was to review the recent literature on risk factors for suicide in schizophrenia from genes to clinical characteristics to identify different pathways leading to suicide and present a life-span developmental model of suicide in schizophrenia. We performed a database search in Medline, PubMed, PsycInfo, and Web of Science with the keywords suicide AND schizophrenia, limiting the results to the years 2003-2006. There seem to be five main pathways for schizophrenia patients leading to suicide: One obvious pathway is comorbid depression that leads to suicide. Second, there is a group of patients with a difficult, chronic course of illness and many relapses and exacerbations. They lose their hope progressively over time. The third group comprises patients (mostly young males) with impulsiveness, dysphoric affect and substance abuse. Fourth, there is a relatively small but theoretically interesting and clinically important group of mainly young patients with high premorbid functioning and above average intellectual capacity. The high suicide rate among this group may be a consequence of their own and their relatives' high expectations that are in line with their good premorbid functioning. The fifth group, failure in treatment, comprises patients lacking social support whose treatment has failed. We also propose a life span model showing these five different pathways to suicide in schizophrenia. We hope that pathways we present could be useful in identifying some main groups of patients who are at particularly high risk for suicide. They might also provoke some further research ideas and hypotheses.

REFERENCES:

1. Alaräisänen A, Heikkinen J, Kianickova Z, Miettunen J, Räsänen P, Isohanni M Pathways leading to suicide in schizophrenia. A review with special reference to novel research between 2003-2006. Current Psychiatry Reviews, In Press.
2. Hawton K, Sutton L, Haw C, Sinclair J, Deeks JJ Schizophrenia and suicide: systematic review of risk factors. Br J Psychiatry 2005; 187: 9-20.

No. 21

RECOVERY IN A SUBGROUP OF PATIENTS WITH SCHIZOPHRENIA WHO DISCONTINUE ANTIPSYCHOTIC MEDICATIONS: A 15-YEAR FOLLOW UP

Martin Harrow, Ph.D., 1601 West Taylor Street, M/C 912, Chicago, IL 60612, Thomas H. Jobe, M.D., Ellen Astrachan-Fletcher, Ph.D., Cherise Rosen, Ph.D., Linda S. Grossman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to make better decisions about whether all of their patients with schizophrenia need to use antipsychotic medications continuously throughout their lives and, if not, which types may eventually be able to discontinue them for prolonged periods without relapse.

SUMMARY:

Goal: Recent research has begun to explore issues about whether all patients with schizophrenia need to use antipsychotic medications continuously throughout their lives. The current 15-year longitudinal research was designed to study which particular types of schizophrenia patients may profitably be able to stay off antipsychotic medications for prolonged periods. *Method:* We evaluated 223 patients from the Chicago Followup Study at acute hospitalization and then followed them up five times over the next 15 years. This included 62 patients with schizophrenia. Based on standardized instruments patients were assessed for positive and negative symptoms, for cognitive impairment, social and work functioning and recovery. At each follow-up, use of first and second-generation antipsychotic medications and other treatments were studied. *Results:* (1) By the 4.5-year followups almost 40% of patients with schizophrenia had discontinued antipsychotic medications; (2) A subgroup of those schizophrenia patients who discontinued antipsychotic medications during the post-hospital phase did not relapse quickly, and showed prolonged periods of recovery; (3) This subgroup of patients in recovery showed less vulnerability to anxiety and greater subjective comfort in social situations ($p < .05$); and (4) They also showed less vulnerability to minor somatic complaints, better neurocognitive skills, and better premorbid developmental achievements ($p < .05$). Importance: The 15-years of longitudinal data indicate that not all patients with schizophrenia need to use antipsychotic medications continuously throughout their lives. The relatively favorable outcomes of a subgroup of schizophrenia patients off antipsychotics are partly a result of internal characteristics of these patients. These internal characteristics include better premorbid developmental achievements, possibly linked to less neurodevelopmental impairment during earlier stages of development.

REFERENCES:

1. Lieberman J, Stroup S, McEvoy J, et al.: Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. New England Journal of Medicine, 2005; 353:1209–1223.
2. Harrow M, Jobe T: Factors involved in outcome and recov ery in schizophrenia patients not on antipsychotic medica tions: A 15-year multi-follow-up study. The Journal of Ner vous and Mental Disease 207; 195:406–414.

SCIENTIFIC AND CLINICAL REPORT SESSION 08-METABOLIC SYNDROME AND EATING BEHAVIOR

No. 22

DEVELOPING AND IMPLEMENTING A PSYCHIATRIC CLINIC-BASED METABOLIC SCREENING: PART I

Catherine Batscha, M.S.N., Psychotic Disorders Program, 912 South Wood, Chicago, IL 60612, Mark E. Schneiderhan, Pharm. D. BCPP, Cherise Rosen, Ph.D., Robert Marvin, M.D., Dennis Beedle, M.D., Ovidio DeLeon, M.D., Gaston Baslet, M.D., Tsing-Yi Koh, Pharm.D., ManYan Yu, Pharm.D., Wendy Ng, Jamie Joseph, Pharm.D., Jeffrey Bishop, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) outline the process and challenges of implementing metabolic screening in a psychiatric medication clinic; (2) identify necessary components to be included in a metabolic screening; and (3) conduct a quick, thorough metabolic screening using the screening tool.

SUMMARY:

A pre-metabolic screening clinic was initiated as a quality assurance project to address the 2004 consensus guidelines for monitoring patients on antipsychotic agents and the logistical difficulty of obtaining fasting glucose and lipids. The team is comprised of a clinical pharmacist, a clinical nurse specialist, and a research nurse who assisted with SPSS data management. Initial and follow-up screening tools serve multiple functions including a coded data input record, a clinical source document, and a clinician letter that provides demographic, current and past metabolic history, family history, medication history, and recommendations to the psychiatrist. Purpose: The screening tools were developed to: (1) provide an efficient and realistic assessment of risk of undetected metabolic disorders in patients treated with antipsychotic agents and, (2) provide psychiatrists with recommendations for follow-up. Methods: Selected components from definitions of metabolic syndrome from NECP-ATP-III*, WHO*, and AACE* were incorporated into the screening tool. Components assessed were: BMI, abdominal obesity (waist circumference, waist-to-hip ratio), impaired glucose tolerance/pre-diabetes (random glucose >140mg/dL), blood pressure, sedentary lifestyle, ethnicity, age and family history of diabetes, hypertension and hyperlipidemia. Recommendations included three month repeat screening, referral to a weight management group, fasting blood work or referral to primary care. Results/discussion: A total of 93 patients treated with antipsychotic agents underwent initial pre-screening since initiation of the screening clinic. Recommendations were sent to psychiatrists. An appointment recall notification system was implemented to repeat screenings every three months for one year. Use of the screening tool facilitates ease and efficiency of screening. This metabolic screening triage system is relevant when fasting blood work cannot be obtained in large clinic populations.

REFERENCES:

1. Bermudes RA, Keck PE, McElroy SL, eds.: Managing Metabolic Abnormalities in the Psychiatrically Ill: A Clinical Guide for Psychiatrists. Washington, DC, American Psychiatric Publishing, 2007.

2. Cohn TA, Sernyak MJ: Metabolic monitoring for patients treated with antipsychotic medications. Can J Psych 2006; 15(8):492-501.

No. 23

INITIAL PRE-METABOLIC RISK OF 93 PATIENTS ON SECOND-GENERATION ANTIPSYCHOTICS: PART 2

Mark Schneiderhan, Pharm.D., University of Illinois at Chicago, College of Pharmacy, 833 S. Wood Street, Room 164, Chicago, IL 60612, Catherine Batscha, APRN, B.C., Cherise Rosen, Ph.D., Robert Marvin, M.D., Dennis Beedle, M.D., Ovidio DeLeon, M.D., Gaston Baslet, M.D., Tsing-Yi Koh, Pharm.D., ManYan Yu, Pharm.D., Wendy Ng, Pharm.D., Jamie Joseph, Pharm.D., Jennifer Splawski, Jeffrey Bishop, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) identify metabolic syndrome as defined by Third Adult Treatment Protocol-III(NECP-ATP-III) guidelines; (2) define ”metabolic risk” and “re-diabetes risk” assessed by waist measurements/blood pressures and random capillary glucose/post-prandial times, respectively; and (3) describe the strengths and limitations of screening patients for actual “Metabolic Syndrome” versus ”metabolic risk” and “pre-diabetes risk”.

SUMMARY:

Purpose: Metabolic abnormality prevalence rates are two to three times higher in patients on antipsychotic agents compared with patients not taking antipsychotic agents. Ufortunately, many of these patients do not receive adequate primary care. The purpose of our study was to identify patients with metabolic abnormalities. Methods: Retrospective analysis was used to quantify initial metabolic risk and pre-diabetes risk of patients treated with antipsychotics. We defined “metabolic risk” as meeting two of the NECP-ATP-III guidelines: abdominal obesity (Females, waist = 89cm and males, waist = 101cm) and blood pressures (systolic =130 or diastolic =85). Pre-diabetes risk was defined as a two-hour post-prandial capillary blood glucose > 140mg/dL. The two-hour post-prandial value was based upon patient recall of the time of last food intake. Results: A total of 93 patients underwent initial screening. Fifty-four percent (n=50) of the patients were African American. 71.4% females and 65.9% males met criteria for “metabolic risk.” 18% (17/93) of patients (n= 8 Female; n= 9 male) had random glucose measures greater than 140 mg/d and of these, only 9/17 patients had documented post-prandial times and 5% (5/93) of these patients met criteria for “pre-diabetes risk.” Relevance: The “metabolic risk” measurements can be easily obtained in the psychiatrist’s office/clinic. However, pre-diabetes risk is more difficult to assess because of the poor validity associated with patient self-reporting of post-prandial times. Five percent of patients treated with antipsychotics were found with evidence of “pre-diabetes risk” in the absence of previously diagnosed diabetes. Importantly, even abnormal random glucose measurements in the absence of post-prandial times were still perceived to signal higher metabolic risk. The clinical significance of metabolic screenings in patients treated with antipsychotic agents warrants continued observations.

REFERENCES:

1. McEvoy JP, Meyer JM, Goff DC, Nasrallah HA, Davis SM, Lullivan L, Meltzer HY, Hsiao T, Stroup S, Lieberman J: Prevalence of the metabolic syndrome in patients with schizophrenia: Baseline results from the Clinical Antispsychotic Trials of Intervention Effectiveness (CATIE) schizophrenia trial and comparison with national estimates from NHANES III. Schizophr Res 2005; 80:19-32.
2. Cohn TA, Sernyak MJ: Metabolic monitoring for patients treated with antipsychotic medications. Can J Psych 2006: 15(8):492-501.

No. 24

A COMPARISON OF THE EFFECTS OF MODAFINIL ON OLANZAPINE-ASSOCIATED EATING BEHAVIORS IN NORMAL HUMAN SUBJECTS

James Roerig, Pharm.D., 120 South 8th Street, Fargo, ND 58107, Kristine Steffen, Pharm.D., James E. Mitchell, M.D., Ross D. Crosby, Ph.D., Blake A. Gosnell, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the application of modafinil as a prophylactic intervention for olanzapine-associated weight gain.

SUMMARY:

Introduction: Weight gain has been associated with many atypicals including clozapine, olanzapine, risperidone, and quetiapine. Blockade of histamine-1 receptors by these agents is felt to underlie this effect. Modafinil is an agonist at the histamine-1 receptor. The objective of this trial is to determine the effect of modafinil on olanzapine, associated weight gain. Methods: This study is a three week, randomized, double-blind, placebo-controlled, trial. All subjects received olanzapine titrated to 10mg/d. Concurrently subjects were randomized to receive modafinil titrated to 200mg/d or placebo. Weight and feeding lab assessments were conducted at baseline and endpoint. Results: Fifty subjects signed informed consent; ten subjects were dropped due to adverse reactions resulting in 20 subjects per group completing the trial. The primary outcome variable was change in weight over the three weeks of the trial. Both groups demonstrated a significant weight gain from baseline to endpoint, placebo = 2.67 kg; $t(19)=-6.674$, $p=0.00$; modafinil = 1.33 kg; $t(19)=-4.219$, $p=0.000$. Analysis of covariance of the end point BMI revealed a significant difference between groups with the modafinil group gaining less weight than the placebo group $F(1,37)=5.558$, $p=.024$. The analysis was covaried for baseline BMI and a Bonferroni correction for multiple comparisons was completed. Analysis of kilocalories consumed in a dinner feeding lab session revealed the modafinil group consuming 1489.96 kcal vs 1791.45 for the placebo group. However, this difference was not found to be significant $F(1,37)=5.28$, $p=.472$. Discussion: This trial demonstrated that subjects who received olanzapine plus modafinil experienced approximately half of the weight gain found in the olanzapine/placebo group. In light of these findings, modafinil may be able to serve as a prophylactic intervention to attenuate olanzapine associated weight gain in a patient population.

REFERENCES:

1. Allison DB, Mentore JL, Heo M, Chandler LP, Cappelleri JC, Infante MC, Weiden PJ: Antipsychotic-induced weight gain: a comprehensive research synthesis. Am J Psychiatry 1999;

156:1686–1696.
2. Roerig JL, Mitchell JE, de Zwaan M, Crosby RD, Gosnell BA, Steffen KJ, Wonderlich SA: A comparison of the effects of olanzapine and risperidone versus placebo on eating be haviors. J Clin Psychopharmacol 2005; 25:5: 413-418.

TUESDAY, MAY 6, 11:00 AM - 12:30PM

SCIENTIFIC AND CLINICAL REPORT SESSION 09- THE INTERNET AND PSYCHIATRY

No. 25

CLINICAL ENCOUNTERS WITH INTERNET PORNOGRAPHY

Thomas Kalman, M.D., 11 East 87th Street, Apt. 1B, New York, NY 10128

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to detect and identify symptoms and behaviors of patients that are representative of problems arising from the use of internet pornography (IP). The participant will gain awareness about patterns and prevalence of IP use in our society and be introduced to concepts about sexual addiction, the psychodynamics of pornography content, and prior research on the effects of general pornography use on individuals and families.

SUMMARY:

Pornography, if understood to involve the depiction of sexual activity, organs, and experiences, is perhaps as old as human civilization itself. Thriving during classical Greek and Roman culture, then virtually disappearing until the late middle ages, pornography dissemination has historically been linked to various technological innovations, most notably the printing press, still and motion photography, the advent of video and the home VCR, and most recently, computing and the internet. Within the mental health professions, substantial research (of inconsistent quality) exists on the effects of viewing general pornography; however, the specific impact of the use of internet pornography is only beginning to be examined. This paper presents an overview of internet pornography, including information on its scope of use and special characteristics that may contribute to the development of clinical problems. Through a series of clinical vignettes, the paper describes and illustrates problems involving the use of Internet Pornography presented by outpatients in a private psychiatric practice. Some of the difficulties encountered include i)decreased sexual satisfaction with and desire for one's partner by the pornography user ii)a progressive "numbing" such that increasing amounts of pornography of increasingly intense content are needed to achieve sexual arousal iii)compromises of judgment regarding the use of Internet Pornography in the workplace (with potentially disastrous consequences iv)influence on sexual expectations and interpersonal relationships and v)emotional isolation and withdrawal from romantic partners. The paper concludes with observations about helpful clinical interventions and suggestions for further research in this area.

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1. Manning JC: The impact of internet pornography on marriage and the family: A Review of the Research. Sexual Ad diction and Compulsivity 2006; 13:131-165.
2. Brown D: Commercial sex: Pornography (ch 11), in Sex and Sexuality v.1, Sexuality Today: Trends and Controversies Ed ited by McAnulty RD and Burnette MM; Westport Ct, Prae ger Publishers, 2006, pp. 265-298.

No. 26

CYBERSUICIDE: "PRO" AND "HOW TO" SUICIDE INFORMATION ON THE WEB

Patricia Recupero, M.D., J.D., Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906, Samara E. Harms, B.A., Jeffrey M. Noble, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify several of the types and sources of harmful pro- or how-to suicide information available on the world-wide web. The participant will learn how patients may access such material and what a suicidal patient might find should he or she attempt to locate suicide information through internet search engines. The presentation also suggests interventions to help clinicians work with web-savvy, high-risk patients.

SUMMARY:

Objective: This study examined what types of resources a suicidal person might find through search engines on the internet. We were especially interested in determining the accessibility of potentially harmful resources, such as pro-suicide forums, as such resources have been implicated in completed suicides and are known to exist on the web. *Method:* Using five popular search engines and four suicide-related search terms, we collected quantitative and qualitative data about the search results. Several co-raters assigned codes and characterizations to web pages, which were then confirmed by consensus ratings. Search results were classified as being either pro-suicide, anti-suicide, suicide-neutral, not a suicide site, or error (i.e., page would not load). Additional information was collected to further characterize the nature of the information on these web sites. *Results:* Suicide-neutral pages were the most frequent, followed by anti-suicide pages. While pro-suicide resources were less frequent, they were nonetheless easily accessible. *Conclusion:* Mental health professionals should ask patients about their internet use. Depressed, suicidal, or potentially suicidal patients who use the internet may be especially at risk. Clinicians may wish to assist patients in locating helpful, supportive resources online so that patients' internet use may be more therapeutic than harmful. Detailed, how-to instructions for unusual and lethal suicide methods, and organizations and individuals advocating suicide, are easily located through internet search engines.

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1. Alao AO, Yolles JC, Armenta W: Cybersuicide: The internet and suicide. Am J Psychiatry 1999; 156(11):1836-1837.
2. Gallagher KE, Smith DM, Mellen PF: Suicidal asphyxiation by using pure helium gas: Case report, review, and discussion of the influence of the internet. Am J Forensic Med Pathology 2003; 24(4):361-363.

No. 27

SELF-EXPLORATION AND IDENTITY NEGOTIATION ON THE INTERNET

Lydia Sit, M.D., 2150 Pennsylvania Ave NW, 8th Floor, Washington, DC 20037, Washington, DC 20037

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) describe the newest online entities that are available for users, including blogs, forums, Massively Multiplayer Online Role Playing Games (MMORPG), and virtual communities (Second Life); (2) identify various psychological factors affecting internet usage (anonymity, temporal flexibility, multiplicity, etc.); and (3) discuss several observable outcomes and possible future trends as a result of the Internet revolution.

SUMMARY:

The internet is a rapidly growing system of networks. With these developments come greater changes in the way we think, interact, and form communities. For many people it has become a powerful force in negotiating their identity. As mental health professionals, there will inevitably be, if there are not already, patients who will report some degree of their online activities. As such it is our duty to begin building a framework for our understanding of the internet revolution. *Objective:* This paper is an exploration of the wide array of motivations and meanings of internet-related behaviors. *Methods:* Systematic literature review on published papers related to internet-related psychology, usage, and behavior. Results: There are several studies already published and also ongoing research observing the interactions of users in chat rooms, virtual communities, and MMORPGS. There are also several books and papers that attempt to elucidate the meanings and psychological constructs behind these behaviors. Conclusions: With the internet comes a set of distinct psychological factors that affect its usage: anonymity, temporal flexibility, recordability/public domain, flexibility, and mutliplicity. Together these create unique opportunities for identity negotiation in addition to the potential outcomes of Internet addiction and online disinhibition. In conclusion, the internet revolution has already arrived. As we move forward in our careers as mental health professionals, we need to be cognizant of the changes it has brought with it and so we can better both understand and help our patients.

REFERENCES:

1. Suler J R: The basic psychological features of cyberspace. The Psychology of Cyberspace, 2002, www.rider.edu/suler/psycyber/basicfeat.html.
2. Turkle S: Life on the Screen: Identity in the Age of the Inter net. New York: Simon and Schuster, 1995.

SCIENTIFIC AND CLINICAL REPORT SESSION 10-ALCOHOL AND CANNABIS DEPENDENCE

No. 28

INTEGRATED GROUP THERAPY FOR PATIENTS WITH BIPOLAR DISORDER AND SUBSTANCE DEPENDENCE CAN BE SUCCESSFULLY DELIVERED BY DRUG COUNSELORS

Roger Weiss, M.D., 115 Mill Street, Belmont, MA 02478, Margaret L. Griffin, Ph.D., William B. Jaffee, Ph.D., Rachel E. Bender, B.A., Fiona Graff, B.A., Robert J. Gallop, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand and implement successful behavioral treatment strategies with patients with co-occurring bipolar and substance use disorders. Participants will understand specific patterns of medication non-adherence in patients with bipolar disorder and substance dependence. Participants will be able to recognize typical thought and behavior patterns in this population that are conducive to recovery and relapse.

SUMMARY:

Introduction: Bipolar disorder (BD) is the Axis I disorder with the highest risk of a coexisting substance use disorder (SUD). However, treatments for this population have been understudied. We developed a manualized therapy for these patients, Integrated Group Therapy (IGT), using a cognitive-behavioral model focused on similarities in thoughts and behaviors in recovery from BD and SUD. In a previous randomized, controlled trial, IGT was more effective than standard group drug counseling (GDC) in reducing substance use; mood outcomes were similar. The current study tested a "community-friendly" version of IGT, designed to be more amenable for adoption in community drug abuse treatment programs. We attempted to replicate our previous findings in an effectiveness trial using drug counselors with no previous CBT training; the treatment was reduced from 20 to 12 sessions to increase feasibility. *Method:* A randomized, controlled trial (N=61) compared 12 weekly sessions of IGT with GDC. We hypothesized that IGT patients would again have a greater reduction in days of substance use and fewer weeks ill with a mood episode than GDC patients. *Results:* Adherence/competence ratings showed satisfactory performance by the counselors, and group attendance was high in both treatments. IGT had better substance use and mood outcomes than GDC. IGT patients were significantly more likely to abstain throughout the 3 months of treatment, were more likely to attain at least one abstinent month, and had a shorter time to the first abstinent month; there was also a trend for fewer days of substance use for IGT patients. Further, IGT patients had fewer weeks ill with depression than GDC patients. *Conclusion:* These findings corroborate earlier results showing that IGT is more effective than GDC for patients with BD and SUD. This study also demonstrates that drug counselors can be trained to implement this intervention effectively, and that a shortened version of IGT remains effective.

REFERENCES:

1. Weiss RD, Griffin ML, Greenfield SF, Najavits LM, Wyner D, Soto JA, Hennen JA: Group therapy for patients with bipolar disorder and substance dependence: results of a pilot study. J Clin Psychiatry 2000; 61(5): 361-367.
2. Weiss RD, Griffin ML, Kolodziej ME, Greenfield SF, Naja vits LM, Daley DC, Doreau HR, Hennen JA: A randomized trial of integrated group therapy versus group drug counseling for patients with bipolar disorder and substance dependence. Am J Psychiatry 2007; 164(1): 100-107.

No. 29

CANNABIS WITHDRAWAL IN NON-TREATMENT-SEEKING ADULT CANNABIS USERS

David Gorelick, M.D., NIDA IRP, 5500 Nathan Shock Drive, Baltimore, MD 21224, Kenneth H. Levin, BA, Marc L. Copersino, Ph.D., Stephen J. Heishman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) recognize the major symptoms of cannabis withdrawal; and (2) understand the role of withdrawal in relapse to cannabis use.

SUMMARY:

Objective: Cannabis withdrawal is not recognized in *DSM-IV*, in part because its "clinical significance is uncertain" (*DSM-IV*-TR, 2000, p. 236). We previously reported in 104 adults that 70% experienced over three withdrawal symptoms; a majority (56%) took some action to relieve withdrawal. (Copersino et al., 2006) This study aimed to confirm these findings in a larger, more varied sample recruited from the community. *Method:* Subjects over 18 years old, over 8th grade English reading level, had made more than one "serious" (self-defined) attempt to quit cannabis use, and gave written informed consent completed a Marijuana Quit Questionnaire. The quitting experience in subject subgroups was compared using chi-square and t tests. *Results:* A total of 469 subjects provided usable data, with a mean (SD) age of 31.2 (10.3) years, 58% male, 79.5% African American. They used cannabis as marijuana cigarettes (88.7%) and blunts (82%); 71.2% reported lifetime cannabis use more than 1000 times. Their age at first cannabis use was 14.8 (3.2) years. 79.7% reported using more cannabis than at first to get the same "high" (suggestive of tolerance); 42.4% reported experiencing withdrawal symptoms when quitting. One-third of subjects resumed cannabis use to reduce or avoid withdrawal symptoms, suggesting that withdrawal served as a negative reinforcer for relapse. Such subjects were significantly more likely than others to be younger (29.5 vs. 31.8 years old), African American (85.3% vs. 14.7%), less confident in the success of their quit attempt, and to report tolerance and psychological dependence. *Conclusions:* Study findings show that one-third of adult heavy cannabis users resume cannabis use to minimize or avoid withdrawal. This suggests that cannabis withdrawal serves as a negative reinforcer for relapse, supporting its clinical importance as a focus of treatment for patients with cannabis dependence. Supported by the Intramural Research Program, NIH, National Institute on Drug Abuse.

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1. Budney AJ, Hughes JR, Moore BA, Vandrey R: Review of the validity and significance of cannabis withdrawal syn drome. Am J Psychiatry 2004; 161:1967-1977.
2. Copersino ML, Boyd SJ, Tashkin DP, Huestis MA, Heish man SJ, Dermand JC, Simmons MS, Gorelick DA: Cannabis withdrawal among non-treatment-seeking adult cannabis us ers, Am J Addict 2006; 15:8-14.

No. 30

LONG-TERM SAFETY AND TOLERABILITY OF EXTENDED-RELEASE NALTREXONE IN ALCOHOL- AND/OR OPIOID-DEPENDENT PATIENTS: A RANDOMIZED, ACTIVE-CONTROLLED STUDY

Kyle Kampman, M.D., University of Pennsylvania, Treatment Research Center, 3900 Chestnut Street, Philadelphia, PA 19104, Irina Gromov, M.D., Ph.D., Alan Sirota, M.D., Ph.D., Bernard Silverman, M.D., Xinjian Qiao, Sc.D., David R. Gastfriend, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be familiar with the long-term safety and tolerability profile of extended-release naltrexone (XR-NTX) in patients with alcohol and opioid or mixed dependence.

SUMMARY:

Objective: The chronicity of alcohol dependence requires that medications have tolerable safety profiles over time. The long-term safety and tolerability of repeat doses of extended-release naltrexone (XR-NTX) 380 mg were evaluated in alcohol- and opioid- or mixed-dependent patients in a randomized, multicenter, active-controlled study for =one year. *Methods:* Consenting patients were randomized (6:1) to receive intramuscular injections of XR-NTX 380 mg every four weeks (physician administered) or oral naltrexone 50-mg tablets daily (patient administered), in combination with psychosocial support. *Results:* Mean (SD) patient age was: overall (N=436) 40.7 (11.3), alcohol- (N=315) 43.2 (10.4), and opioid- or mixed-dependence (N=121) 34.1 (10.8) years. Of the 371 patients randomized to XR-NTX 380 mg, 119 (32%) received all 13 scheduled doses. Of the 65 patients randomized to oral naltrexone, medication for the entire regimen was distributed to 22 patients (34%). Similar percentages of patients in both treatment groups completed the study. In total, 60 (14%) patients withdrew due to adverse events (AEs). The treatments were generally well tolerated. Most AEs were mild or moderate in intensity. Overall, the most common were nausea (22%), headache (16%), nasopharyngitis (12%), insomnia (11%), upper respiratory tract infection (10%), and depression (10%). The AE profile of XR-NTX 380 mg was comparable to that of oral naltrexone, with the exception of injection-site reactions which occurred with 14% of XR-NTX injections. Similar AEs were reported by alcohol- and opioid- or mixed-dependent patients. There was no evidence of drug-related hepatotoxicity. Heroin overdose was reported in 3 patients with opioid or mixed dependence (2 receiving XR-NTX 380 mg, 1 oral naltrexone); all 3 recovered and discontinued from the study. *Conclusion:* Long-term administration of XR-NTX 380 mg was generally safe and well-tolerated in alcohol- and opioid- or mixed-dependent patients.

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1. Garbutt JC, Kranzler HR, O'Malley SS, Gastfriend DR, Pettinati HM, Silverman BL, Loewy JW, Ehrich EW; Vivitrex Study Group: Efficacy and tolerability of long-acting injectable naltrexone for alcohol dependence. a randomized controtrolled trial. JAMA 2005; 293:1617-1625.
2. Silverman B, Lucey M, Illeperuma A, O'Brien CP: Hepatic Safety of Once-Monthly Long-Acting Intramuscular Naltrexone (LA-NTX) in Alcohol-Dependent Subjects: A Pooled Analysis From 2 Clinical Studies [poster]. Presented at the 159th Annual Meeting of the American Psychiatric Associa-

tion; May 20-25, 2006; Toronto, Canada.

SCIENTIFIC AND CLINICAL REPORT SESSION 11-GERIATRIC PSYCHIATRY

No. 31

FEASIBILITY AND EFFECTIVENESS OF TELEMEDICINE FOR PSYCHIATRIC CONSULTATION TO CHINESE IMMIGRANTS IN A NURSING HOME

Albert Yeung, M.D., Suite 401, 50 Staniford Street, Boston, MA 02114, Wan-Chen Claire Weng, Daniel Johnson, B.A., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will understand the usefulness of telemedicine for psychiatric consultations to Chinese immigrants in a nursing home.

SUMMARY:

Objective: To investigate the feasibility and effectiveness of telemedicine for psychiatric consultations to depressed Chinese immigrants in a nursing home. *Method:* Polycom® VSXTM3000 systems were installed at the Massachusetts General Hospital Depression Program and at South Cove Manor, a nursing home in Boston's Chinatown serving predominantly Chinese immigrants. The equipment was connected using IP and transmissions are at 384K with no audio delay. Starting in January 2007, all nursing home patients who required a psychiatric consultation were directed to the PI who provided one-time face-to-face consultation at the nursing home. After patients or their guardians had consented to the study, the PI arranged follow-up visits using videoconferencing. For patients who are hard of hearing, a nursing home staff assisted communication during videoconferencing visits. All patients received two to six follow-up visits depending on their clinical conditions. Patients' and nursing home staff's satisfaction, patients' improvement in clinical symptoms, and social functioning were measured. *Results:* This is an ongoing study, which has enrolled seven patients from the nursing home. All subjects had no difficulty being interviewed using telemedicine for their follow-up visits. All subjects, family members, and nursing home staff responded being satisfied or highly satisfied to the intervention. Five out of seven of the patients have improved with intervention based on their Clinical Global Improvement Scores; the remaining two subjects received consultation only for diagnostic purposes. *Conclusions:* It is possible to use telemedicine to provide psychiatric consultations to ethnic minority patients in a nursing home. Telemedicine has the potential to be an effective tool for decreasing mental health treatment disparities among ethnic minorities with language barriers.

REFERENCES:

1. Montani C, Billnud N, Tyrrell J, Fluchaire I, Malterre C, Lauvernay N, et al: Psychological impact of a remote psychometric consultation with hospitalized elderly people. Journal of Telemedicine and Telecare, 3:140-5,1997.
2. Hyler SE, Gangure DP, Batchelder ST: Can telepsychiatry replace in-person psychiatric assessments? A review and meta-analysis of comparison studies. CNS Spectrums, 10: 403-413, 2005.

No. 32

POOR SLEEP QUALITY INDEPENDENTLY PREDICTS DEPRESSION IN COMMUNITY-DWELLING OLDER ADULTS

Hyong Cho, M.D., Cousins Center for Psychoneuroimmunology, UCLA Semel Institute for Neuroscience and Human Behavior, 300 Medical Plaza, Suite 3156, Los Angeles, CA 90095, Michael R. Irwin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to apply a simple two-step strategy to identify those older adults at risk for depression in his/her clinical practice, especially to: (1) inquire about a prior history of depression, a non-modifiable, but easy-to-assess risk factor; and (2) assess the presence of sleep disturbance, a potentially modifiable risk factor.

SUMMARY:

Background: Sleep disturbances and depressive disorders in late life are major public health issues. However, data supporting sleep disturbance as a risk factor for geriatric depression are limited. *Objective:* To examine whether sleep disturbances predict both occurrence and recurrence of depression in late life independently of prior depression history and other depressive symptoms. *Design:* Prospective cohort study. *Setting:* three urban communities in the United States. *Participants:* 351 older adults aged 60 or older, 145 with a history of major or non-major depression in full remission and 206 who have never been mentally ill. Measurements: Participants were assessed at baseline, six weeks, one year, and two years for depressive episodes (major and non-major), depressive symptom severity, sleep quality, and chronic medical illness, respectively using the Structured Clinical Interview for the DSM-IV, the Beck Depression Inventory, the Pittsburgh Sleep Quality Index, and the Chronic Disease Score. Results: Group status (prior depression vs. control), sleep disturbance and other depressive symptoms were independent baseline predictors of depression occurrence during two-year follow up with respective adjusted odds ratios of 38.65 (95% CI 4.72 to 316.43), 3.05 (1.07 to 8.75) and 1.19 (1.07 to 1.33). Within the prior depression group, depression recurrence was independently predicted by sleep disturbance (hazard ratio 3.99; 95% CI 1.24 to 12.86) and other depressive symptoms (1.15; 1.02 to 1.30). Conclusions: Sleep disturbance was an independent risk factor for both occurrence and recurrence of depression in community-dwelling older adults. Proper identification and treatment of sleep disturbances in older adults may prevent future depressive episodes, particularly, in those with a prior depression history.

REFERENCES:

1. Cole MG, Dendukuri N: Risk factors for depression among elderly community subjects: a systematic review and meta-analysis. Am J Psychiatry 2003; 160:1147-56.
2. Irwin MR, Cole JC, Nicassio PM: Comparative meta-analysis of behavioral interventions for insomnia and their efficacy in middle-aged adults and in older adults 55+ years of age. Health Psychol 2006; 25:3-14.

No. 33

ASSOCIATION BETWEEN FRONTAL LOBE COGNITIVE AND EXECUTIVE FUNCTIONS AND DOMAINS OF DEPRESSIVE SYMPTOMS IN EARLY POST-STROKE PATIENTS

Matldes Sobreiro , Psy.D., Av. Dr. Ovidio Pires de Campos 785, 3º, Instituto de Psiquiatria, Sala 13, Cerqueira Cesar, São Paulo, Brazil 05403-010, Kátia O. Pinto, Ph.D., Luisa Terroni, M.D., Mara C. De Lucia, Ph.D., Gisela Tinone, Ph.D., Dan V. Iosifescu, M.D., Renério Fráguas, Ph.D., Milberto Scaf, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant, while considering a first-ever stroke patient, should be able to describe the relationship between the domain of retardation and cognition on the 31-item Hamilton Depression Rating Scale (HAM-D-31) as well as the functions of the frontal lobe, specifically working memory and executive functions.

SUMMARY:

Objective: The aim of this study was to investigate the relationship between frontal lobe functions and domains of depressive symptoms in first-ever ischemic stroke patients. Methods: We assessed 72 consecutive males and females patients admitted to the neuro-clinic unit of the HCFMUSP-SP with diagnosis of first ischemic supratentorial stroke. All patients were 18 years or older and had no previous history of depressive disorders. They were evaluated between six to 23 days after the stroke (mean + SD =12 + 3.8). Seven domains of depressive symptomatology (cognitive symptoms, accessory symptoms, retardation, fatigue and interest, eating and weight, insomnia, and anxiety) as been reported by Jamerson et al. (2003) were assessed by a psychiatrist using the HAM–D-31. A neuropsychologist assessed the frontal lobe functions using the Digit Span (WAIS-R), the Verbal Fluency words/min (FAS) and the Stroop Test. Results: Inverse correlation was found between scores on the retardation domain of the HAM-D-31 and the performance on the Digit Span backward subtest (t=-1.95; P=0.055; 95% confidence interval [CI]: -0.65 to 0.01) and on the FAS test (t=-2.97; P=0.004; 95%CI: -5.21 to -1.02); and positive correlation was found between scores on the retardation domain of the HAM-D-31 and the performance on the Stroop-D (t=3.11; P=0.005; 95%CI: 1.41 to 6.93), Stroop-W (t=2.70; P=0.012; 95%CI: 1.57 to 11.54) and Stroop-C (t=2.41; P=0.023; 95%CI: 1.53 to 19.70) tests. The domain of cognitive symptoms on the HAM-D-31 was positively correlated with the performance on the Stroop-D (t=2.36; P=0.026; 95%CI: 0.47 to 6.77) and Stroop-C (t=2.15; P=0.041; 95%CI: 0.44 to 20.28) tests. Conclusion: The results suggest that domains of retardation and cognition symptoms of the HAM-D-31 in early post-stroke patients are related to impairment in working memory and executive functions as assessed with the Stroop, Digit Span, and FAS tests.

REFERENCES:

1. Jamerson BD, Krishnan KR, Roberts J, Krishen A, Modell JG: Effect of bupropion SR on specific symptom clusters of depression: analysis of the 31-item Hamilton Rating Scale for depression. Psychopharmacol Bull 2003; 37:67-78.
2. Pohjasvaara T, Vataja R, Leppavuori A, Kaste M, Erkinjuntti T: Depression is an independent predictor of poor long-term functional outcome post-stroke. Eur J Neurol 2001; 8:315-9.

SCIENTIFIC AND CLINICAL REPORT SESSION 12-CANCELED

SCIENTIFIC AND CLINICAL REPORT SESSION 13-ADULT BEHAVIORAL AND PERSONALITY DISORDERS

No. 34

FACTOR STRUCTURE AND DIAGNOSTIC EFFICIENCY OF *DSM-IV* CRITERIA FOR AVOIDANT PERSONALITY DISORDER IN HISPANIC MEN AND WOMEN WITH SUBSTANCE USE DISORDERS

Daniel Becker, M.D., Mills-Peninsula Medical Center, 1501 Trousdale Dr., Burlingame, CA 94010, Luis Miguel Añez, Psy.D., Manuel Paris, Psy.D., Luis Bedregal, Ph.D., Carlos M. Grilo, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the factor structure and diagnostic efficiency of the *DSM-IV* criteria for avoidant personality disorder in Hispanic patients, and the extent to which these metrics may be affected by gender.

SUMMARY:

Objective: This study examined the factor structure and diagnostic efficiency of the *DSM-IV* criteria for avoidant personality disorder (AVPD), and the extent to which these metrics may be affected by gender. *Method:* Subjects were 130 monolingual Hispanic adults (90 males, 40 females), who had been admitted to an outpatient clinic specializing in the aftercare treatment of substance abuse. All were reliably assessed with the Spanish-language version of the Diagnostic Interview for *DSM-IV* Personality Disorders. The AVPD diagnosis was determined by the best-estimate method. After evaluating the internal consistency and cohesiveness of the AVPD criterion set, an exploratory factor analysis was performed using principal components with varimax rotation. Then, diagnostic efficiency indices were calculated for all AVPD criteria. Subsequent analyses examined males and females separately. *Results:* For the overall group, internal consistency of AVPD criteria was good—as indicated by a coefficient alpha of .93, the pattern of significant inter-item correlations (range, .51 to .78), and the lack of improvement in coefficient alpha when any of the criteria was deleted. Exploratory factor analysis revealed a one-factor solution, accounting for 67% of the variance (eigenvalue = 4.68), thus supporting the unidimensionality of the AVPD criterion set. The best inclusion criterion was "reluctance to take risks," while "interpersonally inhibited" was the best exclusion criterion and the best predictor overall. When males and females were examined separately, similar results were obtained for both factor structure and diagnostic efficiency—with only slight variation noted between the genders in the patterning of diagnostic efficiency indices. *Conclusions:* These psychometric findings—which were similar for males and females—support certain important aspects of the AVPD diagnosis in general, and may shed light on the nature of this disorder within this particular clinical population.

REFERENCES:
1. Grilo CM: Factorial Structure and diagnostic efficiency of the DSM-IV criteria for avoidant personality disorder in patients with binge eating disorder. Behav Res Ther 2004; 42:1149-1162.
2. Hummelen B, Wilberg T, Pedersen G, Karterud S: An investigation of the validity of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition avoidant personality disorder construct as a prototype category and the psychometric properties of the diagnostic criteria. Compr Psychiatry 2006; 47:376-383.

No. 35

TATTOOS AND ANTISOCIAL PERSONALITY DISORDER

William Cardasis, M.D., 202 E. Washington Street, Ste. 208, Ann Arbor, MI 48104, Alissa Huth-Bocks, Ph.D., Kenneth R. Silk, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand how the presence of tattoos on inpatients in a forensic psychiatric setting can alert clinicians to the diagnosis of antisocial personality disorder and other relevant historical information and behavioral characteristics.

SUMMARY:

Objective: The relationship of tattoos to the diagnosis of antisocial personality disorder (ASPD) was explored in a forensic psychiatric inpatient setting. It was hypothesized that a greater proportion of forensic inpatients that possessed tattoos had ASPD than patients who did not possess tattoos. *Method:* Forensic male psychiatric inpatients (N=36) were administered a semi-structured interview to determine the presence of a tattoo. Antisocial personality disorder (ASPD) was determined by criteria on a *DSM-IV* antisocial personality disorder checklist and by *DSM-IV* admission diagnosis. Demographic and background characteristics of the patients were collected, and details about each tattoo were obtained including a calculation of the surface area of each tattoo. *Results:* Significantly more forensic psychiatric inpatients with a diagnosis of ASPD had tattoos compared with patients without ASPD. These patients also had a significantly greater number of tattoos, a trend toward having a greater percentage of their total body surface area tattooed, and were more likely to have a history of substance abuse. Also, tattooed subjects, with or without ASPD, were significantly more likely to have histories of substance abuse, sexual abuse, and suicide attempts. *Conclusions:* Forensic psychiatric inpatients with tattoos should be assessed carefully for the presence of ASPD as well as for substance abuse, sexual abuse, and suicide attempts, factors having potentially significant influence on the assessment and treatment of such patients.

REFERENCES:
1. Buhrich N, Morris, G: Significance of tattoos in male psychiatric patients. Australian and New Zealand Journal of Psy chiatry 1982: 16:185-189.
2. Hare RD: Psychopathy: a clinical and forensic overview. Psychiatric Clinics of North America 2006; 29:709-724.

No. 36

RESULTS FROM A RANDOMIZED, CONTROL TRIAL OF AN INTEGRATED TREATMENT FOR COMORBID ANGER AND GAMBLING PROBLEMS

Lorne Korman, Ph.D., British Columbia Provincial Youth Concurrent Disorders Program, Mental Health Building, Box 141 4500 Oak Street, Vancouver, Canada V6H 3N1, Jane Collins, B.Sc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: (1) describe the prevalence of anger problems among individuals with addictions problems; and (2) describe the findings of a research study evaluating an integrated treatment for anger and addictions.

SUMMARY:

Results from a study evaluating an integrated treatment for comorbid gambling, substance use, and anger problems will be presented. Problem gamblers with comorbid anger problems (n=42), half of whom also had substance use disorders, were randomized to either a 14-week integrated treatment addressing both anger and addictions, or to a specialized gambling and substance use treatment-as-usual (TAU). Participants were assessed at baseline (Tl), 14 weeks (T2), and at 12 weeks follow-up (T3). Relative to the TAU, participants in the integrated anger and addiction treatment were more likely to be engaged in treatment, and reported significantly less gambling at T2 and T3, and less trait anger and substance use at T3. Findings suggest it is important to treat anger and addiction problems concurrently, and to use active treatment engagement strategies for this population.

REFERENCES:
1. Korman LM: Treating anger and addictions concurrently. In A Handbook for Practitioners, edited by Skinner WJ, Toronto, Centre for Addiction and Mental Health, 2005, pp 215-233.
2. Korman LM, Toneatto TT, Skinner WJ: Pathological Gambling. In A Practitioner's Guide to Evidence Based Psychotherapy, edited by Fisher JE, O'Donohue W, New York, Springer Publishing Company, 2006, pp 291-300.

SCIENTIFIC AND CLINICAL REPORT SESSION 14- ANTIPSYCHOTIC MEDICATIONS IN BIPOLAR DISORDER AND SCHIZOPHRENIA

No. 37

GENDER-SPECIFIC PATTERNS IN NMS SYMPTOMS

Zack Cernovsky, Ph.D., 98 Greenbrier Crescent, London, Canada N6J 3X9, Varadaraj Velamoor, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should become aware that while the expression of NMS is similar regardless of gender, males may be overrepresented among the victims of NMS.

SUMMARY:

Introduction/Hypothesis: Survey data from various medical centers of 225 suspected NMS cases have been analyzed statisti-

cally to evaluate if gender is associated with systematic differences in NMS symptom patterns. Methods: The mean age of the 225 patients was 41.0 years (SD=17.9). Correlations were calculated of gender to data that included vital signs (temperature, BP, pulse), laboratory measures (Creatine Kinase, WBC, PH, P-02, P-C02), and ratings of numerous behavioral symptoms (including rigidity, dysarthria, dysphagia, agitation, coma, etc.) relevant in NMS research. Results: Men were relatively overrepresented in our sample of suspected cases (63.1% versus 36.9%). None of the individual symptoms or laboratory measures were significantly correlated with gender, regardless of whether the data were calculated on all 225 suspected cases or only on the 188 who met DSM-4 criteria for NMS. While men and women did not differ in relative proportions of those classified as NMS by DSM-4 (83.8% of men and 83.1% of women met the criteria), there was a significant difference with respect to those meeting Caroff criteria (38.7% of men with confirmed NMS versus only 25.3% of women, x2 = 4.2, p=.04, 2-tailed). While statistically significant, the relationship of Caroff's criteria to gender is only weak (phi=.14). Conclusion/Discussion: Gender does not have a major modifying impact on NMS symptom patterns, however, the ratio of males to females in our sample approached 2 to 1, suggesting a powerful gender factor in the incidence of NMS.

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2. Mann SC, Caroff SN, Keck PE, Lazarus A: Neuroleptic Malignant Syndrome and Related Conditions, Second Edition. Washington, DC, American Psychiatric Press, 2003.

No. 38

COMPARISON OF INTRAMUSCULAR ZIPRASIDONE, OLANZAPINE, OR ARIPIPRAZOLE FOR AGITATION: A QUANTITATIVE REVIEW OF EFFICACY AND SAFETY

Leslie Citrome, M.D., Nathan S. Kline Institute for Psychiatric Research, 140 Old Orangeburg Road, Orangeburg, NY 10962

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) identify the different pharmacotherapeutic choices for the treatment of agitation; and (2) apply the tools of evidence-based medicine, namely number needed to treat (NNT) and number needed to harm (NNH), to compare treatment efficacy and safety among the different medications available.

SUMMARY:

Objective: To compare the efficacy and safety of the intramuscular formulations of ziprasidone, olanzapine, and aripiprazole in treating agitation. *Data sources:* The pivotal registration trials were accessed by querying on-line literature and clinical trial databases. Pharmacovigilance data and posters were requested from the manufacturers. *Study Selection:* Nine double-blind, randomized, controlled clinical trials were identified. *Data Extraction:* Number needed to treat (NNT) for response for treating agitation and number needed to harm (NNH) for extrapyramidal effects were calculated from the study reports. Additional safety outcomes subject to NNH analysis were obtained from product labeling. *Data Synthesis:* Using the a priori definitions of response at 2 hours after the first injection, NNT for response versus placebo (or placebo equivalent) for treating agitation for the pooled data for the recommended dose of ziprasidone 10–20 mg was 3 (95% CI=2 to 4), for olanzapine 10 mg, 3 (95% CI=2 to 3), and for aripiprazole 9.75 mg, 5 (95% CI=4 to 8). Treatment-emergent adverse events occurring during the pivotal trials revealed statistically significant NNH versus placebo (or placebo equivalent) for aripiprazole for headache (NNH 20, 95% CI=11 to 170) and nausea (NNH 17, 95% CI=11 to 38), for ziprasidone for headache (NNH 15, 95% CI=8 to 703), and for olanzapine for treatment-emergent hypotension (NNH 50, 95% CI=30 to 154). Olanzapine and aripiprazole had a more favorable extrapyramidal side-effect profile compared with haloperidol (there was no haloperidol treatment arm in the ziprasidone studies). *Conclusions:* Although the lowest NNT, and hence strongest therapeutic effect, was seen for the studies of ziprasidone and olanzapine as opposed to aripiprazole, head-to-head controlled studies directly comparing these three agents are needed.

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2. Citrome L: Dissecting clinical trials with 'number needed to treat'. Current Psychiatry 6(3):66-71, 2007.

No. 39

ATYPICAL ANTIPSYCHOTIC AGENTS, NEUROCOGNITIVE DEFICITS, AND AGGRESSION IN SCHIZOPHRENIC PATIENTS

Menahem Krakowski, M.D., Nathan Kline Institute for Psychiatric Research, 140 Old Orangeburg Road, Orangeburg, NY 10962, Pal Czobor, Ph.D., Karen Nolan, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) understand better the different ways in which the new atypical agents may affect cognition, including direct cognitive enhancement and indirect effects mediated through decreased side effects, improved symptoms or through decreased need for concomitant anticholinergic agents; and (2) understand better the various ways in which cognitive impairments can impact on aggressive and impulsive behavior.

SUMMARY:

Objective: To compare improvement in cognitive function in typical versus atypical antipsychotic agents in violent schizophrenic patients and to determine whether change in cognitive function is related to aggression. Methods: One hundred physically aggressive schizophrenic inpatients were assigned to a randomized, double-blinded, parallel-group, 12-week treatment. There were 33, 34, and 33 subjects in the clozapine, olanzapine, and haloperidol groups, respectively. They were administered a battery of tests assessing psychomotor function, general executive function, visual and verbal memory, and visuospatial ability. The number and severity of aggressive events was measured by the overrall score on the Modified Overt Aggression Scale (MOAS). Results: The primary cognitive measure was the general cognitive index derived from the above battery. There

was a significant difference in the change in general cognitive index with treatment (F=7.02, df=2,85, p=.001) among the three groups. This was further characterized in post hoc tests by advantages of olanzapine over both haloperidol and clozapine. Further analyses revealed significantly greater improvement with olanzapine in several cognitive domains. There was a significant interaction between treatment assignment and change in the overall cognitive index in determining overall aggression score on the MOAS (c2=33.0, df=2,85, p<.001). Improvement in the general cognitive index was significantly associated with a decrease in violence in the olanzapine group, but not in the other two groups. Conclusion: Olanzapine treatment is associated with better cognitive functioning relative to haloperidol and clozapine in violent schizophrenic patients. This may be explained in several ways. This improvement in neurocognitive function is associated with a decrease in aggressive behavior. As clozapine markedly reduced aggression, there appear to be different pathways for the anti-aggressive effect of olanzapine and that of clozapine.

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SCIENTIFIC AND CLINICAL REPORT SESSION 15- PSYCHOPHARMACOLOGY OF MOOD DISORDERS

No. 40

QUETIAPINE AS MAINTENANCE THERAPY IN BIPOLAR I DISORDER

Trisha Suppes, M.D., Department of Psychiatry, Bipolar Disorder Research Program, 5323 Harry Hines Blvd., Dallas, TX 75390-9121, Eduard Vieta, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the relapse-preventing effectiveness of quetiapine combined with lithium or divalproex versus monotherapy lithium or divalproex as maintenance treatment for patients with bipolar I disorder. The relative risks and benefits of the long-term use of quetiapine combination therapy will also be understood.

SUMMARY:

Objectives: To assess the efficacy/safety of quetiapine (QTP) combined with lithium (Li)/divalproex (DVP), two similarly designed, randomized, double-blind, up to 104-week studies (D1447C00126+ D1447C00127) were conducted. *Methods:* Patients with bipolar I disorder, most recent episode manic, mixed or depressed (DSM-IV), received open-label QTP (400–800 mg/d; flexible, divided doses)+Li (0.5–1.2 mEq/L)/DVP (50–125 µg/mL) for 36 weeks maximum and a minimum of 12 weeks clinical stability, followed by double-blind randomization to QTP+Li/DVP or placebo+Li/DVP for up to 104 weeks. Primary endpoint was time to recurrence of any mood event as defined by medication initiation, hospitalization, YMRS or MADRS =20 at two consecutive assessments, or study discontinuation due to a mood event. *Results:* The open-label stabilization phase entered 3,414 patients, and 1,334 entered the randomized treatment phase. Each trial demonstrated a significant effect for quetiapine on risk reduction for any mood event recurrence. Similarly, when studies were pooled, significantly fewer patients experienced a mood event with QTP+Li/DVP (19.3%; total n=646) than placebo+Li/DVP (50.4%; total n=680), with a hazard ratio for time to recurrence of 0.30 (95% CI 0.24–0.37; P<0.001). Hazard ratios for time to recurrence of manic and depressed events were both 0.30 (95% CI 0.22–0.41 and 0.23–0.40; P<0.001). Adverse event incidence was similar between the two groups. The incidence and incidence density of a single emergent fasting blood glucose value =126 mg/dL was higher in the QTP+Li/DVP than in the placebo+Li/DVP group (10.7% vs 4.6% and 18.03 vs 9.53 patients per 100 patient-years, respectively). *Conclusions:* Quetiapine in combination with Li/DVP demonstrated significant efficacy as maintenance treatment of bipolar I disorder in prevention of manic or depressive relapse. The combination treatment for long-term use was generally well tolerated. Supported by funding from AstraZeneca Pharmaceuticals LP.

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2. Vieta E: Mood stabilization in the treatment of bipolar disorder: focus on quetiapine. Hum Psychopharmacol 2005; 20:225-236.

No. 41

EFFICACY OF DESVENLAFAXINE SUCCINATE 50 MG/D AND 100 MG/D: RESULTS FROM TWO PLACEBO-CONTROLLED, FIXED-DOSE STUDIES IN DEPRESSED OUTPATIENTS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Describe the antidepressant efficacy of the SNRI desvenlafaxine at doses of 50 mg/d and 100 mg/d; and (2) discuss the safety and tolerability of desvenlafaxine at doses of 50 mg/d and 100 mg/d for the treatment of MDD.

SUMMARY:

Introduction: Desvenlafaxine succinate (desvenlafaxine) is a serotonin-norepinephrine reuptake inhibitor (SNRI)1 with demonstrated efficacy for the treatment of major depressive disorder (MDD). *Methods:* Two identically designed, randomized, double-blind, placebo-controlled studies were conducted: one in the European Union (EU) and one in the United States (US). Patients met Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (*DSM-IV*) criteria for MDD with a 17-item Ham-

ilton Depression Rating Scale (HAM-D17) total score =20 at screening and baseline. Two fixed daily doses of desvenlafaxine (50 mg or 100 mg) or placebo were administered for eightweeks (including a one week, 50 mg titration period for the patients receiving 100 mg). The primary efficacy variable, change from baseline on the HAM-D17, was analyzed using analysis of covariance. For all efficacy analyses, the final on-therapy evaluation was the primary end point and the primary population was the intent-to-treat (ITT) population. *Results:* The ITT population in these studies were: EU: desvenlafaxine 50 mg (n=164), desvenlafaxine 100 mg (n=158), and placebo (n=161); US: desvenlafaxine 50 mg (n=150), desvenlafaxine 100 mg (n=147), and placebo (n=150). Mean baseline HAM-D17 scores ranged from 23.0 to 24.4. Adjusted mean change from baseline scores on the HAM-D17 in the EU study were significantly greater for both desvenlafaxine groups (50 mg: –13.2 vs -10.7, P=0.002; 100 mg: –13.7 vs -10.7, P<0.001) compared with placebo. In the US study the 50 mg desvenlafaxine group separated significantly from placebo (–11.5 vs –9.5; P=0.018) but the 100 mg group did not (–11.0 vs -9.5; P=0.065). In both studies, both doses of desvenlafaxine were generally well tolerated and adverse events were consistent with those of the SNRI class. *Conclusions:* These results generally support the efficacy of desvenlafaxine 100 mg/d for improving the symptoms of MDD and establish efficacy of the 50 mg/d dose.

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2. DeMartinis NA, Yeung PP, Entsuah R, Manley AL: A double-blind, placebo-controlled study of the efficacy and safety of desvenlafaxine succinate in the treatment of major depressive disorder. J Clin Psychiatry 2007; 68:677-688.

No. 42

ASENAPINE IN BIPOLAR DISORDER: AN OVERVIEW OF CLINICAL TRIALS IN THE OLYMPIA PROGRAM

Roger McIntyre,, Head, Mood Disorders Psychopharmacology Unit, University Health Network, University of Toronto, 399 Bathurst Street, MP 9-325, Toronto, Canada M5T 2S8, Roger McIntyre, Robert Hirschfeld, Joseph Calabrese, John Panagides

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) describe the acute effects of asenapine versus placebo on acute mania symptoms in patients with bipolar I disorder; (2) describe the long-term efficacy and safety of asenapine in acute mania; and (3) compare the long-term efficacy and safety of asenapine in acute mania with that of olanzapine.

SUMMARY:

Asenapine is a novel psychopharmacologic agent being developed for treatment of schizophrenia and bipolar disorder. The Olympia clinical trial program is a comprehensive assessment of the efficacy, tolerability, and safety of asenapine against placebo or active comparators in short- and long-term trials in these populations. As part of the Olympia program in patients with bipolar I disorder, the Ares trials comprise a pair of placebo-controlled three-week trials followed by extension studies totalling one year of treatment. A combined population of almost 1,000 patients began monotherapy with asenapine 10 mg BID (most patients remained on this dosage), olanzapine, or placebo. Asenapine produced 13- and 14-point reductions in the Young Mania Rating Scale (YMRS) total score from baseline to day 21 (P<0.05 versus placebo; there was no comparison of asenapine vs olanzapine). In the extension trials, direct comparison showed that asenapine was at least as effective as olanzapine; for both groups, YMRS total scores were reduced by 24 points at week 12 and by 28–29 points at week 52, and there were no significant between-group differences in the rates of response (YMRS total score reduced by at least 50% from baseline) or remission (YMRS total score 12 or below at study end). In terms of safety and tolerability, sedation and somnolence were commonly reported in both groups. Treatment-emergent extrapyramidal symptoms were more common with asenapine, but olanzapine was associated with a higher incidence of clinically significant weight gain and a rising incidence of metabolic syndrome. The next phase of the Olympia program will be the Apollo trials, which will assess the use of asenapine in combination with mood stabilizers or other standard treatments for bipolar disorder. Collectively, the data thus far available indicate that asenapine is effective and well tolerated in the treatment of bipolar I disorder. This research was funded by Organon International Inc and Pfizer Inc.

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1. Potkin SG, Cohen M, Panagides J: Efficacy and tolerability of asenapine in acute schizophrenia: a placebo- and risperidone-controlled trial. J Clin Psychiatry 2007; In press.
2. McIntyre RS, Mancini DA, Lin P, Jordan J: Treating bipolar disorder. Evidence-based guidelines for family medicine. Can Fam Physician 2004; 50:388-94.

SCIENTIFIC AND CLINICAL REPORT SESSION 16-CONSULTATION-LIAISON AND EMERGENCY PSYCHIATRY

No. 43

DEPRESSION AND SUBJECTIVE INCOMPETENCE AS SEPARATE COMPONENTS OF DEMORALIZATION

Cheryl A. Cockram, Ph.D., P.O. Box 573, Cheshire, CT 06410-0573, John M. de Figueiredo, MD, ScD (presenting), Gheorghe Doros, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the differences between depression and demoralization and the relationships of depression and subjective incompetence -- with each other and with both perceived stress and social bonds -- in the context of demoralization.

SUMMARY:

Objective: To demonstrate empirically that depression and subjective incompetence are separate components of demoralization. *Method:* The subjects were patients at a palliative care clinic at a cancer center who agreed to participate and met the following criteria: age between 20 and 90 years; diagnosis of gastrointestinal or colorectal cancer; able to read and understand English.

Subjects with known mental disorder or previous psychiatric treatment were excluded. Each subject completed a questionnaire on sociodemographics; perceived stress measured by Impact of Events Scale (IES); social bonds measured by Interpersonal Social Evaluation List, Short form (ISELSF); depression measured by Center for Epidemiologic Studies Scale (CES-D); and subjective incoompetence, measured by Subjective Incompetence Scale (SIS). Descriptive statistics and bivariate correlations were obtained on all scales. Results: When perceived stress is low and social support is high, depression and subjective incompetence are not likely to occur together, and therefore demoralization is not likely to occur ($r = -0.57$; $p<0.02$). When social supports are weak and/or perceived stress is high, depression and subjective incompetence may or may not coexist. *Conclusion:* The findings give further support to the hypothesis that depression and subjective incompetence are separate components of demoralization and that their coexistence is influenced by degree of perceived stress and availability and adequacy of social bonds.

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2. Griffith JL, Gaby L: Brief psychotherapy at the bedside: countering demoralization from medical illness. Psychosomatics 2005; 46(2): 109-116.

No. 44

INFLUENCE OF DEPRESSIVE AND ANXIETY SYMPTOMS ON SURVIVAL IN PATIENTS WITH END-STAGE RENAL DISEASE

Klaas-jan Nauta, M.D., Wijttenbachstraat 11 N, Amsterdam, Netherlands 1093 HR, Robert Riezebos, M.D., Carl Siegert, M.D., Ph.D., Adriaan Honig, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand: (1) the difficulties of assessment of depressive symptoms in patients with ESRD; (2) the relevance of depressive and anxiety symptoms in poor prognosis of ESRD; and (3) the clear need for integrating assessment of these symptoms in clinical work-up of ESRD patients.

SUMMARY:

Objectives: Depressive symptoms are identified as common complicating factors in chronic somatic diseases. In patients with end-stage renal disease (ESRD)prevalence rates for depressive symptoms have varied between 0% and 100%. There is evidence for a relation with increased mortality and morbidity. A recent finding suggested that co-occurrence of depressive and anxiety symptoms were independent predictors of mortality in cardiac patients. In patients with ESRD, to our knowledge this relation has not been investigated yet. *Methods:* A prospective, single center registry was conducted assessing the prevalence of depressive and anxiety symptoms in a cohort of patients with ESRD on HD treatment. Assessment of symptoms was done using the Hospital Anxiety and Depression Scale (HADS). High depressive symptoms were defined as HADS D score > 7, high anxiety symptoms as HADS A score > 8. The primary endpoint of the study was the one-year mortality. *Results:* Currently, 73 patients have completed the one year follow up. 33 (45%) patients showed a HADS D score > 7, and 23 (32%) showed a HADS A score>8. There were no differences in baseline characteristics between the groups. Treatment rates were low (3%). At one-year follow up the mortality rate in patients with high depressive symptoms was 24% compared with 8% in the HADS D-group. (RR 3.0, $p<0.05$). In addition, patients in the HADS A group showed increased mortality rates as compared with those in the HADS A+group. (20% vs 4%, RR 5.0, $p=0.03$) Using this data a subgroup at risk with high depressive symptoms and low anxiety symptoms could be identified. This HADS D+/A- (26% of the total population) subgroup showed an excessive one year mortality of 37% as compared with 7% for the residual population. (RR 5.3. $p=0.02$). Conclusions: Depressive symptoms are highly prevalent in HD patients (42%). High depressive symptoms and low anxiety symptoms are both strongly associated with poor patient survival.

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No. 45

PSYCHIATRIC EMERGENCIES ON AN OBSTETRICS SERVICE: AGITATION FROM UNRECOGNIZED POSTTRAUMATIC STRESS DISORDER TRIGGERED BY ROUTINE HOSPITAL CARE

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) describe how symptoms of agitation and impulsivity can appear in obstetric settings when a patient's unrecognized PTSD is activated by routine hospital care; (2) describe specific risks for PTSD activation during late pregnancy, peripartum, and postpartum periods of pregnancy; and (3) list principles for management of PTSD in hospitalized pregnant, peripartum, and postpartum patients.

SUMMARY:

Few psychiatric emergencies so unsettle medical clinicians as mental instability in a pregnant woman during late pregnancy, delivery, or postpartum period. Clinicians and family members fear not only for the well-being of the mother, but also for the safety of the unborn child or infant. Agitation, impulsivity, or unreasoned refusals of medical treatment prompt urgent calls for immediate psychiatric intervention. Agitation or impulsivity due to activation of unrecognized posttraumatic stress disorder (PTSD) is a special problem since it can be triggered by stressors occurring during routine hospital care, such as pelvic examinations, loss of privacy with exposure of the body, a need to trust

strangers, or lack of acknowledgement of the patient's experience in a biomedical setting. Activation of chronic PTSD often is most manifest by hyperarousal symptoms of panic, hostility, insomnia, and physical agitation, which fail to communicate to the medical staff an association with past traumatic stress. Such agitation is thus commonly misdiagnosed as psychosis, mania, or a personality disorder. Psychiatrically, accurate diagnosis is essential since symptoms often remit promptly when: (1) overreliance upon antipsychotic medications and sedatives is avoided; (2) the patient can be educated about posttraumatic symptoms and engaged as a partner in anticipating difficulties; (3) nursing staff are educated to recognize and remove triggers from the environment, such as unexpected touching of the body or failures to respond to the nursing call button; and (4) the patient can be taught dearousal methods, such as grounding techniques, controlled breathing, relaxation techniques, and use of guided imagery. In this presentation, we will utilize three clinical cases (late pregnancy, peri-partum, post-partum) to illustrate symptom presentation, diagnostic assessment, and clinical management of agitation and impulsivity due to activation of unrecognized PTSD during pregnancy.

REFERENCES:

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SCIENTIFIC AND CLINICAL REPORT SESSION 17- ANXIETY SYNDROMES AND DISORDERS

No. 46

TAPERING OUT CLONAZEPAM IN PANIC DISORDER PATIENTS AFTER AT LEAST THREE YEARS OF TREATMENT

Antonio Nardi, M.D., Laboratory of Panic & Respiration, Federal University of Rio de Janeiro, R Visconde de Piraja 407/702 Rio de Janeiro RJ, 22410-003 Brazil 22410003, Fabiana L. Lopes, M.D., Rafael C. Freire, M.D., Alexandre M. Valença, M.D., Isabella Nascimento, M.D., Valfrido L. de-Melo-Neto, M.D., André B. Veras, M.D., Arabella Rassi, M.D., Gastão L. Soares-Filho, M.D., Marco A. Mezzasalma, M.D., Anna Lucia King, Psy. D., Marcio Versiani, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to conduct a tapering out of a benzodiazepine, recognizing the importance of a slow tapering, observing the withdrawal signs and the possibility of some adjunct drug that may be useful for some cases.

SUMMARY:

Objective: The efficacy of clonazepam monotherapy or in association for the treatment of panic disorder (PD) was established in multicenter studies. After a long-term treatment with clonazepam the tapering out schedule should be carefully designed to avoid severe withdrawal symptoms. *Method:* We tapered out clonazepam in PD patients taking it for at least three years of treatment. We used scales for anxiety and withdrawal symptoms at every visit during the period of tapering out and follow up. Seventy-three patients who were asymptomatic of their PD for at least one year and desired to leave the medication participated in this trial. The protocol consisted of dose decrease during 4 months and another eight months of follow up. The dose was decreased 0.5 mg per two-week period until it reaches 1 mg per day, then 0.25mg was taken out every week. *Results:* The mean dose at starting the tapering out was 2.7±1.2 mg/day. Fifty-one (68.9%) of the patients were free of the medication after the four months of tapering as the protocol. 19 (26.0%) needed another three months to leave the medication. Nine (12.3%) of this last group used also mirtazapine or carbamazepine as adjunct therapy during this period. Three (4.1%) patients gave up the tapering due to return of anxiety symptoms. The withdrawal symptoms were mild and observed in 55 (75.3%) patients. No serious adverse events were observed. Insomnia, tremor, nausea, sweating, headache, and subjective anxiety were the main complains. Fourty (54.8%) patients were asymptomatic without any medication after the eight months follow-up and 10 (13.7%) had returned to the use of benzodiazepine. *Conclusions:* It is possible to take the clonazepam slowly out even after a long treatment without any major withdrawal symptom. The dose should be tapering slowly and some adjunct drug may be useful for some cases. Supported by the Brazilian Council for Scientific and Technological Development (CNPq), Grant 554411/2005-9.

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

No. 47

EVIDENCE FOR THE EXISTENCE OF A TEMPORAL SEQUENCE IN COMORBID OBSESSIVE-COMPULSIVE DISORDER AND SCHIZOPHRENIA: WHICH COMES FIRST?

Kavi Devulapalli, B.A., 7635 Settlers Court, Mentor, OH 44060, Henry A. Nasrallah, M.D., Jeffrey A. Welge, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the temporal sequence of onset of schizophrenia and obsessive-compulsive disorder in patients suffering from both disorders, and the clinical implications for the optimal pharmacotherapy in such patients.

SUMMARY:

Background: Obsessive-compulsive disorder (OCD) is often a comorbidity in Schizophrenia (SCZ). However, little is known about whether OCD emerges before or after diagnosis of SCZ prior to treatment with atypical antipsychotic medications, which have been reported to trigger OCD symptoms. The authors ana-

lyzed data from clinical studies reporting the temporal sequence of OCD and SCZ in patients who suffer from both disorders to determine if there is a significant statistical difference between the mean ages of onset in both disorders and the percentage of patients diagnosed with OCD prior to SCZ. *Methods:* A MEDLINE search was conducted using the keywords "OCD" and "schizophrenia." Studies were assessed for the presence of data regarding the ages of onset of patients comorbid for both disorders as well as the number of patients in each study diagnosed with OCD first, SCZ first, or both disorders concurrently. For studies reporting the temporal sequence of diagnosis, a meta analysis, using Random Effects (RE) and Fixed Effects (FE) models, was performed to test the a priori hypothesis that OCD is diagnosed prior to SCZ in patients comorbid for both disorders. The unstandardized mean difference in the ages of onset of OCD and SCZ was calculated. *Results:* Statistical analysis suggested that OCD precedes SCZ (RE: P=0.10, FE: P=0.04). There is no statistically significant difference in the mean age of onset of OCD (21.2 years) and schizophrenia (24.9 years), an unstandardized difference of 1.04 years (RE: 95% CI: -0.67, 2.15, P=0.07; FE: 95% CI:-0.75, 2.84, P=0.16), despite a strong trend in the data. *Discussion:* A strong trend in the data exists suggesting the onset of OCD prior to SCZ in patients comorbid for both disorders. The clinical and biological implications of these findings will be discussed. Future prospective studies employing a larger sample size are warranted.

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No. 48

SOCIAL ANXIETY AND FUNCTIONAL IMPAIRMENT IN PATIENTS SEEKING SURGICAL EVALUATION FOR HYPERHIDROSIS

Franklin Schneier, M.D., New York State Psychiatric Institute, 1051 Riverside Drive, Unit 69, New York, NY 10032, Lyall Gorenstein, M.D., Catherine Whitman, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize features of hyperhidrosis and be aware of the relationship between hyperhidrosis, social anxiety, and functional impairment.

SUMMARY:

Primary hyperhidrosis is characterized by excessive sweating and may be associated with anxiety and fears of embarrassment. However, there has been little study of social anxiety in hyperhidrosis patients. The purpose of this study was to assess severity of sweating, social anxiety, and functional impairment in hyperhidrosis. Patients seeking evaluation for surgical treatment of hyperhidrosis at a hospital-based clinic completed self-ratings, sweating and impairment in quality of life due to hyperhidrosis. These patients and social anxiety disorder patients seeking evaluation for cognitive-behavioral and pharmacological treatment at an anxiety disorders clinic also completed the Sheehan Disability Scale and the Self-Rated Liebowitz Social Anxiety Scale, modified to assess the extent to which subjects attributed their social anxiety in each of 24 situations to sweating. Thirty-four subjects with hyperhidrosis reported social anxiety that was elevated (LSAS total = 62.1+/-30.5), although significantly lower (P<.05) than that of 60 patients with social anxiety disorder (LSAS total = 73.9+/-19.6). On the Sheehan Disability Scale, work disability was significantly greater in patients with hyperhidrosis (6.9+/-1.8 vs 5.3+/-2.9). Social, family/home, and overall disability did not differ between the groups. Ratings of social anxiety attributable to sweating were greater in hyperhidrosis (38.4+/-18.9 vs. 13.2+/-16.1). Within the hyperhidrosis group, severity of social anxiety on the LSAS, but not severity of sweating, was significantly associated with all Sheehan Disability subscale scores and with a measure of impairment in quality of life due to hyperhidrosis. Patients with hyperhidrosis report elevated social anxiety, and they attribute more of their social anxiety to sweating than do patients with social anxiety disorder. Social anxiety may mediate functional disability and impairment in quality of life in patients with hyperhidrosis.

REFERENCES:

1. Ramos R, Moya J, Morera R, Masuet C, Perna V, Macia I, Escobar I, Villalonga R: An assessment of anxiety in patients with primary hyperhidrosis before and after endoscopic thoracic sympathicolysis. Eur J Cardiothorac Surg 2006; 30:228-231.
2. Davidson JR, Foa EB, Connor KM, Churchill LE: Hyperhi drosis in social anxiety disorder. Prog Neuropsychopharmacol Biol Psychiatry; 2002; 26:1327-31.

WEDNESDAY, MAY 7, 11:00 AM - 12:30PM

SCIENTIFIC AND CLINICAL REPORT SESSION 18-CONVERSION, SOMATIZATION AND CHRONIC FATIGUE

No. 49

SOMATIZATION INCREASES ROLE IMPAIRMENT AND DISABILITY INDEPENDENT OF PSYCHIATRIC AND MEDICAL COMORBIDITY

Arthur J. Barsky, M.D., Brigham and Women's Hospital 75 Frances Street, Boston, MA 02115, Ashley M. Harris, M.D., E. John Orav, Ph.D., David W. Bates, M.D., MSc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) recognize the overlap and comorbidity of somatoform disorders with anxiety and depressive disorder; (2) understand the role of somatization in causing disability and role impairment; and (3) know how the disability associated with somatization compares with that resulting from major psychiatric and medical conditions.

SUMMARY:

This study compared the functional disability and role impairment of somatizing and non-somatizing patients and determined the unique contribution of somatization to disability after taking into account co-occurring psychiatric and medical illnesses. A

total a 467 consecutive patients attending two primary care clinics completed self-report questionnaires assessing somatization, psychiatric disorder, role impairment, and disability. Aggregate medical morbidity was assessed with a standardized, structured, medical record audit. Patients with somatization, as well as those with anxiety and depressive disorders and those with serious medical illness had significantly more impairment of activities of daily living and social activities. When these predictors were considered simultaneously in a multivariable regression, the association with somatization remained highly significant and was comparable in magnitude to, or exceeded that of, several serious medical conditions such as coronary artery disease and diabetes. Somatization had a similar detrimental relationship to occupational disability. In sum, patients with somatization had substantially greater functional disability and role impairment than non-somatizing patients. Adjusting the results for psychiatric and medical comorbidity had little effect on these findings.

REFERENCES:

1. Barsky AJ, Orav EJ, Bates DW: Somatization increases medical utilization and costs independent of psychiatric and medical comorbidity. Arch Gen Psychiat 2005; 62:903-910.
2. Kessler RC, Frank RG: The impact of psychiatric disorders on work loss days. Psychol Med 1997; 27:861-873.

No. 50

THE COMPARATIVE EPIDEMIOLOGY OF CHRONIC FATIGUE BETWEEN BRAZILIAN AND BRITISH PRIMARY CARE: PREVALENCE, REPORTING, RECOGNITION, AND LABELING

Hyong Cho, M.D., Cousins Center for Psychoneuroimmunology, UCLA Semel Institute for Neuroscience and Human Behavior, 300 Medical Plaza, Suite 3156, Los Angeles, CA 90095

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the importance of the sociocultural context in determining how primary care patients and doctors respond to a common somatic symptom such as fatigue.

SUMMARY:

Background: Whilst fatigue is a ubiquitous symptom across countries, how patients and doctors respond to it may differ according to their sociocultural context. Objectives: To estimate the prevalence of unexplained chronic fatigue (UCF) and chronic fatigue syndrome (CFS) in Brazilian primary care. To compare the prevalence of fatigue as a symptom measure using a standardized assessment ("fatigue-symptom"), as a complaint presented to the doctor ("fatigue-complaint") and as a diagnostic label given by the doctor ("fatigue-diagnosis") between Brazilian and British primary care. Method: A primary care survey was conducted in Sao Paulo and London. Consecutive attenders (n=3,914 in Brazil and n=2,459 in Britain), aged 18-45 years, completed questionnaires on fatigue, psychological distress, and sociodemographic characteristics. Those with substantial fatigue lasting six months or more were interviewed to ascertain the presence of CFS and their medical records were reviewed. The prevalence of fatigue-symptom (UCF and CFS), fatigue-complaint, and fatigue-diagnosis was compared between the two samples. *Results:* The prevalence of fatigue-symptom was comparable between Brazil and Britain (UCF 12.2% vs. 10.3%, P=0.02; CFS 1.6% vs. 2.1%, P=0.20). Brazilian patients were less likely to present with fatigue (fatigue-complaint 2.3% vs. 4.5%, P<0.001) and less likely to receive a fatigue-related diagnosis (fatigue-diagnosis 0% vs. 4.1%, P<0.001) than their British counterparts. *Conclusion:* The importance of sociocultural factors consists not so much in the occurrence and distribution of fatigue but more in the reporting and recognition/labeling of fatigue. In Brazil, where unexplained fatigue is not sanctioned as a medical illness, it is more likely to be considered as a part of everyday adversity and less likely to be reported to doctors or recognized as a disorder.

REFERENCES:

1. Wessely S, Chalder T, Hirsch S, Wallace P, Wright D: The prevalence and morbidity of chronic fatigue and chronic fatigue syndrome: a prospective primary care study. Am J Public Health 1997; 87(9):1449-55.
2. Lee S, Yu H, Wing Y, Chan C, Lee AM, Lee DT, Chen C, Lin K, Weiss MG: Psychiatric morbidity and illness experience of primary care patients with chronic fatigue in Hong Kong. Am J Psychiatry 2000; 157(3):380-4.

No. 51

DEMOGRAPHIC, CLINICAL, AND TREATMENT OUTCOME PROFILES IN 71 CONSECUTIVE, PROSPECTIVELY STUDIED PATIENTS WITH CONVERSION DISORDER(CD)

Patricia Rosebush, M.D., HSC-3G15, 1200 Main West, Hamilton, Ontario, Canada L8N 3Z5, Michael F. Mazurek, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) recognize the nature and severity of CD; and (2) appreciate that patients with CD, even when the illness is longstanding, are amenable to treatment and can enjoy full recovery.

SUMMARY:

Method: This is a naturalistic study of consecutive patients with CD who were not involved in litigation and who were referred to our neuropsychiatry clinic over 15 years. *Results:* The sample of 71 included 58F, 13 M; x age 35.7 years; range 11-63. Eleven were < 16 years of age. Forty percent of adults had an educational level beyond high school. Duration of CD prior to presentation was long at 40.3 months (SD 43.6). 55 (77%) had a complete inability to function at home, work or school (x GAF= 36.3; SD 10.9) reflecting severe illness. The nature of the CD included paralysis (n=26), bizarre movements (n=21), pseudoseizures (n=16), speech impediment (n=7) and blindness (n=1). Other underlying psychiatric disorders were present in 52 (74%); a history of significant abuse or neglect in 49(69%) and a clear precipitant to the CD could be identified 55 (77%) although this often took time to discern. Of 52 patients who completed treatment 37 (71%) recovered completely; 12 (23%) had partial but functionally significant improvement and only 3 (6%) showed no change. Improvement was not related to the duration of the CD. fourteen patients (20%) could not be engaged in treatment; one of the fourteen enjoyed a spontaneous recovery and another died from the complications of prolonged immobility. Treatment included hospitalization in 30 and all patients received a combination of psychotherapy, medication for underlying disorders, physiotherapy, speech therapy,

video feedback, and an individually constructed hierarchy of expected functional achievements. Follow up of treated patients over many years indicates that improvements are sustained. *Conclusions:* CD is a serious, functionally debilitating illness that is very responsive to a multi-faceted treatment approach even when it has been long standing.

REFERENCES:
1. Rosebush P, Mazurek M: The treatment of conversion disorder. In Psychogenic Movement Disorders, edited by M. Hallet, Philadelphia, PA: Lippincott Williams & Wilkins; 2005, pp 289-301.
2. Stone J, Carson S, Sharpe M: Functional symptoms in neurology: management. J Neurol Neurosurg Psychiatry 2005; 76(Suppl 1): i13-i21.

SCIENTIFIC AND CLINICAL REPORT SESSION 19- MANAGING BEHAVIOR IN PATIENTS AND PSYCHIATRISTS

No. 52

ATTACHMENT, CONTEMPORARY INTERPERSONAL THEORY, AND IPT: AN INTEGRATION OF THEORETICAL, CLINICAL, AND EMPIRICAL PERSPECTIVES

Paula Ravitz, M.D., 250 College Street, Toronto, Ontario, Canada M5T 1R8, Robert Maunder, M.D., Carolina McBride, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) understand principles of attachment & interpersonal theories as they apply to Interpersonal Psychotherapy; (2) become familiar with psychotherapy studies that examine attachment change; and (3) learn how adult attachment and interpersonal problems might change over a course of IPT.

SUMMARY:

Interpersonal psychotherapy (IPT) is an effective, pragmatic treatment for depression, however interpersonal explanations of its effectiveness are not fully developed. This presentation focuses on interpersonal explanations of the effectiveness of IPT. An integration of aspects of attachment and contemporary interpersonal theories are presented to explain how interpersonal interactions contribute to a clinical understanding of depression and its treatment through IPT. We test hypotheses of interpersonal change in a case series of depressed patients treated with IPT. Of 183 patients who qualified for IPT, 145 (79.2 %) completed treatment. Full remission was obtained by 71 patients (38.8 % of all patients, 49.0 % of treatment completers) and partial remission by 52 patients (28.4 % of all patients, 35.9 % of treatment completers). Depression, attachment insecurity, and interpersonal problems were measured at the onset and completion of treatment. The results demonstrate that both attachment insecurity and interpersonal problems improve significantly over a 16, week course of treatment. Of the 145 patients who completed treatment, 106 (73.1 %) completed pre- and post-treatment measures of attachment style. Over the course of therapy there was a decrease in attachment anxiety (mean change – 0.27 ± standard deviation 0.94, df = 105, p = 0.007), in attachment avoidance (– 0.26 ± 0.94, df = 105, p = 0.004) and in total interpersonal problems (– 17.5 ± 29.3, df = 104, p < 0.001). When patients were grouped by treatment response, improvements in interpersonal problems were present across the full range of the interpersonal circumplex, but were limited to patients with a partial or full treatment response. Attachment anxiety and attachment avoidance were significantly reduced in patients with a full treatment response. Further research into the interpersonal processes that alleviate depression is needed.

REFERENCES:
1. Ravitz P, Maunder R, McBride. Attachment, Contemporary Interpersonal Theory and IPT: An integration of theoretical, clinical and empirical perspectives. J of Contemporary Psychotherapy. (in press).
2. McBride C, Atkinson L, Quilty L C, Bagby R M: (2006). Attachment as moderator of treatment outcome in major depression: A randomized control trial of interpersonal Psychotherapy Versus Cognitive Behavior Therapy. Journal of Consulting and Clinical Psychology, 74, 1041-1054.

No. 53

CLINICAL TRIAL REPORTS IN PSYCHIATRY BEFORE AND AFTER THE CONSORT STATEMENT

Changsu Han, M.D., Department of Psychiatry, Korea University Medical Center, South Korea; and Department of Psychiatry, Duke University Medical Center, 2218, Elder St, Room 203, Durham, NC 27705, Chi-Un Pae, M.D., Kamal Bhatia, M.D., David Marks, M.D., Clement Oguejiofor, M.D., Prakash S. Masand, M.D., Ashwin A. Patkar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) recognize the importance of reporting of randomized-controlled trial (RCT) in a standardized manner; and (2) understand the impact of CONSORT guidelines in improving the quality of reporting of RCT in psychiatry.

SUMMARY:

Objective: To determine whether the CONSORT checklist had an effect on the quality of reporting of randomized-controlled trials (RCTs) in the field of psychiatry. Methods: We selected seven high impact journals (New England Journal of Medicine, JAMA, Archives of General Psychiatry, American J Psychiatry, Biological Psychiatry, Lancet, and British Medical Journal) and search for randomized, clinical trials in the field of psychiatry during the period of 1992-1996 (pre-CONSORT) and 2002-2007 (post-CONSORT). We confined the term to "English, Publication Date from 1992/01/01 to 1996/12/31, Clinical Trial, Randomized Controlled Trial, Controlled Clinical Trial, Humans." Then we rated on the CONSORT checklist and compared the results. Results: 736 studies were retrieved. Among them, 336 were published during the pre-CONSORT period and 400 were post-CONSORT. Rating on the CONSORT checklist during the post-COSORT period were more frequently checked on most items of the list except the item 1-4, 7, 12, 20. Reporting on getting the informed consent was not significantly different. Conclusions: The quality of reports on psychiatric RCTs generally improved after the adoption of the CONSORT guideline. Reports on the sample size, subject eligibility criteria, statistical methods, interpretation of

the results, and on the informed consent should be improved.

REFERENCES:
1. Plint AC, Moher D, Morrison A, Schulz K, Altman DG, Hill C, Gaboury I: Does the CONSORT checklist improve the quality of reports of randomised controlled trials? A systematic review. Med J Aust 2006; 185(5):263-7.
2. Kane RL, Wang J, Garrard J: Reporting in randomized clinical trials improved after adoption of the CONSORT state ment. J Clin Epidemiol 2007;60:241-9.

No. 54

FIRST MAILED EDUCATIONAL INTERVENTION TO PHYSICIANS REDUCED PHARMACY, HOSPITAL, AND OUTPATIENT COSTS

Harold Carmel, M.D., One Copley Parkway, #534, Morrisville, NC 27560, Jeffrey Veach, M.S., Jack Gorman, M.D., Joseph J. Parks, M.D., Richard Surles, Ph.D., John Docherty, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate understanding of the effectiveness of a specially-designed system for providing educational messages to physicians in improving outcomes, such as reducing pharmacy, and inpatient and outpatient costs.

SUMMARY:

Given limited resources, it is important to find ways to promote best practices in psychotropic prescribing, reduce costs, and improve outcomes. We studied the effect of the first mailed educational message to a physician about psychotropic medication prescribing practices ("intervention") on the rate of change of pharmacy, hospital, and outpatient costs in a state Medicaid system. Patients were adults on psychotropic medications, continuously Medicaid-eligible throughout 2002-05. A first intervention was mailed from 6/03 to 11/04. Three groups were studied: (1) patients for whom a first intervention was mailed ("Direct Effect", N=16,962); (2) patients whose physician got a mailing on another patient but who themselves needed no intervention ("Collateral Effect", N=42,960); and (3) a subset of the "Direct Effect" group with schizophrenia ("Subgroup," N=6310). Pharmacy claims data were available for all three groups; inpatient and outpatient claims data for the "Subgroup." For each patient, the rate of change in the outcome measure for the year after first-intervention was compared with the rate of change for the entire 2002-05 period before intervention. The analysis was based on a repeated measures analysis of covariance using mixed model methodology to estimate mean cost/pt/m for each patient. A significant difference ($p<0.0001$) was found between the rate of change before and after intervention for psychotropic pharmacy costs in all three groups. "Subset" pts showed significant savings in input costs ($799/pt/yr, 24.1%) and output costs ($277/pt/yr, 3.8%), a significant drop in admissions (0.132/pt/yr, 22.8%) & bed days (1.2/pt/yr, 26.9%). Estimated cost reductions for all three groups for the year after each patient's first intervention totaled $36.5 million. Mailed educational interventions to physicians on psychotropic drug prescribing practices can reinforce best practice and substantially reduce pharmacy, hospital and outpatient costs. This study was supported by Comprehensive NeuroScience, Inc.

REFERENCES:
1. Parks J, Surles R: Using best practices to manage psychiatric medications under Medicaid. Psychiatr Serv 2004; 55:1227-1229.
2. Andersson K, Petzold MG, Sonesson C, Lonnroth K, Carlsten A: Do policy changes in the pharmaceutical reimbursement schedule affect drug expenditures? Interrupted time series analysis of cost, volume, and cost per volume trends in Sweden 1986-2002. Health Policy. 2006; 79:231-243.

SCIENTIFIC AND CLINICAL REPORT SESSION 20-SIDE EFFECTS OF PSYCHOPHARMACOLOGICAL TREATMENT

No. 55

LONG-TERM FOLLOW-UP OF PATIENTS WITH MAJOR DEPRESSIVE DISORDER: CHANGES IN SYMPTOMS, TREATMENT, AND SIDE EFFECTS

John Goethe, M.D., Institute of Living, 200 Retreat Avenue, Hartford, CT 06106, Stephen B. Woolley, D.Sc., Alex A. Cardoni, M.S. Pharm., Brenda A Woznicki, B.S., Deborah A. Piez, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify risk factors for, and time trends in changes in, depression, antidepressant use, and side effects during the 12 months following initiation of index antidepressant treatment.

SUMMARY:

Objective: To examine among patients with major depressive disorder the time course and risk factors for changes in depression, antidepressant use, and side effects (SE). *Methods:* Patients (n=404) were assessed every three months for one year (or until they discontinued the index antidepressant) to document depression (Beck FastScreen score >4), treatment (changing or discontinuing index drug), and SE. Proportional hazards regression models contrasted factors significant in early vs late follow up. *Results:* Increasingly steep monotonic declines (all $p<.01$) were found for depression (sharp decline at six months), drug discontinuation (sharp decline at nine months), and experiencing one or more SE (sharp decline at six months). Patients who switched antidepressants were 17% more likely to remain depressed compared with those who discontinued treatment ($p=.09$) and 25% more likely to remain depressed than those remaining on index drug ($p=.01$). Patients who discontinued treatment were more frequently hospitalized at three, six and nine months ($p<.01$). "Extremely bothersome" SE were initially common (40% at three months) but less so at six (15%), nine (3%), and 12 months (3%); nevertheless, in >50% of patients who discontinued treatment SE were a stated reason at 6-12 months. Few patients (<13%) cited costs or never wanting medication as reasons to discontinue. Regression analyses found that discontinuation was associated ($p<.05$) with complaints of weight change (at three, six, and twelve months), rash and swelling (three months), dizziness (six months), and extremely bothersome SE and decreased sex drive/function (six and twelve months). *Conclusions:* Rates of depression and discontinuation of treatment were highest in the first six months. SE were a reason for discontinuation during the entire year, although the contribution of severity and of the type

of SE varied with time.

REFERENCES:
1. Demyttenaere K, Albert A, Mesters P, Dewé W, De Bruyckere K, Sangeleer M: What happens with adverse events during 6 months of treatment with selective serotonin reuptake inhibitors? J Clin Psychiatry 2005; 66:859-863.
2. Beck AT, Steer RA, Brown GK: BDI-FastScreen for Medical Patients. Orlando, FL, The Psychological Corporation, Harcourt Brace & Company, 2000.

No. 56

IDENTIFICATION AND ATTRIBUTION OF SIDE EFFECTS OF ANTIDEPRESSANTS BY SELF-REPORT AND PSYCHIATRIST INTERVIEW

Rajnish Mago, M.D., 833 S. Chestnut Street East, Suite 210 E, Philadelphia, PA 19107, Nancy Diazgranados, M.D., Constantine Daskalakis, Sc.D., Scott Waldman, M.D., Ph.D., David Oslin, M.D., Barry Rovner, M.D., Michael Thase, M.D.

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

Background: Existing methods of evaluation of side effects have various limitations and are therefore rarely used. *Methods:* Patients who had started an antidepressant in the preceding three months completed the Patient-Rated Inventory of Side Effects (PRISE). For each symptom, they completed the Scale for Assessment of Side Effects (SAS) and were interviewed by a psychiatrist blind to the results of the SAS. The SAS is a patient-rated questionnaire designed in this study to assess the likelihood that each symptom is a side effect of the antidepressant. Similar to the Adverse Drug Reaction Probability Scale (ADRPS), it asks a series of questions to classify each symptom as a 'possible' or 'doubtful' side effect. The SAS ratings were compared with the rating of the psychiatrist based on a careful, detailed interview that included the ADRPS. *Results:* The 27 patients endorsed 2–14 (median 8) symptoms on the PRISE (total of 188 symptoms). Of these 188 symptoms, only 61 (32.4%) were rated as "possible side effects" based on the psychiatrist's global judgment. Of 61 symptoms rated as "possible side effects" by the psychiatrist, the SAS correctly identified 59 (sensitivity 96.7%). Of 127 symptoms rated as "doubtful side effects" by the psychiatrist, the SAS correctly identified 97 (specificity 80.3%). Sensitivity and specificity on comparison to the ADRPS alone were 88% and 84.1%. The SAS was rated easy to fill out by 85% of patients, and 89% would be willing to be assessed with it prior to doctor visits. *Discussion:* On the symptom inventory, patients reported a large number of symptoms which would make assessment time consuming, though two thirds of these were found to be "doubtful" side effects. Because the SAS ruled many symptoms that are not side effects (moderately high specificity), making assessment by the physician manageable, and ruled out very few true side effects (very high sensitivity), it could lead to a scale useful in clinical practice and research.

REFERENCES:
1. Greenhill LL, Vitiello B, Riddle MA, Fisher P, Shockey E, March JS, Levine J, Fried J, Abikoff H, Zito JM, McCracken JT, Findling RL, Robinson J, Cooper TB, Davies M, Varipatis E, Labellarte MJ, Scahill L, Walkup JT, Capasso L, Rosengarten J: Review of safety assessment methods used in pediatric psychopharmacology. J Am Acad Child Adolesc Psychiatry. 2003;42(6):627-33.
2. Naranjo CA, Busto U, Sellers EM, Sandor P, Ruiz I, Roberts EA, Janecek E, Domecq C, Greenblatt DJ: A method for estimating the probability of adverse drug reactions. Clin Pharmacol Ther. 1981;30(2):239-45.

No. 57

ANTIPSYCHOTIC-INDUCED EXTRAPYRAMIDAL SIDE EFFECTS IN BIPOLAR DISORDER AND SCHIZOPHRENIA

Keming Gao, M.D., 11400 Euclid Avenue, Suite 200, Cleveland, OH 44106, Joseph R. Calabrese, M.D., Stephen J. Ganocy, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) understand the different vulnerabilities of antipsychotic-induced extrapyramidal side effects in bipolar mania, bipolar depression, and schizophrenia; and (2) understand the different risks of each individual antipsycotics for extrapyramidal side effects in these three conditions.

SUMMARY:

Objective: Some early studies showed that patients with BPD were more vulnerable to developing TD as well as acute EPS than those with schizophrenia, but others found that the risk was similar. It remains unclear if patients with BPD have a similar degree of vulnerability to developing acute EPS as those with schizophrenia when being treated with antipsychotics. *Methods:* English-language literature cited in Medline was searched with terms, antipsychotic (generic/brand name), typical antipsychotic, atypical antipsychotic, safety, akathisia, EPS, anticholinergic use, and bipolar mania/depression, BPD, or schizophrenia, randomized, and clinical trial. Randomized, double-blind, placebo-controlled, monotherapy studies in both BPD and schizophrenia were included. Absolute risk increase (ARI) and number needed to treat to harm (NNTH) for akathisia, overall-EPS, and anticholinergic use relative to placebo were estimated. *Results:* Eleven trials in mania, three in bipolar depression, and eight in schizophrenia were identified. Haloperidol significantly increased the risk for akathisia, overall-EPS, and anticholinergic use in both mania and schizophrenia. However, the magnitude of increased risk was larger in trials of mania, with a NNTH for akathisia of 5 vs. 9, EPS of 3 vs. 6, and anticholinergic use of 2 vs. 4. Among atypical antipsychotics, only ziprasidone significantly increased the risk for overall-EPS and anticholinergic use in both mania and schizophrenia. Again, larger differences were observed in trials of mania with a NNTH for overall-EPS of 11 vs. 19 anticholinergic use of 5 vs. 9. In addition, risks were significantly increased for overall-EPS (NNTH=5) and anticholinergic use

(NNTH=5) in risperidone-treated mania, akathisia (NNTH=9) in aripiprazole-treated mania, and overall-EPS (NNTH=19) in quetiapine-treated bipolar depression. *Conclusion:* Bipolar patients were more vulnerable to having acute antipsychotic-induced movement disorders than those with schizophrenia.

REFERENCES:
1. Nasrallah HA, Churchill CM, Hamdan-Allan GA: Higher frequency of neuroleptic-induced dsytonia in mania than in schizophrenia. Am J Psychiatry 1988; 145:1455-1456.
2. Khanna R, Das A, Damodaran SS: Prospective study of neuroleptic-induced dystonia in mania and schizophrenia. Am J Psychiatry 1992; 149:511-513.

SCIENTIFIC AND CLINICAL REPORT SESSION 21- BIOLOGICAL PSYCHIATRY

No. 58

NORMALIZATION OF IMMUNE CELL IMBALANCE AFTER PHARMACOLOGICAL TREATMENTS OF PATIENTS SUFFERING FROM OBSESSIVE-COMPULSIVE DISORDER

Donatella Marazziti, M.D., Dipartimento di Psichiatria, Neurobiologia, Farmacologia e Biotecnologie, University of Pisa, Pisa, Italy 56100, Giorgio Consoli, M.D., Mario Catena Dell'Osso, M.D., Stefano Baroni, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will have an increased awareness of the immunological mechanisms possibly involved in OCD as well as of the potential use of antidepressants as immunomodulators.

SUMMARY:

Introduction: Recent data have shown the presence of immunological alterations in adult patients suffering from obsessive-compulsive disorder (OCD). The objective of this study was to examine the possible effects of 12 months of treatment with different serotonergic drugs, such as clomipramine and selective serotonin reuptake inhibitors (SSRIs), on peripheral immunological cells in 18, out of a total of 20 patients, evaluated at baseline and showing a significant increase of CD8+ and decrease of CD4+ lymphocytes, as compared with a similar group of healthy control subjects. *Materials and Methods:* Peripheral blood of patients was analyzed before and after treatments by means of a Facstar Flow Sorter apparatus and both the absolute number and percent of CD4+, CD8+, CD3+, CD19+ and CD56+ cells were measured. Results: A significant decrease of CD8+ and increase of CD4+ cells, as well as an increase of the CD4+/CD8+ ratio, were observed, as compared with baseline values, in parallel with the clinical improvement. *Conclusion:* These data suggest that the alterations of immune cells reported in OCD patients at baseline may be reverted by treatments with SRIs and should be considered a state-dependent marker, perhaps related to a condition of psychic stress.

REFERENCES:
1. Marazziti D, Presta S, Pfanner, C, Gemignani A, Rossi A, Sbrana S, Rocchi V, Ambrogi F. Cassano GB: Immunological alterations in adult obsessive-compulsive disorder. Biol Psychiatry 1999; 15: 810-814.
2. Swedo SE: Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS). Mol Psychiatry 2002; Suppl 2: S24-25.

No. 59

VENTRAL CAPSULAR/VENTRAL STRIATAL GAMMA CAPSULOTOMY FOR OBSESSIVE-COMPULSIVE DISORDER: FIRST RESULTS OF A DOUBLE-BLIND, RANDOMIZED, CONTROLLED TRIAL

Antonio Lopes, M.D., R Dr Ovídio Pires de Campos, 785, 3. and, Ala Norte, sala 9 (PROTOC), São Paulo, Brazil 01060970, Maria E. de Mathis, Psy.D., Anita Taub, Psy.D., Carina C. D'Alcante, Psy. D., Miguel M. Canteras, M.D., Marcelo Q. Hoexter, M.D., Fernando S. Gouvea, M.D., Benjamin D. Greenberg, M.D., Georg Norén, M.D., Eurípedes C. Miguel, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that: (1) a subgroup of obsessive-compulsive patients are treatment refractory; and (2) a specific technique of radiosurgery may be considered as a treatment option for these treatment-refractory patients.

SUMMARY:

Background: Up to 40% of obsessive-compulsive disorder (OCD) patients do not respond to medications/psychotherapy. For this subgroup, a stereotactic radiosurgery called Gamma-Knife anterior capsulotomy is a treatment option. An improvement of this technique was recently developed at Brown University, called ventral capsular/ventral striatal (VC/VS) Gamma capsulotomy. However, there is a lack of studies reporting results with this new technique. *Objective:* To assess efficacy and safety issues of VC/VS Gamma capsulotomy, including preliminary results of a randomized, controlled trial. *Method*: Fourteen refractory DSM-IV OCD patients were selected. Five were operated as part of a pilot study. Nine patients were randomized to either receive active or "sham" radiosurgery, in a double-blind, randomized, controlled trial (RCT). Every patient was assessed in the pre and post-operative follow-up periods, with psychopathological, global status, neuropsychological and personality scales being applied, as well as morphometric magnetic resonance imaging (MRI) scans. More than 35% improvement in Yale-Brown Obsessive Compulsive Scale and "improved" or "much improved" scores in Clinical Global Impression scale were taken as the primary treatment response criteria. *Results:* Six out of nine (67%) patients who had received active radiosurgery fulfilled our response criteria 12 months or more after surgery. None of the five sham radiosurgery patients were responders until the 12th month of follow up. Episodic headaches, dizziness, nausea, and one manic episode were observed. Regarding neuropsychological changes, improved performances on verbal IQ (p=0.04), global IQ (p=0.04), logical memory (p=0.04), and simple visual attention (p=0.04) were noted in the pilot patients. Conclusions: Preliminary results suggest that VC/VS Gamma capsulotomy for OCD shows some efficacy, with few adverse effects. More results from our ongoing RCT will better investigate its efficacy and safety.

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No. 60

ALTERATIONS OF THE DOPAMINE TRANSPORTER IN LYMPHOCYTES OF PATIENTS WITH DIFFERENT PSYCHOTIC DISORDERS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have an increased awareness on the dopamine changes possibly involved in psychotic disorders.

SUMMARY:

Introduction: The dopamine (DA) transporter (DAT) controls the intrasynaptic DA concentrations through its reuptake into the nerve terminals. The evidences of the involvement of the DA systems in the etiology, symptomatology, and treatment response of psychoses led to investigate DAT in these conditions. The aim of our study was to explore and compare the presence of DAT in blood lymphocytes of patients with psychotic disorders and healthy control subjects by means of the binding of 3H-WIN 35,428 and by means of the specific reuptake of 3H-DA. Methodology: Twenty-five outpatients with a *DSM IV-R* diagnosis (SCID) of bipolar I disorder with psychotic features or schizophrenia were included in the study. Twenty-five healthy, drug-free subjects, with neither family nor personal history of any major psychiatric disorder, were included as control subjects. The 3H-DA uptake was performed according to the method of Amenta et al. (2001), with some modifications. Results: The binding of 3H-WIN 35,428 represented approximately 75% of the total and was specific and saturable; the Scatchard analysis of saturation data revealed the presence of one site only. The Bmax values (mean+SD, fmol/mg protein) of the patients were 21±2.1, significantly lower than those of healthy control subjects (38.5±3.2, p=0.009). As far as 3H-DA uptake is concerned, the Vmax (mean+SD, pmol/109cells/min) of patients was 8.2±1, significantly lower than that of healthy subjects (52.9±21, p=0.01). No differences were found in the Kd and in the Km. Conclusions: Patients with different psychotic disorders seem to present a decrease in the lymphocyte DAT as compared with healthy control subjects. It may suggest that patients with psychotic disorders might have a decreased density of the DAT in pre-synaptic neurons. Such a hypofunctionality might represent a primary or a secondary phenomenon, representing an adaptation to changes in DA levels in the brain.

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SCIENTIFIC AND CLINICAL REPORT SESSION 22-DIAGNOSIS

No. 61

THREATS TO VALIDITY IN CAUSALITY RESEARCH USING PSYCHIATRIC DIAGNOSES

Stephen Shanfield, M.D., 122 Chester St. #2, San Antonio, TX 78209, Stephen B. Shanfield, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to recognize the underlying threats to validity in psychiatric diagnostic categories and their implications for causality research.

SUMMARY:

Objective: The objective is to discuss underlying threats to validity of the psychiatric diagnostic categories and their implications for causality research. *Method:* The author draws from the research literature. *Results:* In psychiatric causality research, diagnostic categories are treated as fixed. Once present, they are accepted as is. Threats to validity are essentially ignored. However, serious threats to validity involve the diagnostic constructs themselves. Construct validity is concerned with whether a construct actually does what is intended, with its content, whether it reflects the theory behind it. This includes convergent and discriminant validity, the closeness or distance from other disorders. Threats to validity among the categories are manifold. They involve an unknown but often considerable magnitude of unmeasured and unknown elements, often not in the definition of the disorder. For instance, major psychiatric disorders overlap. The boundaries between normal and a disorder are fuzzy. Other discrete disorders are embedded in a category so that these disorders can be broken into smaller units. Some categories cannot be determined at the time of study. Core symptoms of a disorder appear in other disorders. Cooccurrence of disorders is the rule rather than the exception, a particular problem in research using samples of convenience. Finally, psychiatric symptoms have many unspecified elements. *Conclusions:* Threats to the validity of the diagnostic categories are usually hidden, subtle, and submerged. While measures may be correlated, inference about causal explanation is impaired because of these fundamental threats. Such confounds lead to substantial errors in the interpretation of causal forces. Replication of studies and the use of control populations including pre- and post-test strategies do not rectify the threats. A central task is to focus on an understanding of deeper and smaller elements of the categories and their links.

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Quasi-Experimental Designs for Generalized Causal Inference. Boston, Houghton Mifflin, 2002.
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No. 62

WHAT CAN WE LEARN FROM VALID DIAGNOSES?

Roger Peele, M.D., P. O. Box 1040, Rockville, MD 20849-1040, Enrico Suardi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to explicate the characteristics of valid diagnoses in psychiatry and what that forcasts as to future valid diagnoses.

SUMMARY:

Almost half of *DSM-IV-TR*'s diagnostic entities have an etiology tied to a substance, a neurological illness, another medical illness, a mental trauma/stress, a season, or a postpartum period. A review of the psychopathology associated with substances, neurological illnesses, etc., finds that none of the manifestations fit totally within one existing diagnostic entity. This suggests that the present division of psychopathology into psychotic, mood, anxiety disorders, etc., may not outline valid diagnoses. This finding is consistent with the high prevalence of comorbidity in psychiatry. This review implies that when new etiological agents/factors are identified, whether biologic, psychological, or social, their clinical manifestations will cut across psychopathology as to *DSM-IV-TR*'s present organization. Restated, the pursuit of the etiology of depression, schizophrenia, bipolar disorder, and so forth, seems unlikely to support taxonomic frameworks that fit within the *DSM-IV-TR*'s criteria set of depression, schizophrenia, bipolar disorder, and so forth. If increasing the validity of diagnoses is a goal for *DSM-V*, the emphasis may have to: (1) Shift from approaches suggested by Robins and Guze (1970), Kendler (1982) and Kendell (1988), Kendell and Jablensky (2003) to a fuller recognition that any etiopathologic agent will have a broad range of manifestations; and (2) Change the taxonomic structure of *DSM-IV-TR*.

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No. 63

IS BIPOLAR DISORDER OVERDIAGNOSED?

Mark Zimmerman, M.D., 235 Plain Street, Suite 501, Providence, RI 02905, Camilo J. Ruggero, Ph.D., Iwona Chelminki, Ph.D., Diane Young, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be aware of: (1) research showing that bipolar disorder is often overdiagnosed; and (2) how to empirically demonstrate a problem with overdiagnosis.

SUMMARY:

Objective: Bipolar disorder, a serious illness resulting in significant psychosocial morbidity and excess mortality, has been reported to be frequently underdiagnosed. However, during the past few years we have observed the emergence of an opposite phenomenon—the overdiagnosis of bipolar disorder. In the present report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project we empirically examined whether bipolar disorder is overdiagnosed. Methods: Seven hundred psychiatric outpatients were interviewed with the Structured Clinical Interview for *DSM-IV* (SCID) and completed a self-administered questionnaires which asked the patients whether they had been previously diagnosed by a health care professional with bipolar or manic-depressive disorder. Family history information was obtained from the patients regarding their first-degree relatives. Diagnoses were blind to the results of the self-administered scale. *Results:* Less than half the patients who reported that they had been previously diagnosed with bipolar disorder received a diagnosis of bipolar disorder based on the SCID. Patients with SCID-diagnosed bipolar disorder had a significantly higher morbid risk of bipolar disorder than patients who self-reported a previous diagnosis of bipolar disorder that was not confirmed by the SCID. Patients who self-reported a previous diagnosis of bipolar disorder that was not confirmed by the SCID did not have a significantly higher morbid risk for bipolar disorder than the patients who were negative for bipolar disorder by self-report and the SCID. *Conclusions:* Not only is there a problem with underdiagnosis of bipolar disorder, but an equal, if not greater, problem exists with overdiagnosis.

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1. Bowden CL: Strategies to reduce misdiagnosis of bipolar depression. Psychiatric Services 2001; 52(1):51-55.
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SCIENTIFIC AND CLINICAL REPORT SESSION 22-SOCIAL AND COMMUNITY PSYCHIATRY

No. 64

TREATING OBESITY: INTERVENTIONS FOR IMPROVING BODY MASS INDEX AND INCREASING FITNESS IN AN INNER-CITY HISPANIC AND AFRICAN-AMERICAN SPMI POPULATION

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to learn some effective methods to foster weight loss and fitness in this population.

SUMMARY:

Objective: The problems of obesity, metabolic syndrome, and diabetes in the Hispanic and African-American SPMI population are well known, complex, and difficult to treat. The team implemented a comprehensive protocol to improve body mass index and increase fitness in this population. *Methods:* We initiated

a Quality Improvement Study in 2005 in compliance with the N.Y.C. Department of Health and Mental Hygiene's mandate for ongoing quality assurance. This is a report on preliminary data (at 21 months) in an ongoing Quality Improvement Study in an inner-city SPMI Continuing Day Treatment Program. All patients with a BMI.>30 (n=33) were included in the Quality Improvement Study. We developed a comprehensive prospective program to promote healthy eating habits, weight loss, and increased exercise. Our interventions were based on and informed by CBT, DBT, and adherence techniques. *Results:* 66.6% of patients lost weight; 63.6% of patients lost 5 lbs. or more; 51.5% lost from 10-39 lbs. There was a five-fold increase in exercise session participation. *Conclusion:* Treating obesity and increasing fitness are well documented global public health issues. Few effective protocols exist for treating obesity in the S.P.M.I. population. That 66.6% of patients lost weight indicates that effective interventions can produce results even in this treatment resistant population. These interventions may help decrease the risk and incidence of diabetes and cardiovascular disease in this population.

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No. 65

FACT, A DUTCH VERSION OF ACT (ASSERTIVE COMMUNITY TREATMENT)

J. Remmers van Veldhuizen, M.D., Praediniussingel 20/9, Groningen, Netherlands 9711 AG

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) compare the principles of FACT (Function ACT) with principles of ACT; and (2) answer the questions: Why ACT only focuses on the 20% most severe mentally ill? What happens with patients in ACT teams when they are stable and not in need of intensive outreaching services? How we can organize continuity of care for the SMI? How is FACT organized on a regional scale in a different Mental Healt System?

SUMMARY:

Assertive Community Treatment (ACT) is a well-defined service delivery model for the care and treatment of the most severely mentally ill people (SMI) in the community. In some areas in the Netherlands ACT teams have been set up, but more regions have opted for a Dutch version named FACT. FACT is a rehabilitation-oriented clinical case management model, which is based on the ACT model but is more flexible and able to serve a broader range of clients with severe mental illness. FACT offers the original ACT as one of several treatment or care models. The FACT team is a case management team with partly an individual approach and partly a team approach; the approach varies from patient to patient, depending on the patient's needs. For more stable long-term patients, FACT provides coordinated multidisciplinary treatment and care by individual case management. Unstable patients at risk of relapse, neglect, and readmission are provided with intensive assertive outreach care by the same team, working with a shared caseload for this subgroup. This lecture describes the development of the FACT model, the service model and everyday practice in FACT. We discuss the advantages of FACT as compared with standard ACT and future challenges in the Dutch situation. Some questions are posed for the situation in the U.S., following the comments of Bond and Drake; Should the U.S. adopt the Dutch Version of ACT?

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2. Bond, GR, Drake RE: Should We Adopt the Dutch Version of ACT? Commentary on "FACT: A Dutch Version of ACT". Community Mental Health Journal, 43(4):435-437, 2007.

No. 66

PSYCHIATRIC HOUSING: CORRELATES OF COMMUNITY INTERACTION

Allison Zippay, Ph.D., Rutgers University, 536 George Street, New Brunswick, NJ 02186

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify outreach strategies and neighborhood characteristics that were associated with greater community interaction among residents of psychiatric housing in this study.

SUMMARY:

Objective: A goal of community-based housing for individuals with severe mental illness is the promotion of social and community interaction. Yet little empirical information is available regarding factors that facilitate such interactions. This study examined and identified neighborhood characteristics and agency, sponsored outreach efforts that were positively associated with community and social interaction among residents of shared, supervised psychiatric housing in seven study states. *Method:* Interviews were conducted with administrators from 169 randomly sampled mental health agencies that establish and manage psychiatric housing in seven states. These respondents were asked to describe the types (if any) of neighborhood and community outreach strategies used at their most recently sited residence. Interviews were also conducted with on-site supervisors at these residences to solicit information on the types of interactions that residents had with neighbors and in the community. Block level demographic data from the 2000 U.S. Census were collected for each site. Findings: The frequency and intensity of interaction with neighbors and other community members by the residents of the psychiatric housing were positively correlated with neighborhood density; mixed use, pedestrian oriented neighborhoods with access to a commercial district; and sites at which sponsoring agencies initiated outreach and social activities with neighbors. Conclusions: Agency siting strategies that locate psychiatric housing in more dense neighborhoods with pedestrian access to business districts and public facilities, and include post-siting outreach may positively affect community interaction among residents of psychiatric housing. This study was funded by a grant from the National Institute of Mental Health.

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Policy Research, 2003.
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SCIENTIFIC AND CLINICAL REPORT SESSION 24-TREATMENT DECISIONS AND OUTCOME IN DEPRESSION

No. 67

DISEASE MANAGEMENT FOR PATIENTS WITH DIFFICULT TO TREAT DEPRESSION

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be able to recognize that there are useful nonpharmacological adjunctive treatment options for patient with difficult to treat depressions.

SUMMARY:

Background: A significant minority of depressed patients (approximately 33%) have a form of depression that does not remit even with multiple combinations of antidepressant treatments. For these patients, more attainable goals include improved quality of life and psychosocial functioning in spite of persisting depressive symptoms. The aim of this pilot study was to evaluate the effectiveness of an adjunctive disease management program to achieve those goals. *Method:* 14 depressed patients who had not responded to adequate antidepressant treatment and their family member(s) participated in a combination of individual, family and telephone disease management sessions, over 16 weeks, designed to help them cope better with the non-remitting course of the depression. Change scores from baseline to week 16 were compared using the Quality of Life and Enjoyment Questionnaire (Q-LES-Q) and the Scales of Psychological Well-Being (SPWB), the Montgomery-Asberg Depression Scale (MADRAS), the Beck Depression Inventory (BDI), and the Family Assessment Device. Results; After 16 weeks there was significant improvement in Q-LES-Q scores (17.2 ± 6.5 to 23.4 ± 8.1, p=.019). Patients showed significant improvement in self-acceptance, environmental mastery, and purpose in life (all p-values <.05). Family functioning showed a trend in improvement (p<.07). BDI scores improved significantly over the 16 weeks (p<.02) while MADRAS scores improved significantly by week eight but not week 16. Conclusions; Learning how to cope with and manage their depression helped patients improve their self-acceptance, environmental mastery, and perceived quality of life in spite of persisting depressive symptoms.

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No. 68

EVIDENCE-BASED MEDICINE AND OUTCOME: THREE-MONTH FOLLOW-UP OF INPATIENTS WITH MDD

Bonnie Szarek, R.N., Institute Of Living, 200 Retreat Avenue, Hartford, CT 06106, John W. Goethe, M.D., Stephen B. Woolley, D.Sci.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) discuss evidence-based treatment guidelines for MDD; and (2) evaluate the course of treatment of MDD patients post-hospital discharge.

SUMMARY:

Objective: To determine, in a sample of recently discharged patients with MDD, (1) the proportion of patients with pharmacotherapy consistent with published treatment guidelines and evidence-based medicine (EBM) and (2) the association between EBM and outcome three months post-discharge. *Methods:* Consenting patients with MDD were interviewed by phone (n=198, 76.3% of eligible patients discharged in the 18-month study period) using a questionnaire that included the Beck FastScreen (score ?4 = depressed) and items about current treatment. Inpatient treatment data were obtained from retrospective chart review. Pharmacotherapies were independently rated for consistency with EBM guidelines (yes/no). Statistical analyses included chi square and logistic regression. *Results:* Pharmacotherapy at hospital discharge was consistent with EBM guidelines in 100% of patients, but medication at follow up met these criteria in only 43.9% of the sample. At follow up 25.3% of patients said they had not improved and 65.2% remained depressed (mean score = 7.5, range 0-21). Depression was much less common in the EBM group (38.8% vs 88.9%, p<.001; OR=0.2, CI 0.01-0.09). Baseline therapy was frequently changed (70.7% of all patients) but not significantly more so in depressed (73.6%) vs non-depressed patients (64.1%) or in the EBM (73.6%) vs non-EBM group (68.4%). *Conclusions:* The association of EBM with superior outcome is consistent with previous research, and this study extends such findings to recently hospitalized (and probably more severely ill) patients. Many patients remain symptomatic three months post-discharge, but the large number receiving non-guideline-based treatment was unexpected.

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2. Zetin J, Hopener CT, Bjornson L: Rational antidepressant selection: applying evidence-based medicine to complex real-

world patients. Psychopharmacol Bull 39:38-104, 2006.

No. 69

A CLINICALLY USEFUL DEPRESSION OUTCOME SCALE

Mark Zimmerman, M.D., 235 Plain Street, Suite 501, Providence, RI 02905, Iwona Chelminski, Ph.D., Joseph B. McGlinchey, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be more familiar with a depression outcome measure that is feasible to include in clinical practice.

SUMMARY:

If the optimal delivery of mental health treatment ultimately depends on examining outcome, then precise, reliable, valid, informative, and user-friendly measurement is the key to evaluating the quality and efficiency of care in clinical practice. Self-report questionnaires are a cost-effective option because they are inexpensive in terms of professional time needed for administration, and they correlate highly with clinician ratings. In the present report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project, we describe the reliability and validity of the Clinically Useful Depression Outcome Scale (CUDOS). The CUDOS was designed to be brief (completed in less than 3 minutes), quickly scored (in less than 15 seconds), clinically useful (fully covering the *DSM-IV* symptoms of major depressive disorder and dysthymic disorder), reliable, valid, and sensitive to change. We studied the CUDOS in more than 1,400 psychiatric outpatients and found that the scale had high internal consistency and test-retest reliability. The CUDOS was more highly correlated with another self-report measure of depression than with measures of anxiety, substance use problems, eating disorders, and somatization, thereby supporting the convergent and discriminant validity of the scale. The CUDOS was also highly correlated with interviewer ratings of the severity of depression, and CUDOS scores were significantly different in depressed patients with mild, moderate, and severe levels of depression. The CUDOS was a valid measure of symptom change. Finally, the CUDOS was significantly associated with a diagnosis of major depressive disorder. Thus, the results of this large validation study of the CUDOS show that it is a reliable and valid measure of depression that is feasible to incorporate into routine clinical practice.

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SCIENTIFIC AND CLINICAL REPORT SESSION 25-STUDIES IN THE COURSE OF SCHIZOPHRENIA

No. 70

PREDICTING SCHIZOPHRENIA SPECTRUM DISORDERS WITH PSYCHOLOGICAL SCALES: THE NORTHERN FINLAND 1966 BIRTH COHORT

Jouko Miettunen, Ph.D., Department of Psychiatry, University of Oulu, P.O.Box 5000, FIN-90014 Oulu, Finland, Oulu, Finland 90014, Juha Veijola, M.D., Ph.D., Matti Isohanni, M.D., Ph.D., Tiina Paunio, M.D., Ph.D., Nelson Freimer, M.D., Ph.D., Erika Lauronen, M.D., Ph.D., Jesper Ekelund, M.D., Ph.D., Leena Peltonen, M.D., Ph.D., Matti Joukamaa, M.D., Ph.D., Dirk Lichtermann, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to utilize psychological scales when studying risk factors or genetics of schizophrenic psychoses.

SUMMARY:

Objective: The aim of the study was to evaluate concurrent and predictive validity of several psychological scales for schizophrenic psychoses. *Method:* Psychological scales (Perceptual Aberration, Physical and Social Anhedonia, Hypomanic Personality, Schizoidia, and "Bipolar II" scales) were filled in as part of the 31-year follow-up survey of the prospective Northern Finland 1966 Birth Cohort. In total 4,926 participants (2,203 males and 2,723 females) filled in adequately at least one of the scales. We compared subjects without any previous hospitalizations by age 31 years to those with previous hospital diagnoses (concurrent validity) and to those who in the eight-year-long follow-up were hospitalized due to schizophrenic psychosis (predictive validity). We also compared the subjects with schizophrenia spectrum disorders and subjects with other psychiatric disorders (discriminant validity). *Results:* In most scales, subjects with schizophrenia spectrum disorders differed from healthy subjects. The Perceptual Aberration Scale was the best scale for concurrent (Effect Size = 1.89) and discriminant validity (Effect size = 0.64). Subjects having a high score in Hypomanic Personality Scale were in the highest risk for developing schizophrenic psychoses during the follow up (OR 10.72; 2.87-40.06). *Conclusions:* Subjects with schizophrenia spectrum disorders differed statistically significantly in most of the scales from healthy controls and from subjects with other psychiatric disorders. Many of the scales were useful predictors for future hospitalizations due to schizophrenic psychoses; however scales were not very diagnosis specific. The predictive power of the scales is limited; these scales are probably not useful as screening instruments but can be used in several ways when studying, e.g., risk factor or genetics of schizophrenic psychoses.

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No. 71

SEPARABLE DEVELOPMENTAL TRAJECTORIES IN SCHIZOPHRENIA FROM WOMB TO GRAVE: RESULTS FROM THE NORTHERN FINLAND 1966 BIRTH COHORT

Matti Isohanni, Ph.D., P.O. Box 5000, Peltolantie 17, Oulu, Finland FIN-90014, Jouko Miettunen, Ph.D., Antti Alaräisänen, Irene Isohanni, Ph.D., Erika Lauronen, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand what is currently known on the longitudinal trajectories of schizophrenia during the entire life span.

SUMMARY:

Subtle developmental abnormalities are often present before psychosis. Their predictive power is small, and the longitudinal trajectory can be difficult to tease apart. The Northern Finland 1966 Birth Cohort Study aims to examine life-span developmental trajectory of schizophrenia in a population-based cohort using developmental markers at birth, at ages 1, 16, and 31 (genetics, brain morphology, cognitive capacity, clinical status). The main results were: the schizophrenia group achieved developmental milestones later and showed altered patterns of development over time and poorer outcomes (mortality, somatic health) when compared with non-psychotic controls. Among schizophrenia subjects, we have identified evidence of dysfunction in a distributed network involving a fronto-striatal-cerebellar circuit ("developmental dysmetria"). After the illness onset, the clinical and social course of illness was remarkable heterogenous. We conclude that the developmental trajectories in schizophrenia from womb to grave are distinctly different compared to controls. These findings emphasize the neurodevelopmental aspects and the value of longitudinal birth cohort studies.

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No. 72

RECOVERY FROM SCHIZOPHRENIA: A META-ANALYSIS

Erika Lauronen, B Med, P.O.BOX 5000, FIN-90014 University of Oulu, Oulu, Finland, Juha Veijola, M.D., Ph.D.; John McGrath, M.D., Ph.D., Sukanta Saha, MSc., Johanna Heikkinen, M.A., Matti Isohanni, M.D., Ph.D., Jouko Miettunen, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: (1) understand the heterogeneity of outcomes and the chances of recovery in schizophrenia; and (2) be aware of the lack of, and need for, standardized, commonly accepted measures and definitions of good and poor outcome and recovery in schizophrenia.

SUMMARY:

Objective: Recovery in schizophrenia is still a controversial issue. The aim was to collect studies related to this topic and synthesize the data with meta-analytic techniques. *Methods:* Potentially relevant studies from seven electronic databases and manual literature searching were identified. Keywords "schizo', psychotic, psychos's and "recovery, remission, outcome' , course, prognosis, follow-up, longitudinal" were used as a title search. The second search in abstracts included keywords schizophrenia and recovery or remission. Studies in English, with primary data, not therapy/drug trials/interventions, with at least 15 subjects, follow-up data for at least two years were included. Recovery needed to be measured by utilizing both clinical and social dimensions. All abstracts and articles were analyzed by two of the authors. *Results:* The search identified 4,234 unique potentially relevant articles. After further screening, we identified 670 articles for inclusion. So far all the studies published 1995-2004 (N=210) and a random sample (N=227/460, 49%) of other articles have been evaluated. From these 26 articles have met all our criteria. Based on these, 0-32% of the subjects 'recovered' (mean 17.5%). The percentage of recovered individuals in the 16 older studies (published 1943-1991) was on average 20.7%, while in the 10 more recent studies (published 1995-2007), the percentage was 12.2% (meta-regression, z test 2.61, p=0.01). The definition of recovery varied greatly among the studies. *Conclusions:* Based on these findings, recovery from schizophrenia does occur, but it is uncommon. The proportion of patients meeting recovery criteria appears lower in recently published studies. Relatively little primary data on recovery in schizophrenia exist, and various conceptual and methodological pitfalls cause challenges when studying the topic. More accurate reporting of multidimensional recovery results and structured consensus criteria is needed.

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2. Hegarty JD, Baldessarini RJ, Tohen M, Waternaux C, Oepen G: One hundred years of schizophrenia: A meta-analysis of the outcome literature. Am J Psychiatry 151: 1409-1416, 1994.

SCIENTIFIC AND CLINICAL REPORT SESSION 26- PSYCHOPATHOLOGY AND PSYCHIOBIOLOGY OF BORDERLINE PERSONALITY DISORDER

No. 73

TRAUMA AND PSYCHOPATHOLOGY IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER AND THEIR SISTERS

Joel Paris, M.D., Institute of Community and Family Psychiatry, 4333 Cote Ste-Catherine Rd,, Montreal, Canada H3T 1E4, Lise Laporte, Ph.D., Herta Guttman, M.D., N.M.K. Ng, Ph.D., George Schwartz, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) understand the pathways leading to the development of borderline personality disorder; (2) understand interactions between traits and life adversities in BPD; and (3) take into account the treatment implications of this data.

SUMMARY:

The purpose of this study was to examine genetic and environmental risk factors for borderline personality disorder (BPD) by comparing women with this disorder and their sisters. Diagnoses were established for 37 pairs of sisters (mean age=29) in which at least one met criteria on the Diagnostic Interview for Borderlines, Revised (DIB-R). Only two pairs were concordant for BPD. The samples were comparable on demographics (age, marital status, socioeconomic class, and education). Psychopathology was assessed with HAM-A, HAM-D, and SCL-90. Personality traits were assessed with the Barratt impulsivity Scale (BIS), the Diagnostic Assessment of Personality Pathology (DAPP-BQ), and the Affective Lability Scale (ALS). Psychosocial adversity was assessed with the Childhood Trauma Interview (CTI), the Parental Bonding Instrument (PBI), and the Life Experiences Survey (LES). Paroxetine binding was also assessed. Most measures of psychopathology were significantly higher in the patient group, and most sisters reported no significant symptoms. Levels of reported childhood abuse did not differ in nature and severity between pairs of sisters. The main exceptions were physical abuse, which was more prevalent (64% vs. 31%) in patients, and sexual abuse, where patients reported more perpetrators in the immediate family. The groups did not differ in LES and PBI scores. There were no significant differences in Bmax (807 vs. 748 fmol/mg) or Kd (0.25 vs. 0.23 Nmol /mg) between the BPD and BPD sister groups, although both groups had a significantly (<.005) lower BMax than female controls (from an earlier study). These results suggest that BPD patients and their normal sisters suffer similar severe childhood adversities but do not develop the same disorder as adults. Furthermore, these groups have a different outcome in spite of having similar abnormalities in serotonergic activity.

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1. Paris J: The developmental psychopathology of impulsivity and suicidality in borderline personality disorder. Development and Psychopathology 17:1091-1104, 2005.
2. Ng F, Paris J, Zweig-Frank H, Schwartz G, Steiger H and Nair V: Paroxetine binding in relation to diagnosis and underlying traits in patients with borderline personality disorder compared with normal controls. Psychopharmacology 182: 447-451, 2005.

No. 74

SPECIFICITY OF GLUTAMATERGIC NEUROTRANSMISSION AND BORDERLINE PERSONALITY DISORDER

Bernadette Grosjean, M.D., Harbor UCLA, 1000 West Carson Street, Box 497, Torrance, CA 90509, Jonathan Still, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the model of glutamatergic neurotransmission dysregulation in borderline personality disorder (BPD) and to articulate it with recent research in neuroscience.

SUMMARY:

Objective: Borderline personality disorder (BPD) is characterized by emotion dysregulation, frequent self injurious behaviors, alteration of perception and multiple cognitive dysfunctions. A recent model suggests that glutamatergic-NMDA neurotransmission may be dysregulated in patient suffering from BPD. In this paper we examine how recent clinical studies may corroborate this model. Method: Review of the glutamatergic dysregulation model in BPD and articulation with recent clinical and neurobiological research involving glutamatergic neurotransmission in BPD.

REFERENCES:

1. Grosjean B, Tsai G: NMDA Neurotransmission as a critical mediator of borderline personality disorder. Journal of Psychiatry and Neurosciences, March 2007; 32 (2) 103-115.
2. Pittenger C, Krystal JH, Coric V: Initial evidence of the beneficial effects of glutamate-modulating agents in the treatment of self-injurious behavior associated with borderline personality disorder. J Clin Psychiatry 2005 Nov;66(11):1492-3.

No. 75

PAIN IN BORDERLINE PERSONALITY DISORDER: EXAMINING THE ROLE OF NMDA NEUROTRANSMISSION

Jonathan Still, M.D., Harbor-UCLA Medical Center, 1000 West Carson, Torrance, CA 90509, Bernadette Grosjean, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the multifaceted mechanisms of pain perception and the specificity of pain in borderline personality disorders, particularly with regard to N-methyl-D-aspartic acid (NMDA) neurotransmission.

SUMMARY:

Introduction: Borderline personality disorder (BPD) is a debilitating condition characterized by affective instability, impulsivity, and self-injurious behavior. Several studies have described aberrations in pain perception in patients with BPD. Specifically ,it has been well documented that during selfarm behavior, patients with BPD present elevated pain threshold. Other studies show that BPD patients have a higher incidence of chronic pain. Finally, recent research suggests that disturbed pain processing may normalize following or parallel to the remission of self-injurious behaviors. The mechanisms underlying these findings have not been clearly elucidated. Multiple studies have shown that the NMDA system is involved in mechanisms of pain perception and transmission. Recent models suggest that NMDA-glutamatergic neurotransmission maybe dysregulated in BPD. Accordingly, we explore the role that NMDA neurotransmission may have in the mechanism of pain perception and/or processing in BPD. Method: In this presentation, we review and articulate the mechanisms of pain perception at sensory and cognitive levels, the specificity of pain perception in BPD, and the model of NMDA-glutamatergic dysregulation in BPD. Conclusion: Some specificity of the modalities of perception in BPD and their clinical implications can be integrated within a model for BPD pathology implying dysregulation of NMDA-glutamatergic neurotransmission.

REFERENCES:

1. Grosjean B, Tsai G : NMDA Neurotransmission as a critical mediator of borderline personality disorder. Journal of Psychiatry and Neurosciences. March 2007; 32 (2) 103-115.
2. Purves D et al: Pain. In Neuroscience Edited by Purves D,

Augustine G J, et al, Massachussets, USA, Sunderland, Massachusetts,1996, pp209-228.

THURSDAY, MAY 8, 11:00 AM - 12:30PM

SCIENTIFIC AND CLINICAL REPORT SESSION 27- PSYCHOPHARMACOLOGY OF SCHIZOPHRENIA

No. 76

RACIAL DIFFERENCES IN PRESCRIBING PRACTICES IN THE TREATMENT OF SCHIZOPHRENIA

Karen Bullock, Ph.D., Braceland Center for Mental Health & Aging, Institute of Living/Hartford Hospital, 200 Retreat Avenue 6th Floor Research Bldg, Hartford, CT 06106, Bonnie L. Szarek, R.N., John W. Goether, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the association between race and pharmacotherapy with black, white and latino patients with schizophrenia.

SUMMARY:

Objective: Health disparities research suggests that an over-diagnosing of certain psychiatric disorders among African Americans may explain systematic differences in pharmacotherapy. This study examined inpatient adults with schizophrenia to: (1) determine if there are racial differences in the pharmacotherapies used, and (2) determine the association between clinical and demographic factors and these variations in diagnostic and treatment patterns. *Methods:* A retrospective analysis of discharge data for black, white, and latino inpatient adults (4/1/04-3/31/06) with schizophrenia (n=741). Race was the primary predictor variable of interest. Independent variables included clinical, and demographic factors. Associations were determined by using stepwise logistic regression. Demographic, clinical and treatment variables were examined using chi-square and logistic regression. *Results:* The sample was (31.3%) black, (46.6%) White, and (22.1%) Latino. Blacks were more likely to be prescribed typical antipsychotics than whites (48.7% vs 32.2%, p<.001) and Latinos (31.1%, p<.001). Latinos were less likely to receive olanzapine (8.5%) than whites (17.7%, p=.007) or blacks (16.8%, p=.017). There were also significant differences in use of atypical antipsychotic medications across racial groups, but no difference in use of antipsychotic polypharmacy (31.3% of Whites, 29.3% of blacks, 28.7% of Latinos). *Conclusion:* There were significant differences in prescribing practices when comparing patients by race. Whites may be more likely than blacks to receive newer medications (e.g., atypical antipsychotics, clozapine).

REFERENCES:

1. Minksy S, et al.: Diagnositc patterns in Latino, African American, and European American psychiatric patients. Arch Gen Psychiatry 2003; 60:637-644.
2. Shi L, et al.: Characteristics and use patterns of patients taking first-generation depot antipsychotics or oral antipsychotics for schizophrenia. Psychiatric Services 2007; 58:482-488.

No. 77

RISPERIDONE ALONE VERSUS RISPERIDONE PLUS VALPROATE IN THE TREATMENT OF PATIENTS WITH SCHIZOPHRENIA AND HOSTILITY

Leslie Citrome, M.D., Nathan S. Kline Institute for Psychiatric Research 140 Old Orangeburg Road, Orangeburg, NY 10962, Constance B. Shope, Ph.D., Karen A. Nolan, Ph.D., Pal Czobor, Ph.D., Jan Volavka, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) recognize the different long-term pharmacotherapeutic choices in managing patients with schizophrenia who also exhibit hostile and aggressive behavior; and (2) understand the limitations of controlled research in the study of schizophrenia and hostile behavior.

SUMMARY:

The objective of the study was to compare the antiaggressive efficacy of risperidone monotherapy versus risperidone plus valproate in patients with schizophrenia. This was an eight-week open-label, randomized parallel group clinical trial in hospitalized adults diagnosed with schizophrenia and with hostile behavior. Patients were randomly assigned to receive risperidone alone (n= 16) or risperidone plus valproate (n= 17). To minimize bias, raters were blinded to the assigned treatment arm. Outcome measures included the Positive and Negative Syndrome Scale (PANSS), Buss–Durkee Hostility Inventory (BDHI), Barratt Impulsiveness Scale (BIS), Nurses Observation Scale for Inpatient Evaluation (NOSIE), and the Overt Aggression Scale (OAS). Although significantly fewer patients randomized to monotherapy completed the study (v2 =8.62, d.f. =1, P = 0.003), no significant differences between monotherapy or combination treatment were observed in change of the BDHI, BIS, NOSIE, PANSS total scores, OAS measures of aggressive behavior, or the hostility item of the PANSS. In conclusion, although patients receiving combination treatment were more likely to complete the study, we were unable to detect a meaningful advantage for combination therapy as measured by rating scales.

REFERENCES:

1. Citrome L, Shope CB, Nolan KA, Czobor P, Volavka J: Risperidone alone versus risperidone plus valproate in the treatment of patients with schizophrenia and hostility. International Clinical Psychopharmacology (in press).
2. Citrome L: The psychopharmacology of violence with emphasis on schizophrenia, Part 2: Long-term treatment. Journal of Clinical Psychiatry 68(2):331-332, 2007.

No. 78

ASENAPINE IN SCHIZOPHRENIA: AN OVERVIEW OF CLINICAL TRIALS IN THE OLYMPIA PROGRAM

Steven Potkin, M.D., Department of Psychiatry and Human Behavior, University of California, Irvine, Brain Imaging Center, 5251 California Avenue, Ste. 240, Irvine, CA 92617, Steven G. Potkin, M.D., John M. Kane, M.D., Robin A. Emsley, M.D., Dieter Naber, M.D., John Panagides, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) summarize the clinical experience to date with asenapine in terms of efficacy versus placebo and long-term safety in patients with schizophrenia; and (2) assess the efficacy and safety of asenapine in comparison with risperidone, olanzapine, and haloperidol, in patients with schizophrenia.

SUMMARY:

Asenapine is a novel psychopharmacologic agent being developed for treatment of schizophrenia and bipolar disorder. The Olympia clinical trial program is a comprehensive assessment of the efficacy, tolerability, and safety of asenapine against placebo or active comparators in short- and long-term trials in general and special populations with these disorders. The Olympia program includes studies involving a planned total enrollment of approximately 3,500 patients with schizophrenia. In two randomized, controlled six-week Phase II and Phase III trials (the Hera trials) in almost 700 patients, asenapine produced 19- to 21-point reductions in PANSS total score (significantly superior to placebo in a mixed-model for repeated measures analyses). Asenapine also showed benefit in reducing negative symptoms and was associated with minimal or mild effects on weight and prolactin levels. Forthcoming trials in the Hera series will look at fixed and flexible dosing regimens in almost 700 patients. In a year-long safety study (called ACTAMESA) in 1,200 patients treated with flexibly dosed asenapine or olanzapine, the proportion of patients who completed the study was greater with olanzapine but overall adverse event (AE) rates were similar for asenapine and olanzapine (drug-related AEs, 60% and 61%, respectively; withdrawals due to serious AEs, 6.3% and 6.8%). Extrapyramidal symptoms were more common with asenapine but significant weight gain was more common with olanzapine. The forthcoming Aphrodite trials, with a total enrollment of almost 900 patients, will focus on treatment of prominent persistent negative symptoms. Future trials in the Olympia program will focus on the elderly and other special populations, and long-term treatment (extensions of the shorter trials). The data thus far available indicate that asenapine is effective and well tolerated in the treatment of schizophrenia. This research was funded by Organon International Inc and Pfizer Inc.

REFERENCES:

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2. Shahid M, Walker GB, Zorn SH, Wong EHF: Asenapine: a novel psychopharmacologic agent with a unique human receptor signature. J Psychopharmacol 2007; In press.

SCIENTIFIC AND CLINICAL REPORT SESSION 28-ATTENTION DEFICIT DISORDER IN ADULTS

No. 79

EFFICACY AND SAFETY OF LISDEXAMFETAMINE DIMESYLATE IN ADULTS WITH ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

Lenard Adler, M.D., New York University School of Medicine Department of Psychiatry 530 First Avenue #7D, New York, NY 10016, David W. Goodman, M.D., Scott H. Kollins, Ph.D., Richard Weisler, M.D., Suma Krishnan, M.S., M.B.A., Yuxin Zhang, Ph.D., Joseph Biederman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to describe the evidence supporting lisdexamfetamine dimesylate (LDX)in the treatment of adults diagnosed with attention-deficit/hyperactivity disorder (ADHD).

SUMMARY:

Objective: Psychostimulants are considered first-line treatment for children and adults with ADHD. LDX, the first prodrug stimulant, is a therapeutically inactive molecule that is converted to l-lysine and active d-amphetamine after oral ingestion. This study evaluated the efficacy of LDX 30, 50, and 70 mg/d, compared with placebo, in adults diagnosed with ADHD. *Methods:* Adults aged 18 to 55 years with ADHD, as measured by the ADHD-Rating Scale with adult prompts (ADHD-RS; ADHD-RS score at baseline =28), were included in this phase 3, randomized, double-blind, placebo-controlled study. Subjects were randomly assigned to receive 30, 50, or 70 mg/d LDX or placebo. Safety measures included treatment-emergent adverse events (TEAEs), vital signs, and electrocardiograms. *Results:* At endpoint, the reduction in ADHD-RS score was significantly greater in each LDX group compared with placebo (placebo = -8.20; LDX 30 mg/d = -16.24; LDX 50 mg/d = -17.36; LDX 70 mg/d = -18.61; all P<.0001). Effect sizes at endpoint were 0.72, 0.82, and 0.94 for the 30-mg/d, 50-mg/d, and 70-mg/d groups, respectively. There were no statistically significant mean changes in either systolic or diastolic blood pressure. Mean heart rate increases were 2.8, 4.2, 5.2, and 0 beats per minute in the LDX 30-, 50-, 70-mg/d groups, and placebo, respectively. There were no QTcF changes from baseline greater than 60 msec and no readings above 480 msec. Overall, TEAE rates were 78.8% for the LDX group and 58.1% for the placebo group. Adverse events were generally mild (68%) to moderate (39%) in intensity. Adverse events occurring at an incidence of 5% or greater and twice placebo were decreased appetite (27%), dry mouth (26%), insomnia (19%), nausea (7%), diarrhea (7%), and anxiety (6%). *Conclusions:* Each of the three LDX doses was significantly more effective than placebo, as shown by the primary endpoint ADHD-RS. LDX was generally well tolerated. Supported by funding from Shire Development Inc.

REFERENCES:

1. Biederman J, Krishnan S, Zhang Y, McGough JJ, Findling RL: Efficacy and tolerability of lisdexamfetamine dimesylate (NRP-104) in children with attention-deficit/hyperactivity disorder: a phase III, multicenter, randomized, double-blind, forced-dose, parallel-group study. Clin Ther 2007; 29:450-463.
2. Pliszka SR, Crismon ML, Hughes CW, Conners CK, Emslie GJ, Jensen PS, McCracken JT, Swanson JM, Lopez M, and the Texas Consensus Conference Panel on Pharmacotherapy of Childhood Attention-Deficit/Hyperactivity Disorder: The Texas Children's Medication Algorithm Project: revision of the algorithm for pharmacotherapy of attention-deficit/hyper-

activity disorder. J Am Acad Child Adolesc Psychiatry 2006; 45:642-657.

No. 80

ADULT ATTENTION-DEFICIT/HYPERACTIVITY DISORDER IN AN ANXIETY DISORDERS POPULATION

Michael Van Ameringen, M.D., Anxiety Disorders Clinic, McMaster University Medical Centre-HHS, 1200 Main Street West, Hamilton, Canada L8N 3Z5, Catherine Mancini M.D., FRCPC, Beth Patterson, B.ScN., B.Ed., Bill Simpson, B.Sc., Wendy Freeman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) become familiar with the prevalence of ADHD in an anxiety disorders clinic population; (2) examine the relationship of comorbid anxiety, mood, and other psychiatric disorders in anxiety disorders clinic patients who have ADHD as compared with those who do not; and (3) examine the impact of a diagnosis of ADHD on functional impairment in anxiety disorders.

SUMMARY:

Background: Adult-Attention Deficit/Hyperactivity Disorder (ADHD) is a life-long, chronic disorder which has its onset in childhood and is associated with significant functional impairment. Upwards of 36% - 55% of childhood cases maintain symptoms into adulthood. The rate of lifetime *DSM-IV* adult ADHD in the community is 8.1%. ADHD appears to be highly comorbid with other psychiatric disorders. There is a dearth of information in anxiety disorder clinical samples. *Method:* Consecutive patients referred to an anxiety disorders clinic completed the Adult ADHD self-report scale and were assessed with a Structured Clinical Interview for *DSM-IV*, including the ADHD module of the Mini International Neuropsychiatric Interview. *Results:* Of the 72 patients assessed, the rate of adult ADHD was 12.5 % (14.3% for men; 11.4 % for women, NS); ADHD NOS was 5.6% and the combined rates of adult ADHD and adult ADHD NOS (termed ADHD spectrum) was 18.1%. ADHD spectrum was most commonly associated with a primary diagnosis of obsessive- compulsive disorder (30.8%, NS). The age of onset of primary anxiety disorder was younger for those with ADHD spectrum vs without ADHD and approached significance. The most common comorbid disorders associated with ADHD were major depressive disorder (53.8%), social phobia (38.5%), generalized anxiety disorder (23.1%), and impulse control disorders (30.8%), the only disorder that was significantly greater in those with ADHD. Higher rates of divorce, being single, as well as lower rates of marriage were found in those with ADHD spectrum compared to those without the disorder. Individuals with ADHD spectrum were also more likely to have less high school education and less likely to have a university degree than those without ADHD. *Conclusion:* The prevalence of adult ADHD was higher in our anxiety disorders clinic sample than found in the general population. The presence of ADHD with anxiety disorder was associated with greater social and occupational impairment.

REFERENCES:

1. Barkley RA: Attention-Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment. 3rd Edition. New York, The Guilford Press, 2006.
2. Sobanski E: Psychiatric comorbidity in adults with attention deficit/hyperactivity disorder. Eur Arch Psychiatry Clin Neurosci 2006; 256 (Suppl 1): I26 – I/31.

No. 81

INATTENTION AND HYPERACTIVITY SYMPTOMS IN INDIVIDUALS AT RISK FOR PSYCHOSIS

Juha M. Veijola, Ph.D., P. O. Box 5000, Peltolantie 5, Oulu, Finland 90014, Mervi Ilmarinen, Marika Kaakinen, B.A., Jouko Miettunen, Ph.D., Irma Moilanen, M.D., Anja Taanila, Ph.D., Hanna Ebeling, M.D., Tuula Hurtig, Ph.D., Pirjo Mäki, M.D., Erika Lauronen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand that ADHD symptoms may overlap prodromal features of psychosis and that people with ADHD symptoms probably have relatively high vulnerability for developing psychosis.

SUMMARY:

Objective: We were able to study in a general population sample whether adolescents vulnerable to psychosis have common features of attentional-deficit hyperactivity disorder (ADHD). Methods: Members of the Northern Finland 1986 Birth Cohort (N=9,215) were invited to participate in a field survey conducted during 2001-2002. Vulnerability for psychosis was defined by parent having had psychotic episode or by adolescent having prodromal features of psychosis at age of 15-16 years. The Finnish Hospital Discharge Register was used to find out psychotic episodes in parents during 1972-2000. The field study including 21-item PROD-screen questionnaire, which includes a subscale of 12 specific prodromal symptoms for psychosis with recommended screening cut off point of three or more symptoms. The field study also included the Strengths and Weaknesses of ADHD Symptoms and Normal Behaviors (SWAN), which was sent to the parents to measure ADHD symptoms in their offspring. In 2,728 of the males and in 2,872 of the females it was possible to evaluate both vulnerability for psychosis and ADHD symptoms. Results: Parental psychosis did not predict ADHD symptoms in the offspring. According to the SWAN 5.4% of those who had more than two prodromal symptoms had possible Inattentional type ADHD, compared with 3.9% (p=0.01) of those who had two prodromal features or less. Respective figures for probable hyperactivity-impulsive type disorder were 5.2% vs. 4.1% (p=0.05). Conclusions: Both inattention and hyperactivity symptoms were relatively prevalent in subjects who had prodromal features of psychosis. Even though the results were somewhat contradictory, there seems to be some an association between prodromal features of psychosis and ADHD symptoms.

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2. Hurtig T, Taanila A, Ebeling H, Miettunen J. Moilanen I: Attention and behavioural problems of Finnish adolescents may be related to the family environment. Eur Child Adolesc Psychiatry 2005; 14(8):471-8.

SCIENTIFIC AND CLINICAL REPORT SESSION 29- TOPICS IN MOOD DISORDERS

No. 82

PATIENTS' INVOLVEMENT IN TREATMENT DECISIONS AND ANTIDEPRESSANT DISCONTINUATION

Stephen Woolley, D.Sc., Burlingame Center for Psychiatric Research and Education, The Institute of Living, 200 Retreat Avenue, Hartford, CT 06106, Lisa Fredman, Ph.D., John W. Goethe, M.D., Alisa Lincoln, Ph.D., Timothy Heeren, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the possible effects on longitudinal continuation of antidepressant treatment of: (1) involving depressed patients in decisions about their treatment; and (2) providing to them information about depression and its treatment.

SUMMARY:

Objective: To assess whether patients who felt uninvolved in decisions about treatment were more likely to discontinue antidepressant treatment over a three-month period. *Methods:* The sample included 403 psychiatric in and outpatients with major depression who were telephoned three months post-discharge. Analysis examined patient and doctor reasons for stopping treatment, drug side effects, change in depression, use of services, and whether patients were provided information about depression and treatment. Logistic regression analysis was used to examine the association between involvement in decisions and antidepressant discontinuation. *Results:* 24% of patients discontinued antidepressants and 17% reported being uninvolved in treatment decisions. Patients who were uninvolved in treatment decisions were 67% more likely to discontinue treatment over the follow-up period (adjusted odds ratio, OR=1.67; 95% confidence interval=0.89-3.12). Patients who discontinued treatment had more severe depression (relative risk, RR=2.46; 1.75, 3.46), early drug side effects (RR=1.61; 1.03, 2.52), extremely bothersome side effects (RR=1.54; 1.07, 2.22), and reported not receiving information about depression and its treatment (RR=2.01; 1.03, 4.30). Patient and doctor reasons for discontinuation were side effects (52.0% and 23.5%, respectively), drug did not help (44.9%, 27.6%), recovery (12.2%, 3.1%), and having switched antidepressant (1.0%, 41.8%). Patients also cited cost (12.6%). *Conclusions:* The odds of subsequently discontinuing antidepressant treatment were increased by 67% for patients who felt uninvolved in decisions about their own treatment. Patients who did not receive information about depression and treatment were twice as likely to discontinue. These results suggest that clinicians can improve the probability of adherence to antidepressant treatment by actively engaging patients in choosing therapy.

REFERENCES:

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2. Rollins G: Doctor-patient communication increases duration of antidepressant therapy. Rep Med Guidel Outcomes Res 2002;13:1-2.

No. 83

PREVALENCE AND CHARACTERISTICS OF BIPOLAR MIXED DEPRESSION IN STEP-BD PATIENTS

Joseph Goldberg, M.D., 128 East Avenue, Norwalk, CT 06851, Roy H. Perlis, M.D., S. Nassir Ghaemi, M.D., Lauren Marangell, M.D., Andrew A. Nierenberg, M.D., Gary S. Sachs, M.D., Michael E. Thase, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to identify and understand the clinical features of bipolar mixed depressive episodes, their distinction from pure manic and pure depressed phases of bipolar illness, and the potential for their clinical worsening with antidepressant pharmacotherapy.

SUMMARY:

There has been growing interest in clinical states that involve simultaneous manic and depressive symptoms among patients with bipolar disorder. Criteria for *DSM-IV* mixed episodes stipulate the presence of a full manic and depressive syndrome for at least one week in patients with bipolar I disorder, but little is known about the prevalence or characteristics of subsyndromal mania during bipolar depressed episodes. The present study evaluated concomitant mania symptoms in 1,211 patients with bipolar disorder during a full depressive episode, upon entry into the National Institute of Mental Health Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). Results indicated that bipolar depression rarely occurred in the absence of signs of mania; two-thirds of bipolar depressed patients had one or more concomitant mania symptoms, most often manifested by distractibility (46%), psychomotor agitation (25%), and flight of ideas/racing thoughts (22%). Mania symptoms were subsyndromal (i.e., fell short of *DSM-IV* criteria for a mixed state) in 53% of cases. As compared with patients with pure bipolar depression, those with mixed depression were significantly more likely to be female, non-Caucasian, have past year *DSM-IV* rapid cycling, have an earlier age at first lifetime mania, and carry diagnoses of bipolar II (versus I) disorder. The findings support the view that most bipolar depressive episodes entail at least subsyndromal manic features, supporting a broadened diagnostic view of mixed affective episodes than now specified in *DSM-IV*.

REFERENCES:

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No. 84

DEPRESSIVE SYMPTOMS PREDISPOSE FEMALES TO METABOLIC SYNDROME: A POPULATION-BASED 7-YEAR FOLLOW-UP STUDY

Hannu Koponen, M.D., Department of Psychiatry, Kuopio University Hospital and Kuopio University, P.O. Box 1777, Kuopio, Finland FIN-70211, Mauno Vanhala, M.D., Jari

Jokelainen, M.Sc., Sirkka Keinänen-Kiukaanniemi, M.D., Esko Kumpusalo

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize depression as a risk factor for metabolic syndrome.

SUMMARY:

Objective: Previous cross-sectional studies have suggested that patients with depression have a high risk for metabolic syndrome (MetS). As there is paucity in the data concerning their temporal relationship, we decided to evaluate the risk to develop MetS when having depressive symptoms at baseline in a population-based follow-up study. *Methods:* The prevalence of depressive symptoms and MetS at baseline, and after a seven-year follow-up as measured with Beck's depression inventory with cut-off score of 10 points, and using the modified National Cholesterol Education Program – Adult Treatment Panel III - criteria for MetS were studied in a large, middle-aged population-based sample collected from the central Finland. *Result:* After adjusting for age, education, physical activity, smoking, alcohol use, marital status and the use of postmenopausal hormonal replacement therapy the logistic regression analysis showed a 2.4-fold risk (95%CI 1.06-5.4) for the female cohort members with depressive symptoms at baseline to have MetS at the end of the follow up. In males, no depression-MetS connection was observed. *Conclusions:* The higher risk for MetS in females with depressive symptoms at baseline suggest that depression may be an important predisposing factor for the development of MetS. Effective treatment of depression could also be important for the prevention of Mets.

REFERENCES:

1. Heiskanen TH, Niskanen LK, Hintikka JJ, Koivumaa-Honk anen HT, Honkalampi KM, Haatainen KM, Viinamäki HT: Metabolic syndrome and depression: A cross-sectional analysis. J Clin Psychiatry 2006; 67:1422-1427.
2. Kinder LS, Carnethon MR, Palaniappan LP, King AC, Fortman SP: Depression and the metabolic syndrome in young adults: findings from the third national health and nutrition examination survey. Psychosom Med 2004; 66:316-322.

MONDAY, MAY 5, 9:00 AM-12:00PM

SYMPOSIUM 01

EPIGENETIC MECHANISMS OF DEPRESSION AND ANTIDEPRESSANT ACTION

National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium the particpant should have increased knowledge of: (1) How changes in gene expression are associated with changes in chromatin structure; (2) How chromatin structure has been implicated in several psychiatric and neurologic disorders; (3) The important role played by several types of chromatin modification in the pathophysiology of depression and in the mechanism of action of antidepressants; and (4) How this research may lead to fundamentally new approaches to the development of novel antidepressant treatments.

No.1A

EPIGENETIC MECHANISMS IN MEMORY FORMATION

David Sweatt, Ph.D., 1825 University Blvd, Birmingham, AL 35294

SUMMARY:

This presentation will address the idea that conservation of epigenetic mechanisms for information storage represents a unifying model in biology, with epigenetic mechanisms being utilized for cellular memory at levels from behavioral memory to development to cellular differentiation. The area of epigenetics is very unfamiliar to most neurobiologists: epigenetic mechanisms typically involve alterations in chromatin structure, which in turn regulate gene expression. An emerging idea is that the regulation of chromatin structure, mechanistically via histone modification and DNA methylation, may mediate long-lasting behavioral change and learning and memory. We find this idea fascinating because similar mechanisms are used for triggering and storing long-term "memory" at the cellular level, for example when cells differentiate.

No.1B

ROLE OF HISTONE ACETYLATION AND METHYLATION IN SOCIAL DEFEAT STRESS

Eric J. Nestler, M.D., 5323 Harry Hines Blvd, Dallas, TX 75390-9070

SUMMARY:

Antidepressant medications are highly effective, but new treatments are needed since only half of all patients with depression show full remission with available medications. We are interested in the potential utility of agents that regulate chromatin remodeling in two brain regions implicated in depression, the nucleus accumbens (NAc) and hippocampus (HP). Histone acetylation and methylation occur at specific lysine residues on their N-terminal tails, and these two processes dynamically regulate gene transcription. In mice, chronic social defeat stress diminishes the motivation to engage in naturally rewarding behaviors, and correspondingly alters neuronal histone acetylation and methylation. Accordingly, we are studying the role of histone deacetylase (HDAC) inhibitors infused directly into the NAc or HP on behavioral abnormalities induced by chronic social defeat. Continuous bilateral infusion of class I or class II HDAC inhibitors via osmotic mini-pumps into the NAc or HP exerts antidepressant-like effects, with different depression-like behaviors affected upon manipulation of the two brain regions. Importantly, systemic administration of certain HDAC inhibitors also shows antidepressant-like activity, which suggests their potential for the treatment of human depression. We are also exploring, by use of viral gene transfer, the activity of enzymes that affect histone methylation in depression and antidepressant assays. In parallel, we are using chromatin immunprecipitation (ChIP) followed by promoter chip analysis to identify genes in the NAc and HP that show alterations in histone acetylation or methylation after chronic defeat stress and how these changes in gene expression are affected by standard antidepressants and by HDAC inhibitors. These gene discovery investigations should provide novel insight into the specific genes affected by chronic defeat stress in the NAc and HP and provide new directions in efforts to develop novel antidepressant treatments.

No. 1C

EPIGENETIC PROGRAMMING OF GENE EXPRESSION AND FUNCTION VIA MATERNAL CARE

Michael Meaney, Ph.D., Sackler Program For Epigenetics and Psychobiology McGill Univerisity, Montreal, H3A2T5 Canada

SUMMARY:

Maternal care alters development of adaptive behavioral and endocrine responses to stress--an example of maternally-regulated phenotypic plasticity. The underlying mechanisms involve stable changes in expression of genes in brain regions mediating stress reactivity and processing information about the stressor. Systems that regulate central corticotrophin-releasing factor (CRF) synthesis and release from the hypothalamus and amygdale play a key role. Adult offspring of mothers that exhibit increased pup licking/grooming (LG) show increased glucocorticoid receptor (GCR) mRNA throughout the hippocampus. The differences in GCR expression are associated with both negative feedback inhibition and HPA responses to stress; the offspring of High LG dams show increased hippocampal GCR expression, enhanced negative feedback regulation and more modest HPA responses to stress. This suggests maternal care acts to 'program' HPA responses in the offspring through effects on the regulation of CRF activity. Adoption studies reveal direct effects of maternal care. Recent studies focus on mechanisms by examining DNA methylation within a brain-specific GCR gene promoter.

No. 1D

ANTIDEPRESSANT ACTIVITY OF HISTONE DEACETYLASE INHIBITORS

Schahram Akbarian, M.D., Department of Psychiatry University of Massachusetts Medical School, Worcester, MA 01604, Caroline Connor, Hsien-Sung Huang, Frederick Schroeder

SUMMARY:

Psychiatric diseases, including mood & anxiety disorders, are thought to result from a genetic predisposition operating in conjunction with environmental influences. We describe evidence that two major "epigenetic" modifiers of gene expression and function – (i) methylation of DNA cytosine residues and (ii) methylation of nucleosome core histones – are dynamically regulated in the human cerebral cortex across a wide age range, involve differentiated neurons, and potentially affect a subset of genes implicated in mood and anxiety disorders. We also used an animal model and cell culture to examine whether chromatin remodeling, including changes in histone acetylation and methylation, are involved in antidepressant mechanism of action. In mice, co-treatment with the prototype SSRI, fluoxetine, and the histone deacetylase inhibitor, sodium butyrate, was more efficient in improving a subset of depression-like behaviors, than either agent singly. Systemic injection of sodium butyrate induced short-lasting histone hyperacetylation in hippocampus and frontal cortex. Among the four treatment paradigms that resulted in an antidepressant-like response, three were associated with a transient increase in brain derived neurotrophic factor (Bdnf) in frontal cortex. Furthermore, treatment with the atypical antipsychotic drug, clozapine induced recruitment of histone methyl-transferase and histone methylation changes at a subset of GABAergic gene loci. Collectively, our results suggest that "epigenetic" modifiers of gene expression –including covalent modifications of genomic DNA and nucleosome core histones – are dynamically regulated in the human brain not only during early development but also throughout all subsequent stages of maturation and aging. Furthermore, the potential antidepressant-like effects and molecular actions of histone modifying drugs warrant further exploration in the experimental animal model and in translational settings.

REFERENCES:

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2. Schroeder FA, Lin CL, Crusio WE, Akbarian S (2007) Antidepressant-like effects of the histone deacetylase inhibitor, sodium butyrate, in the mouse. Biol Psychiatry 62:55-64.
3. Weaver ICG, Cervoni N, Champagne FA, D'Alessio AC, Sharma S, Seckl JR, Dymov S, Szyf M, Meaney MJ (2004) Epigenetic programming by maternal behavior. Nat Neurosci 7:847-854.
4. Miller CA, Sweatt JD (2007) Covalent modification of DNA regulates memory formation. Neuron 53:857-869

SYMPOSIUM 02

BUPRENORPHINE FOR OPIOID DEPENDENCE: RECENT CLINICAL AND RESEARCH FINDINGS

American Academy of Addiction Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; (1) review most recent findings regarding the use of buprenorphine for the treatment of opioid-dependent patients; and (2) apply these findings in the context of buprenorphine use by certified practitioners.

No. 2A

BUPRENORPHINE MAINTENANCE FOR HEROIN ADDICTS

Eric C. Strain, M.D., Johns Hopkins University School of Medicine, 5510 Nathan Shock Drive, Baltimore, MD 21224

SUMMARY:

Sublingual buprenorphine for the treatment of opioid dependence has been available for over ten years in France, and for nearly five years in the United States. It is also available in several other countries, and there are an increasing number of patients being maintained on this medication. Prior to its U.S. approval, clinical studies with buprenorphine tended to focus upon determining its efficacy compared to placebo or methadone (superior to the former, but not to the latter), and assessing its safety (no significant problems with its use). Following its approval in the U.S., studies have generally shifted to report on clinical experience with its use, especially in office based settings. Compared to patients treated with methadone, it appears that a larger proportion of patients maintained on buprenorphine have prescription opioid misuse. Maintenance doses have varied considerably, although this may reflect the substantial variability between patients in buprenorphine's bioavailability. Outcomes from treatment have generally been good, although the level of non-pharmacologic services provided with office based buprenorphine treatment appears to be lower than that associated with methadone treatment, and further improvements in outcome may occur with more attention on increasing the level of non-pharmacologic services provided to this patient population.

No. 2B

DIFFERENTIAL PATTERNS OF BUPRENORPHINE USE IN THE U.S.

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

SUMMARY:

Sublingual buprenorphine became commercially available around March 2003. Initial slow uptake involved: lack of waivered physicians, especially in non-urban and rural areas; the 30-patients per doctor limit; high cost of medication and inadequate coverage by managed care, and the Veterans Administration; and reluctance of physicians to start prescribing opioids to addicts after 80 years of federal discouragement of such practice.

No. 2C

THE USE OF BUPRENORPHINE IN PATIENTS WITH CHRONIC PAIN

Joseph G. Liberto, M.D., MHCC 116 VA Maryland Health Care System, 10 North Greene Street, Baltimore, MD 21201, Adam J. Gordon, M.D., M.P.H., F.A.C.P.

SUMMARY:
In recent years, chronic pain has been recognized as a major public health concern. This concern has lead to better pain assessment and more people being treated with opioid analgesic agents. The potential exists for opioid abuse and dependence in this treatment population, however, and is highlighted by the dramatic rise in nonmedical use of opioid analgesic agents since the mid 1990s. Increasingly addiction specialists are being consulted to help differentiate addiction from pseudoaddiction and to provide guidance for the management of addictive disorders in patients with chronic pain. Since DATA 2000 and its subsequent FDA approval for the treatment of opioid dependence, sublingual buprenorphine has provided a new treatment modality to consider for opioid dependent patients including those who suffer with chronic pain. While not FDA approved for pain management, owing in part to its unique pharmacologic properties, sublingual buprenorphine appears to be an effective analgesic. Consideration for the clinical use of sublingual buprenorphine in opioid dependent patients with comorbid chronic pain will be reviewed utilizing cases that illustrate common assessment and management issues.

No. 2D

BUPRENORPHINE FOR DETOXIFICATION OF OPIOID-DEPENDENT PATIENTS

Laura F. McNicholas, M.D., Philadelphia VAMC Behav Health (116D) 3900 Woodland Avenue, Philadelphia, PA 19104

SUMMARY:
In order for opioid-dependent patients to engage in drug-free treatment, the patient usually undergoes a medically managed detoxification from the opioids that have been abused. Traditionally, methadone and/or clonidine were used to relieve the discomfort of opioid withdrawal. Further, most patients were more successful in achieving abstinence in an in-patient setting. Buprenorphine has been shown to be effective as a pharmacotherapeutic agent in managing opioid detoxification. Various protocols for in-patient and out-patient settings are available and will be discussed. The efficacy of the various protocols, when available, will be presented. The optimal length of medically managed detoxification as well as engagement techniques for aftercare will also be discussed. The various factors that should be considered in the decision to use detoxification versus agonist maintenance will be discussed.

REFERENCES:

1. Kakko J, Svanborg KD, Kreek MJ, Heilig M: 1-Year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomized, placebo-controlled trial. Lancet 2003; 361: 662-668.
2. Mattick RP, KimberJ, Breen C, Davoli M: Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database Syst Rev 2004; (3):CD002207.
3). Johnson RE, Fudala PJ, Payne R: Buprenorphine consideration for pain management. J Pain symptom management 2005; 29: 297-326.
4. Galanter M, Dermatis H, Glickman L, et al.: Network therapy: decreased secondary opioid use during buprenorphine maintenance. JSAT 2004; 26: 313-318.

MONDAY, MAY 5, 2:00 PM- 5:00PM

SYMPOSIUM 03

DIAGNOSIS AND TREATMENT OF ADOLESCENTS/ YOUNG ADULTS WITH SUBSTANCE USE DISORDERS

National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:
At the conclusion of this presentation, the participant should be able to understand the types and prevalence of co-occurring psychiatric disorders in adolescents/young adults with opioid, alcohol and marijuana use disorders, and methods commonly used to treat them. The participant should be able to understand findings from two recent studies using buprenorphine and psychosocial treatment for opioid dependent adolescents/young adults and the potential role of buprenorphine in their treatment.

No. 3A

MENTAL HEALTH AND SUBSTANCE USE TREATMENT UTILIZATION IN ADOLESCENTS WITH SUBSTANCE USE DISORDERS

Oscar G. Bukstein, M.D., Western Psychiatric Institute and Clinic 3811 O'Hara St., Pittsburgh, PA 15213, Jack Cornelius, M.D., M.P.H. Annette C. Trunzo, Ph.D., Thomas M. Kelly, Ph.D, D. Scott Wood, Ph.D.

SUMMARY:
Background: Adolescents in treatment programs for substance use disorders (SUDs) have both on-going needs for substance use disorder treatment as well as treatment for mental health problems (MH). This presentation examines mental health (MH) and substance use disorder (SUD) treatment utilization and potential predictors of treatment utilization, among both psychiatric and drug and alcohol variables in the first year after the index SUD treatment episode. Methods: The subjects were 393 adolescents and young adults, age 12.9 to 18.11 years, who met *DSM-IV* criteria for a lifetime history of a SUD at baseline assessment. *DSM-IV* psychiatric, SUD diagnoses, and treatment utilization were obtained by semi-structure. Drug and alcohol variables were obtained via self-reports. Results: At the 1-year follow up, 15.9% of subjects reported subsequent SUD treatment, 25.2% MH treatment , 5.6% both SUD and MH treatment, and 20. 5% were prescribed psychotropic medications. For mental health (MH) treatment, Major Depressive Disorder, Attention Deficit Hyperactivity Disorder and Conduct Disorder were associated with MH treatment. For SUD treatments, there were essentially no variables strongly associated with treatment. Conclusions: The best potential predictors of who receives SUD treatment at follow up may not be related to comorbidity or other dimensional variables of clinical severity. Rather, treatment utilization may to be related to environmental factors, which may include family factors, adolescent and parental motivation, access to treatment,

or to the use of appropriate treatment modalities.

No. 3B

PSYCHIATRIC DISORDERS IN ADOLESCENTS WITH OPIOID USE DISORDERS (OUD) VERSUS. MARIJUANA/ ALCOHOL USE DISORDERS

Geetha Subramaniam, M.D., Johns Hopkins University Mountain Manor Treatment Center 3800 Frederick Ave, Baltimore, MD 21229

SUMMARY:

Background: Adolescents entering substance abuse treatment programs often present with co-occurring psychiatric disorders. While most adolescents enter treatment for marijuana and alcohol use problems, the number of adolescents seeking treatment for opioid use disorders (OUD) has increased over 150% in the past decade. Little is known about the psychiatric profiles of these youth and how they compare with those having marijuana/alcohol use disorders. Methods: 94 adolescents with opioid use disorders were recruited from those entering an adolescent treatment program in Baltimore, Maryland and matched to 72 adolescents with marijuana and/or alcohol use disorders, by age, gender and treatment setting. The participants were assessed for the prevalence of current DSM-IV Axis-I psychiatric disorders by psychiatrists who conducted the Diagnostic Interview for Children and Adolescents. The patients were also administered self-reported Beck Depression Inventory for data on depressive symptoms. Results: Both the OUD and the comparison groups had high rates of any DSM-IV psychiatric disorders (83% vs. 78%, respectively, p=0.313) with no significant differences between the groups for each of the psychiatric diagnoses. In the OUD group over 50% had CD, 40% MDE or GAD and approximately a third ADHD, while PTSD, Mania and ODD had lower prevalence. Self-reported mean depressive symptoms (BDI scores) were higher for the OUD group (17.2 vs. 14.3, p=0.058); a greater proportion of OUD adolescents (48% vs. 33%, p=0.048) reported moderately severe depressive symptoms (i.e. >16). Conclusions: Adolescents with OUD have high rates of co-occurring psychiatric disorders, similar to rates in non-OUD samples but higher rates of depressive symptoms. Findings highlight the need to further examine the impact of psychiatric conditions on treatment retention/outcome and how best to integrate psychiatric treatments with pharmacological treatments aimed at reducing opioid use.

No. 3C

EVIDENCE-BASED BEHAVIORAL AND PHARMACOLOGICAL TREATMENT FOR OPIOID-DEPENDENT ADOLESCENTS

Lisa A. Marsch, Ph.D., National Development and Research Institutes 71 West 23rd St., 8th Floor, New York, NY 10010 Ramon Solhkhah, M.D.

SUMMARY:

Background: Although the recreational use of heroin and other opioids among youth has increased in recent years, limited research has been conducted to identify science-based treatment interventions for opioid-dependent adolescents.

No. 3D

BRIEF STRATEGIC FAMILY THERAPY (BSFT) FOR ADOLESCENT DRUG ABUSERS: A MULTI-SITE CLINICAL TRIAL

Michael S Robbins, Ph.D., University of Miami Miller School of Medicine Center for Family Studies 1425 NW 10th Ave, Miami, FL 33136, José Szapocznik, Ph.D., Viviana Horigian, M.D.

SUMMARY:

Family therapy has been shown to be efficacious in the treatment of adolescent drug abuse, e.g., BSFT was found to be significantly more efficacious than group counseling in reducing adolescent drug use and behavior problems (Santisteban et al., 2003). The purpose of this study is to compare the effectiveness of BSFT to treatment as usual in community-based treatment programs in improving adolescent drug use, conduct problems, prosocial behaviors, and sexual risk behaviors, as well as family functioning, and engagement and retention in treatment. One of the strengths of this study is that it uses as a control the usual treatment provided to adolecents in the treatment agency, thus permitting us to answer the public policy question, "is BSFT better than usual treatment?" The study is being conducted in eight sites located in Arizona, California, Colorado, Florida, North Carolina, Ohio, and Puerto Rico. Participants are 480 families, representing over 2,000 adolescent and family members, that have been randomized to BSFT and TAU. Adolescent target participants are between the ages of 12 and 17, and were largely referred (72%) by the juvenile justice system. The present sample includes 193 Hispanic and 107 African American adolescents, and 25% are girls. Adolescents and their family members completed a rigorous baseline assessment prior to randomization and are periodically followed for one year post-randomization. Clinical services in BSFT have been completed for over 95% of cases and follow-up assessments will be completed in February 2008. This presentation will provide a) an overview of this effectiveness study and the context in which the study is being conducted, b) a description of the rigorous procedures for clinical training and remote supervision that were employed to maintain therapist adherence to a complex psychotherapy; and c) preliminary evidence of therapist adherence, family members' engagement and retention in treatment, and baseline analyses.

No. 3D

BUPRENORPHINE TREATMENT IN OPIOID ADDICTED ADOLESCENTS/YOUNG ADULTS

George E. Woody, M.D., Treatment Research Institute 150 S. Independence Mall, West Suite 600, Philadelphia, PA 19106, Sabrina Poole, M.A., Geetha Subramaniam, M.D., Michael Bogenschutz, M.D., Ashwin Patkar, M.D., Mark Publicker, M.D., Marc Fishman, M.D., Patrick Abbott, M.D., Robert Kushner, M.D., Karen McCain, R.N., Hilary S. Connery, M.D., Jennifer Potter, Ph.D., Paul Fudala, Ph.D., Victoria Vetter, M.D., Robert Forman, Ph.D., Cynthia Clark, C.R.N.P., Laura McNicholas, M.D., Ph.D., Jack Blaine, M.D., Karen Dugosh, Ph.D., Kevin Lynch, Ph.D.

SUMMARY:

Background: The usual treatment for opioid addicted adolescents/young adults is detoxification and counseling. Buprenor-

phine but it may be useful compared to methadone it produces less physical dependence, has a higher margin of safety, and can be administered in primary care. Methods: The study was done at 6 programs in the NIDA Clinical Trials Network; subjects were 14-21 and opioid dependent. Excluded were those with serious medical or psychiatric disorders, pregnant, unable to provide benzodiazepine negative urine, or recently overdosed on sedatives. Assent and parental consent were obtained if under 18. 154 subjects were randomized to a 12-weeks of buprenorphine/naloxone (Bup/Nal) with a taper during weeks 9-12, or a 7-14 day bup/nal detoxification (TAU), each with individual and group counseling. Primary outcome was opioid positive urine tests at weeks 4, 8 and 12. Results: 229 subjects consented and 152 were randomized. Average age was 19; 27 were under 18 including one aged 15; 42% were female, 25% Hispanic, 2% African-American, 58% Caucasian; average years addicted was 2. Primary drug was heroin for 55%, prescription opiates 35%, 10% polydrug. 19% were hepatitis C+ at baseline and 3 became positive by week 12. Bup/Nal had fewer opioid positive urines than TAU (p<. 0001) and better retention (p<. 01). Need for additional treatment occurred in both groups following dose taper with 48 TAU subjects shown to need it in the first 12 weeks as compared to 4 in Bup/Nal. Headaches occurred in 20-23% and were slightly more common in Bup/Nal; other AEs were reported in less than 10%. One patient died of opioid overdose after dropping out. Conclusions: Bup/Nal was safe and resulted in significantly fewer opioid positive urines and better retention than TAU. Many subjects needed additional treatment following dose taper suggesting that maintenance should be studied in these patients that are at very high risk for adverse events, including overdose death.

REFERENCES:

1. Gordon SM, Mulvaney F, Rowan A: Characteristics of adolescents in residential treatment for heroin dependence. Am J Drug Alcohol Abuse 2004; 30(3): 593-603
2. Grella CE, Hser Y-L, Joshi V, Rounds-Bryant J L: Drug treatment outcomes for adolescents with comorbid mental and substance use disorders. J. Nerv. Ment. Disease 2001; 189: 384–392.
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SYMPOSIUM 04

TRAUMATIC STRESS, HORMONES AND DEPRESSION

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand relationships among early life trauma, HPA and oxytocin dysfunction, stress response to medical illness, and depression. Participants will also learn about the effects of novel treatment approaches to disease-related stress.

No. 4A

THE EFFECTS OF DEPRESSION TYPE, LENGTH AND COMORBIDITY ON HPA FUNCTION

Craig B.Taylor, M.D., 401 Quarry Road, Rm 1324, Stanford, CA 94305-5722, David Spiegel, M.D.

SUMMARY:

This study reviews recent evidence that different types of depression may have different daytime cortisol patterns and reactions to psychological stress. Whereas depression with melancholic features appears to be associated with hypercortisolemia, depression with atypical features appears to be associated with lower levels of cortisol, particular in relationship to psychological stress. These differing patterns appear to have different effects on cardiovascular risk factors (including metabolic syndrome factors), In addition to severity, length of depression may also affect HPA function such that long-standing depression may lead to HPA changes resistant to pharmacologic or psychological treatment, at least in the short run. History of PTSD also interactions with depression to affect HPA function. Pilot data to support these arguments will be presented from a study examining changes in HPA function in depressed individuals (n= 48) randomized to a cognitive behavior therapy or non-depressed control (n=20.) Conclusion: Studies on HPA function in depressed individuals need to careful assess lifetime history of depression and PTSD.

No. 4B

PERSISTENT CSF OXYTOCIN REDUCTION AFTER CHILDHOOD ABUSE

Charles B. Nemeroff, M.D., Department of Psychiatry & Behavioral Sciences Emory University School of Medicine 101 Woodruff Circle Suite 4000, Atlanta, GA 30322, Larry J. Young, Ph.D., D. Jeffrey Newport, M.D., M.S., Tanja Mletzko, M.S., Andrew H. Miller, M.D., Christine Heim, M.D.

SUMMARY:

Early-life disruption of the parent-child relationship, e.g. in the form of abuse, neglect or loss, increases risk for psychiatric disorders in adulthood. The neuropeptide oxytocin (OT) plays a seminal role in mediating social attachment, social support, maternal behavior, and trust, and decreases amygdala reactivity. We hypothesized a role for CNS OT circuits in the vulnerability to psychiatric disorders after early-life adversity. We therefore examined CNS OT activity after early-life adversity in adult women. We measured OT concentrations in cerebrospinal fluid (CSF) collected from 22 medically healthy women, aged 18-45 years, with regular menses, no psychosis or bipolar disorder, current substance abuse or eating disorders, and free of medication. Women were categorized into those with none-mild versus those with moderate-severe exposure to various forms of childhood abuse or neglect according to scores in the Childhood Trauma Questionnaire. Exposure to any maltreatment was associated with decreased CSF OT concentrations [t(20)=-2.229, p=0.037]. CSF OT concentrations decreased with increasing number of exposure categories [F(3,21)=4.901, p=0.012]. A particularly strong effect

was identified for emotional abuse [t(20)=-3.517, p=0.002]. There were inverse correlations between CSF OT concentrations and total abuse [r(22)=-.542, p=0.009], emotional abuse [r(22)=-.621, p=0.002], and emotional neglect [r(22)=-.469, p=0.028] scores, and the duration of emotional abuse [r(22)=-.452, p=0.035]. Consistent with its putative anxiolytic role, CSF OT concentrations were negatively correlated with anxiety ratings [r(22)=-.448, p=0.037]. We conclude that childhood adversity is associated with deficient CNS oxytocinergic activity in adulthood, supporting a mechanism by which early social experience may influence adaptation and health throughout the lifespan. Research into the "social brain" may lead to new methods to prevent and reverse the adverse outcomes of early adversity.

No. 4C

STRESS SENSITIVITY IN METASTATIC BREAST CANCER: ANALYSIS OF HYPOTHALAMIC-PITUITARY-ADRENAL AXIS FUNCTION

David Spiegel, M.D., Room C231 Department of Psychiatry & Behavioral Studies 401 Quarry Road, Palo Alto, CA 94305-5718, Janine Giese-Davis, Ph.D., C. Barr Taylor, M.D., and Helena Kraemer, Ph.D.

SUMMARY:

Normal diurnal cortisol cycle peaks in the morning, decreasing rapidly over the day, with low levels at night, rising rapidly again to the morning peak. Disrupted pattern, characterized by a flatter daytime slope and higher than normal cortisol values late in the day, has been associated with more rapid cancer progression in both animals and humans. We studied the relationship between daytime cortisol and cortisol responses to both pharmacological and psychosocial challenges of hypothalamic-pituitary-adrenal (HPA) axis function,DHEA and natural killer cell number and cytotoxicity in a sample of 99 women with metastatic breast cancer, in hopes of elucidating the dysregulatory process. We found that the different components of HPA regulation: the daytime cortisol slope, and cortisol response to various challenges, including the rise in cortisol from waking to 30 minutes later, dexamethasone (DEX) suppression, corticotrophin releasing factor (CRF) activation, and cortisol response to the Trier Social Stress Task, were relatively independent. Flatter daytime slope was associated with DEX non-suppression, but not with pharmacologic or behavioral stimulation of cortisol secretion. Daytime slope was significantly correlated with the rise in cortisol 30 minutes after waking (r=0.29, p=.004, N=96), but not with waking Cortisol level (r=-0.13, p=.19, N=96).Escape from suppression caused by 1 mg of dexamethasone administered the night before was associated with flatter daytime cortisol slopes (r=0.30, p=.005, N=88 at waking, r=0.29, p=.005, N=90 at wake plus 30 minutes; r=0.26, p=.01, N=90 at 1200h; r=0.29 ,p=.005, N=93 at 1700h; and r=0.28, p=.007, N=92 at 2100h). Flatter (abnormal) daytime cortisol slopes were modestly associated with the rise in cortisol from waking to 30 minutes after awakening (Spearman r=.29, p=.004, N=96). We could not detect association between daytime cortisol slope and activation of cortisol secretion by either CRF infusion or the Trier Social Stress Task. Flatter daytime cortisol slopes were significantly correlated with the slope of DHEA (r=.21, p=.04, N=95), but not with NK cell number or cytotoxicity. Findings suggest that flatter daytime cortisol slopes among metastatic breast cancer patients are related to disrupted feedback inhibition rather than hypersensitivity in response to stimulation.

No. 4D

STRESS, CORTISOL, THE SEROTONIN POLYMORPHISM TRANSPORTER, AND COGNITIVE DECLINE

Ruth O'Hara, Ph.D., Department of Psychiatry and Behavioral Sciences, Stanford University, 401 Quarry Road, Stanford, CA 94305, Carmen Schroder, M.D., Helena Kraemer, Ph.D., Joachim Hallmayer, M.D.

SUMMARY:

The serotonin transporter gene (5-HTT) is implicated in the development and integrity of neural systems subserving complex emotional and cognitive processing. Recent studies find the s allele variant of the 5-HTT gene moderates the relationship of stress to depression and anxiety. Investigators suggest the s allele impacts a variety of behavioral symptoms in neurodegenerative disorders, particularly in response to stress. We investigated whether 5-HTT genotype interacts with cumulative life stress and HPA-axis measures of waking and diurnal cortisol to impact cognition in 154 non-depressed, older adults. Structural images of hippocampal volume were acquired on a subsample of 56 participants. The 5-HTT s allele was associated with significantly higher waking cortisol levels in a dose-dependent fashion (P<.01), and was also associated with lower delayed verbal memory (p<.001)). Further, the s allele interacted with higher waking cortisol to negatively impact memory. There was an additive effect of the 5HTT s allele and the noted risk factor for cognitive impairment and decline, the Apolipoprotein E4 allele, on memory function (p<.01). Individuals who carried both the 5-HTT s allele and the E4 allele had the worst memory performance. We also observed a significant interaction of higher waking cortisol and the s allele on lower hippocampal volume. Smaller hippocampal volume and higher cortisol were associated with lower delayed recall only in s allele carriers (p<.05). No impact or interactions of cumulative life stress with 5-HTT or cortisol were observed. Overall our findings suggest an important role for the Serotonin Polymorphism Transporter in memory and hippocampal function in older adults. Our observed association of the s allele with higher waking cortisol suggests HPA function may mediate the previously observed vulnerability of the s allele to a variety of neuropsychiatric outcomes in response to stress.

No. 4E

MINDFULNESS MEDITATION ALLEVIATES FIBROMYALGIA SYMPTOMS AND REDUCES THE CORTISOL AWAKENING RESPONSE

Sandra E. Sephton, Ph.D., Department of Psychological and Brain Sciences University of Louisville 2301 South Third Street Life Sciences Building, Suite 317, Louisville, KY 40292, Inka Weissbecker, Ph.D., Paul Salmon, Ph.D.

SUMMARY:

Fibromyalgia has been characterized as a disorder of psychological and physiological stress-responses. Patients exhibit chronic pain with mood disturbance and hypothalamic-pituitary-adrenal

(HPA) dysfunction. The Mindfulness-Based Stress-Reduction (MBSR) intervention reduced depressive symptoms among fibromyalgia patients in a randomized clinical trial. Here we present the effects of MBSR on symptoms of illness and neuroendocrine function among women with fibromyalgia.
A randomized prospective trial (study 1) examined effects of MBSR on perceived stress and symptoms of illness including pain, sleep problems, fatigue, and impairment. Diurnal salivary cortisol profiles were assessed over three days among 91 patients prior to random assignment to the 8-week MBSR treatment or a wait list control condition. Follow-up data were collected immediately post-program and two months after the intervention. Analyses were guided by intent-to-treat principles and adjusted for demographic and medical variables. MBSR reduced stress, fatigue and impairment with gains maintained at follow-up. However, effects on neuroendocrine function reached only marginal significance.
A second within-subjects trial (study 2) provided data pre- and immediately post-MBSR from a group of 43 fibromyalgia patients screened for medications likely to affect neuroendocrine outcomes. Once again, MBSR alleviated fatigue and impairment. In addition, participants reported better sleep and less pain following the intervention. Statistically significant neuroendocrine changes were also observed in this trial: the cortisol response to awakening was reduced after MBSR. These results suggest that in addition to alleviating depressive symptoms, Mindfulness-based Stress Reduction can improve fatigue and impairment related to fibromyalgia. Mindfulness practice may also attenuate the adrenal response to stress as indicated by the cortisol response to awakening.

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SYMPOSIUM 05

THE SOCIAL RESPONSIBILITY OF UNIVERSITIES FOR THE MENTAL HEALTH OF STUDENTS AND COMMUNITY SAFETY

American Association for Social Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; (1) Facilitate care for college students who need diagnosis and treatment; (2) Appreciate the legal restraints in sharing information about a student's psychiatric history and treatment; and (3) Develop prevention strategies to maximize safety on the university campus.

No. 5A

ACTIVE MINDS: INVOLVING STUDENTS IN ENSURING THE MENTAL WELL-BEING OF THEIR PEERS ON CAMPUS

Alison Malmon, 1875 Connecticut Ave, NW Suite 418, Washington, DC 20009

SUMMARY:

To truly address preventing tragedies like the one that occurred at Virginia Tech in 2007, one must examine the role of the whole campus community in creating a mental health safety net for college students. With the proper support, student activism can be an invaluable resource and students can effectively educate their peers about mental health and promote help-seeking behavior. Active Minds, the only national organization dedicated to utilizing the student voice to raise mental health awareness on college campuses, is one tool to foster this activism.

No. 5B

THE UNIVERSITY AS A SOCIAL STRUCTURE

Beverly J. Fauman, M.D., 1500 East Medical Center Drive, Ann Arbor, MI 48109

SUMMARY:

Recent events force a thoughtful look at how universities are structured, what expectations there are for their function, and what limitations there are toward carrying out those expectations. The university has played a role in the growth and development of civilizations for hundreds of years, but in recent years the percentage of people attending a university, as well as the concept of "delayed adolescence," a component of prolonged educational efforts, has increased the need of administrators to define the extracurricular responsibilities of the university. University campuses form a society, non-democratic but otherwise comparable to a small town, providing food, shelter, campus security, health care, and entertainment, in addition to education. Demographically, a large number of the population is in the age range of 18 to 30 years. A purpose of this grouping is to facilitate transformation of this population to adulthood. Participants are there by choice, have limited say in that society, and are transient.

No. 5C

THE CHALLENGES OF COLLEGE MENTAL HEALTH

Jerald Kay, M.D., Department of Psychiatry, Boonschoft School of Medicine Wright State University, Elizabeth Place, 628 Edwin C. Moses Blvd, Dayton, OH 45401

SUMMARY:

This presentation provoides an epidemiological overview of mental health disorders on college and university campuses. The dramatic increase in the number of students entering college and university with previous mental health treatment will be described as well as challenges to meet current student mental health needs. Many institutions are under significant strain to provide services for the treatment of, but not limited to, affective

disorders, suicidal behavior, self-harm behavior, eating disorders, anxiety disorders, sexual abuse, and substance abuse. Graduate student mental health issues will also be addressed.

No. 5D

LEGAL AND ETHICAL ISSUES IN CAMPUS VIOLENCE

Paul S. Appelbaum, M.D., New York State Psychiatric Institute 1051 Riverside Drive, Unit 122, New York, NY 10032

SUMMARY:

Prevention of violence on campus implicates a balance between the rights of college students to privacy and non-discriminatory treatment, and the rights of the broader campus community to safety. Federal law protects the privacy of students with regard to educational records (Family Educational Rights and Privacy Act—FERPA) and, in some cases, medical records (Health Insurance Portability and Accountability Act—HIPAA). Both statutes, however, contain exceptions for situations in which students or third parties may be endangered, allowing greater flexibility than is often assumed. The same is true of state confidentiality laws. Hence, information about students thought to be potentially violent can often be shared both on and off campus. Once such students are identified, the question of what actions can be taken includes consideration of the rights of students with disabilities (including mental disabilities), which are specifically protected by the Americans With Disabilities Act (ADA). The extent to which colleges can compel evaluation or treatment remains somewhat unclear, and reasonable accommodations must be attempted before disabled students can be excluded from campus activities or residences. Schools may be at risk of lawsuit if they violate students' rights to non-discriminatory treatment. However, the ADA, too has exceptions for potentially violent persons, allowing a much greater range of interventions. In the end, colleges and universities are faced with the task of balancing a legitimate desire for safety against the negative consequences of creating a climate of intolerance or fear. Avoiding overreaction in the face of horrors like the killings at Virginia Tech is a difficult, but critical part of developing reasonable approaches to campus violence.

No. 5E

WHY ARE COLLEGE MENTAL HEALTH CRISES SO DIFFICULT TO MANAGE? AN EXAMINATION OF THE CHALLENGES TO PROVIDING MENTAL HEALTH CARE ON COLLEGE CAMPUSES

Victor I. Schwartz, M.D., 155 E 38th St #2A, New York, NY 10016

SUMMARY:

The tragic events at Virginia Tech focused national attention (and the attention of the psychiatric community) on what has already been called the "crisis in college mental health." Much has been written about both the increasing challenges to providing adequate mental health care on college campuses and the legal complexities inherent in managing mental health crises on college campuses. Much less has been written addressing precisely what it is about college communities that make these crises so complicated to manage.

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2. Kadison R, DiGeronimo T: College of the Overwhelmed: The Campus Mental Health Crisis and What to Do About It. Jossey-Boss, 2004.
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SYMPOSIUM 06

RECENT ADVANCES IN PREVENTION SCIENCE: IMPLICATIONS FOR PRACTICE AND *DSM-V*

APA Corresponding Committee on Prevention of Mental Disorders and Promotion of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, participants will learn; (1) substantive findings of recent prevention research in the areas of early onset psychosis, depression and substance abuse; (2) the implications of these studies for *DSM-V*; and (3) the implications of these studies for practice with families experiencing serious mental illness.

No. 6A

PREVENTION OF SUBSTANCE ABUSE: EVIDENCE FROM CONTROLLED TRIALS

J. D. Hawkins, Ph.D., Social Development Research Group 9725, 3rd Ave NE Suite 401, Seattle, WA 98105, Rick Kosterman, Ph.D., Richard F. Catalano, Ph.D., Sabrina Oesterle, Ph.D.

SUMMARY:

Over the last two decades, through randomized controlled trials prevention scientists have identified effective interventions for the prevention of substance use and abuse among adolescents and young adults. These effective preventive interventions have targeted empirically identified predictors of substance abuse and dependence. Universal interventions, including curricula for students in elementary, middle and high schools, and programs for parents in community and clinic settings have shown positive effects in reducing drug use behaviors up to six years after intervention and have been found effective in producing reductions in and discontinuation of drug use behaviors among those at greatest risk. Some of these preventive interventions have also reduced other health and behavior problems of adolescents including STD risk behaviors, delinquent behavior, and depressive symptoms. Community wide preventive interventions focused on changing community norms and attitudes toward alcohol and other drug use also have shown positive effects. A public health challenge currently is adoption of science based prevention strategies with sufficient fidelity, reach, and duration to affect the prevalence of

health compromising drug use and drug abuse community wide. This presentation will review current trials seeking to address this challenge and present results of a 24 community randomized trial of a strategy for activating local stakeholders to use epidemiologic indicators of risk and protection levels to inform the selection and implementation of tested and effective preventive interventions. Implications of these studies for clinicians will be discussed, including opportunities to engage in preventive practice and to provide leadership for community wide installation of tested and effective preventive interventions.

No. 6B

RECENT PROGRESS IN PREVENTING SCHIZOPHRENIA

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

SUMMARY:

The field of schizophrenia research and treatment is alive with interest in what early detection and intervention may hold for prevention in this chronic disorder. This includes studies engineering early detection both after onset (i.e., during the first episode) and before onset (i.e., during the prodromal phase of illness development. Early detection in first episode schizophrenia aims to reduce the duration of untreated psychosis and to track the earlier detected patients over time compared to non early detected patients. Such a project from Norway and Denmark will be presented that demonstrates how successfully early detection reduces the severity of symptoms and the extent of collateral damage associated with onset of psychosis, an example of tertiary prevention. Two year follow up data from the same project addresses the question of whether reducing the duration of untreated psychosis also reduces progression of disorder (chronicity) and confers secondary prevention in first episode schizophrenia. Identifying people prior to onset of psychosis is a second early detection and intervention strategy and targets persons in their prodromal stage of a first break of psychosis. Treatment intervention at this stage can delay or prevent the onset of illness (possible primary prevention). A double-blind placebo controlled randomized trial of an atypical neuroleptic (olanzapine) demonstrates the benefits and risks of this approach. Concluding remarks will address the current state of prevention in schizophrenia, both nationally and internationally.

No. 6C

ARE PREVENTION CONCEPTS APPROPRIATE FOR THE *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FIFTH EDITION (DSM-V)?*

Wilson M. Compton III, M.D., 6001 Executive Blvd MSC5153, Bethesda, MD 20892-9589, William Beardslee, M.D. Harold Goldstein, Ph.D., Robert King, M.D., Thomas McGlashan, M.D., Robert Post, M.D., David Reiss, M.D.

SUMMARY:

Prevention has been defined as "actions aimed at eradicating, eliminating, or minimizing the impact of disease." The first question in determining whether prevention concepts can fit into *DSM-V* is to consider which concepts are appropriate for inclusion and then to determine where in the manual they might fit. *DSM* has multiple purposes. Core parts are the diagnostic categories and criteria, but the supporting text also serves as an important teaching and reference tool. Prevention concepts might fit into either or both areas. Three key concepts have been identified: 1) prodromal syndromes, 2) risk factors and 3) high familial risk groups (i.e., children of persons with mental illness). Prodromal syndromes include sub-threshold psychotic and mood disorders, substance misuse (without addiction) and acute stress syndromes. For all these types of conditions, promising or effective interventions have been developed that improve outcomes. These syndromes may be considered putative diagnostic categories themselves. In this way, such issues as reliability, validity, and feasibility need to be considered. Risk factors can be seen at all levels (i.e., intra-individual, familial, social environmental, etc.) and increase chances of the development of a disorder. A key example is child abuse and neglect which has been demonstrated to be linked to a range of negative outcomes including mood disorders, antisocial behavior, and addictions (e.g. Caspi 2000). A description of risk factors would not seem appropriate for diagnostic criteria but may be incorporated into the *DSM* text. Finally, children of persons with mental illness are themselves at elevated risk of negative outcomes and recent work has demonstrated that interventions in high risk offspring may delay/reduce onset of mental illness. Again, careful discussion of this topic is recommended for the *DSM-V* text

No. 6D

PREVENTION OF DEPRESSION IN YOUTH AND FAMILIES: RECENT FINDINGS AND FUTURE DIRECTIONS

William R. Beardslee, M.D., Department of Psychiatry, Children's Hospital, 1 Autumn Street, Suite 435, Boston, MA 02215

SUMMARY:

Over the past two decades, important new advances in conceptual frameworks for understanding how to prevent depression in children and adolescents have occurred and a series of methodologically sound studies have been conducted. A recent meta-analysis has confirmed the value of depression prevention efforts. This presentation will describe in detail the results of a four-site, multi center effectiveness trial of a cognitive behavioral approach for adolescents at double risk for depression because they have symptoms of depression or have had past depression and because their parents are depressed. It will also review long-term evidence of effectiveness for a family-based, public health approach for parental depression and highlight other approaches. One persistent challenge is how to move from efficacy trials to effectiveness and then large-scale programs. Experience in taking the family-based public health approach to scale in several large systems will be presented. The implications for clinical practice will be discussed. The relationship between treatment of depression and prevention of depression will be explored and promising future directions for research and practice highlighted. These findings will also be discussed in the context of the Institute of Medicine's committee to review progress in the prevention of mental illness over the last twelve years.

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1. McGlashan TH: Early detection and intervention in schizophrenia: Research. Schizophrenia Bulletin 22:327-345, 1966
2. Beardslee WR, Hosman C, Solantaus T, van Doesum K, Cowling V: Children of mentally ill parents: An opportunity for effective prevention all too often neglected. In Hosman C, Jane-Llopis E, Saxena S (eds.). Prevention of mental disorders: Effective interventions and policy options. Oxford, Oxford University Press (in press).
3. Hawkins JD, Catalano RF, Kosterman R, Abbott R, Hill KG: Preventing adolescent health-risk behaviors by strengthening protection during childhood. Archives of Pediatrics & Adolescent Medicine 153(3):226-234, 1999
4. Compton WM, Cottler LB, Phelps DL, Abdallah AB, Spitznagel EL: Psychiatric disorders among drug dependent subjects: Are they primary or secondary? American Journal on Addictions 9(2):126-134,2000

SYMPOSIUM 07

MEDICAL CONUNDRUMS: A GUIDE FOR THE TREATING PSYCHIATRIST

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to; (1) Identify better ways to help patients psychologically with chronic pain or GI distress; (2) Understand the interplay among psychologic, immunologic, genetic, and environmental contributions to chronic medical syndromes; (3) Describe the abnormally expressed CNS pain amplification pathways that underlie fibromyalgia and chronic Lyme disease; and (4) Devise an effective treatment protocol for patients with hypochondriasis.

No. 7A

A RANDOMIZED TRIAL OF THREE PSYCHOSOCIAL TREATMENTS FOR RHEUMATOID ARTHRITIS SYMPTOMS.

Arthur J. Barsky, M.D., Brigham and Women's Hospital 75 Frances Street, Boston, MA 02115, David K. Ahern, Ph.D., E. John Orav, Ph.D., Matthew H. Liang, MD

SUMMARY:
A total of 139 patients with rheumatoid arthritis were randomly assigned to one of three treatments designed to palliate symptoms and improve role function: 12 group sessions of cognitive/behavior therapy; 8 group sessions of relaxation training; or 8 group sessions of a structured educational program. All patients continued to receive medical care as usual throughout the trial. At baseline, all patients completed a research battery assessing arthritis severity, medication regimen, psychiatric morbidity, arthritis symptoms and functional status and role impairment. This battery was repeated 6 and 12 months after treatment. All three groups benefited from treatment to a similar extent, with improvements over baseline of approximately 25% in arthritis symptoms and in physical and social role function. These benefits persisted after controlling statistically for the possible confounding effects of arthritis severity, medication regimen, and psychiatric comorbidity. Treatment effect sizes were in the moderate range of .25-.35. These effects were somewhat attenuated at 12 month follow-up but remained statistically significant. The 3 treatments did not differ significantly from each other on any of the major outcome measures at 6 or 12 month follow-up. These findings provide support for the effectiveness of several different psychosocial treatments for rheumatoid arthritis symptoms, above and beyond the benefits of standard arthritis care.

No. 7B

CHRONIC LYME DISEASE: HELPING THE PATIENT DESPITE THE CONTROVERSIES AND UNCERTAINTIES

Brian A Fallon, M.D., Columbia University Medical Center New York State Psychiatric Institute 1051 Riverside Drive, Unit 69, New York, NY 10032, John Keilp, James Moeller, M.D., Kathy Corbera, M.D., Eva Petkova, M.D., Harold Sackeim, M.D.

SUMMARY:
Chronic lyme disease (CLD) describes the disease state in which symptoms persist or relapse despite prior antibiotic therapy against the infectious agent of Lyme disease. Characterized by a mixture of pain, fatigue, physical impairment, and cognitive problems, CLD evokes controversy in the medical field, including lawsuits and licensing board issues against doctors and anti-trust investigations against professional medical organizations. Patients with CLD are uncertain whom to trust and which doctor's approach is more likely to yield help. This talk will present the results of a double-masked placebo controlled-study of repeated antibiotic therapy for patients with chronic lyme encephalopathy as well as functional brain imaging findings that identify an abnormally expressed brain map in patients with neurologic Lyme disease. The results of this study will be placed in the context of other controlled studies. Specific treatment approaches and tests will be described that will help the mental health clinician guide his/her patient through the challenging personal decision process of balancing the search for a cure with the need to acknowledge that optimization of functioning may also require symptomatic pharmacotherapies and better psychological and behavioral strategies.

No. 7C

UPDATE ON MECHANISMS AND MANAGEMENT OF FIBROMYALGIA

Daniel J. Clauw, M.D., Michigan Institute for Clinical and Health Research The University of Michigan, 24 Frank Lloyd Wright Drive, Ann Arbor, MI 48106

SUMMARY:
Fibromyalgia (FM) is now acknowledged to be one of many "central" pain syndromes, which includes conditions such as irritable bowel syndrome, temporomandibular disorders, and a variety of other conditions. Mechanistic studies have led to a much clearer picture of what causes FM and these overlapping central pain conditions. This condition is very familial, and

specific genes that confer an increased risk of developing these conditions are beginning to be identified. Various types of stress such as trauma, infections, and emotional stress are also capable of triggering the expression of symptoms. After developing the syndrome, the hallmark abnormality that can be identified with sensory testing, evoked potentials, or functional neuroimaging is augmented central pain/sensory processing. FM patients given a variety of stimuli (pressure, heat, noise, etc.) will experience both subjective and objective evidence of more pain or discomfort than an individual without FM. There is accumulating evidence that this may be due to either a decrease in descending anti-nociceptive pathways (especially those pathways that use serotonin and norepinephrine), and/or an increase in excitatory neurotransmitters (e.g., Substance P, excitatory amino acids). Insights from mechanistic research suggest that neurobiological, psychological, and behavioral factors may all contribute to symptom expression, and thus suggest that FM and related syndromes require a multimodal management program. Thus, the treatment of these conditions may need to be quite different than the treatment of "peripheral" pain (i.e., acute or inflammatory pain). For example, NSAIDS and opioids that are the mainstays of treatment of peripheral pain are either ineffective or modestly effective in FM. In contrast, the most efficacious compounds for FM and related conditions include the tricyclic drugs and mixed reuptake inhibitors that simultaneously increase serotonin and norepinephrine, and the alpha-2-delta ligands that reduce the release of excitatory neurotransmitters. In addition to these pharmacological therapies which are useful in improving symptoms, nonpharmacological therapies such as exercise and cognitive behavioral therapy are extremely useful adjunct treatments for restoring function to individuals with FM.

No. 7D

TREATMENT OF IBS: A BRAIN-GUT DISORDER

Douglas A. Drossman, M.D., University of North Carolina at Chapel Hill, Chapel Hill, NC 27599

SUMMARY:

The irritable bowel syndrome (IBS) is the most studied within the broad classification of functional GI disorders, and is characterized by brain-gut (CNS-enteric nervous system) dysfunction. As such, treatment will depend on targeting the gut, brain or both depending on their relative physiological contributions to symptom expression. With milder symptoms there is altered motility, increases visceral sensitivity and as shown recently, alterations in bacterial flora with impaired mucosal immunity. When pain symptoms are more severe there is associated psychosocial dysfunction with increased gut reactivity to stress and more severe symptoms of pain with impaired quality of life. The CNS dysfunction relates to altered pain regulation via cingulate cortical activation and altered HPA response. When planning treatment, milder symptoms involve agents directed toward the gut and depending on the predominant bowel habit may include peripheral serotonergic agents (e.g., tegaserod, alosetron) or others with neurotransmitter action (e.g., lubiprostone, clonidine) or probiotics. Central treatments for more severe symptoms involve antidepressants particularly low dose TCAs and SNRI, which can be augmented by other central medications. Psychological treatments (e.g., CBT, stress management, hypnosis) have been shown beneficial for patients with moderate to severe symptoms and can be considered as synergistic agents in the overall treatment plan.

REFERENCES:

1. Barsky AJ, Orav EJ, Ahern DK, Rogers MP, Gruen SD, Liang MH: Somatic style and symptom reporting in rheumatoid arthritis. Psychosomatics 1999; 40:396-403.
2. Clauw D. "Fibromyalgia: update on mechanisms & management". J Clin Rheumatology 13: 102-109, 2007.
3. Drossman D.A: The Functional Gastorintestinal Disorders and the Rome III Process. Gastroenterology 130: 1377-90, 2006.
4. Fallon B.A: A Randomized double-masked study of IV ceftriaxone for patients with chronic lyme encephalopathy. Neurology, in press.

SYMPOSIUM 08

EXTERNALIZING DISORDERS OF CHILDHOOD: A *DSM-V* RESEARCH AGENDA

American Psychiatric Institute for Research and Education

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to appreciate the shared and distinctive features of common childhood conditions that cluster under the rubric of "externalizing disorders." Reviews of several longitudinal epidemiologic datasets will help to illustrate how these disorders evolve and differentiate over the course of development. Presentations covering cross-cultural and environmental influences, neurobiology, neuroimaging, genetics, and comorbid substance use will suggest opportunities for revising diagnostic criteria for these disorders and potential changes in their placement in the *DSM-V*.

No. 8A

HOW CARDINAL ARE CARDINAL SYMPTOMS IN PEDIATRIC BIPOLAR DISORDER?

Joseph Biederman, M.D., 55 Fruit Street, YAW 6A, Boston, MA 02114 Janet Wozniak, M.D.

SUMMARY:

Although it has been proposed by some investigators that pediatric bipolar disorder is best characterized by key "cardinal symptoms" of euphoria and grandiosity, this approach represents a clear departure from the *DSM* and its empirical basis remains elusive. To help address this issue, we compared bipolar symptom, functioning and patterns of comorbidity in 86 youth satisfying full *DSM-IV* criteria for bipolar I disorder with and without the proposed cardinal symptom. We found that among Criterion A (abnormal mood), severe irritability was the predominant abnormal mood in youth with bipolar disorder rather than euphoria (94% vs 51%). We also found that among Criterion B items, grandiosity was not uniquely overrepresented in youth with mania, nor did the rate of grandiosity differ whether irritability or irritability plus euphoria were the Criterion A mood symptom. Neither symptom profile, patterns of comorbidity nor measures of functioning differed related to the presence or absence of euphoria . These findings challenge the notion that euphoria and

grandiosity represent cardinal symptoms of mania in children. Instead they support the clinical relevance of severe irritability as the most common presentation of mania in the young. They also support the use of unmodified *DSM-IV* criteria in establishing the diagnosis of mania in pediatric populations.

No. 8B

RESEARCH ON KEY QUESTIONS REGARDING OPPOSITIONAL DEFIANT DISORDER AND CONDUCT DISORDER: CURRENT STATUS AND RECOMMENDED NEXT STEPS

Jeffrey D. Burke, Ph.D., Western Psychiatric Institute and Clinic 3811 O'Hara Street, Pittsburgh, PA 15213

SUMMARY:

Oppositional defiant disorder (ODD) and conduct disorder (CD) are among the most prevalent disorders among children and adolescents in treatment, yet key questions regarding the course of the disorders and their comorbid relationship with other child psychopathology have remained. Research using both clinic and community derived data sets in recent decades has helped to address, but not fully resolve, these questions. This presentation will review evidence regarding essential questions, and will describe specific recommendations for research needed to resolve these questions. Primary among these questions are the following: What is the evidence indicating that ODD and CD should be maintained as distinct disorders? What modifications could be made to the criteria for the disorders that would improve the prediction of those who transition from ODD to CD and from CD to antisocial personality disorder? Is there evidence for the incorporation of callousness into the diagnoses of ODD or CD? What explains the comorbidity observed between the externalizing and internalizing disorders? How should gender bias in ODD and CD be addressed? Other recommendations for diagnostic revisions and for research needed in the area of ODD and CD are discussed.

No. 8C

ADULT ADHD

James J. McGough, M.D., 300 UCLA Medical Plaza, Suite 1414, Los Angeles, CA 90095

SUMMARY:

Objective: Attention-deficit/hyperactivity disorder (ADHD) frequently persists into adulthood. However, *DSM-IV* ADHD criteria, which were developed and field tested solely in school-age children, have never been validated in older patients. This report examines the usefulness of current *DSM* criteria in research and clinical assessment of adults with ADHD. Method: Published studies and clinical data sets were reviewed to assess the clinical utility of *DSM-IV* ADHD criteria for adults. Results: Epidemiological evidence suggests that ADHD occurs in up to 4.4% of U.S. adults and persists in 30%-60% of childhood cases. *DSM-IV* ADHD symptoms are often not developmentally appropriate for adults. Alternative symptoms better discriminate adult ADHD from both clinical and non-clinical comparison subjects. Current symptom thresholds for diagnosis are too severe in adults, and fail to identify significant numbers of patients with clinically significant impairment. Domains of impairment, as defined in *DSM-IV,* are too restrictive for adult patients. Evidence argues against requiring age of onset prior to 7 years and suggests this be changed to age 16 or 18, or abandoned entirely. There is no evidence to support the validity of ADHD subtypes as currently defined. Conclusions: *DSM-IV* criteria for ADHD do not optimally serve research or clinical needs with adults. Significant evidence exists to guide future revisions ADHD diagnostic criteria, particularly as they apply to older patients.

No. 8D

SHOULD YOUTH WITH CHRONIC IRRITABILITY BE DIAGNOSED WITH BIPOLAR DISORDER?

Ellen Leibenluft, M.D., Section on Bipolar Spectrum Disorders Mood and Anxiety Program NIMH Building 15K, Room 203, MSC 2670,, Bethesda, MD 20892 Melissa Brotman, Ph.D., Daniel Dickstein, M.D., Brendan Rich, Ph.D., Daniel Pine, M.D.

SUMMARY:

It is common for youth to present with symptoms of ADHD and severe, non-episodic irritability. Because of the absence of discrete manic episodes, these youth do not meet *DSM-IV* criteria for bipolar disorder (BD), yet their clinical presentation shares some clinical features with BD. Therefore, the question has been raised as to whether severe, non-episodic irritability, coupled with ADHD, should be seen as a developmental presentation of mania. We have studied this question by operationalizing criteria for severely impairing, non-episodic irritability and hyperarousal (severe mood dysregulation, SMD), and comparing patients with SMD with youth who clearly meet *DSM-IV* criteria for BD. Data indicate that SMD youth differ from those with BD in family history and likely clinical outcome. In addition, the brain mechanisms mediating frustration appear to differ between the two groups. Both populations have deficits in face emotion identification and cognitive flexibility although, again, the brain mechanisms mediating these differences may differ between groups. Therefore, while SMD may share some pathophysiological features with BD, there also appear to be important differences between the groups in terms of clinical outcome, family history, and brain function. Importantly, the data indicate that severe, impairing irritability with ADHD is a common clinical presentation in youth, but this syndrome has no clear nosologic home in *DSM-IV.*

No. 8E

RESEARCH OPPORTUNITIES FOR ADHD: IS THERE A NEED TO REFORMULATE CRITERIA IN *DSM-V*?

Luis Augusto L. Rohde, M.D., Department of Psychiatry Hospital de Clínicas de Porto Alegre Rua Ramiro Barcelos 2350 - 4 floor, Porto Alegre, 90035-003 Spain

SUMMARY:

Increasing interest is evident in research opportunities to improve the nosology of ADHD in the *DSM-V*, *ICD-11*, and other psychiatric classification systems. Two primary challenges for all diagnoses are 1) to move toward a unified *DSM/ICD* conceptualization of disorders and 2) to study the validity of disorders while

assessing whether it is possible to incorporate criteria based on new information about pathophysiology into classification systems. This presentation will review recent research that has identified differences between current criteria for ADHD in *DSM* and *ICD* and assess the clinical and research impact of such differences. In addition, we present key questions addressing the validity of ADHD criteria as proposed by the *DSM* such as: 1) Would incorporating dimensional measures into ADHD criteria afford a better understanding of the disorder? 2) How might new classifications for ADHD be made more developmentally sensitive? 3) Does gender dictate need for different criteria? 4) Are any biological markers for ADHD currently available or on the near horizon for use in forthcoming classification systems? 5) Can we identify specific ADHD criteria in *DSM-IV* that differentially require data on their validity? Relatedly, are existing sub-types of ADHD valid and how can research ensure the validity of any proposed new subtypes? 6) Is age-of-onset of symptoms/impairment a valid criterion for ADHD? Finally, we will address the very problematic issue of ADHD diagnosis in adults.

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SYMPOSIUM 09

CONTINUATION TREATMENTS TO PREVENT RELAPSE FOLLOWING ECT

National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this Symposium, the attendee will:

(1) Understand the need for and role of various approaches (pharmacotherapy and continuation ECT) to relapse prevention following a successful course of ECT; (2) Have learned the role of ECT in reducing the risk of suicide in major depression; and (3) Understand, based on controlled trials, the impact of illness (e.g., psychosis) and treatment variables (e.g., electrode placement, stimulus pulse characteristics) on short- and longer-term response.

No. 9A

CONTINUATION PHARMACOTHERAPY IN PREVENTING RELAPSE FOLLOWING ECT

Harold A. Sackeim, Ph.D., Department of Biological Psychiatry NYSPI 1051 Riverside Drive Unit 126, New York, NY 10035

SUMMARY:

Adverse cognitive side effects and early relapse are the two key clinical limitations in the use of ECT. While substantial progress has been made in reducing adverse cognitive side effects, such as the introduction of ultrabrief stimulation, high rates of relapse remain a persistent problem. Indeed, in the modern era, if no biological treatment is given following ECT, the relapse rate is estimated to be 90% within 6 months. The most common form of continuation treatment following ECT is pharmacotherapy. Standard practice involves stopping the effective treatment (ECT) abruptly and switching to a new treatment, pharmacotherapy, that is usually associated with a delay in onset of action and often extensive treatment failures. In a previous study we showed that relative to treatment with placebo, use of nortriptyline alone as a continuation therapy was associated with a modest reduction in the relapse rate (60%). The combination of lithium and nortriptyline was markedly superior (39% relapse). Almost all the relapse in this study on the combination occurred shortly following ECT discontinuation and it might be possible to avoid these relapses by starting the antidepressant medication earlier. In a new trial, we randomized patients to treatment with placebo, nortriptyline or venlafaxine during the ECT course. Following ECT, those treated with placebo were randomized to one of the antidepressants while the others continued on the drug they were on and lithium was added for everyone. This trial has shown that addition of an antidepressant markedly improves the rate of remission to ECT (whether bilateral or unilateral) and that cognitive side effects were reduced in patients receiving nortriptyline but worsened in patients receiving venlafaxine. However, starting the antidepressant early did not have any effect on relapse rates, which again were unacceptably high. The problem of early relapse has been only partially addressed and remains a significant clinical concern.

No. 9B

EFFECTIVENESS OF ECT IN SUICIDE RISK REDUCTION IN PATIENTS WITH MAJOR DEPRESSION

Joan Prudic, M.D., NYSPI 1051 Riverside Drive, Unit 126, New York, NY 10032

SUMMARY:

For major psychiatric disorders, in which suicidality is often a symptom, electroconvulsive therapy (ECT) is an established, highly effective treatment. In fact, suicidal risk may be an indication for the use of ECT. Earlier studies focused on the impact of ECT on the long term risk of suicide and mortality from any cause. As part of large NIMH supported studies of continuation medication and electrode placement in optimizing ECT for patients with major depression, the effects of ECT on suicidal intent, as measured on items #3 and #4 of the Hamilton Depression Rating Scale (HRSD), was examined in work from two research groups, Columbia University and Consortium for Research in Electroconvulsive Therapy (CORE).

No.9C

CONTINUATION ECT AND CONTINUATION PHARMACOTHERAPY FOR RELAPSE PREVENTION IN MAJOR DEPRESSION

Charles Kellner, M.D., Behavioral Health Sciences Building 183 South Orange Avenue Floor F, Room 1436, Newark, NJ 07103 - 3620

SUMMARY:

Relapse after successful treatment of major depression remains a large public health problem. Functional impairment and suicide risk may be the consequences of relapse. The Consortium for Research in ECT (CORE) carried out a study to collect the first randomized trial data on the efficacy of continuation ECT. In Phase I of the study, 531 patients received a course of bilateral ECT. 64.2% remitted, 10% did not remit and 25.8% exited early. Among those who completed the full course of ECT (n=394), 87% remitted, after an average of 7 ECT. Older patients had higher remission rates. In Phase II, patients were randomized to either a fixed schedule of continuation ECT (C-ECT) (10 treatments over 5 months) or the pharmacotherapy combination of lithium and nortriptyline (C-Pharm) (ITT sample n=184). 46% of both the C-ECT(41/89) and C-Pharm(44/95) groups remained relapse free for 6 months, with no statistically significant difference between groups in the outcome proportions. Among patients who relapsed (n=63), the mean time to relapse for the C-ECT group was 9.1(±7.0) weeks compared with 6.7(±4.7) weeks for the C-Pharm group(p=0.131). Both treatments were reasonably well tolerated. The implications of these results for designing better treatment strategies and future research studies will be discussed.

No. 9D

DOES PSYCHOSIS PREDICT ECT RESPONSE IN MAJOR DEPRESSION?

Georgios Petrides, M.D., New Jersey Medical School Behavioral Health Sciences Building 183 South Orange Avenue Floor F, Room 1556, Newark, NJ 07103 - 3620

SUMMARY:

Two hundred and forty three patients completed an index course of bilateral ECT for a major depressive episode, unipolar type, in the CORE* Continuation ECT versus Pharmacotherapy Trial. This is a multicenter, randomized study designed to compare the relative efficacy of continuation ECT vs. continuation pharmacotherapy (lithium plus nortriptyline) for relapse prevention in patients with unipolar major depression. Diagnosis was based on SCID-IV interviews. Seventy seven subjects were diagnosed with major depression with psychosis; 276 were not psychotic. HAM-D (24 item) ratings were obtained three times per week. Approximately 87% of patients met strict responder criteria (HAM-D 10 at 2 consecutive visits and >60% reduction from baseline). Of the psychotic patients who completed the course, 95.5% (64/67) met response criteria versus 83.3% (125/153)of the non psychotic patients (p= 0.011). Psychotic patients were more severely ill at baseline (mean HAM-D= 37.8 ±7.6 versus 33.8 ± 6.4 for non-psychotic, p= <0.0001), and had a greater decrease in HAM-D scores from baseline to endpoint than non-psychotic patients mean for psychotic, 29.2 ±9.9, non-psychotic 23.7±9.2; p= <0.0001). These differences hold when HAM-D ratings are rescored to exclude psychotic items (delusional guilt, somatic delusions and paranoia).

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SYMPOSIUM 10

SAFETY ISSUES IN CHILD AND ADOLESCENT PSYCHOPHARMACOLOGY: RESEARCH UPDATE AND CLINICAL IMPLICATIONS

National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should know of the most recent findings about safety concerns in the use of medications for the treatment of children and adolescents, and be able to discuss the implications of these data regarding: (1) the risk for suicidality during treatment with antidepressants; (2) risk for metabolic syndrome and other adverse effects of antipsychotic medications; and (3) cardiovascular effects and growth during treatment with stimulant medications.

No. 10A

ASSESSING SAFETY OUTCOMES OF TREATMENT OF ADOLESCENTS WITH MDD

Graham Emslie, M.D., 5323 Harry Hines Blvd, Dallas, TX 75390-8589

SUMMARY:

Objective: To examine safety and adverse event outcomes in two recent NIMH-funded randomized clinical trials (RCT's) of depressed adolescents.

Method: Using data from two large NIMH trials (Treatment for Adolescents With Depression Study [TADS] and Treatment of Resistant Depression in Adolescents [TORDIA]), we will examine physical, psychiatric, and suicide-related adverse events using both spontaneous report and prospective methods.

Results: These two studies provide a unique perspective by combining both medication and CBT interventions. In addition, one of the trials was conducted throughout the recent antidepressant

controversy, and modifications to the methodology were required. The TADS study randomized 439 adolescents to CBT, fluoxetine, placebo, or combination treatment. There was substantial difference in safety assessment based on whether systematic measures or spontaneous report were used to assess safety in three areas (physical, psychiatric, and suicidal). In the TORDIA study, 334 adolescents with depression who had failed to respond to a SSRI were randomized to a 2x2 factorial design to alternate SSRI/venlafaxine and CBT/no CBT. This sample overall reported substantially high rates of suicidality at baseline and throughout treatment. Type of antidepressant or presence of CBT did not show significant differences in safety profile. Methodological changes made in this study in response to the FDA advisory will also be discussed.

Conclusion: RCTs, in addition to providing information on efficacy, also provide important information on safety. However, substantial differences in results are noted based on methods used to elicit adverse events.

No. 10B

LONG-TERM EFFECTS OF STIMULANTS IN CHILDREN WITH ADHD

James M. Swanson, M.D., 19722 MacArthur Boulevard, Irvine, CA 92612

SUMMARY:

Growth suppression in children with ADHD during clinical treatment with stimulant medication was proposed by Safer et al. (1972), but consensus reviews decades apart (Roche et al., 1979: NIH Consensus Conference, 1998) discounted the clinical significance of this hypothesis. Recent publications on growth in the Multimodal Treatment study of ADHD (MTA) (MTA Group, 2004 Swanson et al, 2007) and the Preschool ADHD Treatment Study (PATS) (Swanson et al, 2006) revived the hypothesis. However, the evaluation of long-term growth suppression in these studies is problematic, due to self-selection of treatment over time that produces naturalistic subgroups based on pattern of treatment with stimulant medication over time. In the MTA, evaluation of naturalistic subgroups revealed greater than expected annual growth rates in cases not treated with stimulant medication and smaller than expected annual growth rates in cases following initiation of treatment, with divergence that may accumulate over three years to produce stimulant-related growth suppression of about an inch in height and five pounds in weight. (Swanson et al, 2007) Data from the prospective MTA and PATS will be presented to characterize long-term treatment with stimulants in terms of consistency of treatment and total exposure to stimulant medication.

No. 10C

ADVERSE EFFECTS OF ANTIPSYCHOTIC TREATMENT ON EARLY ONSET SCHIZOPHRENIA SPECTRUM DISORDERS

Linmarie Sikich, M.D., University of North Carolina at Chapel Hill, CB 7160, 101 Manning Drive, Chapel Hill, NC 27599-7160, Jean Frazier, M.D., Jack McClellan, M.D., Robert Findling, M.D., Benedetto Vitiello, M.D., Jeffrey Lieberman, M.D.

SUMMARY:

This presentation will review and discuss the safety data from the recently completed Treatment of Early Onset Schizophrenia Spectrum (TEOSS), a multi-site, publicly funded clinical trial comparing three different antipsychotic medications in youths. Special focus will be on metabolic changes associated with treatment. In TEOSS, 119 children and adolescents (age 8-19 years) with schizophrenia or schizoaffective disorder were randomly assigned to receive double blind treatment with molindone, olanzapine, and risperidone for up to one year. Prophylactic benztropine was provided to minimize extrapyramidal symptoms (EPS) in the molindone group. Possible presence of adverse effects was elicited systematically. EPS, akathisia, and tardive dyskinesia were evaluated with structured examinations. Safety laboratory tests were done at weeks 0, 4, 8, 24, 36, and 52. Sedation was reported by 30% of youth, restlessness by 25%, weight gain by 24%, irritability by 22%, insomnia by 17%, and depression by 13% during the first eight weeks of treatment. Weight gain was greater on olanzapine than on the other medications. From 9 -52 weeks, weight gain was reported by 37%, anxiety by 22%, sedation by 19%, and depression by 11%. Few EPS were observed, other than akathisia. Adverse effects were common in youths during antipsychotic treatment. The safety profile differed across medications.

No. 10D

STIMULANTS AND RISK OF VASCULAR EVENTS

Mark Olfson, M.D., New York State Psychiatric Institute Unit 24, 1051 Riverside Drive, New York, NY 10032

SUMMARY:

Specific Purpose: There is considerable concern that stimulants may increase the risk of vascular events. This presentation will summarize clinical and epidemiological research on stimulants and cardiovascular safety and describe potential avenues for future research. Specific Purpose: There is considerable concern that stimulants may increase the risk of vascular events. This presentation will summarize clinical and epidemiological research on stimulants and cardiovascular safety and describe potential avenues for future research. *Methodology*: A review will be provided of the cardiovascular effects of mixed amphetamine salts (MAS) and methylphenidate (MPH) in youth and adults at therapeutic doses, relationships between blood pressure and heart rate to risk of vascular events, and case report evidence linking stimulant treatment to vascular events. *Results*: MAS and MPH are adrenergic agonists with acute chronotropic and pressor effects. In child and adult studies, short-term and long-term stimulant treatment at therapeutic doses results in statistically significant elevations of blood pressure and pulse. Although there is a continuous and direct relationship between blood pressure and risk of cardiovascular or cerebrovascular mortality in adults throughout the normal range of usual blood pressure, these relationships have not been well studied in youth. A review of the FDA Adverse Event Reporting System data of sudden death between January 2002 and February 2005 identified 14 deaths in children receiving MPH and six in children receiving amphetamines, several of whom had pre-existing cardiac risk factors. Following this review, the FDA ordered that labels of all stimulants indicate that sudden death had been reported in association with stimulant treatment

at usual doses and that these medications generally should not be used in youth with serious heart problems. Traditional epidemiological methods, such as case control and cohort analyses, have not been used to assess associations between stimulant use and vascular events. *Significance*: Although pharmacological properties of stimulants, epidemiological studies of risk factors, and case reports suggest that stimulant treatment may increase the risk of vascular events.

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SYMPOSIUM 11

DEPRESSION AND GENERALIZED ANXIETY: RESEARCH PLANNING FOR THE *DSM-V*

American Psychiatric Institute for Research and Education

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand current views on the inter-relationship between MDD and GAD from the perspectives of genetics, neurobiology, treatment, course and a cross-cultural perspective. The participant should also be familiar with the on-going debate as to whether and how these findings should be translated into changes in *DSM-V* and in particular what criteria might be used to decide the placement of diagnoses into categories in our diagnostics.

No. 11A

NEUROBIOLOGICAL VALIDATORS APPLIED TO MDD AND GAD

Charles B. Nemeroff, M.D., Department of Psychiatry & Behavioral Sciences Emory University School of Medicine 101 Woodruff Circle Suite 4000, Atlanta, GA 30322, Elizabeth Martin, M.D.

SUMMARY:

Observations of frequent comorbidity, at the phenomenologic level, of generalized anxiety disorder (GAD) and major depressive disorder (MDD) have triggered interest in formulating new approaches to the grouping and classification of these disorders in *DSM-V.* This presentation will review a variety of neuroendocrine, neurotransmitter, and neuroanatomical findings, which suggest need for caution in premature closure on the notion that anxiety and depression are not distinct disorders. The presentation will illustrate how neurotransmitter system disruption in MDD and GAD is complicated by the high degree of interconnectivity between neurotransmitter and neuropeptide-containing circuits in limbic, brain stem, and higher cortical brain areas, and how neuroimaging studies conducted to date have lacked the highly selective inclusion criteria needed to avoid confounds caused by comorbidity between both syndromal GAD and MDD, or by patients who have GAD with prominent depressive symptoms and the converse. The presentation will consider alternatives to consolidation of MDD-GAD such as introduction of diagnostic spectra in *DSM-V*.

No. 11B

CROSS-CULTURAL ASPECTS OF ANXIETY AND DEPRESSION

Dan J. Stein, M.D., University of Cape Town Department of Psychiatry E36A, Rm71-GSH-J2 Block, Anzio Road Observatory, Cape Town, 7925 South Africa

SUMMARY:

Cross-cultural psychiatry offers a range of concepts and methods for approaching psychiatric disorders. A "classical" approach has emphasized that psychiatric disorders in different parts of the world have a universal form, albeit with somewhat varying local content. In contrast, a "critical" approach has argued that both the form and content of symptoms are determined by culture, with our nosologies themselves best understood as cultural artifacts. In medical and psychiatric practice, clinicians may usefully be able to integrate aspects of both the "classical" and "critical" view. We can conceptualize major depressive disorder (MDD) and generalized anxiety disorder (GAD) as biomedical disorders caused by psychobiological mechanisms, but also accept that they are necessarily expressed and experienced within sociocultural contexts. Although in some contexts (eg primary care) it is possibly useful to conceptualize both depression and anxiety symptoms as representing an expression of emotional distress, ongoing advances in psychobiology and treatment indicate that it is often important to make distinctions between MDD and GDD.

No. 11C

MDD AND GAD: BACKGROUND AND GENETIC RELATIONSHIP

Kenneth S. Kendler, M.D., Dept Psychiatry Virginia Commonwealth University PO Box 980126, Richmond, VA 23220

SUMMARY:

The history of the relationship between MD and GAD will be reviewed, beginning with the Research Diagnostic Criteria and carried forward up until *DSM-IV*. Relevant conceptual issues will also be examined including the rules adopted by *DSM* for the

assignment of disorders into categories. Currently a tension exists between prior *DSM* approaches which emphasized clinical similarity in the decision about disorder placement and efforts to move toward a more etiologically based diagnostic system. Parallels will be outlined between these efforts and those by philosophers of biology to develop rules for the classification of species. The findings from a series of twin and family studies will be reviewed most, but not all of which, point toward a strong genetic relationship between MD and GAD.

No. 11D

COMORBIDITY BETWEEN *DSM-IV* GENERALIZED ANXIETY DISORDER AND MAJOR DEPRESSION IN THE NATIONAL COMORBIDITY SURVEY FOLLOW UP

Ronald C. Kessler, Ph.D., Department of Health Care Policy Harvard Medical School 180 Longwood Avenue, Boston, MA 02115, John M. Hettema, M.D., Ph.D., Kimberly A. Yonkers, M.D.

SUMMARY:

Data are presented on comorbidity between *DSM-IV* generalized anxiety disorder (GAD) and major depression (MD) in the National Comorbidity Survey follow-up, a nationally representative two-wave panel sample of 5000 people initially interviewed in the early 1990s and then followed up over a decade to study changes in the onset, persistence, and progression of their mental disorders. Results are presented of analyses of associations between GAD and MD in predicting onset and persistence of each other along with associations between other variables in predicting onset-persistence of both GAD and MD. The goal of the analyses is to determine whether asymmetries can be found that would indicate differences in risk factors or natural history of the two syndromes that are sufficiently pronounced to consider them separate disorders on the basis of these data patterns.

No. 11E

BIOLOGICAL AND TREATMENT ASPECTS

David J. Kupfer, M.D., Dept of Psychiatry University of Pittsburgh School of Medicine Western Psychiatric Institute and Clinic 3811 O'Hara Street, Suite 279, Pittsburgh, PA 15213, Ellen Frank, Ph.D.

SUMMARY:

Almost four decades after Robins and Guze specified five features that they defined as underpinning diagnostic validity, accumulated behavioral and neuroscience research has now sharpened the earlier validity measures, which could now consist of behavior phenotype, neurobiological profile, genetics/familial pattern, context/environment, and treatment response/follow-up studies. As an example of the degree of change, the "neurobiological profile," which supplants the older "laboratory findings," would include data on susceptibility genes, pharmacogenomics; pharmacological response, neuroimaging, and other neurobiological features. Drawing on the review of GAD and MDD prepared for the APA/WHO/NIH research planning exercise for *DSM-V*, this presentation will review the dividends to be realized from linking the full array of neurobiological data to outcomes of both psychological and pharmacologic interventions. Selection of well-defined, comparable clinical samples will assume increasing importance, as will utilization of appropriate, highly sensitive analytic measures. Emphasis on these and other standards of rigor raise the question of how useful past findings will be in answering questions about the validity of diagnoses that loom ahead: the importance of developmental issues, including age of onset, and the important distinction between comorbidity and the "evolution" of disorders over their long-term course.

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SYMPOSIUM 12

PSYCHIATRIC GENETICS: NEW DISCOVERIES KNOCKING AT THE CLINIC DOOR

National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be;(1) More familiar with the latest findings in the genetics of bipolar disorder, schizophrenia, and autism; (2) Better able to understand the clinical relevance of advances in psychiatric genetics; and (3) Better prepared to answer questions from patients and their families about the genetic contribution to major psychiatric illnesses.

No. 12A

SEARCHING HIGH AND LOW FOR BIPOLAR DISORDER GENES

James B. Potash, M.D., Johns Hopkins Hospital Meyer 4-119, Baltimore, MD 21287

SUMMARY:

Family, twin, and adoption studies have made it abundantly clear that genes play a dominant role, accounting for about 75% of the susceptibility to bipolar disorder. Research for the last 20 years has focused on determining which of the 20,000 or so human genes account for this risk. The major modality for screening the human genome has been the linkage study, a low resolution approach to the problem, which has identified some chromosomal neighborhoods likely to harbor disease genes. In 2007, the first whole genome association studies of bipolar disorder, which screen the genome at about 1,000 fold higher resolution than does linkage, were published. Genes identified in these screens are currently being studied intensively, to assess their relationship to bipolar disorder generally and to assess potential relationships to clinical subtypes of illness. A method that will provide the ul-

timate level of high resolution in screening for DNA variations conferring risk for bipolar disorder, whole genome resequencing, is developing rapidly. New discoveries could ultimately result in new diagnostic tests and improved treatment methods. Currently clinicians use family histories to help with diagnosis. They also need a familiarity with the most up-to-date evidence to answer the questions of an increasingly sophisticated population of patients, relatives, spouses, and prospective spouses requesting genetic counseling.

No. 12B

A SYSTEMATIC APPROACH TO ASSOCIATION STUDIES OF SCHIZOPHRENIA

Pablo V. Gejman, M.D., 1001 University Place, Evanston, IL 60201

SUMMARY:

The discovery of disease genes for complex genetic disorders, such as schizophrenia, has proven more difficult than first predicted. The demarcation of true positive results from false positive results has been particularly challenging. Many have argued that this problem can be attributed to the relatively small size of the investigated samples in relation to the genetic effects, but other significant issues include liberal statistical interpretations (such as the use of uncorrected p-values from analyses with multiple comparisons), unsystematic replication attempts, and lack of adequate linkage disequilibrium maps. However, this landscape has been rapidly changing recently. The generation of high quality linkage disequilibrium maps by the International HapMap Project, a better understanding and standardization of the applied statistics, and the consistent funding of large-scale collaborative efforts are expected to correct many fundamental problems. Currently, individual experiments of unprecedented scale are being conducted whether the study of association of a large case-control sample with a dense map of genetic markers (e.g., we use the Affymetrix Genome-Wide Human SNP Array 6.0 which includes over 900K genetic markers), known as a genome-wide association experiment (GWA), has become the most accepted model. Our sample is comprised of 3,000 schizophrenia cases and 3,000 controls of European ancestry, and 1,300 cases and 1,000 controls of African-American ancestry. Primary data from the GWA experiment and its initial follow up, as well as data from focused candidate gene experiments, will be presented.

No. 12C

HIGH-RESOLUTION ANALYSIS OF GENOME COPY NUMBER VARIATION IN AUTISM SPECTRUM DISORDERS

Jonathan L. Sebat, Ph.D., Cold Spring Harbor Laboratory, Cold Spring Harbor, NY 11724

SUMMARY:

New methods for detecting changes in DNA copy number (CNVs) have begun to shed new light on genetic risk factors for autism spectrum disorders. What these studies have shown is that large scale deletions and duplications of genes are a significant contributor to genetic risk, and furthermore that CNV risk factors are frequently the result of spontaneous germline mutation. Spontaneous CNVs have been detected at many loci throughout the genome, and no single locus has been shown to account for more than 1% of cases. These data are consistent with the notion that there are many genes in the genome that, when altered, can produce a similar disease phenotype. We hypothesize that the common features of autism (impaired social interaction, difficulty with communication, and restricted interests and behaviors) owe there "commonality," not to common genes, but to a common biological pathway involving a large and diverse set of genes.

No. 12D

GENES CAN'T READ *DSM*: DISSECTING GENOTYPE-PHENOTYPE CORRELATIONS

Thomas G. Schulze, M.D., Genetic Basis of Mood and Anxiety Disorders NIMH 35 Convent Drive Bldg. 35, Rm 1A202 MSC 3719, Bethesda, MD 20892-3719

SUMMARY:

In psychiatric genetic research, the ever-increasing sophistication of molecular genetic tools has outpaced our understanding of the disorders we study. While a multitude of linkage and association studies have discovered potential vulnerability genes, the challenge now is to identify complex genotype-phenotype relationships that may go beyond traditional diagnostic concepts embodied in the *DSM*.

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SYMPOSIUM 13

PSYCHOPHARMACOLOGY IN THE ATHLETE INTERNATIONAL SOCIETY FOR SPORT PSYCHIATRY

EDUCATIONAL OBJECTIVES:
At the conclusion of this session the participant will be able to recognize the role of psychotropic medications in the athlete. They will learn the unique considerations when choosing a psychotropic medication in this population, with particular attention to untoward effects, as well as sports specific phenomena. This will be demonstrated through both athletes and sport psychiatrists. The medication classes will include antipsychotics, antidepressants, psychostimulants, and lithium.

No.13A
THE USE OF NEUROLEPTIC MEDICATION IN PROFESSIONAL ATHLETES

Douglas L . Geenens, D.O., 10511 Mission Road, #204, Leawood, KS 66206

SUMMARY:
Professional athletes require special considerations when prescribing psychiatric medications. Of particular importance is the rationale for use of antipsychotic medications and their impact on performance and cognition. Although psychopathology has not been systematically studied in professional athletes, anecdotal and clinical evidence suggests common diagnoses to include anxiety, substance abuse, ADD, and bipolar disorder. The current treatment strategies for bipolar disorder primarily encompass anticonvulsants and atypical antipsychotics. Traditional treatment of psychotic disorders and mood disorders have largely targeted some degree of traquilization. In the professional athlete, this can be disastrous and functionally end their professional career. I will present a case of a professional athlete (NFL) who was adequately treated for bipolar disorder with ziprasidone and was able to continue his professional career.

No.13B
LITHIUM IN THE ATHLETE

Antonia L. Baum, M.D., 5522 Warwick Place, Chevy Chase, MD 20815

SUMMARY:
The use of lithium in the athlete has not been well documented. In this presentation, we will show that the common assumption, that lithium toxicity is likely to occur with physical exertion, is not the rule. Given the potential therapeutic potency of lithium, it behooves us to consider the possibility of using lithium, even in the elite athlete. The existing case reports will be discussed, as well as the various considerations when using lithium in the athlete, from tremors to dehydration, and their effect on lithium levels. Guidelines on the management of athletes on lithium will be presented. An ironman triathlete will present her history on lithium, from side effects to efficacy. The salient point is that lithium can be used successfully—if used judiciously, and managed carefully—in the athlete.

No. 13C
PSYCHO-STIMULANT USE DURING ATHLETIC COMPETITION; WHAT ARE THE RISKS AND BENEFITS?

David O. Conant-Norville, M.D., 15050 SW Koll Parkway Suite 2A, Beaverton, OR 97006

SUMMARY:
Use of psychostimulant medication is the first line treatment for Attention-deficit hyperactivity disorder, (ADHD) yet is banned for use by athletes during competition by many sport governing organizations. This presentation will review the history leading to restrictions of psychostimulant use in sport, the potential risks to the athletes, and the data suggesting a possible performance enhancement effect. Specific rules banning psychostimulant use in various amateur and professional sport organizations will be discussed as well as procedures to obtain therapeutic use exemptions for athletes with medically legitimate reasons for using these agents during competition. This presentation should provide practical information regarding treatment of ADHD in the high level athlete so as to avoid medical complications or doping sanctions.

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1. Baum AL: Psychopharmacology in Athletes. In Sport Psychiatry, edited by Begel D, Burton RW, New York, WW Norton & Co, Inc, 2000, pp 249-259.
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SYMPOSIUM 14

SOMATIC PRESENTATIONS OF MENTAL DISORDERS

American Psychiatric Institute for Research and Education

EDUCATIONAL OBJECTIVES:
At the end of this symposium, participants will better understand the "territory" of somatic complaints, patterns of comorbidity with psychiatric and general illnesses, the influence of culture on somatic presentations, and factors that influence course and prognosis. Presentations will review challenges to research in this area, such as patients' poor symptom recall, and will preview recommendations for naming and placing these conditions in future classification systems.

No. 14A
BIOLOGICAL SUBSTRATE FOR SOMATOFORM DISORDERS

Joel E. Dimsdale, M.D., 9500 Gilman Drive Dept 804, La Jolla, CA 92093-0804

SUMMARY:
Somatoform disorders are deeply troubling to both patients and physicians. The diagnosis regrettably relies on the presence of subjective distress in the absence of objective findings. As a result, there is always the possibility that a diagnosis will

be "missed." In addition, there is a clear underlying physiology of distress which implies that there is a two way street—both psychosomatic and somatopsychic in terms of production and experience of somatoform symptoms. In particular, studies on communication pathways from the immune system to the brain provide exciting new information on the pathophysiology of inflammation-associated symptoms.

No. 14B

DIFFERENTIAL RESPONSE TO TREATMENT FOR SOMATOFORM DISORDER SUBTYPES

Kurt Kroenke, M.D., 1050 Wishard RG6, Indianapolis, IN 46202

SUMMARY:

Somatoform disorders are among the most common mental disorders presenting in the general medical setting. However, compared to other common disorders like mood and anxiety, less is known about effective treatment of somatoform disorders. This presentation will review the evidence for a differential response to specific treatments for subcategories of somatoform disorders. CBT has been studied in all disorders (except conversion) and found beneficial in 11 of 13 studies reviewed. For somatization disorder (and its variants), a consultation letter to the general practitioner (GP) has been shown effective in most studies, whereas the benefits of GP training have not yet been established. SSRIs are effective for treating body dysmorphic disorder. Antidepressants have been less well studied for other somatoform disorders. No proven therapy has been identified for conversion disorder and no randomized controlled trials have been conducted for pain disorder or undifferentiated somatoform disorder. Both CBT and antidepressants are effective for functional somatic syndromes.

No. 14C

RETHINKING SOMATOFORM DISORDERS IN *DSM-V*: A VIEW FROM CULTURAL PSYCHIATRY

Laurence J. Kirmayer, M.D., 4333 Cote Ste Catherine Rd., Montreal, Quebec, H3T 1E4 Canada

SUMMARY:

This paper examines the impact of culture on symptom experience to draw out implications for the nosology of somatoform disorders in *DSM-V*. Although globalization and migration are changing the meanings of culture, the result is not homogenization but complex forms of hybrid identity and local practice that require careful attention to individual experience and social context in diagnostic assessment. Cross-national epidemiological studies have shown the ubiquity of somatic presentations of distress in primary care and mental health settings and the wide range of culture-specific somatic symptoms, syndromes, and illness explanations. Culturally influenced modes of somatic awareness and interpretations of symptoms may contribute to specific forms of somatic amplification resulting in persistent symptoms and disability. However, bodily symptoms often function as cultural idioms of distress that may not indicate psychopathology but point to social, interactional, or systemic problems. An independent axis of illness behavior may be a more effective way to capture these personal, social, and cultural dimensions of somatic symptoms and syndromes.

No. 14D

CLINICAL COURSE AND TREATMENT OF SOMATOFORM DISORDERS

Winfried Rief, Ph.D., University of Marburg, Marburg, 35032 Germany

SUMMARY:

Somatoform disorders are frequently a disabling condition, which is difficult to manage and treat in clinical practice. A literature analysis of the spontaneous course of patients with multiple medically unexplained symptoms shows that individual symptoms may vary, but the syndrome of multiple medically unexplained symptoms tends to persist. A stepped care approach will be presented including the following steps: (1) clinical management in general practitioner settings, (2) minimal interventions by psychiatrists and health care professionals, (3) cognitive behavioral therapy, and (4) psychopharmacological treatment. Evidence for the approaches will be reported from other studies and three studies of our own group, including the evaluation of a general practitioner's training as well as a randomised clinical trial with 150 patients. It is emphasized that somatoform disorders need a specific management and treatment approach in all of the aforementioned settings. The empirically-based treatment options are compared with the reality of health care seeking, which is analyzed in a population-based study including 2,500 participants. The presentation will close with consideration of the implications of course, treatment results, and health care seeking on the revision of classification criteria.

No. 14E

THE ASSOCIATION OF SPECIFIC SOMATIC SYNDROMES WITH ONE ANOTHER

Simon Wessely, M.D., Institute of Psychiatry King's College London DeCrispigny Park (Denmark Hill), London, SE5 8AF United Kingdom

SUMMARY:

This presentation will review the association between the various functional somatic syndromes seen across medical specialties (e.g., irritable bowel syndrome, fibromyalgia, atypical chest pain, tension headache, etc.). Overall, unexplained medical symptoms are common in primary care settings (occurring in more than 50% of patients in one study). Given the extensive overlap among the symptoms included in the definitions of the various functional syndromes, the more symptoms one has that are characteristic of one syndrome, the more likely one is to have symptoms characteristic of the other syndromes as well. Despite a significant association of the functional syndromes with depression or anxiety, the modest effect size (0.68) indicates that depression and anxiety do not entirely explain the functional syndromes. Furthermore, population-based studies of fatigue suggest that there is a reasonably stable set of neurasthenia cases (i.e., fatigue syndrome) that do not overlap with depression and anxiety. A latent class analysis of functional somatic symptoms in the community suggests the presence of the following five classes: a chronic fatigue-like entity, a pan/myalgia-like entity, an irritable bowel syndrome-like

entity, a depression entity, and an anxiety entity. These data suggest accepting the existence of a concept of functional somatic symptoms/syndromes that differ from anxiety and depression, and that within this broad category, continuing to respect the integrity of fibromyalgia, irritable bowel syndrome, chronic fatigue syndrome, and their cultural variants.

REFERENCES:

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2. Katon W, Lin EH, Kroenke K: The association of depression and anxiety with medical symptom burden in patients with chronic medical illness. Gen Hosp Psychiatry 29(2):147-55, 2007.
3. Lee DT, Kleinman J, Kleinman A: Rethinking depression: an ethnographic study of the experiences of depression among Chinese. Harv Rev Psychiatry 15(1):1-8, 2007.
4. Salmon P, Peters S, Clifford R, et al: Why do general practitioners decline training to improve management of medically unexplained symptoms? J Gen Intern Med 22(5):565-71, 2007.

SYMPOSIUM 15

GLOBAL GAPS IN PSYCHIATRY: THE MENTAL HEALTH NEEDS OF CHILD SOLDIERS

APA Council on Global Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to:(1) Recognize the global extent of the use of child soldiers in armed conflict; (2) Identify psychiatric symptoms that child soldiers can manifest; (3) Describe specific mental health interventions that can facilitate rehabilitation of child soldiers; and (4) Recognize the potential for child soldiers to exhibit resiliency, sustain mental health, and reintegrate into their communities.

No. 15A

A LONG WAY GONE: WAR, REDEMPTION AND HOPE THROUGH THE EYES OF A CHILD SOLDIER

Ishamael Beah, B.A., C/O Laurel Cook (Publicist) Farrar Straus & Giroux 19 Union Square West, New York, NY 10003

SUMMARY:

Author of A Long Way Gone: Memoirs of a Boy Soldier (Ferrar, Straus & Giroux, 2007), Ishmael Beah was born in Sierra Leone in 1980, a country ravaged by civil war from 1991-2002. By the time he was 13 years old, his parents and two brothers were killed, and he was abducted as a child soldier by a disenfranchised group of the Sierra Leone Army. Mr. Beah fought for over two years before he was rescued by UNICEF and taken to a rehabilitation center. In 1997, he fled from the increasing violence in Freetown and traveled to New York City.

No.15B

INTERVENTIONS FOR DEPRESSION SYMPTOMS AMONG ADOLESCENT SURVIVORS OF WAR AND DISPLACEMENT IN NORTHERN UGANDA

Judith Bass, Ph.D., Department of Mental Health Johns Hopkins Bloomberg School of Public Health 624 North Broadway 8th Floor, Baltimore, MD 21205 Theresa Betancourt, Sc.D., Liesbeth Speelman, M.A., Grace Onyango, M.A., Kathleen F. Clougherty, M.S.W., Richard Neugebauer, Ph.D., Laura Murray, Ph.D., Helen Verdeli, Ph.D.

SUMMARY:

Prior qualitative work with internally displaced persons in war-affected northern Uganda showed significant mental health and psychosocial problems. The objective of this presentation is to assess the effect of locally feasible interventions on depression, anxiety, and conduct problem symptoms among adolescent survivors of war and displacement in Northern Uganda.

No. 15C

THE REINTEGRATION OF FORMER CHILD SOLDIERS IN NORTHERN UGANDA

Jeannie Annan, Ph.D., NYU Program for Survivors of Torture 462 First Avenue, CD 733, New York, NY 10016

SUMMARY:

The Lord's Resistance Army (LRA) in northern Uganda has been abducting adolescent boys and girls as their main source of recruitment for more than a decade. This study draws on a representative survey of over a 1,000 male and female ex-combatants and non-combatants in this region to examine the impact of soldiering on psychological distress and social reintegration.

No. 15D

CHILD SOLDIERS IN MOZAMBIQUE

Jon A Shaw, M.D., Leonard M. Miller School of Medicine University of Miami Dept of Psychiatry & Behavioral Sciences Room 1404, Mental Health Hospital Center 1695 NW 9th Avenue, Miami, FL 33136

SUMMARY:

The presentation will review the global problem of child soldiers and factors associated with their recruitment. I will present experiences from working with children in Mozambique who had been abducted by Renamo (an anti-communist group sponsored by the Rhodesian Intelligence Service in the mid-1970s) and forced to participate in armed conflict against the government. These child soldiers were eventually captured by government forces who endorsed providing treatment for these abducted child soldiers with the hope of rehabilitating them and returning them to their families. The children were held in a Catholic school that was converted to a rehabilitation center, and the intervention was predicated on group education.

No.15E

MOZAMBICAN CHILD SOLDIER LIFE OUTCOME STUDY

Neil G. Boothby, Ed.D., Heilbrunn Department of Population and Family Health, Columbia University Mailman School of Public Health, 60 Haven Avenue, B-4, New York, NY 10032

SUMMARY:
The presentation will focus on the adult life outcomes of former child soldiers. Between 1988 and 2004, information was collected on 40 male former child soldiers in Mozambique. Research began at a rehabilitation center in Maputo, continued after they were reintegrated into communities, and culminated with an examination of adult outcomes.

REFERENCES:

1. Bolton P, Bass J, Betancourt T, Speelman L, Onyango G, Clougherty KF, Neugebauer R, Murray L, Verdeli H: Interventions for Depression Symptoms Among Adolescent Survivors of War and Displacement in Northern Uganda: A Randomized Controlled Trial. JAMA 2007; 298: 519 – 527.
2. Boothby NG: Waging a New Kind of War. Children of the Gun. Sci Amer 2000; 282: 60-65.
3. Shaw JA: Children Exposed to War & Terrorism. Clin Child Fam Psychol Rev 2003; 6: 237-246.
4. Wessells M: Child Soldiers. From Violence to Protection. Cambridge, MA, Harvard University Press, 2007.

SYMPOSIUM 16

EUROPEAN AND AMERICAN PSYCHIATRY: IDENTITY AND PRIORITIES

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to; 1) better understand the psychiatric identity that prevails at the present time in America and Europe; 2) develop priorities to address the most relevant mental health problems faced in Europe and America; and 3) to draft solutions for the most important mental health problems faced in Europe and America.

No.16A
CURRENT EUROPEAN PERSPECTIVES ON THE CONCEPT OF SCHIZOPHRENIA

Mario Maj, M.D., Department of Psychiatry, University of Naples SUN, Largo Madonna delle Grazie, Naples, 80138 Italy

SUMMARY:
The *DSM-IV* diagnosis of schizophrenia is essentially a diagnosis by exclusion. The *DSM-IV* symptomatological, chronological and functional criteria, taken together, do not characterize schizophrenia as a syndrome (all of them may be fulfilled by several cases of bipolar disorder, major depression, and dementia). The exclusion criterion becomes decisive for the diagnosis. Should the schizophrenic syndrome be really diagnosed by exclusion? Does this syndrome not have characteristics? Three alternative answers to these questions emerge from the recent European psychiatric literature: 1) The schizophrenic syndrome does have characteristics. However, its essence does not lie in a constellation of symptoms, but in a "mode of being" of the subject, that the trained psychiatrist is able to grasp, but operational diagnostic criteria are unable to communicate. 2) The schizophrenic syndrome does have characteristics, but the *DSM-IV* criteria fail to catch one or more aspects which are essential for the diagnosis. In particular: 2a) the form and content of the anomalies of self-experience in patients with schizophrenia require a more in-depth characterization, reversing the recent process of reduction of psychotic phenomena to their smallest common denominator, of which the *DSM-IV* laconic formulation is the outcome; 2b) the basic relational deficit shared by individuals with schizophrenia and schizophrenic spectrum disorders should be better characterized and operationalized; 2c) the cognitive impairment of patients with schizophrenia may have a characteristic pattern, especially if examined longitudinally. 3) Schizophrenia is not a discrete disease entity. There is a continuous distribution of psychotic phenomena in the general population, and a substantial overlap between schizophrenia and bipolar disorder from both the clinical and biological viewpoint. A dimensional approach to the classification of psychosis is now mature.

No.16B
CLINICAL AND THEORETICAL PSYCHOPATHOLOGY IN THE EDUCATION OF THE FUTURE PSYCHIATRIST

Michael Musalek, M.D., Anton-Proksch Institute Mackgasse 7-11, 1230 Vienna, 4663 Austria

SUMMARY:
In the last decades in psychiatry we became confronted more and more with various interesting and important results of studies carried out in different research fields, e.g., neurosciences, genetics, neuro-immunology, sociology, psychology, psychotherapy, philosophy, ethics, anthropology, etc., which led to a high complexity of psychiatric knowledge. This development obviously creates new needs in the training of psychiatrist, in particular the need for education in clinical and theoretical psychopathology. In order to provide future psychiatrists with the possibility to assess critically new research results and to put them into the framework of their daily clinical work, basic knowledge in the theory of science and in the theoretical foundations of contemporary clinical psychopathology (e.g., history of ideas epistemological, ethical and aesthetical reflections of theories in psychiatry, etc.) becomes necessary. Moreover, theoretical reflections on education in psychiatry itself, represents an important tool in developing future psychiatry. Theoretical Psychopathology is not so much seeking to solve only clinical problems as to study the concepts that structure and guide our thinking in psychiatry and to lay bare the foundations and suppositions of our daily work in clinical psychopathology and diagnostics, treatment and education itself. Psychopathology discourse on the theoretical backgrounds of our clinical and scientific work is what happens when our daily practice becomes self-conscious.

No.16C
WORLD PSYCHIATRY: EUROPEAN CONTRIBUTIONS

Wolfgang Gaebel, M.D., Department of Psychiatry and Psychotherapy Heinrich-Heine-University Düsseldorf Bergische Landstr 2, Duesseldorf, 40629 Germany

SUMMARY:
Psychiatry in European countries has a long, rich and influential tradition. European psychiatry, however, is still in statu nascendi, starting to discover its common roots and future challenges, thereby developing a European identity - beyond languages and schools. Harmonization and certification of education and training, promotion and funding of cross-national collaborative

research etc. are amongst those transnational goals. The current process of revisiting diagnosis and classification in psychiatry also fits into the agenda for joining activities in order to contribute European knowledge and experience to this worldwide endeavour. These global challenges, however, do not only require exchange of opinions across the European member states and their professional organizations, but also within the international community. Accordingly, the identity of psychiatry has already been made an issue of debate on an international level, e.g., by respective American (APA), European (AEP) and World (psychiatric) associations (WHO, WPA).

REFERENCES:

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2) Furedi J, Mohr P, Swinder D, et al.: Psychiatry in Selected Countries of Central and Eastern Europe: An Overview of the Current Situation. Acta Psychiatrica Scandinavica, 114: 223-231, 2006.
3) Cox JL: European Psychiatry: Moving Towards Integration and Harmony. World Psychiatry, 6(1): 54-56, 2007.
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SYMPOSIUM 17

WOMEN'S HEALTH: STRAIGHT TALK ABOUT TANGLED PROBLEMS - PREGNANCY-RELATED PSYCHIATRIC ISSUES

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; appropriately recognize and adequately treat women's mental health problems linked to pregnancy, miscarriage or pregnancy termination.

No.17A

POSTPARTUM DEPRESSION: EFFECTS ON THE DEVELOPMENT OF MOTHER AND CHILD

Alexandra M Harrison, M.D., 183 Brattle Street, Cambridge, MA 02138

SUMMARY:

Depressed mothers often lose the flexibility necessary to attend to and recognize the infant's communicative signals, and therefore repairs of interactive errors are not made. Maternal responses are often characterized by either withdrawal or intrusion, and these maternal responses do not match the infant's affect or intention. The infant comes to expect a particular kind of misattuned response from the mother and tries to protect himself or herself by either withdrawing from the intrusive maternal behaviors or protesting the withdrawn maternal behaviors. In either case, the infant may develop a coping style that influences his/her ability to explore the inanimate world and make social relationships. The expectancies of misattuned responses from the mother becomes part of the baby's core affective self and may influence the infant's response to strangers. Negative social interactions with others then have a confirmatory effect, supporting negative expectancies, limiting positive social experiences, and predisposing the infant to depression. Therapeutic intervention directed at the mother-infant pair, using videotape to demonstrate both healthy and problematic micropatterns to the mother, can have a beneficial effect and interrupt the intergenerational transmission of depression.

No.17B

DILEMMAS CONCERNING MISCARRIAGE AND GENETIC TERMINATIONS.

Gail E. Robinson, M.D., Toronto General Hospital 8-231 E.N., 200 Elizabeth St,, Toronto, ON, M4W 3M4 Canada

SUMMARY:

Approximately 20% of pregnancies miscarry in the first trimester. The psychological impact is often ignored or minimized. Others may not understand why the woman is grieving for a child she never knew. Male partners may not express grief openly, leaving the woman to feel isolated and alone. Often there is no clear reason for the miscarriage, leaving women to feel responsible and guilty. Often, there are no institutional policies in place as there would be to help parents who suffered a stillbirth. Some researchers see the resulting emotions as resolving in the first six months whereas others have found long-lasting grief reactions. There is also a debate as to whether the best psychological outcomes are obtained by quickly doing a D&C or adopting a policy of expectant waiting to see if the embryo is absorbed. With a termination for genetic indications, the decision to end the pregnancy is often a difficult one. Couples worry about how others may judge their decision. This may result in their not explaining what has happened, thereby, not obtaining needed emotional support.

No.17C

ANTENATAL MATERNAL MENTAL HEALTH: BLISSFUL CARE

Gisèle Apter-Danon, M.D., 121 bis Avenue du Général Leclerc, Bourg-La-Reine, 92340 France

SUMMARY:

Pregnancy has long been considered a blessed period, free of psychiatric disorders. However pregnancy is not the disorder-free time that was imagined. There is now strong evidence that relapse of major depressive disorders and bipolar episodes may take place not only after birth but even during the prepartum if adequate management and treatment are not implemented. Somatic complaints and hormonal changes tend to be attributed to the pregnancy itself creating confounders of prenatal depression for physicians and primary care professionals. Women with past history of sexual abuse present more functional symptoms of depression during the prepartum. However, maternal history of trauma, PTSD, borderline personality, and depression often overlap, major diagnostic difficulties and hindering recognition of mental health issues during pregnancy. This leaves even more women undiagnosed and untreated.

No.17D

THE MYTH OF THE ABORTION TRAUMA SYNDROME

Nada L. Stotland, M.D., 5511 South Kenwood Avenue, Chicago, IL 60637

SUMMARY:

Much of the recent literature about the psychiatric sequelae of abortion concludes that the effects are negative. However, there are serious methodological flaws in this literature; failure to establish baseline mental health and failure to correct for confounding variables are among them. Nevertheless, the United States Supreme Court and a number of state legislatures have rendered opinions or enacted legislation on the basis of these supposed negative outcomes. Women may terminate pregnancies because they have pre-existing psychiatric disorders and/or serious psychosocial problems. The best predictor of post-abortion status is pre-abortion status. Whereas postpartum depression and psychosis were recognized by Hippocrates, and are included in the *DSM*, "Abortion Trauma Syndrome" and "Post Abortion Depression" are terms coined by anti-abortion activists. These terms were coined to mimic valid psychiatric conditions, and psychiatrists need to be aware of the state of the scientific data.

REFERENCES:

1. Nielsen S, Hahlin M, Möller A and Granberg S: Pregnancy: Bereavement, grieving and psychological morbidity after first trimester spontaneous abortion: comparing expectant management with surgical evacuation Human Reproduction, 1996, Vol. 11, No. 8, pp. 1767-1770.
2. Needle RB, Walker LEA: Abortion Counseling: A Clinician's Guide to Psychology, Legislation, Politics, and Competency. Springer Publishing NY 2007.
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SYMPOSIUM 18

THE APPLICATION OF TRANSLATIONAL AFFECTIVE NEUROSCIENCE TO THE UNDERSTANDING OF ANXIETY DISORDERS

National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should have: a clearer understanding of the implications of animal work for the pathophysiology associated with the anxiety disorders, a clearer understanding of the development of GAD and SAD in childhood, a clearer understanding of the distinct differences in pathophysiology between GAD, SAD, and PTSD, and a clearer understanding of the relationship, at the neural level, between anxiety and a distinct.

No.18A

GENERALIZATION OF CONDITIONED FEAR AS A PATHOGENIC MARKER OF PTSD

Shmuel Lissek, Ph.D., MAP/NIMH/NIH 15K North Drive Room 208, MSC 2670, Bethesda, MD 20892-2670, A. Biggs, S. Rabin, R. Alvarez, B. Cornwell, M. Vythilingham, Daniel.S. Pine, M.D., C. Grillon

SUMMARY:

A recent meta-analysis of lab-based, fear-conditioning studies in the anxiety disorders implicates heightened anxious reactivity to conditioned stimuli (CSs) signaling safety as an important correlate of clinical anxiety generally, and of posttraumatic stress disorder (PTSD), specifically. Whereas healthy controls display anxious reactivity to CSs paired (CS+: danger cue) but not unpaired (CS-: safety cue) with an aversive unconditioned stimulus (US), PTSD patients tend to display fear responses to both CS+ and CS-. Given that stimuli employed as CS+ and CS- by this literature share many stimulus properties (e.g., size, shape, duration), such findings implicate an enhanced tendency among PTSD patients to generalize conditioned fear from danger cues to safety cues with overlapping features. This interpretation is consistent with the clinically observed PTSD process, by which fear to a traumatic event transfers to safe conditions that "resemble"aspects of the trauma (*DSM-IV*). Unfortunately, very little work on generalization of conditioned fear has been conducted in humans and no such studies to our knowledge have been applied to study PTSD. The current effort introduces a generalization paradigm consisting of 10, quasi-randomly presented, rings of gradually increasing size. For half of participants the smallest ring is the CS+ (paired with an electric shock US) and for the other half, the largest serves as CS+. The eight rings of intermediary size create a continuum of similarity from CS+ to CS- and are included to assess generalization gradients of conditioned fear. Presented data provide psychophysiologic validation (startle EMG, SCR) of the paradigm as well as comparisons between generalization gradients among those with versus without PTSD.

No.18B

VIOLENCE AND VICTIMS: DISSOCIABLE DYSFUNCTIONS IN AMYGDALA-CORTICAL INTERACTIONS IN PTSD AND PSYCHOPATHY

Abigail Marsh, Ph.D., MAP/NIMH/NIH 15K North Drive Room 208 MSC 2670, Bethesda, MD 20892-2670, R.J.R. Blair, M.D.

SUMMARY:

Both posttraumatic stress disorder (PTSD) and psychopathy have been associated with dysfunction in specific amygdala-ventromedial frontal cortex circuitry. In this paper, two event related fMRI studies will be presented involving patients with PTSD and healthy comparison individuals (N = 14 in both groups in both studies). Data will be presented from the same two paradigms from children with conduct disorder (CD) and psychopathic tendencies and two comparison populations; healthy children and children with attention-deficit hyperactivity disorder (ADHD) but without CD. Patients groups are matched with their corresponding comparison groups for age, IQ, gender and ethnicity. In study 1, subjects were presented with fearful, angry and neutral expressions. In study 2, subjects performed passive avoidance learning paradigms – learning to approach some stimuli associated with reward and avoid other stimuli associated with punishment.

No.18C

DIFFERENTIATING GENERALIZED SOCIAL PHOBIA FROM GENERALIZED ANXIETY DISORDER AT THE NEURO-COGNITIVE LEVEL.

Karina S Blair, Ph.D., MAP/NIMH/NIH 15K North Drive Room 208, MSC 2670, Bethesda, MD 20892-2670, Daniel S. Pine, M.D.

SUMMARY:

Generalized social phobia (GSP) and generalized anxiety disorder (GAD) are two anxiety disorders seen in children and adulthood that cause considerable suffering but whose bases are only beginning to be understood. They also appear to be significantly comorbid with the clear potential implication that an individual with GSP and GAD has a more severe form of GSP than an individual with GSP alone. Of course, an alternative possibility is that in cases of GSP+GAD, the generalized anxiety relating to the GAD has simply broadened to the social domain; i.e., the pathophysiology associated with GSP may not be seen in cases with GSP and GAD.

No.18D

TRANSLATING DEVELOPMENTAL MODELS OF ANXIETY TO CHILDREN

Daniel S. Pine, M.D., MAP/NIMH/NIH, 15K North Drive, Room 208, MSC 2670, Bethesda, MD 20892-2670

SUMMARY:

Advances during the past 20 years have produced major changes in conceptualizations of both normal and abnormal variations in emotional responses. Some of the most dramatic advances have emerged through studies of anxiety and depression. This work examines the nature of organisms' responses to dangerous situations or stimuli. While advances have emerged in both basic and clinical perspectives, relatively few studies have capitalized on the opportunity to conduct "translational" work that integrates insights from basic and clinical domains. The nature of recent findings in basic science and discuss the relevance of this work for clinical advances.

REFERENCES:

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2. Blair RJ: The amygdala and ventromedial prefrontal cortex in morality and psychopathy. Trends Cogn Sci 2007; 11(9):387-92
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SYMPOSIUM 19

COMPARING NOTES: INTERNATIONAL EXPERIENCES IN EVALUATING RESIDENTS' SKILLS

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the attendee should be able to: (1) describe similarities and differences in educational efforts in the U.S., the U.K., and Canada in addressing the challenge of competency and performance assessment of psychiatry trainees; (2) recognize the challenges of validity, reliability, and feasibility of in-training assessment of interviewing and case presentation skills; and (3) describe ways to improve the validity, reliability and feasibility of such assessments.

No.19A

TITLE TRAINEES' ASSESSMENT AT WORK PLACE: THE U.K. EXPERIENCE

Dinesh Bhugra, M.D., PO 25Health Service & Population Research Dept, David Goldberg Centre Institute of Psychiatry, De Crespigny Park, London, SE5 8AF United Kingdom

SUMMARY:

With the recent changes in postgraduate education in the UK, new curricula have been introduced which focus on competencies. In addition, the assessments focus on competencies rather than high stake examinations alone. In the last year several methods have been piloted by the Royal College of Psychiatrists. In this presentation details are offered of several different methods of workplace based assessments (WPBA). In addition to a short introduction and background to these methods the presentation will cover long case; multi-source feedback (MSF); mini-clinical examination (mini-CEX); direct observation of procedural skills (DOPS); case-based discussion (CBD); patient satisfaction and multi-source feedback and presentation and teaching assessments along with journal club assessment. For each assessment method, initially the approach is defined, along with research evidence from the literature. These tools were used in over 600 trainees in 17 sites around the United Kingdom with training schemes varying from eight to 80 trainees in rural and urban settings. The findings from the pilot data will be presented along with pros and cons of using different methods. Among the new tools used in pilot studies, patient satisfaction questionnaires have particular problems associated with them. However, multi-source feedback allows the assessors and trainees to ascertain the overall functioning of the individual and responses to their actions and behaviors by other stake holders. All of these approaches have particular strengths and weaknesses. Further work on determining their reliability and validity will enable the assessors and trainees to have confidence in their use.

No.19B

WORKPLACE BASED ASSESSMENTS IN PSYCHIATRIC RESIDENT TRAINING IN THE U.K.: THE DEVELOPMENTAL EXPERIENCE

Amit Malik, M.D., The Royal College of Psychiatrists, 17 Belgrave Square, London, SW1X 8PG, United Kingdom Amit

Malik, M.R.C.Psych., Andy Brittlebank, F.R.C.Psych.

SUMMARY:
Postgraduate psychiatric training in the U.K. is undergoing a massive change. There is a major shift in both postgraduate psychiatric training and assessments from the more traditional models toward the competency based models. The new training model will be driven by a competency-based curriculum. The emphasis of assessments will change from "what residents know" to "what residents can do" and these will increasingly occur in the workplace.

No.19C
WHITHER GOEST WE: SUPERVISORS, RESIDENTS AND ANNUAL CLINICAL SKILLS EXAMS

John Manring, M.D., University Hospital, 750 East Adams Street, Syracuse, NY 13210

SUMMARY:
The American Board of Psychiatry and Neurology (ABPN) recently decided to eliminate the live patient interview and oral examination (part 2) of their certification process over the next several years. The Residency Review Committee for Psychiatry of the Accreditation Council of Graduate Medical Education simultaneously released revised requirements for residency training programs which call for an annual evaluation of residents' clinical skills in interviewing patients and families, establishing an appropriate doctor/patient relationship, eliciting psychiatric, medical, social, and developmental history, assessing mental status and providing relevant formulation, differential diagnosis, and provisional treatment plan. These requirements are to a large extent the same skills assessed by the ABPN oral examination.

No.19D
FROM ABPN TO PSYCHIATRY RESIDENCY: TAKING ON THE CHALLENGE OF CLINICAL SKILLS EXAMINATION

Richard F. Summers, M.D., Office of Education, 3535 Market Street, 2nd Fl, Philadelphia, PA 19104

SUMMARY:
This presentation will give an overview of the collaboration of the ABPN and AADPRT in developing parameters and models for clinical skills examination in U.S. psychiatry residencies. Examination models from a variety of residency programs will be presented with a discussion of the pros and cons of various evaluation procedures, frequency and timing of examinations, documentation, standards for passing, and inter-rater reliability.

No.19E
IN-TRAINING ASSESSMENT OF RESIDENT INTERVIEWING AND CASE PRESENTATION SKILLS IN CANADA: THE MCMASTER UNIVERSITY APPROACH

Priyanthy Weerasekera, M.D., McMaster University, St.Joseph's Hospital, 301 James Street South,Fontbonne 415, Hamilton, Ontario, L8P 3B6, Canada Karen Saperson, Ch.B., Lawrence Martin, M.D.

SUMMARY:
The Royal College of Physicians and Surgeons of Canada (RCPSC) recently decided to replace the "long case/live patient" examination format with OSCE type stations. Psychiatry residency program directors, unanimously agreeing to retain an assessment of the skill set involved in the long case, assumed responsibility for this assessment. This has imposed considerable demands on the part of training programs to institute a formal, standardized assessment process so that interviewing and case presentation skills can be reliably and validly assessed during the residency program. This shift emphasizes that these skills be taught in the residency program so that graduating residents possess the necessary skills to develop positive alliances with their patients and interview in an empathic yet semi-structured manner, so that they can obtain the necessary information essential for arriving at a differential diagnosis, formulation, and treatment plan. In addition to this the graduating resident must be able to synthesize and present this material in a coherent manner so that they are perceived as "consultants" in their field.

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SYMPOSIUM 20

THE PSYCHOSES FUSED: THE KRAEPELINIAN DICHOTOMY, A CONTINUUM OR ONE DISORDER: CLINICAL, GENETIC AND COGNITIVE COMPARISONS

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to more accurately diagnose and treat psychotic patients by understanding how the concepts of the functional psychoses developed and changed from the 18th century to the present. Participants

will appreciate the implications of similarities and overlap from comparative clinical, cognitive and genetic studies supporting the continuum theory and suggesting a fusion of the psychoses as a single disease not the Kraepelinian Dichotomy.

No.20A

THE PSYCHOSES DISSECTED OR FUSED: A CORRECT DIAGNOSIS IS CRITICAL FOR CORRECT TREATMENT

Charles R. Lake, M.D., Department of Psychiatry, University of Kansas SOM, 3901 Rainbow Blvd, Kansas City, KS 66160

SUMMARY:

This presentation will review the history of the development of the concepts of the functional psychoses in order to evaluate their validity as separate, a continuum or a single disease. A selected literature of comparison studies will be summarized that demonstrate similarities and overlap between patients diagnosed with schizophrenia and bipolar. These studies cover a wide array of clinical and basic science disciplines including: diagnostic symptoms, course and prognosis, neurochemistry, brain metabolic, brain imaging, genetics and neurocognition. Surprising similarities and overlap when considered with the continuum theory lead to the possibility that the psychotic disorders are a single disease.

No.20B

BIPOLAR DISORDER AND SCHIZOPHRENIA: SHARED GENETIC SUSCEPTIBILITY

Wade H. Berrettini, M.D., Room 2206, 125 S. 31st St., Philadelphia, PA 19104

SUMMARY:

Schizophrenic and bipolar type I disorders are similar in some epidemiologic respects, including age-at-onset, lifetime risk, course of illness, worldwide distribution, risk for suicide, gender-specific risk and heritability. Despite these similarities, schizophrenia and bipolar type I disorders are typically considered to be separate entities, with distinguishing clinical characteristics, non-overlapping etiologies and distinct treatment regimens. Over the past three decades, multiple family studies are consistent with greater nosologic overlap than previously acknowledged. First degree relatives of bipolar probands are at increased risk for bipolar, schizoaffective and unipolar disorders. First degree relatives of schizophrenic probands are at increased risk for schizophrenic, schizoaffective and unipolar disorders. This overlap may be especially evident for psychotic bipolar type I mood disorders. Molecular genetic association studies (conducted during the past 15 years) reveal that some susceptibility loci may be common to both schizophrenic and bipolar type I nosologic classes, including several candidate genes, identified through linkage disequilibrium studies (COMT [22q11], neuregulin 1[8p22], and G72 [13q32]. As these gene are identified, our nosology will require substantial revision during the next decade, to reflect this putative shared genetic susceptibility.

No.20C

BIPOLAR DISORDER AND SCHIZOPHRENIA FROM NEUROPSYCHOLOGICAL AND NEUROIMAGING PERSPECTIVES

Jon-Kar Zubieta, M.D., University of Michigan, MBNI, 205 Zina Pitcher Place, Ann Arbor, MI 48109-0720

SUMMARY:

In spite of over a century of research in the area, there is controversy regarding the validity of nosological distinctions between bipolar disorder and schizophrenia (SZ). A growing literature objectively examining neuropsychological function appears to support a greater overlap between SZ and bipolar disorder than initially expected. This presentation will review neuropsychological data comparing the two illness. Neuroimaging data will be presented that supports both similarities and differences in the neural processing of information between these illnesses. In our laboratory, we have observed that a measure of monoaminergic synaptic density is altered in both bipolar disorder and schizophrenia. Increases were encountered in both samples that correlated with neuropsychological testing results, however their regional distribution differed. In the context of a larger literature examining measures of neuropsychological and neural function, these data confirm and support the hypothesis that both similarities and differences exist between SZ and BDI.

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SYMPOSIUM 21

PHARMACOGENETICS OF TAMOXIFEN AND OTHER CHEMOTHERAPEUTIC AGENTS AND SELECTIVE SEROTONIN REUPTAKE INHIBITORS: DRUG INTERACTIONS AND ALTERATIONS

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; (1) Understand the issues regarding the metabolism of tamoxifen and the shared pathway involving the cytochrome P450 enzyme family, with antidepressants such as venlafaxine, paroxetine and fluoxetine; (2) Appreciate the interactions between CYP2D6polymorphisms and coadministered antidepressants; and (3) Highlight some major research studies that are looking at such drug-drug interactions.

No.21A

INFLUENCE OF DRUG INTERACTIONS AND GERMLINE PHARMACOGENOMICS ON THE EFFICACY, SIDE EFFECTS AND COMPLIANCE WITH TAMOXIFEN

David A. Flockhart, M.D., Division of Clinical Pharmacology, Indiana University School of Medicine, Indianapolis, IN 46202, James M. Rae Ph.D., Daniel F Hayes M.D., Anne Nguyen C.C.R.P., Vered Stearns M.D., Janet Carpenter R.N., Ph.D.

SUMMARY:

Tamoxifen remains the most widely used drug in the world for the prevention and treatment of breast cancer in those women whose tumors express estrogen and progesterone receptors. The drug is widely regarded as effective, resulting in an average 40% reduction in the recurrence of breast cancer after surgery and chemotherapy, and a 50% reduction in risk in high risk women. The primary side effects associated with tamoxifen are vasomotor symptoms including hot flashes that can be treated with SSRI and SNRI antidepressants. Recent data have demonstrated that the efficacy of tamoxifen relies on its conversion to an active metabolite, endoxifen, by cytochrome P450 2D6. This enzyme is genetically polymporphic, with a non-functioanl allelel frequency of ~30%, 20% and 35% in Caucasian, African and Asian populations. Of note, its activity is potently inhibited by paroxetine and fluoxetine and our data demonstrate that these drugs are widely used to treat depression and hot flashes in women who ar prescribed tamoxifen. Other data from our group have made clear that venlafaxine can be used to treat the vasomotor symptoms associated with estrogen blockade in this setting, without inhibiting CYP2D6, and that citalopram and escitalopram have no effect on the activity of this enzyme. Because of the potentially life-saving efficacy of tamoxifen for women with all forms of breast cancer, we believe that antidepressants that inhibit CYP2D6 should not be co-prescribed with tamoxifen.

No.21B

MOOD DISORDERS AND CANCER: IMPLICATIONS FOR TREATMENT

John F. Greden, M.D., 1500 East Medical Center Drive, Ann Arbor, MI 48109-0999

SUMMARY:

Twenty-five percent of cancer patients suffer from major depressive disorder (MDD) over the course of their cancer illnesses. Individuals with cancer are three times more likely to develop depression than those without. Should antidepressant medications be required, SSRIs are traditional “first-line” agents; SSRIs also are frequently prescribed for tamoxifen-induced hot flashes. Thousands of patients with co-occurring depression/cancer receive both tamoxifen and SSRIs. Cytochrome P4502D6 genotypes are involved with metabolizing some SSRIs, tamoxifen and other chemotherapy agents, so such concomitant use can alter outcomes of both cancer and depression treatments (Jin et al, 2005). Consequences can be profound.

No.21C

PHARMACOGENETICS IN MANAGEMENT OF DEPRESSION IN CANCER PATIENTS

Melvin G. McInnis, M.D., University of Michigan Depression Center, 4250 Plymouth Road, Ann Arbor, MI 48109-5795

SUMMARY:

The care and management of mood disorders is a crucial component to the health care of the cancer patient. Effective treatment of mood disorders improves the quality of life of the cancer patient, the likelihood of adherence to the oncological treatment regimen and other lifestyle improvements that impact the overall outcome. Managing depression and other mood disorders in the cancer patient requires establishing and maintaining a collaborative relationship between the oncologist and psychiatrist; the emerging field of pharmacogenetics must also be incorporated as it offers a vocabulary and discipline for such an interaction. Medications commonly used in psychiatry and oncology affect the P450 metabolizing pathways and there are significant implications of selecting specific SRRIs in the treatment of depression in the cancer patient. The emerging field of pharmacogenetics is likely to become an integral component to the assessment of depression and decision for medication selection in the cancer patient, in addition to the consideration of the existing oncology medication. Routine use of pharmacogenetics has not yet been generally endorsed in psychiatry as the very high and very low metabolizing variants of CPY2D6 and CYP2C19 are relatively rare. The specialty patient, as represented by the individual with depression and cancer, has the complex pharmacological and physiological background that will often benefit from knowledge of genetic variations, i.e. pharmacogenetics. “Psychiatry-oncology” clinics will likely to be the first to adopt these emerging advances as well as needed genetic counseling.

No.21D

TEACHING PHARMACOGENOMICS: FINDING SPACE IN OUR ALREADY OVER-CROWDED MEDICAL SCHOOL CURRICULUM

Tamara L. Gay, M.D., Department of Psychiatry, University of Michigan, 1500 E Medical Center Drive, Ann Arbor, MI 48109-0999

SUMMARY:

Today, more medical educators are embracing the field of pharmacogenomics, the science of discovering the genetic basis for individual variations in drug response. Deans and curriculum committee members clearly see the need for students to master this rapidly growing body of knowledge. However, many schools are struggling with where in the curriculum pharmacogenomics belongs. Questions include: Should a separate course be developed and implemented? Or should Pharmacogenomics information be incorporated into the current Pharmacology and/or Advanced Medical Therapeutics Courses? An important principle in medical education is to link as much basic science teaching as possible to clinical disease processes and actual patient care. This argues for incorporation of Pharmacogenomics into the core clinical clerkships as well. During extremely busy clinical rota-

tions, attempting to find room for applied basic science concepts will be challenging. In addition, the Psychiatry Clerkship is often under siege by various factions and forces, who suggest time allocated for teaching psychiatric illness and treatment should be reduced, not expanded. The pivotal question for medical and psychiatric educators is not, Will we bring Pharmacogenomics into our Medical School Curriculum, but How?

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SYMPOSIUM 22

MOMENTS OF CHANGE IN PSYCHOTHERAPY: WHAT CAN WE LEARN FROM THE POSITIVE TURNING POINTS OBSERVED IN

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to;(1) recognize moments of change that occur in patients' psychological treatments; (2) list elements that go into creating these moments; and (3) forsee ways that this new concept can be used in teaching, conducting, and researching psychotherapy.

No.22A

CHANGE MOMENTS IN THERAPY

Daniel Stern, M.D., 14 Ch. Clairejoie, 1225 Chene-bourg, Geneva, Switzerland

SUMMARY:

Purpose: To discuss "moments" of change in psychotherapy as conceived in light of insights from my infant observations and research—and from the work of the Boston Change Process Study Group. Content: "Now moments" emerge in the course of therapy. They potentially alter the immediate course of the therapeutic process. These moments arise in the context of threatening to change (for better or worse) the frame of the therapeutic process or its habitual way of proceeding.

Methodology: The Boston Change Process Study Group has been conducting an ongoing study of change moments in our adult patients' psychotherapies. Several of us conduct grand rounds at institutions around the world regarding these significant processes and then share the questions and comments that come up. We thus have an ongoing cross-discussion and data sharing program to ensure the collection of more examples and the establishment of ruling principles. I have conducted researches throughout my entire career on infant development, especially in terms of the baby-parent relationship and emotional expression. These observations have assisted me in conceptualizing how change takes place in psychotherapy patients in the adult age ranges.

Results: A sort of intersubjective turbulence creates "now moments" between doctors and their patients. As anxiety increases in both patient and therapist, the therapist is temporarily thrown off balance and must search for a response to resolve the situation. Even though there is no fully adequate response in his or her known technical repertoire, the doctor responds as best he or she can.

Importance: Moments between doctor and patient alter the intersubjective field and lead the therapeutic process onto a more open path. The effect of the moment of meeting occurs largely in the implicit domain of knowing. It resembles the quick, unconscious meetings of the eyes (and souls) of infants and their caregivers.

No.22B

CHANGE MOMENTS IN THERAPY

Ethel S.Person, M.D., 135 Central Park West, New York City, NY 10023, Ethel Spector Person, MD

SUMMARY:

Purpose: Describe turning points and transformations as they take a role in the therapeutic situation with adult patients, explain how I realized that this was a neglected but important part of many therapeutic situations, and to show how change moments occur because of our intrinsic capacity as human beings to reconfigure ourselves and to tolerate discontinuities.

Content: I will consider several fictional examples as a way to call attention to specific momentary instances of emotional-cognitive insights in my own patients and those of my supervisees. I will then further expand with more recent examples from my practice and my theoretical understandings of what these mean when taken as a group.

Methodology: I have chosen examples from patients who have been in psychotherapy or psychoanalysis with me or my students. Names and details have been disguised, but the cases remain basically true as to the "moment," the relationship, and the change. Results: Change need not be gradual. The patient may experience an instance in which his or her world feels significantly altered to a greater or lesser degree. This is the result of a change in perception cognition, emotional set, or sense of self-in-the-world. These "moments" come with disruption in the transference situation, countertransference acknowledgements, confrontations between doctor and patient, or errors that the therapist makes and then ac-

knowledges. Transformations, far less common phenomena, may occur as "epiphanies" within transference relationships. Falling into love or falling into identification with the therapist—as well as transference cures—may lie behind these transformative occurrences.

Importance: We need to come to understandings about what action in a therapist correlates with positive change in a patient. This will evolve from research that systematically studies abrupt change in patients and probes in as much detail as possible the sequence of events that leads to this change.s.

No.22C

MAGICAL MOMENTS IN PSYCHOTHERAPY

Lenore C Terr, M.D., 450 Sutter Street, Suite 2534, San Francisco, CA 94108

SUMMARY:

Purpose: To understand what 34 doctors did to contribute to 48 change moments in the therapies of their young patients.

Content: Although in a single psychiatrist's practice there may not be many observable moments of change in young patients, when one pools these moments from a number of doctors, one begins to see trends that account for these childhood turnabouts.

Methodology: 120 psychiatrists were asked for 500-word vignettes describing noticeable moments of positive change in their child and adolescent patients. Over a 3-year period, 48 vignettes were written and analyzed. Three papers were published. This presentation summarizes them.

Results: Moments of change in childhood come from: (1) an aspect of the doctor's persona that strikes the youngster; (2) an aspect of the doctor's atmosphere; (3) a sign that the doctor "gets" the child; and/or (4) a dramatic gesture or word exchange from the doctor. Many of these moments are generated by a well-educated impulse, counter-intuitive move, or on-the-spot remark. Some occur, however, after very careful planning.

Importance: "Moments of change" represents an excellent teaching and research device for understanding child and adolescent psychotherapy. This may turn out to be one way to "evidence-base" the individual psychotherapies of people of all ages.

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SYMPOSIUM 23

THE RELATIONSHIPS BETWEEN THE APA ANNUAL MEETING AND THE PHARMACEUTICAL INDUSTRY: HISTORICAL AND CURRENT PERSPECTIVES AND ISSUES

APA Scientific Program Committee and APA Council on Research

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will have an appreciation of the history of the interaction of the APA and the pharmaceutical industry at its annual meeting. Participants will learn of the adjustments that have taken place over the years to adapt to the changing expectations of physician-pharmaceutical company interactions. The attendees will also have a fuller appreciation of what is industry supported educational initiatives in contrast to marketing and advertising.

No.23A

BALANCING SCIENCE AND SUPPORT AT THE APA ANNUAL MEETING

David A. Baron, D.O., Temple/Episcopal Campus,100 E Lehigh Avenue, MAB, Suite 305, Philadelphia, PA 19125

SUMMARY:

Opinions have been expressed that the APA Annual Meeting has become a large trade show for Big Pharma. While it is accurate to note the presence of the business side of the pharmaceutical industry in the exhibit hall and on give aways at the meeting, the integrity of the science presented at the meeting is closely monitored from the initial submission of presentation material through the final presentation at the meeting. This session will highlight the specific activities in place, including the review process, by the SPC to ensure the quality of the science presented a the meeting. Commendation received by the APA from CME watchdog groups for the effort put into maintaining fair balance in the program will be discussed. Finally, the potential etiology of the culture shift in the perception of the pharmaceutical industry by psychiatrists will be explored within the context of its impact on our meeting.

No.23B

DIFFERENTIATING ADVERTISING FROM EDUCATIONAL SUPPORT: A ROLE FOR BOTH

James H. Scully, Jr., M.D., 1000 Wilson Boulevard, Arlington, VA 22209

SUMMARY:

In addition to funding Industry-Supported Symposia, pharmaceutical companies pay for space in an exhibit hall and for advertising outside the hall in several formats i.e., busses, room keys, bags, etc. Pharma also funds fellowships that pay for resident and faculty registration and travel to the meeting. APA receives income from all these sources. The APA prohibits educational activities in the exhibit area. No research results that are being presented in the scientific meeting are to be presented in the exhibit. No CME credit is allowed Promotional activities or advertising premiums must be approved and must cost less than $10.00. Lists of booth premiums are made available to exhibitors. APA prohibits live speakers, formal presentations, or performances on the exhibit floor. There are additional rules of conduct that are agreed to by exhibitors. Complaints regarding all the activities of exhibitors are reviewed. Activities in the exhibit hall are considered advertising and not education.

No.23C

THE HISTORY OF THE RELATIONSHIP BETWEEN ACADEMIA AND THE PHARMACEUTICAL INDUSTRY: WHAT CAN THE APA LEARN?

Kenneth R. Silk, M.D., 1500 East Medical Center Drive, F6234 MCHC, Ann Arbor, MI 48109-0295

SUMMARY:

The history of the relationship between academia and the pharmaceutical industry is complex. Initially, research was done primarily in separate research institutes owned by the industry. Little research of any kind took place in academia. Toward the end of the 19th and the beginning of the 20th centuries, the research university began to emerge. At this time, there was a substantially impervious boundary between academia and industry. Some academic scientific organizations refused to allow membership to individuals who also participated in any way with industry. This barrier began to crumble after WW II. As the pharmaceutical industry became more profitable and as universities expected researchers to generate larger parts of their salaries through grants, academia and industry ties grew stronger. During periods when federal funding for scientific research grew tighter, the industry stepped in and increased support to researchers. Many successful academics now have extensive relationships with the industry; and yet these same individuals may write review articles on medications, be involved in the generation of guidelines and algorithms, and hold significant intellectual sway over recommendations impacting clinical practice. Research reveals substantial influence upon these "objective" clinical researchers when there are ties to industry though the researchers deny such influences. There is now greater demand that disclosures of these interests be detailed. In situations such as with the recently formed *DSM -V* task force, there are stringent restrictions on the dollar extent of the financial relationship between industry and clinicians who have significant influence on policy and planning. Further demand for more extensive and detailed disclosure will force academicians to choose between ties to industry and involvement in positioning themselves as influencing clinical practice through presentations at specific scientific meetings.

No.23D

PHARMACEUTICAL SUPPORT OF THE ANNUAL MEETING: DOES THE DOG WAG THE TAIL?

Philip R. Muskin, M.D., 1700 York Avenue, New York, NY 10128

SUMMARY:

Objectives: This presentation will review the development of the APA guidelines regarding industry-supported symposia (ISS) from 1983 through the 2008 annual meeting. The past 25 years have been a period of tremendous change and collaboration between the APA and the pharmaceutical industry. Complaints from attendees at the annual meeting, changes in FDA regulations, development of CME guidelines, and forward thinking by the APA have all resulted in a totally different relationship in terms of ISS. In 1983 there were "satellite symposia" conducted by industry without any oversight by the Annual Meeting Scientific Program Committee. Over the next decade the APA discontinued these sessions and required that presentations "sponsored" and now "supported" become part of the educational process of the SPC. Today the APA is the ACCME-accredited sponsor (not the pharmaceutical company) of the symposia. The APA assures the objectivity and balance of the presentations, provides clear demarcation between product promotion and independent education, provides a proper ethical environment, and provides an environment that fosters life-long education. There are no industry-supported sessions at the annual meeting or the Institute on Psychiatric Services that are not reviewed and monitored by the Scientific Program Committee. Between 1997 and 2007 there were approximately 47 ISS per annual meeting (range 33-52). Attendees' ratings of whether speakers' presentations were balanced were measure on a scale of 1-6, with 1 being the most biased. The mean bias score between 1998 and 2006 was 5.297. The mean score in 2007 (1-5 scale used) was 4.49. The scores range from a low of 4.33 to a high of 5.69. Conclusions: The past 25 years reflect a major change in the relationship between the APA and the pharmaceutical industry regarding presentations at APA meetings. The past decade illustrates dramatically positive changes as well as minimal bias in the ISS presentations.

No.23E

THE INDUSTRY SUPPORTED SYMPOSIA AND NEW RESEARCH POSTER SESSIONS: A CRITICAL INTERFACE OF APA'S SCIENTIFIC SESSIONS AND THE PHARMACEUTICAL INDUSTRY

Anthony J. Rothschild, M.D., University of Massachusetts Medical School, Department of Psychiatry, 361 Plantation Street, Worcester, MA 01605

SUMMARY:

The Industry-Sponsored Symposia (ISS) and the New Research Poster Sessions are critical interfaces between the American Psychiatric Association (APA) and the pharmaceutical industry. A detailed description of the submission process, review and grading procedures, selection process, and quality control procedures that occur during the annual meeting for the ISS and New Research Poster Sessions will be discussed. A particular focus will be on how the conflict between providing state of the art knowledge to the annual meeting attendees, while scrupulously avoiding the occurrence or perception of a conflict of interest, is managed.

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SYMPOSIUM 24

THE CHANGING FACE OF TERRORISM: SUICIDE TERRORISM AND RADICALIZATION IN ÉMIGRÉ POPULATIONS

APA Council on Global Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be informed concerning the psychology of terrorism, with a focus on two alarming new trends, the growth of suicide terrorism and alienation and radicalization of émigrés to the West.

No.24A

WHY WOMEN KILL

Farhana Ali, 1200 South Hayes Street, Arlington, VA 22202

SUMMARY:

Muslim female suicide bombers are on the rise. Since at least 2000, women have participated in fewer than 50 suicide operations. Most of these attacks have been conducted by Palestinian and Chechen women, but women of other nationalities and countries have either threatened the use of suicide or committed attacks, including Pakistan, Kashmir, Jordan, Egypt, Uzbekistan, and more recently, Iraq. To date, female bombers in Iraq have participated in at least ten suicide operations, but evidence from Arabic websites suggests that more Iraqi women are joining the Sunni insurgency to fight coalition forces.

Compared with male jihadis, the numbers of Muslim female bombers is low, but the slow and steady trend of the mujahidaat indicates that the phenomenon is growing. Therefore, the gradual progression of suicide attacks conducted by Muslim women in new theaters of operation—namely, Iraq—suggests that women are just as capable of striking the enemy as men and in some cases, far more effective in evading an arrest and escaping detection by security forces. The violent acts committed by the mujahidaat forces the ultimate question of why and how Muslim women are recruited or self-selected for suicide attacks, or as they are known to those who commit them, "martyrdom operations."

As a consequence of more Muslim women ready to detonate by hiding the bomb under the abaya, security services will need to craft more innovative tools and strategies to counter a threat that is malleable, unpredictable, and seemingly invisible. Effective counter-terrorism methods needs to include solutions that aim to improve the lives of women, particularly those living in war, occupation, and armed conflicts, as well as consider ways to deter women living in Western societies from joining terrorist organizations or encouraging their men to participate in suicide attacks.

No.24B

THE RISK OF RADICALIZATION AND TERRORISM IN MUSLIM ÉMIGRÉ COMMUNITIES

Jerrold M. Post, M.D., 1957 E Street, NW #600F, Washington, DC 20052, Gabriel Sheffer, Ph.D.

SUMMARY:

The United States has been remarkably free of terrorist attacks by Muslim Americans, in contrast to Western Europe where the latest attacks have been carried out by Muslim émigrés and recent descendants of Muslim émigrés. Is the United States, as some have suggested, relatively immune to the Islamist extremism wracking Europe because of its more diverse traditions, or is terrorism in the United States just late in developing, and soon to explode?

In this paper, the spectrum of Muslim diasporas is first reviewed. There is not just one, but rather a variety of Muslim diasporas in both Europe and the United States, each of which must be considered in its own unique cultural, social and political context.

A development of great concern to European political leadership is the alarming growth of radicalization and violence within Muslim diasporas. It is estimated that some 80 percent of new recruits to the global Salafi jihad are children and grandchildren of Muslim émigrés who have felt alienated from their host cultures. This alienation is the driving force behind not only Islamist radicalization but also the radicalization that results in more quotidian political and social violence. While the U.S. tradition of diversity may have slowed or deterred the radicalization of Muslim émigrés in the United States, this review suggests reasons to believe that the phenomenon now so threatening in Europe could become more threatening in the United States as well. Policy implications for ameliorating the sense of alienation that provides a fertile soil for radicalization are presented.

No.24C

THE PATH TO PARADISE: THE INNER WORLD OF SUICIDE BOMBERS AND THEIR DISPATCHERS

Anat Berko, Ph.D., International Policy Institute for Counter Terrorism, P.O.Box 167, Herzliya, 46150 Israel

SUMMARY:

Suicide bombers are often compared with "smart bombs." From the point of view of their dispatchers, they are highly effective, inexpensive forms of weaponry, and there is no need to invest in their technological development. Suicide bombers are in fact smarter than smart bombs because they can choose their own target - and they can react to circumstances on the ground, changing their target, or their timing, in an instant, to ensure the maximum damage, destruction, and death. Of course, unlike smart bombs, suicide bombers think and feel, have histories, stories, beliefs, desires - in short, they have an inner world. To learn about the inner world of suicide bombers and their dispatchers, Berko entered Israel's most heavily secured prison cells and conducted intensive and extensive interviews with male and female suicide bombers who had failed their missions, as well as with their dispatchers - including former Hamas spiritual and operative leader Sheikh Ahmed Yassin (later assassinated by Israel).

No.24D

PSYCHIATRIC RESPONSES TO LOSING THE HEARTS AND MINDS OF MUSLIM YOUTH

Stevan M. Weine, M.D., 2216 Lincoln Wood Drive, Evanston, IL 60201

SUMMARY:

In 2006, the American Psychiatric Association released a position statement that condemned the participation of psychiatrists in torture. Torture is one of the counterterrorism measures that have come under criticism from human rights organizations for violating basic human rights and likely increasing the risk for terrorism. Victims, artists, activists, and journalists have also spoken out not only against torture, but other measures including detentions, deportations, and restrictions of movement. They have claimed that such approaches risk losing the "hearts and minds" of Muslims especially youth who are seen as being at risk for radicalization. Organized psychiatry has not spoken to these broader concerns about the unintended consequences of counterterrorism measures. This presentation will consider how psychiatry may contribute to the discourse on this issue through helping to better understand the processes that account for risk for, and protection from, radicalization amongst Muslim youth.

No.24E

INTER-GROUP RELATIONS, PREJUDICE REDUCTION, AND THE THREAT OF JIHADI VIOLENCE

Jeff Victoroff, M.D., Department of Neurology; University of Southern California Kecck School of Medicine; Rancho Los Amigos National Rehabilitation Center; 7601 E. Imperial Highway, Downey, CA 90242

SUMMARY:

Europe faces a dilemma. Its aging, low-fertility native population urgently requires an infusion of young workers. The obvious source of this infusion is Europe's rapidly expanding young Muslim immigrant population. However, at the very same time, Islam is undergoing a global crisis of direction in which large numbers of young Muslims are attracted to the ideological themes of political Islam and small number are attracted to militant anti-western jihad. The result is a cauldron of religiously polarized EU societies with high rates of mutual distrust, enmity, and prejudice. It is plausible that intergroup enmity and perceived prejudice are risk factors for radicalization. Sixty years of applied social psychological research demonstrate the efficacy of prejudice reduction for peace building. We will describe a research program to test the hypothesis that mutually supported programs promoting Muslim/non-Muslim prejudice reduction might reduce the risk of radicalization and terrorism.

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2. Post, JM: The Mind of the Terrorist: The Psychology of Terrorism from the IRA to al-Qaeda. New York, NY: Palgrave Macmillan, 2007.
3. Ali, F: Rocking the Cradle to Rocking the World: The Role of Muslim Female Fighters. Journal of International Women's Studies 2006; 8, 21-35.
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SYMPOSIUM 25

HOMOSEXUALITY AND THERAPY: THE RELIGIOUS DIMENSION

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should have a clearer understanding of the difficulties that gay and lesbian patients with strong religious proscriptions face in presenting for therapy to manage the dissonance caused by their faith. That understanding should include a balanced appreciation of the ethical/spiritual/religious dilemmas regarding psychotherapeutic attempts to address sexual orientation concerns that are underscored by religious conviction.

No.25A

PRACTICE FRAMEWORK FOR MANAGING SEXUAL IDENTITY CONFLICTS

Warren Throckmorton, Ph.D., 100 Campus Drive, Grove City College, Grove City, PA 16127

SUMMARY:

Although many same-sex attracted individuals experience little, if any, conflicts with their sexual identity, others feel distress involving dissonance between sexual feelings and other important personal values and attitudes (e.g., religious beliefs/values). Persons experiencing such conflict often experience a host of problems as the result of being unable to resolve what they perceive to be irreconcilable differences between their values and attitudes and sexual feelings. People who look to mental health practitioners to assist them often find these professionals in similar conflict over how best to help.

No.25B

A PASTORAL APPROACH FOR GAY AND LESBIAN PEOPLE TROUBLED BY HOMOSEXUALITY

Richard A. Mohler, Jr. , Ph.D., 2800 Lexington Rd., Louisville, KY 40280

SUMMARY:

God has a plan for every person, even people who wrestle with homosexual feelings. The pastoral response to individuals who have homosexual feelings should be one of support and caring and help in maintaining abstinence from homosexual behavior through a loving relationship with Christ. Many Christians believe that homosexuality is a choice, fearing that, if homosexuality is not a choice, homosexuality cannot be deemed sinful. These Christians are then concerned that the inerrancy of the Scriptures will be called into question if homosexuality is not sin as described in the Bible. Homosexuality, in fact, may not be a choice. The mental health professions, by and large, have supported that view. That stance, however, does not mean that pastors should sanction homosexual acts (which are outside of God's plan for everyone). God calls individuals who cannot change their homosexual nature to a life of celibacy – which is no different than Christ himself who was called to celibacy in pursuit of His ministry.

No.25C
THE PSYCHO-SOCIAL BASES OF THEOLOGIES THAT COMPEL EFFORTS TO CHANGE SEXUAL ORIENTATION: THE PSYCHIATRIC ETHICAL RESPONSE.

David L. Scasta, M.D., Independent Psychiatric Services, 115 Commons Way,, Princeton, NJ 08540

SUMMARY:
Theology is believed by most Christian faiths to come from divine inspiration and Biblical study. However, different people, of equal piety, citing divine inspiration and studying the same Bible, often develop theological frameworks that are incompatible with each other. Unless true inspiration is limited to a select few (with no reliable way to know who those few are), theology cannot be the product of a universal divine inspiration. From a psychosocial perspective, personal theology is shaped by three major forces: personality, cultural identity, and the pursuit of power. A person with O/C personality traits, for instance, is likely to choose a theology that is rigid and fixed. Adherence to a particular theology may also be a way of defining one's membership in a culture – a "we vs. they" construct. Theology often, however, has been used to create and retain power. The threat of hell in the afterlife kept entire kingdoms under the Church's thumb in the Middle Ages. Today many conservative Christians are gathered under dogmatic banners by leaders intent on controlling national politics. The defense of dogma frequently has been rooted in such quests for power. Defining gay people as they (the evil) vs. we (the righteous) has been part of that power struggle.

No.25D
HOMOSEXUALITY AND THERAPY: THE RELIGIOUS DIMENSION

Right Rev. Gene Robinson

SUMMARY:
Bishop Robinson (New Hampshire) provoke enormous controversy in the Episcopal Church when he became the first openly gay Bishop. The appointment has thrown the Episcopal Church (2.25 million members) into a firestorm of controversy as the conservative wing has moved towards splitting from the Episcopal community and the international Anglican Communion has discussed expelling the American Episcopal Church.

REFERENCES:
1. Throckmorten, W. & Yarhouse, M.A., Sexual identity therapy: Practice framework for managing sexual identity conflicts. Paper presented to the American Psychological Association, 8/07.
2. Robinson, B.A. (2006). "Reparative Therapy and Transformational Ministries: Estimates of Success Rates." http://www.religioustolerance.org/hom_exod1.htm.
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4. I Do Exist (2004). Throckmorton, W. (Producer), http://www.drthrockmorton.com/idoexist.asp.

TUESDAY, MAY 6, 9:00 AM-12:00PM

SYMPOSIUM 26

GENOMIC INVESTIGATIONS OF MOOD DISORDERS

National Institute of Mental Health

EDUCATIONAL OBJECTIVES:
At the conclusion of this symposium attendees' should have increased knowledge of: (1)The genetic causes and vulnerability to bipolar disorder, major depression, and suicide in mood disorders; (2) Recent progress in the areas of candidate vulnerability genes in metabolic and signaling pathways; and (3) The use of expression profiling, whole genome association studies, imaging genetic strategies, genetic interactions between key brain areas, and the use of intermediate phenotypes in these areas of research.

No.26A
GENE EXPRESSION IN LIMBIC THALAMUS AND CEREBRAL CORTEX IN MOOD DISORDERS

Edward G. Jones, M.D., Center for Neuroscience University of California Davis 1522 Newton Court, Davis, CA 95616

SUMMARY:
Nuclei of the mammalian thalamus are aggregations of neurons with unique architectures and input-output connections. The molecular determinants of their organizational specificity and how it may breakdown in major mental disorders remain unknown. By comparing expression profiles of thalamus and cerebral cortex in adult rhesus monkeys and in postmortem human tissue we identified transcripts that are unique to dorsal thalamus or to individual nuclei within it and other transcripts that are co-expressed in a thalamic nucleus and its connected cortical area. Real-time quantitative polymerase chain reaction and in situ hybridization analyses confirmed the findings. Pathway analysis revealed overrepresentation of GO categories related to development, morphogenesis, cell-cell interactions, and extracellular matrix within the thalamus- and nucleus-specific genes, many involved in the Wnt signaling pathway. The genes identified likely underlie nuclear specification, cell phenotype and connectivity during development and their maintenance in the adult thalamus. In comparing expression profiles in anterior cingulate cortex and mediodorsal nucleus or posterior cingulate cortex and anterior thalamic nuclei in brains from patients diagnosed with major depressive disorder, we demonstrated down regulation of certain of the developmentally regulated genes and commonly coordinated expression changes in the thalamic nucleus and its cognate cortical area.

No.26B
BIOLOGIC INTERMEDIATE PHENOTYPES FOR MAJOR DEPRESSION AND SUICIDAL BEHAVIOR

John J. Mann, M.D., NYSPI 1051 Riverside Drive, New York, NY 10032

SUMMARY:
Deficiencies in serotonin and noradrenergic transmission are as-

sociated with major depression and suicidal behavior. Some candidate genes have been identified mostly in the serotonin system. The mechanism by which these genes influence the risk for major depression or suicidal behavior has been little studied. We will examine several candidate genes including TPH1, TPH2, 5-HTT, 5-HT1A and 5-HT2A and biologic intermediate phenotypes that begin to explain the association of these genes with major depression and suicide. TPH1 SNPs predict risk of suicide attempts and are related to serotonin function perhaps because the gene is expressed in neurons in development but not in the mature adult brain. TPH2 is expressed throughout life in serotonin neurons and we have found altered expression in depressed suicides and a SNP that may affect an editing site is associated with major depression. We find low transporter binding in depression and suicide but the regional distribution is different and the cause is not directly due to the 5-HTTLPR low expressing alleles, although those alleles likely have an effect on brain development via the amygdala and in resetting serotonin activiity at a lower level in adulthood. A higher expressing variant of the promotor of the 5-HT1A gene is associated with more autoreceptors and major depression and is a novel mechanism underlying hypofunction of the serotonin system in major depression. The 5-HT2A receptor TT geneotype is associated with more binding and that picture is associated with more aggressive traits and higher binding is also seen in youth suicides and in response to stress. An integration of these findings builds a model of major depression and suicidal behavior that explains how genes and environment can contribute to risk.

No.26C

GENOME-WIDE ASSOCIATION STUDIES OF MOOD DISORDERS

Francis McMahon, M.D., 9000 Rockville Pike, Bethesda, MD 20892

SUMMARY:

Mood disorders are among the most heritable of all illnesses, but genetic studies have until recently made slow progress in finding the actual genes involved. Technological advances now make it possible to test essentially the entire genome for markers that are associated with illness. Such markers, if consistently associated with illness in multiple studies, can open new windows into etiology and suggest novel treatment targets. Genome-wide association studies are now underway in both bipolar disorder and major depressive disorder. The two genome-wide association studies of bipolar disorder that have been published so far both suggest that many genes act together to influence disease risk. This presentation will provide a general overview of genome-wide association studies, highlight some of the most promising findings in recent studies of mood disorders, and discuss the implications of these findings for the diagnosis and treatment of mood disorders.

No.26D

A NEW INTEGRATIVE STRATEGY FOR THE INVESTIGATION OF GENETICS AND IMAGING IN MOOD DISORDER PATIENTS

Steven G. Potkin, M.D., Department of Psychiatry and Human Behavior, University of California, Irvine, Brain Imaging Center, 5251 California Avenue, Ste. 240, Irvine, CA 92617, Jessica A. Turner, Ph.D., James Fallon, Ph.D., Guia Guffanti, Ph.D., David B. Keator, M.S., Anita Lakatos, M.D., Ph.D., Fabio Macciardi, M.D., Ph.D.

SUMMARY:

Brain Imaging and genetic studies have provided important understanding regarding the pathophysiology of mood disorders. Combining and integrating these two approaches, brain imaging and genetics, joins increasingly high resolution information about brain function to increasingly detailed genetic information. Current approaches typically focus on a single genotype, often investigating imaging patterns as affected by only a single nucleotide Polymorphism (SNP). These candidate gene strategies are productive but have only focused on perhaps 1% of the genome and are limited by our current biological knowledge. Genome-wide association (GWA) strategies offer the possibility of simultaneously exploring the entire genome but have been hampered by the considerable difficulty in obtaining well characterized samples of sufficient size, and the statistical challenges of half a million to a million statistical tests. We present an integrative strategy: Rather than beginning with a gene and looking for a phenotype it modulates, we begin with the brain imaging phenotype, and then determine the genes that modulate in the context of a genome-wide scan. The brain response measure is quantitative, richer and less subjective than symptom-based diagnoses. Using such a quantitative trait as brain imaging dramatically increases statistical power, thereby reducing the need for impractically large samples. With this approach, it is now possible to do adequately powered genome-wide scan studies in mood disorders and other illnesses.

No.26E

EXPRESSION PROFILING IN MOOD DISORDERS SIGNALING & METABOLIC PATHWAYS

Stanley J .Watson, M.D., M.B.N.I. 205 Zina Pitcher Place University of Michigan, Ann Arbor, MI 48109, Ann Arbor, MI 48109

SUMMARY:

This presentation will review the progress and the discovery of candidate vulnerability genes in metabolic and signaling pathways in mood disorders through the use of microarrays which provide the opportunity to interrogate up to 30,000 genes in one experiment. The discovery of candidate genes by microarrays is being used in the pharmaceutical industry and in academia to identify unique drug targets, to discover specific disease biomarkers, and to provide fundamental knowledge concerning vulnerability genes in these disorders. New information concerning functional genomic differences in mood disorders defined by high throughput gene expression studies in postmortem brain tissue will be reviewed. The data that several members of a major gene family, fibroblast growth factor (FGF) are differentially expressed in key brain areas in MDD but not in BPD patients will be presented. Basic anatomical protein chemistry and gene splicing studies related to the functional role of specific FGF genes will be discussed. An evaluation of several proteins in the FGF family are potential targets for therapeutic approaches.

REFERENCES:
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3. Turner JA, Smyth P, Macciardi F, Fallon JH, Kennedy JL, Potkin SG: Imaging phenotypes and genotypes in schizophrenia. Neuroinformatics 4(1): 21-49, 2006.
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SYMPOSIUM 27

THE VASCULAR DEPRESSION HYPOTHESIS: NEW FINDINGS 10 YEARS LATER

National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation participants will understand; (1) Findings indicating decreased functional connectivity to the prefrontal cortex in depressed elders suggesting a persistent disturbance perhaps related to frontal vascular lesions; (2) Findings characterizing microstructural WM and frontal processing abnormalities associated with poor antidepressant response; (3) Data documenting that rTMS led to remission rates of drug resistant vascular depression; and (4) Findings relating longitudinal vascular changes to persistent cognitive impairment and incident dementia.

No.27A

ALTERATIONS IN FUNCTIONAL CONNECTIVITY IN VASCULAR DEPRESSION

Howard J. Aizenstein, M.D., Ph.D., Department of Psychiatry, Western Psychiatric Institute & Clinic, University of Pittsburgh, Pittsburgh, PA 15213, Meryl A. Butters, Ph.D., Minjie Wu, M.S., Robert Tamburo, Ph.D., James T. Becker, Ph.D., Cameron S. Carter, M.D., Charles F. Reynolds III, M.D.

SUMMARY:

Previous studies have demonstrated that subjects with vascular depression have structural changes in frontal white matter tracts. The goal of the current study was to identify a functional correlate of these reported structural changes; that is, to determine if vascular depression is associated with alterations in the apparent interactions of brain activation (functional connectivity) during fMRI. Subjects were recruited through a depression-treatment study within the Pittsburgh Intervention Research Center for Late-Life Mood Disorders. Thirteen elderly depressed subjects and 13 non-depressed elderly control subjects participated in these fMRI experiments. The depressed subjects all had late-onset geriatric depression and had white matter hyperintensity burden (on T2-weighted FLAIR images) significantly greater than a group of age-matched non-depressed controls. The depressed subjects participated in the fMRI protocol before initiating and after completing 12 weeks of antidepressant treatment with paroxetine. Functional connectivity was assessed with fMRI during resting and also during a cognitive-control task. During both conditions (rest and task) the functional connectivity measures indicated decreased functional connectivity to the prefrontal cortex in the depressed subjects relative to the non-depressed controls. The decreased functional connectivity was present both before treatment, and persisted after 12-weeks of antidepressant treatment. These results support a model of a persistent neurobiologic component of vascular depression. The altered functional connectivity, perhaps due to vascular damage to the frontal white matter, appears to be a persistent, stable, trait of vascular depression.

No.27B

FRONTO-STRIATO-LIMBIC ABNORMALITIES LINKED TO LATE-LIFE DEPRESSION AND TO TREATMENT RESISTANCE

George S. Alexopoulos, M.D., Weill Medical College of Cornell University, Westchester Division, 21 Bloomingdale Road, White Plains, NY 10605, Faith Gunning-Dixon, Ph.D., Christopher Murphy, Ph.D., Matt Hoptman, Ph.D., Kelvin O. Lim, M.D., John Foxe, Ph.D.

SUMMARY:

The vascular depression hypothesis postulated that vascular lesions impairing fronto-striato-limbic circuits contribute to the development and perpetuation of a late-life depression syndrome. This view was principally supported by the localization of white matter hyperintensities in subcortical regions and the observation that the clinical symptoms and the cognitive abnormalities of vascular depression resemble those of a medial frontal lobe syndrome.

No.27C

REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION AND VASCULAR DEPRESSION

Robert G. Robinson, M.D., 200 Hawkins Drive, #2887 JPP, Iowa City, IA 52242, Ricardo E. Jorge, M.D., and David J. Moser, Ph.D.

SUMMARY:

The term vascular depression (VD) has been used to describe late-life depressive disorders in patients with clinical evidence of cerebrovascular disease. Preliminary data in patients with post-stroke depression suggest that repetitive transcranial magnetic stimulation (rTMS) might also be effective among patients with VD. After stopping antidepressants, 92 patients with treatment resistant VD were randomly assigned to receive either active or sham left prefrontal rTMS using double blind design. Stimulation parameters were: frequency 10 Hz, intensity of 110% of the MT, 6 seconds trains, and one minute inter-train intervals. In Experiment 1, we administered a total cumulative dose (TCD) of 12,000 pulses. In Experiment 2, we administered a TCD of 18,000 pulses. Sham stimulation was performed using a sham

coil. Cognitive functioning was assessed using a neuropsychological battery focused on memory and executive function. In addition, all patients had a research MRI scan. Response and remission rates in the group of patients receiving TCD=12K were not significantly different from those observed in the group of patients receiving sham stimulation. However, a TCD of 18K produced significantly greater response and remission rates than sham stimulation (39.4% and 27.3% versus 6.9% and 3.5% respectively). Response rates to rTMS were negatively correlated with age and positively correlated with higher frontal grey matter volumes. In addition, patients receiving active rTMS had significantly decreased (i.e., improved) TMT-B time compared with patients receiving sham stimulation. To our knowledge, this is the first controlled trial that demonstrates the efficacy of rTMS among geriatric patients with VD. Older age and lower frontal gray matter volumes were associated with a poorer response to rTMS. Prefrontal rTMS may have a beneficial effect in some aspects of executive functioning.

No.27D

THE ROLE OF VASCULAR DEPRESSION IN COGNITIVE DECLINE AND DEMENTIA

David C Steffens, M.D., DUMC Box 3903, Duke University Medical Center,, Durham, NC 27710

SUMMARY:

Distinguishing depression from early dementia in the elderly remains a vexing clinical problem. The clinical reality is that both affective and cognitive symptoms are common in the older population. About 15% to 30% of older adults have significant depression symptoms, and 17% to 23% of non-depressed elderly have cognitive impairment short of dementia. Little is known about the prevalence of co-occurring depression and cognitive impairment; even less is known about their joint or individual effects on risk of dementia conversion.

No.27E

SUPPORT FOR THE VASCULAR DEPRESSION HYPOTHESIS: NEUROPSYCHOLOGICAL AND NEUROIMAGING FINDINGS FROM A PROSPECTIVE TREATMENT TRIAL IN LLD

Yvette I Sheline, M.D., Dept of Psychiatry, 660 S. Euclid Ave,Box 8134, St Louis, MO 63110, Carl Pieper, Ph.D., Deanna M. Barch, Ph.D., Kathleen Welsh-Boehmer, Ph.D., Robert C. McKinstry, M.D., James R. McFall, M.D., Keith Garcia, M.D., Kenneth Gersing, M.D., Ranga R. Krishnan, M.D., and P. Murali Doraiswamy, M.D.

SUMMARY:

Objective: Research on vascular depression has used two approaches to subtype late life depression (LLD): +/- executive dysfunction and +/- white matter hyperintensities (WMH). To evaluate the relationship of neuropsychological performance and WMH to clinical response in LLD a two-site prospective nonrandomized controlled trial was conducted in outpatient clinics at Washington University and Duke University. Methods: 208 subjects age = 60 met *DSM-IV* criteria for major depression, were excluded for cognitive impairment or severe medical disorders and scored = 20 on the MADRS. All subjects received a psychiatric evaluation, physical exam, vascular risk factor score, neuropsychological testing and MRI scan including Fazekas rating for WMH lesion severity and received 12 weeks of prospective sertraline treatment, titrated by clinical response. Results: 66.8% of patients responded (= 50% reduction in MADRS); 35.6% remitted (MADRS = 7). A mixed model examined predictor variable effect on MADRS score over time. Controlling for age, education and race, episodic memory ($p < 0.01$); language ($p < 0.03$); working memory ($p < 0.01$); processing speed ($p < 0.0004$) and executive function factor scores ($p < 0.01$) were significant predictors with a trend for total Fazekas score ($p = 0.056$). Using a hazards model remitter status was predicted by baseline cognitive processing speed ($p < .0008$), executive function ($p < .02$) and episodic memory factor scores ($p < .001$); language ($p< .05$) and working memory ($p < .05$). Baseline processing speed ($p < .0001$), executive function ($p < .0005$), episodic memory ($p < .0025$) and language ($p < .005$) factor scores correlated negatively with total Fazekas scores.

REFERENCES:

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SYMPOSIUM 28

CATATONIA: TREATMENT AND FUTURE RESEARCH

Department of Veteran Affairs

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; (1) Define catatonia and understand different treatment approaches with underlying epidemiology; (2) Understand the pathophysiology of catatonia; (3) Identify current pharmacotherapy options in the treatment of catatonia; (4) Critically analyze treatments, adverse side effects, and potential benefits of pharmacotherapy; (5) Review and discuss current diagnostic scales; (6) Recognize and identify limitations with each diagnostic scale; (7)Understand and consider other medical complications of cata-

tonia; (8) Treatment of medical complications related to catatonia and the need for preventative standard of care measures; (9) Define the KANNER rating scale; and (10) Evaluate, analyze, and discuss the KANNER scale as a diagnostic tool.

No.28A

KATATONIA – A NEW CONCEPTUAL UNDERSTANDING OF CATATONIA AND A NEW RATING SCALE

Brendan T. Carroll, M.D., 330 Taylor Blair Rd., West Jefferson, OH 43162, Rob Kirkhart, Ph.D., PA-C

SUMMARY:

Modern psychiatric nosologies separate catatonia along the lines of presumed etiology: bipolar, major depression, schizophrenia and due to a general medical condition. The presence of catatonic symptoms has always been of significant diagnostic, therapeutic and prognostic value. Kahlbaum's description of this syndrome in his monograph Katatonia included careful documentation of phenomenology. Kahlbaum selected the term "katatonia" to describe tension insanity. He felt that the neuro-motor signs were more important than the content of delusions (e.g., megalomania). While he felt that he was describing a unitary illness, he did identify mood disturbance, psychosis and medical factors in this new illness. Unfortunately, since then Katatonia was relegated to a specifier of other neuropsychiatric illnesses.

It is important to use the term katatonia to avoid the confusion of "catatonia is schizophrenia" and other narrative fallacies. Specifically, katatonia is also observed in mood disorders, general medical conditions and pervasive developmental disorders. The literature supports the view of Dr. Kanner of his description for neuro-motor and neuropsychiatric signs in autistic disorder. We propose that katatonia be used to identify these patients across other clinical groupings. We identify the clinical features of catatonia katatonia? and introduce the KANNER scale to improve conceptualization, detection and measurement of this important clinical syndrome. We will present a videotape/DVD to help with the reliability of catatonia ratign scales.

No.28B

CATATONIA A NEUROPSYCHIATRIC SYNDROME

Jose Ramirez, M.D., 155 Whaley Place, Chillicothe, OH 45601, Rob Kirkhart, Ph.D.,PA-C

SUMMARY:

Catatonia is a neuropsychiatric syndrome of motor dysregulation and is found in as many as 10% of acutely ill psychiatric inpatients. Catatonia has a neuropathology and a neurochemistry that have been identified. There is also evidence to suggest a genetic component in one form of catatonia. Periodic catatonia is highly heritable disorder with a locus on chromosome 15 and smaller cohort with a locus on chromosome 22. Catatonia is associated with psychotic disorders, mood disorders, developmental disorders and a variety of general medical conditions. In some cases discrete structural brain abnormalities have been found and in other cases diffuse CNS or systemic causes can be found.

No.28C

COMMON MEDICAL COMPLICATIONS SECONDARY TO CATATONIC STATES

Harold W. Goforth, M.D., Duke University Medical Center, DUMC 3309, Durham, NC 27710 Xavier Preud'homme, M.D., Sarah Rivelli, M.D.

SUMMARY:

Catatonia is an often under-recognized motoric syndrome that has important implications in the medical prognosis of affected individuals. Consideration of the medical complications of catatonia is imperative for the clinician in order to prevent significant medical comorbidity. This symposium will provide an opportunity to address common medical complications secondary to catatonic states. . Topics covered will include nutritional concerns including topics such as dehydration, malnutrition, and enteral feeding. Vascular complications and their prevention and treatment will also be discussed including issues of deep venous thromboses and pulmonary emboli as well as an update for the practitioner in the prevention, diagnosis, and treatment of these disorders including anticoagulation. Significant attention will be devoted to the comorbid presence of delirium in these patients, and current thoughts relating to the treatment of delirium as it pertains to catatonia and potential neuroleptic malignant syndrome. Finally, infectious issues will be addressed including the potential for aspiration risk, and pressure ulcers. Interventions designed to prevent these complications as well as current treatment will be discussed.

No.28D

PHARMACOTHERAPY OF CATATONIC SYMPTOMS IN SCHIZOPHRENIA

Joseph W. Lee, M.D., Brockway Road Mt. Claremont, University of Western Australia, Perth, 6010, Brendan Carroll, M.D., Rebecca A. Talbert, Pharm.D., Rob Kirkhart, Ph.D.

SUMMARY:

Aim: To review the pharmacotherapy of catatonic symptoms in schizophrenia.

Methods: (a) A literature review of the pharmacotherapy and proposed pathophysiology of catatonic symptoms in schizophrenia was conducted. (b) The treatments used in 71 episodes of catatonia (58 acute, 13 chronic) with schizophrenia were examined. They were first treated with benzodiazepines. Those who failed benzodiazepines received other treatments for their catatonic symptoms.

Results: (a) Supported by case reports and open studies, the efficacy of benzodiazepines in acute catatonia is well documented. A double-blind placebo-controlled study shows that benzodiazepines are ineffective for chronic catatonia. There have been case reports on the use of dopaminergic agents (L-dopa, bromocriptine), glutamate NMDA antagonists (amantadine, memantine), GABAa agonists (Zolpidem), anticholinergics, antiepileptics (carbamazepine, valproate), atypical antipsychotics, and lithium for acute catatonia, and atypical antipsychotics, selegiline (MAO-B inhibitor), amantadine and memantine for chronic catatonia. The place of conventional antipsychotics is unclear. GABAa hypoactivity, dopamine D2 hypoactivity, glutamate NMDA hyperactivity, 5-HT2 hyperactivity, and cholinergic hyperactivity have been

proposed in the pathophysiology of catatonia. (b) 40 (69%) of the acute episodes showed full responses to benzodiazepine; only 1 of chronic catatonia did so (5 with partial responses). In the remaining acute episodes, 10 received electroconvulsive therapy and 5 responded to lithium (with antipsychotics). Of the chronic episodes, 3 showed good responses to amantadine, 2 selegiline, 1 lithium and 3 atypical antipsychotics.

Conclusions: Diverse medications have been used for catatonia in schizophrenia with variable success. Catatonia is probably a heterogeneous condition with subtypes different in treatment responses and pathophysiology.

No.28E

DIRECTIONS FOR FUTURE CATATONIA RESEARCH

William W. McDaniel, M.D., Eastern Virginia Medical School, Eastern, VA 11111, Brendan Carroll, M.D., Rebecca Talbert, Pharm.D., Rob Kirkhart, Ph.D.

SUMMARY:

The KANNER scale for catatonia (katatonia) must be compared against the North American "gold standard," the Bush Francis Catatonia Rating Scale (BFCRS). While these two scales are similar, they differ in scoring, sensitivity to change and conceptual underpinnings. Future research on catatonia requires high inter-rater reliability and conceptual understanding. It may be useful to call together a consensus panel to propose criteria, evaluate rating scales, and identify treatment standards. This has been done for other neuropsychiatric illnesses such as Lewy body dementia. Furthermore, since the KANNER scale is a neuro-motor examination, a DVD with patients might be helpful to achieve improved understanding. There should be further study of the KANNER scale against the BFCRS and other catatonia rating scales. While the other scales have merit, there is limited experience with these scales in North America. Also since the KANNER scale has 3 components, each could be tested separately. [Part one longitudinal nursing observation may be more sensitive than previous scales to detect labile episodes of k/catatonic phenomena occurring throughout the day, especially when occurring with a delirial process] For instance part I could be tested in patients presenting to an emergency department, part 2 could be tested for treatment response in an inpatinnt inpatient unit and part 3 could be tested in patients with chronic catatonia.

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5. Kruger S, Bagby RM, Hoffler J, Braunig P. Factor analysis of the Catatonia Rating Scale and catatonic symptom distribution across four diagnostic groups. Compr Psychiatry 2003;44:472-482.Directions for Future Catatonia Research

SYMPOSIUM 29

SCHOOL SHOOTINGS: THREAT RECOGNITION AND PREVENTION

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; (1) Learn how the FBI evaluates school threats; (2) Recognize the sources for rage in school shootings; (3) Understand the interaction between technology and aggressive impulses; (4) Appreciate the risk of unleashing rage when setting limits on computer usage; (5) Understand the barriers to intervention within some communities; and (6) Describe methods to encourage the reporting of threats within communities.

No.29A

REASSESSING COLUMBINE: VIRTUAL AND REAL RAGE

Jerald J. Block, M.D., 1314 NW Irving St., Ste 508, Portland, OR 97209

SUMMARY:

In this presentation, Jerald Block M.D. will speak about the events that led up to the 1999 attack on Columbine High School by two members of its graduating class. The two students methodically planned and prepared the brutal attack for an entire year. They intended on killing hundreds by blowing up their school, shooting the survivors, and rampaging through the community. When most of their 99 explosive and incendiary bombs failed, the teens' used their guns to execute peers and teachers. 13 were killed and 24 wounded before the shooters eventually committed suicide.

No.29B

WHY TERRIBLE THINGS HAPPEN IN PERFECT PLACES

Katherine S. Newman, Ph.D., c/o Princeton Institute for International and Regional Studies, 320 Aaron Burr Hall, Princeton University, Princeton, NJ 08544

SUMMARY:

This presentation focuses on the organizational features of schools and communities that impede the flow of warning signs of school shootings to adults and authorities who might be able to intervene. Rampage school shootings are typically preceded by long periods of planning on the part of the protagonists, coupled with outbursts and veiled threats. Peers and members of the com-

munity are often witness to troubling behavior that, at least in retrospect, is a clear warning of the violence to come. Yet most of the time, this vital information does not reach those who could intervene.

No.29C
SCHOOL SHOOTINGS AND THREAT ASSESSMENT

Terri E. Royster, B.S., FBI Academy, Behavioral Science Unit, Quantico, VA 22135, Block, Jerald J., M.D., Katherine A.Newman, Ph.D.

SUMMARY:
In this presentation, FBI Supervisory Special Agent Terri Royster will present a four-prong approach used to assess school threats and intervene to prevent school shootings. The guidelines that will be discussed were developed out of a FBI Behavioral Assessment Unit's review of 18 school shooting cases.

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2. Block JJ. Lessons from Columbine: Virtual and Real Rage. Amer J Forensic Psych 2007; 28(2):5-33.
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SYMPOSIUM 30

VIOLENCE IN MINORITY GROUPS: WHAT CAN BE DONE?

APA Assembly Committee of Representatives of Minority/ Underrepresented Groups

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to understand the factors that contribute to violence in various minority groups and identify approaches to prevention.

No.30A
VIOLENCE AGAINST OURSELVES: SUICIDE AMONG NATIVE-AMERICAN YOUTH

Brian T. Benton, M.D., 198 Ross Hill Rd., Lisbon, CT 06351

SUMMARY:
Objective: This presentation will explore the epidemiology, goals and treatment suggestions to aid participants in understanding and dealing with the current epidemic of Native American youth suicide. There will be a general mental health overview to highlight the various issues pertaining to Native American youth today. Risk factors will be reviewed. Protective factors will be underscored. Preventive strategies will be defined and suggested. Treatment opportunities and resources will be reviewed. Indian Health Service, HHS, SAMHSA and other initiatives will be highlighted and discussed. Conclusions: This presentation will provide a candid window on Native American youth and their struggle to integrate Native culture and beliefs in an evolving modern world.

No.30B
PREVENTING VIOLENCE AGAINST WOMEN

Gail E. Robinson, M.D., Toronto General Hospital 8-231 E.N., 200 Elizabeth St, Toronto, ON, M4W 3M4 Canada

SUMMARY:
Compared with many areas of the world, North America is seen as a place where women have equal rights and equal status. However, despite the lack of formal prohibitions against such things as women's autonomous functioning and access to jobs and education, violence against women is epidemic in North America. Such violence includes homicide, assault, domestic violence, incest and child abuse, rape and elder abuse. These crimes are still rampant, often go undetected, are generally poorly dealt with by physicians, police and the courts and can result in low self-esteem and many mental health problems including depression, anxiety, PTSD and substance abuse. Prevention is not an easy matter. There is insufficient evidence about the efficacy of screening for abuse, treatment of victims or interventions for batterers. Despite this, individual clinicians must make decisions as to how to intervene. As well, education in the schools, public awareness campaigns, changes in the approaches by police and the courts and closer integration of various agencies are essential.

No.30C
DOMESTIC VIOLENCE AMONG SOUTH ASIANS: AN EXAMPLE OF RESPONSE OF THE COMMUNITY

Jagannathan Srinivasaraghavan, M.D., Southern Illinois University School of Medicine, Choate Mental Health Center, 1000 N. Main Street, Anna, IL 62906, Surinder Nand, M.D.

SUMMARY:
This paper will define domestic violence and the United Nations declaration of Violence Against Women (VAW). Domestic violence is prevalent in all cultures around the world. Among South Asians violence against women is committed in abortions of the female fetus; infanticide; physical; sexual, and psychological abuse, honor killing, disfigurement and bride-burning. Single, separated, divorced, pregnant women and adolescent girls are at highest risk of being victims of violence. Psychiatric and psychological sequalae resulting from violence can be enormous. Immigrants who are subjected to violence face additional problems due to language difficulties, lack of appropriate support system, unfamiliarity with laws and fear of deportation. Throughout the United States, Asian communities have responded to domestic abuse among their communities in establishing various programs

and organizations for survivors of domestic violence. One such agency is Apna Ghar (Our Home), established in Chicago in 1990 to serve South Asian victims of violence. This shelter has served more than 5000 women and children since its inception. The services provided include crisis line, legal advocacy, individual and group counseling, job assistance and training and therapy for children. Apna Ghar has also raised community awareness by community education and is actively involved in collaborative work with the state, city and local coalitions, councils, advisory boards, community organizations and forums.

No.30D

THE EPIDEMIOLOGY AND MENTAL HEALTH CONSEQUENCES OF VIOLENCE AGAINST LESBIAN, GAY, BISEXUAL, AND TRANSGENDERED (LGBT) PEOPLE

Philip A. Bialer, M.D., Beth Israel Medical Center, First Ave. and 16th St., Fierman 509, New York, NY 10003

SUMMARY:

According to statistics compiled by the FBI, attacks against LGBT people comprise 15-20% of all reported hate crimes in a given year. However, epidemiological studies indicate a lifetime prevalence of violence or harassment in this population of up to 50%. Studies have demonstrated that such violence can lead to serious mental health problems among LGBT people including depression, anxiety disorders, substance use disorders, lowered self-esteem and increased suicidality. Some have suggested that violence against LGBT people has increased as a backlash to certain civil rights victories such as the Supreme Court's decision to strike down anti-sodomy laws in 2003. Others cite intolerance of homosexuality by certain religious and political groups as the basis for increased violence against this population. This paper will summarize what is known about the epidemiology of violence against LGBT people and the psychiatric sequelae. It will also explore the roots of such violence and how this is being addressed by mental health professionals and society.

No.30E

VIOLENCE IN BLACK YOUTH

Rahn K . Bailey, M.D., 614W Main St. Ste D101, League City, TX 77573

SUMMARY:

In June of 1998, James Byrd, Jr., 49, was a middle-aged black man from Jasper, Texas. He was beaten, chained to the back of a pickup truck by his neck, and dragged for miles down a rural road outside the town of Jasper, Texas . It is told that Mr. Byrd survived through this horrifying experience until he was decapitated. Three white men, believed to be linked to a white supremacist group were arrested. Two of the men were sentenced to death for this racial hate crime that shocked the nation and the third man was sentenced to prison for life. Racial bigotry is a rigid intolerance of race differences. It is from this blinded unreasoned intolerance that makes racial bigotry a form of racial discrimination. The result of this is the destruction of those perceived as different in ethnicity. A horrific example is in the case of Mr. James Byrd. Violence is the end product of this so-called hatred against those of color. Groups such as the Ku Klux Klan and other similar racist groups still exist and are very active today in the rural South. These sect groups only magnify the ignorance of the racist mentality that persists, but they in no way justify it. In order to understand the reasons why crimes like this still exist in America, we as clinicians must learn the root causes of the societal environment and indifferences related to the contribution and continuance of racial discrimination.

REFERENCES:

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SYMPOSIUM 31

COMPARISON OF THREE PSYCHODYNAMIC TREATMENTS OF BORDERLINE PERSONALITY DISORDER

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to;

(1) Identify the basic theoretical principles and essential techniques of psychodynamic psychotherapy for borderline personality disorder; (2) List similarities and differences among three psychodynamic treatment models that have demonstrated efficacy for this condition; and (3) Recognize the strengths and limitations of each of the three treatment models.

No.31A

MENTALIZATION-BASED THERAPY (MBT) FOR BORDERLINE PERSONALITY DISORDER–RECENT DEVELOPMENTS

Anthony W. Bateman, M.D., Halliwick Unit,St Ann's Hospital, St Ann's Road,, London, N15 3TH,United Kingdom Prof Anthony W Bateman MD, F.R.C.Psych.

SUMMARY:

Metallization is the process by which we implicitly and explicitly interpret the actions of ourselves and others as meaningful on the basis of intentional mental states (e.g., desires, needs, feelings, beliefs, & reasons). We mentalize interactively and emotionally when with others. Each person has the other person's

mind in mind (as well as their own) leading to self-awareness and other awareness. We have to be able to continue to do this in the midst of emotional states but borderline personality disorder is characterized by a loss of capacity to mentalize when emotionally charged attachment relationships are stimulated. The aim of MBT is to increase this capacity in order to ensure better regulation of affective states and to increase interpersonal and social function. Some specific aspects of this treatment will be discussed and contrasted with other treatments for borderline personality disorder. Some clinical examples of mentalizing interventions will be given as well as a rationale of why some commonly used therapeutic interventions might be harmful in BPD. Therapy has been shown to be more effective than treatment as usual in the context of a partial hospital programme and intensive out-patient treatment. Some patients have been followed up for 8 years following entry into treatment. Results from this long term follow-up will be presented along with data from a recent randomized controlled trial of intensive out-patient treatment.

No.31B

DYNAMIC DECONSTRUCTIVE PSYCHOTHERAPY: NEUROCOGNITIVE REMEDIATION FOR TREATMENT-RESISTANT BORDERLINE PD

Robert J. Gregory, M.D., Department of Psychiatry, SUNY Upstate Medical University, 750 East Adams Street,, Syracuse, NY 13210

SUMMARY:

The author introduces a manual-based treatment, labeled dynamic deconstructive psychotherapy (DDP), developed for those patients with borderline personality disorder (BPD) who are most difficult to engage in therapy, including those having co-occurring substance use disorders or antisocial PD. This treatment model is based on the hypothesis that borderline pathology and related behaviors reflect impairment in specific prefrontal neurocognitive functions, including association, attribution, and alterity, that form the basis for a coherent and differentiated self. DDP aims to activate these neurocognitive functions by facilitating sequential elaboration and integration of affect-laden interpersonal experiences and attributions, as well as providing novel experiences in the patient-therapist relationship that promote self-other differentiation. Treatment involves weekly individual sessions for a predetermined period of time and follows sequential stages. In a recent controlled trial, DDP was effective in reducing parasuicide behavior, alcohol misuse, institutional care, depression, and core symptoms of BPD among patients having co-occurring alcohol use disorder.

No.31C

AN OBJECT RELATIONS TREATMENT FOR PATIENTS WITH BORDERLINE PERSONALITY DISORDER

John F. Clarkin, Ph.D., New York Presbyterian Hospital-Cornell Medical Center, 21 Bloomingdale Road, White Plains, NY 10605

SUMMARY:

We have developed an object relations treatment for borderline personality disorder following the suggestions of Kazdin (2004). In this process, we have developed a treatment manual and training mechanisms. We have completed a randomized clinical trial comparing this treatment to dialectial behavior therapy (DBT) and a supportive treatment in its effectiveness in reducing symptoms of the disorder. Finally, we have examined changes in reflective functioning across these three treatments to see if the object relations treatment does produce changes hypothesized by this treatment approach. These studies will provide data to compare this treatment with others in terms of focus, outcome, mechanisms of change, and treatment indications.

REFERENCES:

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SYMPOSIUM 32

CHRONIC PAIN AND THE PRESCRIPTION OPIOID EPIDEMIC: WHY PSYCHIATRISTS MUST GET INVOLVED

EDUCATIONAL OBJECTIVES:

At the conclusion of this session participants will be able to explain the following strategies for managing chronic pain and limiting opioid abuse and diversion: three reasons psychiatrists must be proactive; how to identify stakeholders, initiate and monitor a community-wide effort; utilizing CBT and exercise; wrap-around buprenorphine treatment to improve outcome, safety and cost; and opioid risk management engaging federal, state, industry, practitioner and patient stakeholders.

No.32A

CHRONIC PAIN AND THE PRESCRIPTION OPIOID EPIDEMIC: WHY PSYCHIATRISTS MUST GET INVOLVED

Alex N. Sabo, M.D., Chairman, Department of Psychiatry, Berkshire Medical Center, 725 North Street,, Pittsfield, MA 01201, John Rogers, Esq, Jennifer Michaels, M.D., Ronald Hayden, M.D., John Harrington, Ph.D., Rocco Iannucci, M.D., Ann MacDonald

SUMMARY:

The monumental effort over the past two decades to identify and treat chronic pain has improved the lives of many but has been associated with an alarming rise in prescription opioid: abuse, diversion, and solo or mixed poisoning deaths that in some states (like Massachusetts) now surpass suicide deaths. A review of

2006-2007 data from our own emergency department showed that 41% of opioid poisonings were associated with expressed suicidal intent, another 15% were intentional massive overdoses where suicidal intent was denied and 15% were reported as recreational overuse; thus, at minimum, 71% were clearly suicidal or part of an active substance abuse syndrome. A recent prospective cohort study at a well-run outpatient academic pain center showed that one in three patients misuse their prescribed opioids. Primary care physicians and various pain specialists now prescribe the majority of opioids, but psychiatrists treat many of the same patients for affective, anxiety, personality and post-traumatic stress disorders often complicated by suicidal states. Assessment and treatment planning are often not well integrated among providers. Psychiatrists certainly treat patients "downstream" of the misuse of opioids but must become proactive "upstream" of the problem. For three broad reasons they must help primary care and pain specialists treating chronic pain patients: first, epidemiological data and clinical issues highlight serious safety concerns; second, pain, reward and fear pathways are so inter-related that practitioners of one specialty cannot intervene in isolation; third, the run-away costs of health care require an integrated approach as the silo approach to chronic pain is not only dangerous and clinically ineffective but also more costly. Empirical data, emerging research and case-cost analysis will be presented to support these hypotheses and show how psychiatrists can become more effective clinically and as agents of positive system change.

No.32B

SAFE AND EFFECTIVE TREATMENT FOR CHRONIC PAIN: COMBINED COGNITIVE-BEHAVIORAL THERAPY AND EXERCISE

John J. Harrington, Ph.D., P.C.O.T, Psychiatry, Berkshire Medical Center, 725 North St., Pittsfield, MA 01021, Douglas Molin, M.D.

SUMMARY:

Chronic pain is a significant public health problem, affecting 70 million Americans and costing the United States an estimated 65-79 billion dollars annually. Recent evidence regarding the effectiveness of some conventional chronic pain treatments, such as opioid medications and lumbar fusion, has been disappointing, despite the expense and risks associated with these treatments. However, there is growing evidence for the relative efficacy and safety of structured treatment combining cognitive-behavioral Therapy (CBT) and exercise, improving physical, psychological, and emotional functioning and reducing outpatient visits. Group CBT and exercise compare favorably with individual treatment. This presentation will review the literature regarding the effectiveness of this less commonly used treatment combination and will present preliminary data from a pilot outpatient program of brief, group treatment using these combined treatment modalities. The pilot Integrative Pain Treatment Program at Berkshire Medical Center provides evidence-based, biopsychosocial group treatment, including CBT and exercise, to individuals with chronic pain. An initial evaluation using comprehensive treatment outcome measures suggests improved functioning among patients participating in the program. Structured group programs that combine CBT and exercise can provide efficacious, cost effective and efficient treatment for patients with chronic pain without increasing risks, such as prescription misuse, and should be considered a first line treatment for chronic pain.

No.32C

POSITIVE OPTIONS AND PRELIMINARY FINDINGS: WRAP-AROUND BUPRENORPHINE TREATMENT CHRONIC PAIN AND ADDICTION

Jennifer L. Michaels, M.D., Brien Center, 333 East Street, Pittsfield, MA 01201

SUMMARY:

Patients struggling with co-occurring pain and opioid dependence are at risk for compromised pain management and worsening of the addictive process. Treatment often lacks integration and consistency. Integration of pain management and addiction treatment services provides the opportunity to more effectively and efficiently address these co-occurring disorders. This presentation will discuss collaboration between a Berkshire County, MA community medical center and a community mental health program. The partnership identified patients with unresolved, co-occurring pain and opioid dependence. Patients received buprenorphine to treat opioid dependence. In addition, the program utilized a wrap-around model of services to address the various clinical needs of the patients. The treatment components of this wrap-around model will be reviewed. Outcome data for all patients receiving buprenorphine, and for the subset of patients with co-occurring pain will be presented. During treatment favorable results were noted for change in employment status, negative urine tests and pain relief. Methods to enhance treatment team communication will be reviewed. Patient self-ratings of pain severity pre-treatment vs. in treatment will be reported. Case reviews of patients with co-occurring pain and opioid dependence will be presented, including data on healthcare expenditure savings.

No.32D

AN EXPERIMENT IN THE FIELD: A COMMUNITY-BASED PAIN MANAGEMENT PROJECT IN BERKSHIRE COUNTY, MASSACHUSETTS

John F. Rogers, Esq., Berkshire Health Systems, 725 North Street, Pittsfield, MA 01201, Alex N. Sabo, M.D., Donald P. Burt, M.D.

SUMMARY:

Noting that local healthcare providers lacked an organized, best-practices approach to assessing and managing chronic pain and were also unwittingly contributing to a growing problem of abuse and diversion of prescription pain medication, in 2004 Berkshire Health Systems, a private, non-profit healthcare organization and principal healthcare provider in the westernmost county of Massachusetts, marshaled an array of physician specialists, allied health professionals, public health regulators and community agencies to address that public health dilemma. Utilizing standardized pain assessment and management tools and electronic medical records for real time communication and coordination of care, providers in the Berkshire County Pain Management Project can improve care for those with chronic pain and better manage the care of those with substance abuse or other issues that make opioid medication an undesirable treatment choice. Early

assessment by a multi-disciplinary team affords an opportunity to identify comorbidities (including behavioral health comorbidities) and design a treatment approach, only one element of which might be pain medication. Access to state prescription monitoring information will allow providers to monitor their own prescribing practices and compare them with those of local colleagues. Appropriate communication with local pharmacies is also available to assist in managing both individual care and prescribing practices. This section will address the legal and practical issues in bringing together such a community-based, collaborative effort with particular focus on the role of psychiatrists in selecting assessment and treatment tools, identifying comorbidities and triaging patients to proper areas of care, creating systems for managing patients foreclosed from improper opioid access and addressing addiction and dependency issues.

No.32E

FOUNDATIONS OF OPIOID RISK MANAGEMENT: ENGAGING GOVERNMENT, INDUSTRY, PRACTITIONERS AND PATIENTS

Nathaniel P. Katz, M.D., 320 Needham St, Ste 100, Newton, MA 02464, Edgar H. Adams, Sc.D., James C. Benneyan, Ph.D., Howard G. Birnbaum, Ph.D., J Simon H. Budman, Ph.D., Ronald W. Buzzeo, R.Ph, Daniel B. Carr, M.D., Theodore J. Cicero, Ph.D., Douglas Gourlay, M.D., James A. Inciardi, Ph.D., David E. Joranson, M.S.S.W., James Kesslick, M.S. Stephen D. Lande, Ph.D.

SUMMARY:

Increased abuse and diversion of prescription opioids has been a consequence of the increased availability of opioids to address the widespread problem of undertreated pain. Opioid risk management refers to the effort to minimize harms associated with opioid therapy while maintaining appropriate access to therapy. Management of these linked public health issues requires a coordinated and balanced effort among a disparate group of stakeholders at the federal, state, industry, practitioner, and patient levels. This paper reviews the principles of opioid risk management by examining the epidemiology of prescription opioid abuse in the United States; identifying key stakeholders involved in opioid risk management and their responsibilities for managing or monitoring opioid abuse and diversion; and summarizing the mechanisms currently used to monitor and address prescription opioid abuse. Limitations of current approaches, and emerging directions in opioid risk management, are also presented.

REFERENCES:

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SYMPOSIUM 33

MEN: POSTPARTUM DEPRESSION AND OTHER ISSUES RELATED TO CHILD BIRTH

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize men's reactions to child birth, pregnancy, infertility, and fatherhood. This would include postpartum depression in men, the impact of the wife's pregnancy on the man, issues around male infertility, and the impact of fatherhood. There will be an increased appreciation of the role of man in the above issues surrounding child birth and also address issues surrounding treatment.

No.33A

THE THERAPIST'S ENTRANCE INTO FATHERHOOD AND ITS IMPACT ON PSYCHOTHERAPY

April E. Fallon, Ph.D., 410 Baird Rd., Merion Station, PA 19066, Virginia Brabender, Ph.D., Mark Famador, M.D., Ryan Kuehner, M.A.

SUMMARY:

With the exception of a few psychoanalytic case examples, precious little has been written about the impact that becoming a father has on the male psychotherapist and the therapeutic interaction. 10 male therapists who had at least one child within the past three years were interviewed using a semi-structured interview. Each interviewee answered open ended questions concerning personal feelings, impact on therapy, transference and counter transference experiences during pregnancy and post childbirth. Issues of disclosure about the child and birth and changes in technique attributed to the experience of becoming a father were also queried. The presentation focuses on the results of the interviews. During the first trimester of pregnancy, male therapists became aware of themes of birthing and parenting, but were unclear whether these were the result of their or their patients' increased sensitivity. In the second trimester, therapists struggled with conflicts around revealing or not revealing their newfound status. In the third trimester therapists focused on what and how to disclose and this is heightened in therapists who intend to be away from the office for more extended periods. After returning to work, therapists report increased empathy for parents in their practices and struggle with re-establishing the balance between professional and home life. When therapists did not reveal their status and their patients learned about the events from elsewhere, the patient's sense of betrayal was often a significant therapeutic issue. Suggestions and recommendations for disclosures and alterations in technique will be offered.

No.33B

THE PSYCHOLOGICAL IMPACT OF INFERTILITY AND THE PSYCHOLOGICAL STRESS ON MALE FERTILITY

Consuelo C. Cagande, M.D., RWJMS-Camden, Department of Psychiatry, 401 Haddon Ave., Camden, NJ 08103

SUMMARY:

The impact of infertility has become a fascinating psychologi-

cal issue in men's health. Studies are increasingly investigating the "psychological profile" of infertility. 15% of couple experience infertility. 40% of them are due to male factors. We know that there are medical conditions that cause infertility but a psychiatric illness should be considered. Some infertile men show increased somatic complaints, reduced self-esteem, marital instability, stigmatization and abuse. They may experience high anxiety, depression, regression, hypochondria, emotional vacuity, anhedonia, introvertion and other negative feelings. Infertile men often can benefit from a supportive attitude from medical staff and provision of medical and psychological services. At the end of this presentation the audience should gain more knowledge of the psychological impact of infertility and how a psychiatric disorder can also play a role and lastly but not the least, how men can benefit from a supportive collaborative service.

No.33C

THE SILENT PARTNER: DEPRESSION IN FATHERS POSTPARTUM AND IN EARLY PARENTHOOD

James F. Paulson, Ph.D., 855 W. Brambleton Avenue, Norfolk, VA 23510

SUMMARY:

Despite the wealth of attention given by clinicians, researchers, and public health advocates to peripartum depression in mothers, very little is known about this experience among new fathers. This presentation will review the research literature regarding the prevalence and concomitants of peripartum depression in fathers and its consequences on family health and child development. We conducted two studies using data from families enrolled in the large, nationally-representative Early Childhood Longitudinal Study –Birth Cohort. The first study examined the rate and severity of depressive symptoms among new parents and documented a high rate (compared with the base rate) of depression among men at 9 months postpartum. Moreover, we found that increased depressive symptoms among fathers were associated with decreases in basic parent-child interaction, such as reading, telling stories, and play. The second study examined the impact of depression at 9 months postpartum on parent-to-child reading and consequent child language development at 2 years. In this study, we found that although depression in both parents predicted less reading, only depression in fathers was associated with poorer child language development at 2 years. These findings suggest a number of research directions, which will be discussed. Practice implications of this young field are relatively clear in message, but complex in execution: increasing the screening for and recognition of depression in new fathers in care settings with which they engage is important for both family health and child development.

No.33D

MEN AND PERIPARTUM, AN OVERVIEW

R. Rao Gogineni, M.D., One Bala Ave,Suite #118, Bala Cynwyd, PA 19004

SUMMARY:

Male psychology issues haven't been paid significant attention to over time, except for some writings about fatherhood. For over the past 10 years, examination of men in peripartal issues, clinically and methodically has increased. A man's wish, desire, ambivalence, readiness, and the willingness to enter fatherhood are being explored. A father's psychological equilibrium, internal disorganization, excitement, anxiety, and Couvades syndrome during the three trimesters are being addressed. The supportive role of the father to maternal distress and well being is also being acknowledged. The father's psychology after child birth, for example: elation, engrossment, pride, and increase in self esteem, and the aspects of bonding with the child, is being studied. The father's reactions to child birth and changes in a couple's psychology are going to be a focus as well.

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SYMPOSIUM 34

NEURODEVELOPMENT AND ITS RELEVANCE TO PSYCHIATRIC DISORDERS

National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Identify the differences between white matter and gray matter developmental trajectories during childhood and adolescence; (2) Discuss recent findings, controversies, and implications of neuroimaging in Autism research; (3)Identify key brain regions involved in Attention/Deficit Hyperactivity Disorder; and (4) Discuss brain imaging findings in childhood-onset schizophrenia and their relationship to changes in typical development and adult onset schizophrenia.

No.34A

CHILDHOOD-ONSET SCHIZOPHRENIA: INSIGHTS FROM NEUROIMAGING

Nitin Gogtay, M.D., Building 10, Room 3B22, 10 Center Drive, Bethesda, MD 20892

SUMMARY:

Childhood-onset schizophrenia (COS; defined as onset by age 12) occurs in approximately 1 in 40,000 people. Converging evidence from electrophysiological, phenomenological, and neuroimaging studies indicate that COS represents a severe and chronic phenotype of the adult illness. People with COS have more pronounced delays in social, motor and language function, a 10% rate of chromosomal abnormalities, and higher familial rates of schizophrenia spectrum disorders than adult onset schizophrenia

suggesting that genetic influences may be more salient in COS. In an ongoing longitudinal study at the NIMH which began in 1990 we have acquired MRI brain scans, extensive clinical and behavioral data, and DNA on 95 COS subjects. Using novel cortical pattern matching algorithms to create time lapse sequences of cortical development, we compare the pattern of change in typical development to the pattern with similarly for several other pediatric neuropsychiatric illnesses, including children with childhood onset schizophrenia (COS), bipolar illness and atypical psychosis. Brain development for COS shows a 'back to front wave' of profound gray matter (GM) loss during adolescence evolving into the adult pattern by age 25. On the other hand, cortical development in pediatric bipolar illness (mapped before and after the onset of bipolar illness), shows a subtle pattern of GM gain in left temporal cortex and GM loss in cingulate areas. These diagnostically specific brain maturation patterns may elucidate distinct anomalous processes underlying the cognitive, emotional, and behavioral features of these debilitating disorders and provide a heuristic to guide future interventions.

No.34B
TRAJECTORIES OF BRAIN DEVELOPMENT IN HEALTHY CHILDREN AND ADOLESCENTS

Jay N. Giedd, M.D., Child Psychiatry Branch, NIMH, Building 10, Room 4C110, 10 Center Drive, Bethesda, MD 20892

SUMMARY:
Studies characterizing brain changes during typical development provide a yardstick from which to assess possible developmental deviations in clinical populations and allow exploration of the unfolding relationship between brain, genes, and behavior. Since 1989 the Child Psychiatry Branch of the National Institute of Mental Health has been conducting an ongoing longitudinal study assessing brain imaging, genetics, and neuropsychological parameters at approximately two-year intervals in participants aged 3 to 30 years. The data set consists of over 5000 MRI scans from 2000 subjects, about half from typically developing subjects and half from clinical populations such as Attention/Deficit Hyperactivity Disorder and Childhood-Onset Schizophrenia. Key findings include increases in white matter, regionally specific inverted U shaped developmental paths for gray matter volumes. Areas involved in integrating input from diverse brain components (e.g. the prefrontal, superior temporal, and inferior parietal cortex) reach peak cortical thickness at later ages than other areas. An emerging implication of the study is the importance of considering the trajectories (i.e. change in size over time as opposed to only the final size) of brain development in linking brain and behavior. Twin studies reveal not only differing heritability of different brain regions but of robust age by heritability interactions with some regions becoming more heritable during adolescence (e.g. white matter volumes) and others becoming less (e.g. cerebellum). Understanding the mechanisms and effects of genetic and environmental factors which influence developmental brain trajectories in health and illness may provide targets for intervention or prevention.

No.34C
IMAGING THE DEVELOPING BRAIN IN AUTISM

Joseph Pivan, M.D., University of North Carolina Chapel Hill, 4123 Bioinformatics Building, Chapel Hill, NC 27599-336

SUMMARY:

Autism is a strongly heritable disorder of the developing brain. To date, the underlying etiology and pathogenetic mechanisms have remained elusive. Converging evidence from MRI, head circumference and post-mortem studies now strongly implicates the latter part of the first year of life as a period of generalized brain overgrowth in autism. These data coincide with parallel evidence for the onset of autistic behavior during the same postnatal period (between 6 and 12 months) in very young siblings of autistic individuals, who themselves go on to develop autism. In this presentation results from recent structural MRI studies of early brain development in autism, along with data from studies of early behavioral development, will be presented to explore common overlapping features from both lines of investigation. Insights from brain imaging that provide new information on potential brain mechanisms and brain – behavior relationships in autism will be reviewed. Data will be presented on the importance of studying brain structure for understanding the genetics of autism and an example of the relationship between brain overgrowth in autism and variation in the serotonin transporter gene will be reviewed as a potential starting point for future efforts. Results from an imaging study of young autistic children with Fragile X Syndrome will also be presented to highlight the heterogeneity inherent in autism and how this may have an important impact on future studies in the field.

No.34D
GENES, CLINICAL OUTCOME AND NEURODEVELOPMENT IN ADHD

Wallace Shaw, M.D., Child Psychiatry Branch, Bethesda, MD 20892

SUMMARY:
ADHD is the most common neuropsychiatric disorder of childhood and is distinguished by its high heritability and its tendency to improve with age. We have studied a cohort of 166 children with combined-type ADHD, acquiring neuroanatomic magnetic resonance scans and clinical data on the children as they grow into adulthood. This allows a determination of neuroanatomic factors which both reflect and predict outcome in the disorder. We found that at baseline children (mean age 10yrs, SD2yrs) who went onto to have partial or complete remission showed little difference in cortical structure from age matched healthy controls. However, children who had persistent ADHD 6 year later had at thinner medial prefrontal cortex at baseline. This neuroanatomic variable explained a modest proportion of the variance of future outcome, more than any other baseline clinical, demographic or neuropsychological variable. Additionally children who had a better clinical outcome showed a distinctive pattern of normalization of the thickness of the right parietal cortex with age, occurring in a region important for early attentional processing. It has been possible to extend this link between clinical outcome and neuroanatomic change to incorporate genetic factors. We found that a well-established risk factor for ADHD (the 7-repeat allele of the dopamine D4 receptor gene) was not only associated with

better clinical outcome but also a pattern of right parietal cortical normalization with age. This represents a first step in linking genes with both clinical outcome and cortical development in ADHD.

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SYMPOSIUM 35

RESEARCH ADVANCES: BRAIN MECHANISMS OF BIPOLAR DISORDER AND MAJOR DEPRESSION

National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify major recent advances in our understanding of the pathophysiology of bipolar disorder and major depression.

No.35A
NEURAL CIRCUITS UNDERLYING THE PATHOPHYSIOLOGY OF MAJOR DEPRESSIVE DISORDER

Wayne C. Drevets, M.D., NIH/NIMH/Mood and Anxiety Disorders Program, Bethesda, MD 20892

SUMMARY:

The neural networks which appear to regulate the evaluative, expressive and experiential aspects of normal emotional behavior have been implicated in the pathophysiology of major depressive disorder (MDD) by data from neuroimaging, neuropathological, and lesion analysis studies. These networks involve the orbital and medial prefrontal cortex, amygdala, hippocampus, and anatomically related areas of the basal ganglia, where reductions in grey matter volume and alterations in neurophysiological activity exist in some MDD subgroups. This presentation specifically reviews the abnormal patterns of neural activity and dynamic neurotransmitter function evident in these circuits in depressed subjects as they perform reward processing tasks, and integrates these results into circuitry-based models which may elucidate the neural basis of the anhedonia, amotivation and mood-congruent processing biases manifest clinically in MDD.

No.35B
ADVANCES IN UNDERSTANDING THE BRAIN CIRCUITRY OF BIPOLAR DISORDER

Hilary P. Blumberg, M.D., Dept of Psychiatry,Yale School of Medicine, 300 George Street, Suite 901,, New Haven, CT 06511, Fei Wang, M.D., Ph.D., Jessica H. Kalmar, Ph.D., Lara G. Chepenik, M.D., Ph.D.

SUMMARY:

Converging findings from research in bipolar disorder (BD) support the presence of abnormalities in a cortico-limbic brain circuit that subserves the adaptive regulation of emotions and impulses. This includes the ventral prefrontal cortex and its cortical and subcortical connections sites including the amygdala and ventral striatum. Structural neuroimaging studies have demonstrated decreases in the volume of these cortico-limbic brain structures in BD. Functional neuroimaging studies of BD have demonstrated abnormalities in the functioning of these brain structures, especially during the processing of emotional stimuli and during tasks that require the inhibition of impulsive responses. New methods to assess the integrity of the connections within this brain circuit, such as diffusion tensor imaging and functional connectivity techniques, provide new evidence that the connections between these brain structures within the circuit are disrupted in BD. The correspondence between the maturation of this circuitry and the emergence of prominent symptoms of BD in adolescence implicate abnormalities in the development of this circuitry during adolescence. Data will be presented that support the development of abnormalities in this circuitry in BD, as well as that suggest that specific genetic variations implicated in BD may influence the developmental trajectory of the circuitry in the disorder. Recent evidence that treatments may have the potential to reverse the circuitry abnormalities, such as through the normalization of circuitry activity or through neurotrophic effects, will be discussed.

No.35C
BRAIN MECHANISMS MEDIATING BIPOLAR DISORDER AND SEVERE IRRITABILITY IN YOUTH

Ellen Leibenluft, M.D., Section on Bipolar Spectrum Disorders Mood and Anxiety Program NIMH Building 15K, Room 203, MSC 2670,, Bethesda, MD 20892, Melissa Brotman, Ph.D., Brendan Rich, Ph.D., Ken Towbin, M.D., Daniel Pine, M.D.

SUMMARY:

Considerable attention has centered recently on the question of whether children with severe, nonepisodic irritability and symptoms of ADHD are exhibiting a developmental presentation of mania. Our group is addressing this question by recruiting youth who meet reliable research criteria for such a clinical presentation (called severe mood dysregulation, SMD), and comparing their clinical outcome, family history, and neural function to that of youth meeting strict *DSM-IV* criteria for bipolar disorder (BD).

Data indicate that youth with BD are significantly more likely than those with SMD to have a parent with BD, and that youth with chronic irritability are at increased risk for major depression in young adulthood. In addition, the brain mechanisms mediating frustration differ between groups, in that patients with BD have attentional difficulties only when frustrated, whereas those with SMD have attentional difficulties in both emotional and non-emotional contexts. However, both SMD and BD youth have difficulties identifying face emotions, a deficit that is not shared by youth with other mood or anxiety disorders. In addition, both SMD and BD youth have difficulty responding flexibly to changes in reward contingencies, although those deficits are more marked in youth with BD than in those with SMD. Emerging neuroimaging data indicate that, just as similar symptoms (i.e., easy frustration) can be mediated by different brain mechanisms in SMD vs. BD, deficits in face emotion identification and cognitive flexibility may be mediated by different neural circuits across diagnostic groups. For example, during a cognitive flexibility task, SMD patients showed dysfunction in precuneus, midbrain, and cerebellum, while BD patients showed dysfunction in fronto-temporal association cortex.

No.35D

DYSREGULATION OF STRESS-REGULATED NEUROTRANSMITTER SYSTEMS IN MAJOR DEPRESSION

Jon-Kar Zubieta, M.D., University of Michigan, MBNI, 205 Zina Pitcher Place, Ann Arbor, MI 48109-0720

SUMMARY:

Current nosology in psychiatry exclusively utilizes the presence of a series of symptom clusters for diagnostic classification, but with little understanding of their biological underpinnings. Neurotransmitter systems implicated or modulated by stress (e.g., serotonergic, endogenous opioid) represent logical targets of study given the association between stressors and the development of episodes of Major Depression (MDE). Serotonergic (5HT) receptor concentrations or function have been frequently observed to be altered in postmortem studies of suicide victims diagnosed with depression. Initial work has shown reductions in 5HT1a receptors in both cell bodies and terminal fields (Drevets et al., 1999; Sargent et al., 2000) in MDE patients; these abnormalities did not change with successful treatment. However, other studies have shown regional increases in receptor concentration, associated with poorer treatment response (Parsey et al., 2006). The reason for these discrepancies may have included effects of medication, or the inclusion of samples enriched with a particular MDE subtype.

We studied unmedicated patients diagnosed with MDE with [11C]WAY-100635 and PET, labeling 5HT1a receptors. Significant reductions in 5HT1a binding were detected in the hippocampal formation, bilaterally, in MDE vs. controls. These were correlated with ratings of functional impairment and were partially normalized after 10 weeks of treatment.

In a second series of studies we also examined the function of the endogenous opioid system under two conditions, during neutral and sad emotion challenges. MDE patients showed lower regional baseline μ-opioid receptor concentrations, as well as greater activation of μ-opioid neurotransmission, during the sadness challenge. These reductions were associated with poor response to treatment with an SSRI.

REFERENCES:

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SYMPOSIUM 36

HEALTH CARE FINANCING REFORM: THE GOOD, THE BAD, AND THE NECESSARY

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the principles of meaningful health care financing reform, understand why psychiatrists should be in the forefront of single-payer reform, assess the prospects for major health care financing reform, know what the candidates are saying and the implications for our work, appreciate how our system fosters crash course prescribing by psychologists, understand a single public system like improved Medicare for all.

No.36A

2008 PRESIDENTIAL CANDIDATES' HEALTH CARE PROPOSALS: AN ANALYSIS

Harvey Fernbach, M.D., 6201 Greenbelt Rd Ste U18, College Park, MD 20740

SUMMARY:

The healthcare proposals of the presidential candidates will be assessed on achieving universal coverage, comprehensiveness, public accountability, cost, simplicity, equitableness and impact on practitioners.

No.36B

WORKING UNDER A UNIVERSAL HEALTH CARE PLAN

Jon Davine, M.D., 2757 King Street East, Hamilton, L8K 2G4 Canada

SUMMARY:

A psychiatrist from McMaster University, in Hamilton, Ontario, will describe Canada's universal health care system. The history of the system will be described, including Federal conditions for funding of the different provincial health plans. Strains affecting the Canadian system will also be discussed. Practical issues of day to day functioning, and the relative "hassle-free" quality of the system for a psychiatric practitioner will be described. This will include referral systems, billing issues, and psychiatric drug availability.

No.36C

OVERVIEW AND PRINCIPLES OF HEALTH CARE FINANCING REFORM: WHO'S AFRAID OF SINGLE-PAYER?

Leslie H. Gise, M.D., 1035 Naalae Road, Kula, HI 96790

SUMMARY:

Health care systems affect all aspects of society and exact costs on all aspects of society. Problems with our health care system affect not only the uninsured, but also the insured, the health-care providers, businesses, labor, private and government sectors. When a health care system does not work, we are all adversely affected. Health care costs are making U.S. businesses non-competitive in a global marketplace and big business is increasingly supporting a national health program to contain costs. The basic principles of health care financing reform are: 1) universal access, everyone is covered, 2) the right to choose one's own doctor, 3) no investor-owned facilities, and 4) medical decisions should be made by doctors and patients. The only way to have sustainable cost control is to have a public system without private insurance companies which spend 30 cents of every health care dollar on administration as opposed to Medicare which spends 3 cents of every dollar on administration. It is good to manage care and be more efficient but it should be done on the basis of health outcomes not on the basis of profit. Furthermore, our profit-driven system begets fraud by private insurance companies. In addition, our current system favors high paid specialists and expensive tertiary care interventions. We pay for liver transplants but not for alcoholism counseling. A public system can focus on prevention and wellness where primary care doctors are paid to talk to patients. We pay twice as much an any other country but our health outcomes are worse. Our current for-profit approach has resulted in more uninsured and medical bills contributing to more than half of personal bankruptcies. The idea behind the new "consumer-driven" plans is "moral hazard," the term economists use to describe the fact that insurance can change the behavior of the person being insured. Fear of moral hazard lies behind the thicket of co-payments, deductibles and utilization reviews which characterize the American health insurance system. Many economists say moral hazard is overblown, rich, well-insured people don't go to the doctor because it is free. Health care financing reform is simple, it just requires political will.

No.36D

WHY PSYCHIATRISTS SHOULD ADVOCATE FOR SINGLE PAYER

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

SUMMARY:

Psychiatry of all medical specialties should support the establishment of a single-payer universal health reform in the United States. There are 47 million Americans without any health insurance, and an additional 20 million Americans who have basic health insurance but no coverage for psychiatric illness. A single-payer system would cover all. For those who have coverage, administrative wastefulness of our current system of multiple private insurers and public insurance hits psychiatry particularly hard. Hospitalization is more burdensome due to multiple payers and many levels of utilization review. Private practice is more problematic because of the hassles of multiple "medical necessity" reviews. Single payer would radically simplify and make more efficient the "overhead" of hospital and office-based care. Our current patchwork system of financing, public and private, has led to the epidemic of mentally ill homeless and the criminalization of individuals with severe and persistent mental illness. Single payer would initiate a wide-scale reform that would bring these patients where they belong – into the mental health system. Finally, single payer would clarify the complexity of psychiatric illness comorbid with medical illness and substance- use disorders. This paper will expand on these issues and clarify the advantages of single payer for the specialty of psychiatry.

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SYMPOSIUM 37

CHANGING CONCEPTIONS OF THE PERSONALITY DISORDERS

Association for Research in Personality Disorders

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium the participant should recognize ways in which our conceptions of the personality disorders have changed over the past few years. This understanding will include aspects of biology, state and trait, personality dimensions and the overlap with bipolar disorder.

No.37A

DIMENSIONAL PERSONALITY TRAITS AND MALADAPTIVE OUTCOMES

Paul T. Costa, Ph.D., NIA/NIH Johns Hopkins Bayview Medical Center, Baltimore, MD 21224, Gerald Nestadt, M.D.

SUMMARY:

The Five-Factor Model of personality (FFM), derived from personality trait psychology, is increasingly used to describe personality disorders (PDs). There has meanwhile been a proliferation of dimensional models designed explicitly to assess dysfunctional personality including the Dimensional Assessment of Personality Psychopathology (Livesley, 2006), the Schedule for Normal and Abnormal Personality (Clark, 1993), and the 5 PD dimensions to measure maladaptivity from the Hopkins Epidemiology of Personality Disorders Study (HEPDS; Nestadt et al., 2006). Empirical research suggests substantial links between the FFM and maladaptive personality dimensions The present talk will review correspondences between the FFM and these alternative dimensional models of maladaptivity. We will highlight the need to understand the expression of PDs in terms of the profile of FFM dimensions rather than a simple one-to-one correspondence, and the importance of lower-level facet scales of the FFM in discriminating between the PDs.

No.37B
THE "FORGOTTEN" PERSONALITY DISORDERS

Donald W. Black, M.D., Psychiatry Research MEB, Iowa City, IA 52442

SUMMARY:

The psychiatric literature is rife with discarded terms for most all conditions. Personality disorders (PDs), in particular, have been abandoned only to be replaced by another term (e.g., hysterical), have been discarded altogether (eg, asthenic), or have been moved to another category (e.g., cyclothymic). Decisions about the changing terminology have been made for political and/or scientific reasons. *DSM-I* included a variety of PDs no longer included in the psychiatric nomenclature: inadequate, cyclothymic, emotionally unstable, compulsive, passive-aggressive, and compulsive types; sociopathic personality was divided into three types: antisocial, dissocial, and sexual deviancy. *DSM-II* included cyclothymia, explosive (epileptoid), hysterical, asthenic, passive-aggressive, obsessive-compulsive (anankastic), and inadequate PDs. Inadequate PD, for example, was used to describe ineffectual persons who were neither mentally or physically deficient. *DSM-III* continued to include passive-aggressive PD, though it was dropped from later editions, while immature PD was listed as an example of an "other" PD in *DSM-II*. Many of these terms continue to be useful descriptively, even though they are not commonly used. The presentation will explore the reasons behind the changing terminology, discuss the advantages/disadvantages of the "forgotten" PDs, and describe their potential use despite their exclusion from *DSM-IV*.

No.37C
STATE AND TRAIT IN PERSONALITY DISORDERS

James H. Reich, M.D., 2255 North Point St., Suite 102, San Francisco, CA 94123

SUMMARY:

Although personality disorders were once considered only trait (enduring and unchangeable) it is now accepted that personality pathology has both state (briefer and episodic) and trait (more enduring) components. This presentation will review the development of our understanding of this phenomenon and will bring us to where we are today. Empirical studies will be reviewed indicating the time course and nature of state personality disorder. Included will be findings on Borderline personality disorder as well as other personality disorders. In general there appear to be varying times for decay of personality disorder symptoms with some relatively rapid (state) while others are comparatively less rapid (trait). Theoretical and clinical implications of this will be discussed.

No.37D
CHANGING BIOLOGICAL CONCEPTIONS OF PERSONALITY DISORDERS

Chandra Sekhar Sripada, M.D., 3070 Barclay Way, Ann Arbor, MI 48105, Kenneth R. Silk, M.D.

SUMMARY:

Biological studies of personality and personality disorders have changed dramatically over the last 30 years. Initially these studies set out to examine similarities and differences between a specific personality disorder and a specific axis I disorder. They then progressed to a series of biological, pharmacologic and other neuroendocrine challenge studies. These studies at first explored the putative biological substrates that were thought to underlie the four main dimensions of personality that could become disordered in personality disorders: cognition, affect regulation, impulsivity and anxiety, though some aspects of these dimensions have been modified over the years. This early research became the foundation upon which further research was to develop. Subsequent studies employed neuroimaging techniques (currently PET, MRI, and fMRI) to explore the impact of pharmacological, biological, and psychological challenges on the working brains of normal subjects as well as those with personality disorders. Genetic studies were added to these paradigms to appreciate more fully the impact of certain genetic polymorphisms on patient responses on neuropsychological and other psychological test performance as well as on changes in fMRI and PET imaging results. In addition, genetic studies led to a greater appreciation of the impact of genetic predispositions not only on susceptibility to psychopathology but perhaps more importantly on resilience to environmental stress. These studies will be reviewed in their historical sequence. Suggestions will be made as to how future biological studies as well as how combining current biological techniques may provide us with a better appreciation of the complexity of the interaction of both vulnerability and resilience on personality and personality disorders.

No.37E
CATEGORICAL AND DIMENSIONAL MODELS OF PERSONALITY DISORDERS: TOWARDS INTEGRATION

Simone S Kool, Ph.D., Jellinek-Mentrum Mental Health Care, Frederik Hendrikstraat 47, Amsterdam,1052 HK, Robert A. Schoevers,Ph.D., M.D.

SUMMARY:

Both clinicians and researchers are regularly confronted with the restrictions and curtailments of the categorical model of clas-

sification of personality disorders. In the past decennia, alternative dimensional models have been developed based on new evidence such as factor analyses of rating scales examining general dimensions of personality and personality pathology. Obviously, diagnostic validity is superior in dimensional models and there are indications that this applies as well to clinical utility. By now, there are approximately twenty alternative models measuring personality, which can be classified into four groups. The first group consists of dimensionalized versions of the present categories such as the prototypal matching proposal; the second group includes dimensional reorganizations of the symptoms of personality disorder, for example by means of the Dimensional Assessment of Personality Pathology (DAPP). Clinical spectra models such as psychobiological models constitute the third group and finally dimensional models have been developed based on the general functioning of personality, for example the five-factor model. In this presentation the most promising models will be delineated, as well as their differences and similarities. Also, the merits and disadvantages of the application of dimensional models of personality pathology in clinical practice will be put forward and a framework for an integrated model of classification of personality disorder will be offered.

No.37F

EVOLVING RELATIONSHIPS BETWEEN BIPOLAR DISORDER AND BORDERLINE PERSONALITY DISORDER

Terence A. Ketter, M.D., 401 Quarry Rd, Rm 2124, Stanford, CA 94305-5723, Terence A. Ketter, M.D., Po W. Wang, M.D., Jenifer L. Culver, Ph.D.

SUMMARY:

There is ongoing controversy regarding the nature of the relationships between bipolar disorder (BD) and borderline personality disorder (BPD). The current (*DSM-IV*) psychiatric nosology involves a categorical approach that has strengths such as simplifying communication, and reflecting clinical decision-making. However, it also has noteworthy limitations, including giving rise to categorical relational hypotheses such as BD and BPD either being variants of one another, or being independent of one another. A dimensional approach to psychiatric nosology has important strengths such as providing a schema for relating mood and personality variations seen in health to those seen in disorders. A dimensional approach can also give rise to dimensional relational hypotheses, such as BD and BPD having overlapping etiologies and clinical features. Indeed, arguments regarding relationships between BD and BPD commonly utilize potentially dimensional data, focusing on the degree of overlap of symptoms, illness course, comorbidities, co-occurrence, family history, and treatment responses. However, the relationships between BD and BPD appear to be sufficiently complex so that even a dimensional approach has important limitations. Thus, although the disorders co-occur, their relationship may not be consistent or specific. Similarly, although phenomenology and medication responses overlap, there are important differences in these areas. Also, family studies suggest clear distinctions, and only a limited number of individuals with BPD develop BD, consistent with categorical differences. It may be that ultimately a mixed approach that invokes dimensional modeling in some, and categorical constructs in other contexts could prove optimal. Research regarding dimensional and categorical approaches to the relationships between BD and BPD is needed to advance our understanding and improve the management of these important disorders.

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SYMPOSIUM 38

CHOOSING THE RIGHT TREATMENT FOR SUBSTANCE ABUSE

APA Council on Addiction Psychiatry and American Academy of Addiction Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to select among the array of treatment options available for substance abuse.

No.38A

CHOOSING THE RIGHT TREATMENT FOR COCAINE DEPENDENCE

Adam Bisaga, M.D., Columbia University/NYSPI, 1051 Riverside Drive, New York, NY 10032

SUMMARY:

Cocaine abuse and dependence remain severe health problems, with treatment difficult, and no commonly accepted pharmacotherapies. A combination of pharmacological and behavioral interventions will likely be required for patients to achieve and maintain abstinence. Antidepressants, with desipramine most studied, have yielded inconsistent results. Medications that affect dopaminergic neurotransmission, including dopamine receptor agonists, dopamine transporter inhibitors, and dopamine receptor blockers, have also not been consistently successful. Recently studied medications, including disulfiram, d-amphetamine, modafinil, tiagabine, and topiramate, are more promising. Strategies to prevent cocaine from entering the brain are also being developed and initial results with a “cocaine vaccine” are promising. Current areas of research interest include the use of medications that affect the neurotransmission of excitatory and inhibitory amino acids, and the function of the HPA axis. A new approach in cocaine treatment trials involves using medications in combination with a specific form of behavioral therapy, such as the use of dopamine enhancers to enhance efficacy of contingency management. Although no single treatment is currently suggested, several treatment combination approaches will be discussed.

No.38B
PSYCHOSOCIAL INTERVENTIONS FOR SUBSTANCE DEPENDENCE AND COMMON PRINCIPLES FOR PROMOTING BEHAVIOR CHANGE

Ken Carpenter, Ph.D., 1051 Riverside Dr., New York, NY 10032

SUMMARY:
Psychosocial interventions are the cornerstone of treatment for addictions, either alone or in combination with medications. Several types of psychotherapeutic interventions have been developed and studied, including cognitive behavioral skill-building approaches (e.g., relapse prevention, community reinforcement approach, contingency management, motivational enhancement therapy, and 12-Step facilitation). Although these interventions employ different therapeutic procedures, they incorporate certain principles that may play an important role in facilitating behavior change among substance-dependent patients. An overview of these principles will be provided, specific interventions that emphasize a particular treatment principle will be highlighted, and their implications for clinical practice will be addressed.

No.38C
CHOOSING TREATMENT FOR CANNABIS DEPENDENCE

Frances R. Levin, M.D., 1051 Riverside Drive, New York City, NY 07666

SUMMARY:
Cannabis is the most commonly used illicit drug in the United States. Compared to the early 1990's, use did not change in the early 2000's. However, the rates of abuse and dependence have increased dramatically. A great deal of work has been completed concerning the basic mechanisms of actions, pharmacology, and neurophysiologic of cannabis. Until recently, it was not commonly known that heavy chronic cannabis use leads to a characteristic withdrawal syndrome upon discontinuation of use. Further, withdrawal symptoms may hinder a patient's ability to reduce or cease his/her use. Although there have been several large clinical trials suggesting that various psychotherapeutic treatment approaches may have clinical utility, no one treatment has been found to be superior (Nordstrom and Levin, in press). In addition, there have been a limited number of controlled laboratory and treatment trials that have assessed the efficacy of pharmacologic interventions. At present, agonist and antagonist therapies have shown promise but much more research is needed to help guide clinical practice.

No.38D
CHOOSING THE RIGHT TREATMENT FOR OPIOID DEPENDENCE

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

SUMMARY:
While the number of heroin addicts has remained stable, the number dependent on non-medical prescription opioids is growing and new initiates now exceed that for marijuana. Fortunately, there are a number of effective pharmacotherapies for opioid dependence. The agonist methadone has been successfully used since 1965; the partial agonist buprenorphine has been available since 2003 has brought into successful treatment a higher percentage of prescription opioid abusers, Caucasians, women, and younger addicts; the antagonist naltrexone blocks opioid use and decreases alcohol abuse but has poor acceptance which may be improved by the 1-month depot injection. New approaches, not yet available for office use, will also be touched upon. Patient selection and the pros and cons of each medication will be described.

No.38E
INTEGRATING PSYCHOSOCIAL INTERVENTIONS WITH MEDICATIONS IN THE TREATMENT OF SUBSTANCE DEPENDENCE

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

SUMMARY:
Psychosocial treatment is the cornerstone of treatment for addictions, either alone or in combination with medications. Several types of psychotherapeutic interventions have been developed and studied, including cognitive behavioral skill-building approaches (e.g., relapse prevention, community reinforcement approach, contingency management, motivational enhancement therapy, and 12-Step facilitation). Such interventions have served as means of achieving abstinence, encouraging lifestyle change, and promoting compliance with medications. Despite encouraging findings in treatment outcome research, many challenges remain. The behavioral interventions are not always successful in securing longer abstinence and commitment to change. Transferring and integrating such treatment models from research to community treatment settings remains a complex task. An overview of these models will be provided, as well as their known efficacy in working with different substances of choice. Obstacles encountered in the delivery of these approaches, the clinical implication of integrating such models, and the efforts thus far to generalize research findings to community settings will be addressed.

REFERENCES:
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SYMPOSIUM 39

ANTIDEPRESSANTS IN BIPOLAR DISORDER: TOWARD A RESEARCH BASED CONSENSUS

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to appreciate the results of the recent randomized studies from the NIMH-sponsored Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) and the Stanley Foundation Bipolar Network (SFBN) on the use of antidepressants in bipolar disorder. Participants will learn how to apply those results to their clinical practice.

No.39A

MAINTENANCE TREATMENT OF BIPOLAR DEPRESSION: OPEN AND RANDOMIZED TRIALS

Lori L. Altshuler, M.D., UCLA Mood Disorders Research Program, 300 UCLA Medical Plaza, Suite 1544, Los Angeles, CA 90095

SUMMARY:

While guidelines for treating patients with bipolar depression recommend discontinuing antidepressants within 6 months after remission, few studies have assessed the implications of this strategy on the risk for depressive relapse. Similarly, few studies have assessed the risk of continued antidepressant exposure on switch rates into mania. In this presentation, we will review data from the Stanley Bipolar Foundation Network that assess these types of clinical questions. We will also review the limited data in this field. Our studies suggest that continued antidepressant treatment for up to 1 year after an acute remission of depression is associated with continued positive antidepressant response, with a low risk of switch into mania. The types of patients, however, that do not switch into mania when given an acute trial of antidepressants, and thus are able to enter to enter into a continuation phase of treatment, may represent a selective subgroup of the overall bipolar population. Maintenance of antidepressant treatment, in combination with a mood stabilizer, may be warranted in some patients with bipolar disorder.

No.39B

A RANDOMIZED CLINICAL TRIAL OF ANTIDEPRESSANTS IN ACUTE BIPOLAR DEPRESSION: PREDICTORS OF RESPONSE AND MANIC INDUCTION

Mark Frye, M.D., Mayo Clinic, Rochester, MN 55905, Trisha Suppes M.D., Ph.D., Susan L. McElroy M.D., Willem A. Nolen M.D., Lori Altshuler M.D., Paul E. Keck Jr. M.D., Gabriele S. Leverich L.C.S.W., Ralph Kupka MD., Ph.D., Heinz Grunze M.D., Jim Mintz Ph.D., Robert M. Post M.D.

SUMMARY:

Background: Few studies have examined the effectiveness of adjunctive antidepressants (efficacy vs. switch liability) in the treatment of bipolar depression.

Methods: The Stanley Foundation Bipolar Network conducted a 10-week, randomized, double-blind, flexible-dosed, comparison study of bupropion, sertraline, and venlafaxine as adjuncts to mood stabilizers in bipolar depressed patients. 3 outcome variables were assessed: response [50% improvement in the Inventory for Depressive Symptoms (IDS) or a 2-point decrease in the CGI-BP depression score], remission [IDS <12 and/or a CGI-BP depression severity score of 1 (normal, not ill) at study endpoint], and treatment emergent mania or hypomania (TEM) defined as either a 2-point increase on the CGI-BP, a CGI-BP manic severity score of >/= 3, or a YMRS score > 13 at any visit.

Results: 174 adults with bipolar disorder I or II depression were included. The acute response rates (49% for bupropion, 53% for sertraline, and 51% for venlafaxine) and the acute remission rates (41%, 36%, and 34%, respectively) were not significantly different by treatment group. On most measures, venlafaxine showed a higher risk of switching into hypomania or mania than on bupropion or sertraline. In a separate post-hoc analysis, baseline manic symptoms as measured by the YMRS prior to randomization, were significantly higher in the group that went on to have TEM versus the groups who went on to respond or not respond to antidepressant therapy ($F(2,187) = 5.33$, $p=0.006$). The overall YMRS and the individual items of motor activity, speech, and thought content remained significantly different among groups after correction.

Conclusion: The use of adjunctive antidepressant therapy was associated with effectiveness in approximately 50% of depressed patients. There did not appear to be a difference in response by treatment group, but there was a difference in switch liability. Furthermore, patients with symptoms consistent with mixed depression may be at greater risk for acute treatment emergent mania or hypomania.

No.39C

ANTIDEPRESSANT EFFECT ON LONG-TERM MOOD MORBIDITY IN BIPOLAR DISORDER

S. Nassir Ghaemi, M.D., Bipolar Disorder Research Program Emory University, Department of Psychiatry, 1841 Clifton Road, 4th Floor, Atlanta, GA 30322, Riff S. El-Mallakh, M.D., Claudia F. Baldassano, M.D., Michael J. Ostacher, M.D., Megan M. Filkowski, B.A., Vanessa A. Stan, Gary S. Sachs, M.D., R.J. Baldessarini

SUMMARY:

Objective: Previous studies suggest that TCAs may worsen the course of bipolar disorder, or may be ineffective in bipolar depressive prophylaxis. Many believe modern antidepressants are more effective and safe. This is the first randomized antidepressant discontinuation study in bipolar disorder with modern antidepressants, and this is the final presentation of the data of a 5 year study.

Method: 70 subjects who first recovered from a depressive episode on mood stabilizer plus antidepressant were openly randomized to continue (LT; n=31) or discontinue (ST; n=39) antidepressants. Primary outcome was total affective morbidity at one year (sum of subscale mania + depression ratings at follow-up visits) on the Clinical Monitoring Form (CMF; scores: 0 euthymia; 1–6 subsyndromal; 6 syndromal depression or mania; 1 point = 1 DSM-IV mood episode criteria). A questionnaire (rated -2 to +2 each) measuring patient opinion on antidepressant use was administered prior to randomization. Subjects were followed up

to 3 years.

Results: LT treatment had no benefit for mood symptoms as there was no overall mood difference between treatments. Mania symptoms were mildly worse in LT treatment group. Results did not change after adjusting for other clinical predictors of response. Rapid-cycling predicted poor outcomes.

Conclusions: Continuation of antidepressants was not effective in reduction of depressive morbidity at one year or longer.

Discontinuation of antidepressants did not lead to notably more rapid relapse into depression. Non-statistically significant evidence of mild worsening of manic morbidity with antidepressant treatment was seen, but no clear increase in mood episode cycling was noted.

Long-term antidepressant use appeared ineffective but not markedly harmful. Residual measurement bias due to lack of blinding cannot be ruled out.

No.39D

A STEP-BD DOUBLE-BLIND, RANDOMIZED STUDY: EFFECTIVENESS OF STANDARD ANTIDEPRESSANTS FOR ACUTE BIPOLAR DEPRESSION

Gary Sachs, M.D., Massachusetts General Hospital, 50 Staniford Street, 5th Floor,, Boston, MA 02114

SUMMARY:

Background: Episodes of depression are the most frequent cause of disability for patients with bipolar disorder. The effectiveness and safety of standard antidepressants for bipolar depression is not well studied. STEP-BD conducted a randomized study designed to determine if adjunctive antidepressants reduce symptoms of bipolar depression without increasing the risk of mania.

Methods: This NIMH-sponsored double-blind placebo-controlled study randomized depressed bipolar subjects to receive up to 26 weeks of treatment with a mood stabilizer and adjunctive antidepressant medication (AAd), or a mood stabilizer plus a matching placebo (NAAd) under conditions generalizable to routine clinical care. The primary outcome variable was the proportion in each treatment group meeting criteria for a durable recovery (eight consecutive weeks euthymia). Secondary effectiveness outcomes and rates of treatment emergent affective switch (TEAS) were examined.

Results: Durable recovery was achieved by 23.5% of 179 AAD subjects and 27.3% of 187 NAAd subjects (p = .40). Modest numerical trends favoring NAAd observed across the secondary measures did not reach statistical significance. Rates of TEAS were similar across the groups.

Conclusion: Adjunctive standard antidepressant medication was associated with neither increased efficacy nor increased risk of TEAS compared to mood stabilizers alone. This study used a relatively stringent definition of outcome (durable recovery) , however, longer term outcome studies are needed to fully assess the benefit/risk ratio of antidepressants for bipolar disorder.

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3. GS Sachs et al. Effectiveness of adjunctive antidepressant treatment for bipolar depression. N Engl J Med. 2007 Apr 26;356(17):1711-22.
4. SN Ghaemi et al. Long-term antidepressant effect on mood morbidity in bipolar depression: A randomized discontinuation study (abstract) New Clinical Drug Evaluation Unit (NCDEU) annual meeting, May 2007, Boca Raton, Florida.

SYMPOSIUM 40

WOMEN AND SUBSTANCE ABUSE TREATMENT: EXPLORING WOMEN-FOCUSED TREATMENTS AND SERVICES

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to identify outcomes and benefits of women-focused treatments for substance use disorders for; (1) single-gender women's group versus mixed-gender group counseling; (2)group trauma treatments for women in substance abuse treatment to reduce PTSD symptoms;(3)implementing a safer sex skills group in reducing sexual risk behaviors among women in SUD treatment; and (4)integrating eating and substance use disorders treatments.

No.40A

NIDA'S CLINICAL TRIALS NETWORK "WOMEN AND TRAUMA" STUDY

Denise Hien, Ph.D., Columbia University School of Social Work, 1255 Amsterdam Avenue #809, New York, NY 10027, Aimee Campbell, MSSW, Gloria Miele, Ph.D., Lisa Cohen, Ph.D., Ned Nunes, M.D.

SUMMARY:

Twenty years of epidemiological research confirm the elevated co-occurrence of post- traumatic stress disorder (PTSD) and addictive disorders among women in community based treatment. The Women and Trauma study emerged as part of an attempt by NIDA's CTN to address questions related to feasibility of implementing Seeking Safety (Najavits, 1998), an efficacious, integrated cognitive behavioral intervention for women with co-occurring PTSD and substance use disorders (SUD), into community substance treatment settings.

No.40B

ASSESSMENT AND TREATMENT OF CO-OCCURRING EATING DISORDERS IN PUBLICLY FUNDED ADDICTION TREATMENT PROGRAMS

Susan M. Gordon, Ph.D., Seabrook House, 133 Polk Lane,, Seabrook, NJ 08302-5055, Aaron Johnson, Ph.D., Shelly Greenfield, M.D., Lisa Cohen, Ph.D., Theresa Killeen, Ph.D., Paul Roman, Ph.D.

SUMMARY:

This study surveyed publicly funded addiction treatment programs (ATPs) to increase the understanding of current eating dis-

order (ED) treatment options for this population. Data were collected as part of the long-term National Treatment Center Study from detailed face-to-face interviews with program directors of a nationally representative sample of 351 publicly funded ATPs between 2002 and 2004. Half (50.8%) of ATPs screen patients for eating disorders; 28.5% admit all ED cases and 48.1% admit cases of low severity. Few programs (17.3%) attempt to treat ED. Programs that admit and treat ED patients are more likely to emphasize a medical/psychiatric model of addiction, use psychiatric medications, assess and admit patients for other co-occurring psychiatric disorders, and have a lower caseload of African-American patients. Programs that treat ED identified differences in ED treatment from standard addiction treatment, and programs that do not provide ED services list reasons for not offering these services. Generally, patients with co-occurring ED and SUD do not appear to receive structured ED assessment or ED treatment in ATPs. These results highlight the need for education of addiction treatment professionals in assessment of eating disorders and the development of integrated treatments.

No.40C

THE WOMEN'S RECOVERY STUDY: A STAGE I TRIAL OF WOMEN-FOCUSED GROUP THERAPY FOR SUBSTANCE USE DISORDERS AND MIXED-GENDER GROUP DRUG COUNSELING

Shelly F. Greenfield, M.D., McLean Hospital, 115 Mill Street, Belmont, MA 02478, Elisa Trucco, B.A., Rebecca Kate McHugh, B.A., M Lincoln, B.A., Robert J Gallop, Ph.D.

SUMMARY:

The aim of this Stage I Behavioral Development Trial was to develop a manual-based 12- session Women's Recovery Group (WRG) and to pilot test this new treatment in a randomized controlled trial against mixed-gender Group Drug Counseling (GDC), an effective manual-based treatment for substance use disorders. After initial manual development, two pre-pilot groups of WRG were conducted to determine feasibility and initial acceptability of the treatment among subjects and therapists. In the pilot stage, women were randomized to either WRG (N=16) or GDC (N=7). No significant differences in substance use outcomes were found between WRG and GDC during the12-week group treatment. However, during the 6-month post-treatment follow-up, WRG members demonstrated a pattern of continued reductions in substance use while GDC women did not. In addition, pilot WRG women with alcohol dependence had significantly greater reductions in average drinks/drinking day than GDC women 6 months post-treatment ($p<.03$, effect size =0.81), as well as reductions in ASI composite scores ($p=.051$, effect size 0.73). While satisfaction with both groups was high, women were significantly more satisfied with WRG than GDC ($p<.009$, effect size 1.11). In this study the newly developed 12-session women-focused WRG was feasible with high satisfaction among participants. It was equally effective as GDC in reducing substance use during the 12-week in-treatment phase, but demonstrated significantly greater improvement in reductions in drug and alcohol use over the post-treatment follow-up phase compared with GDC. Potential moderators of outcome such as high and low psychiatric symptom severity will be discussed. A women-focused single-gender group treatment may enhance longer-term clinical outcomes among women with substance use disorders.

No.40D

HIV/STD SAFER SEX SKILLS GROUPS FOR WOMEN IN DRUG TREATMENT PROGRAMS IN THE NIDA CLINICAL TRIALS NETWORK: PRIMARY OUTCOME RESULTS

Susan Tross, Ph.D., HIV Center For Clinical and Behavioral Studies, NYS Psychiatric Institute,1051 Riverside Drive,, New York, NY 10032, Susan Tross, Ph.D., Aimee Campbell, M.S.W., Lisa Cohen, Ph.D., Martina Pavlicova, Ph.D., Edward Nunes, M.D., Donald Calsyn, Ph.D., Mary Hatch-Maillette, Ph.D., Gloria Miele, Ph.D., Louise Haynes, Mei-Chen Hu, Ph.D., Nancy Nugent, M.S., Weijin Gan, M.P.H.

SUMMARY:

While needle use risk behavior has declined as a vector for HIV among U.S. women, heterosexual transmission has increased. This is an especially salient risk among women in high drug use communities. In the NIDA Clinical Trials Network (CTN), a randomized clinical trial of a gender-specific safer sex skills-building group (SSB) intervention for women was implemented in 12 community-based, outpatient psychosocial or methadone maintenance programs, across the U.S. This action-driven, 5-session intervention, based on the work of El-Bassel and Schilling, mainly consisted of exercises to increase motivation to adopt safer sex behaviors and skills training in safer sex problem-solving, decision-making, and use of safer sex behaviors (especially male and female condom use and safer sex negotiation). A standardized HIV/STD education (HE) group session served as a Treatment-As-Usual control condition. A total of 824 women were screened, and 515 women who had had unprotected (vaginal or anal) sex with a male partner in the prior 6 months participated in the trial. Using Mixed Effects Modeling, primary outcome analysis tested the effect of SSB, as compared to HE, on number of unprotected sex occasions (USO) at 3- and 6- month follow-ups. This analysis obtained: (1) comparable, significant decreases in USO, in both intervention conditions, at 3-month follow-up (HE: Baseline Mean = 19.9; 3-month Mean = 17.3)(SSB Baseline Mean = 18.6; 3-month Mean = 15.08); and (2) significantly divergent findings at 6-month follow-up -- with the SSB condition maintaining this decrease in USO (Mean = 13.9), while the HE condition markedly increased USO (Mean = 24.4)(Time X Intervention $F = 67.18$; $p <.0001$). Implications for the feasibility and efficacy of introducing HIV risk reduction interventions into community-based drug treatment programs will be discussed.

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HIV interventions for at-risk women. AIDS and Behavior, 2, 93-124. Greenfield, S.F., Gordon, S.M., Cohen, L., & Trucco, E. (in press).
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SYMPOSIUM 41

CHILDREN AND WAR

APA Council on Children, Adolescents, and Their Families

EDUCATIONAL OBJECTIVES:
At the conclusion of the symposium, the participant should be able to; (1) Identify the short and long term psychological and psychiatric consequences of exposure to war and terror in children and adolescents; (2) Identify several approaches to foster coping and resilience in children and adolescents exposed to war and terror; and (3) Describe treatment options geared toward minimizing psychiatric and psychological difficulties.

No.41A
PSYCHIATRIC PROBLEMS AMONG WAR DISPLACED CHILDREN IN DARFUR

Abdullah Abdulrahman, M.D., Khartum University Medical School, Khartum, 26505, Sudan Diaa Eldin Elmahi

SUMMARY:
Darfur civil war has caused great problems to the people of the region over the last 2-3 years. Women and children were most affected. Children had suffered the worst and are still suffering. The objective of this study is to explore the psychiatric problems among these children. One camp was randomly selected (Abu Shoke camp) just outside EL Fashir in Northern Darfur. There were about 45000 people in the camp of whom over 50% were children and adolescents. About 2400 individuals were randomly selected and studied in June 2007. The Strength and Difficulties Questionnaire (SDQ) was used for study. The parent version of the SDQ was completed by one of the parents while the adolescent version was completed by those subjects of 11 years and more. Field surveyor helped those who could not read or write. Other relevant factors were studied using an annex to the questionnaire. These included the duration of stay in the camp, the area of previous habitat, schooling in the camp and other parameters. The preliminary results revealed over 20% of individuals are suffering some sort of psychiatric disturbance. The final results will follow.

No.41B
SHORT AND LONG-TERM PSYCHIATRIC CONSEQUENCES OF EXPOSURE TO WAR AND TERROR ON ISRAELI CHILDREN AND ADOLESCENTS

Esti Galili-Weisstub, M.D., Child and Adolescent Psychiatry Hadassah University Hospital Kiryat Hadassah, P.O.B. 12000 Jerusalem 91120 Israel

SUMMARY:
The first part of the talk will describe the immediate clinical presentation of acute stress reactions of children and adolescents who were directly affected by terrorist attacks in Jerusalem during the years 2000 to 2004. The 400 young victims studied were mainly Jewish, with a small number of affected Arab children, and were in the immediate vicinity of the attacks. Following the terrorist event, the children were evacuated to the medical emergency of a general hospital. The clinical and psychosocial interventions done in the emergency room are described.

No.41C
MENTAL HEALTH PROMOTION AMONG ADOLESCENTS IN PALESTINIAN AND ISRAELI COMMUNITIES.

Sami Hamdan, M.Psy., Box 646, Ramle, 72100, Israel, Skinner Harvey, Ph.D., Apter Alan, M.D

SUMMARY:
This project is examining ways to engage youth in health promotion and create youth driven community action in the Middle East, Especially in conflict area.Our applied research focuses on the use of media arts and technologies for youth expression and action on community health issues. Multimedia technologies are used to engage youth expression, identify issues and themes of importance to young people, plan projects that address youth concerns and priorities, and act for youth-centred community development and social change. Our participatory research seeks to reflect best practices for youth engagement, and sustain growth and development of youth initiatives. Global Youth Voices Middle East uses media arts for community development and cross-cultural exchange with Arab and Jewish youth in the Middle East. Youth in Jewish, Bedouin and Palestinian communities used photography and video to identify and take action on personal and community health issues. The four communities reflect the diversity of the Israel/Palestine region: a) Segev Shalom, an Arab/Israeli Bedouin community in the South of Israel, b) Tuba Zangaria, an Arab/Israeli Bedouin community in the North of Israel, c) Eynut Yarden, a school serving Jewish kibbutzim in Israel's Galilee region, and d) Friends School, serving Palestinian youth in Ramallah. All four groups were brought together in a youth forum at Tel Aviv University to share their work. This was a powerful, transforming moment, which provided the opportunity to dispel misconceptions, and build cross-cultural understanding and dialogue.

No.41D
MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT FOR CHILDREN IN POST CONFLICT AREAS IN LOW-INCOME COUNTRIES: A PUBLIC MENTAL HEALTH MODEL

Peter Ventevogel, M.D., HealthNet TPO Burundi, Avenue Muyinga 28, Bujumbura, BP 1110, Burundi, Mark J.D. Jordans, Wietse A. Tol, Ivan H. Komproe Ph.D., Joop T.V.M. de Jong, M.D., Ph.D.

SUMMARY:
Interventions for mental health and psychosocial support have long been considered a luxury in complex humanitarian emergencies such as prolonged war situations in low resource countries. The last decade shows growing recognition of the importance of the mental health consequences of violence and disaster. The nongovernmental organization HealthNet TPO has developed a public mental health model for mental health and psychosocial interventions in (post)conflict settings. The model considers interventions on different levels (society at large, community, family and individual) and for different target groups (universal interventions for the general population, selected interventions for those at heightened risk and indicated interventions for those who have developed psychopathology). The model will be illustrated with examples from various countries.

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SYMPOSIUM 42

THE LONG-TERM COURSE OF THE MAJOR AFFECTIVE DISORDERS: NEW FINDINGS FROM A 25-YEAR HIGH-INTENSITY FOLLOW UP

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be familiar with new information comcerning the long-term course of the bipolar disorders, the effects of aging on affective symptom levels, and the risks for cardiovascular morbidity associated with the major affective disorders.

No.42A
AN EMPIRICAL TYPOLOGY OF BIPOLAR I MOOD EPISODES

David A. Solomon, M.D., Rhode Island Hospital, Dept of Psychiatry JB5S, 593 Eddy Street, Providence, RI 02903

SUMMARY:
Much remains unknown about the nature and relative frequency of the different types of bipolar I mood episodes that occur across the lifetime of patients. The purpose of this study was to delineate a typology for classifying bipolar I mood episodes

The study was conducted under the auspices of the NIMH Collaborative Depression Study, a multi-center, longitudinal observational study of the mood disorders. The sample consisted of 219 subjects with bipolar I disorder according to Research Diagnostic Criteria, who were recruited from 1978-1981 and prospectively followed for up to 25 years. Level of psychopathology was measured with the Longitudinal Interval Follow-up Evaluation, administered every 6 months for the first 5 years of follow-up and annually thereafter.

A total of 1,208 mood episodes were prospectively observed. The episodes were classified as follows: major depression 30.9% (n=373), minor depression 13.0% (n=157), mania 20.4% (n=246), and hypomania 10.4% (n=126). Mixed episodes (major or minor depression concurrent with mania or hypomania throughout the entire episode, with at least one major pole [major depression or mania]) constituted only 0.2% (n=2) of the mood episodes. Major cycling (alternating periods of depression and mood elevation, separated by less than eight weeks of euthymia, with at least one major pole during the episode) constituted 15.1% (n=182) of the mood episodes. Mixed major cycling (an episode of major cycling that included a separate mixed period) constituted 7.8% (n=94) of the episodes. Minor cycling (alternating periods of minor depression and hypomania, separated by less than eight weeks of euthymia) constituted 2.3% (n=28) of the episodes.

Minor depressive episodes and cycling episodes, which are not recognized by *DSM-IV,* constituted more than one-third of the mood episodes observed in this sample of bipolar I subjects. Inclusion of such episodes should be considered as our nosology is revised.

No.42B
ARE RAPID SHIFTS IN MOOD THE FINAL COMMON PATHWAY OF SUICIDALITY?

Hagop A. Akiskal, M.D., UCSD Department of Psychiatry, 9500 Gilman Drive, La Jolla, CA 92093-0603

SUMMARY:
The NIMH Collaborative Depression study of nearly 1000 affectively ill probands in a prospective design of 14 years has revealed that 36 patients committed suicide and 120 made serious suicide attempts. In comparison with 373 mood disorder patients with no recorded suicidal acts, intake clinical and temperament measures showed that the most important long-term predictors of suicidality were previous attempts, impulsivity, lack of assertiveness, substance and/or alcohol abuse, psychic turmoil in the setting of a cycling, mixed bipolar disorder. International research more recently has upheld the relevance of mixed states as being central to suicidal acts, whether one studies "unipolar", bipolar I or bipolar II patients. Bipolar II, in particular, appears to have the highest lethality in terms of low ratio of attempts to completed suicides. These data suggest the hypothesis that rapid mood shifts with sudden dips in mood might be the final common pathway of suicidal acts in most affective disorders, as well as epileptic, physically ill elderly with hopeless cognitions, or those recovering from depression, and possibly those rare individuals without mental illness -- especially if they are knowledgeable of or have access to lethal means. That may explain in part why strong family, social and spiritual bonds are protective.

No.42C
CARDIOVASCULAR DISEASE IN THE COLLABORATIVE DEPRESSION STUDY

Jess G. Fiedorowicz, M.D., 1-289 MEB, 500 Newton Road,, Iowa City, IA 52242

SUMMARY:

Patients with affective disorders appear to have an elevated burden of cardiovascular risk factors including diabetes mellitus, hyperlipidemia, hypertension, the metabolic syndrome, and obesity. Affective disorders and the categorical presence of depressive symptoms have further been associated with an increased risk of cardiovascular mortality. While not designed to make comparisons between those with affective disorders and the general population, the high surveillance, extended follow-up of the National Institute of Mental Health Collaborative Depression Study (CDS) provides a unique opportunity to assess cardiovascular morbidity and mortality within a clinical sample of patients with affective disorders. Within the CDS, there does not appear to be any dose-dependent effects of depressive symptom burden on risk for cardiovascular disease or mortality as tested in a case-control design and with survival analysis. When compared in survival analysis with other affective diagnoses, excess cardiovascular mortality among participants with the bipolar I subtype has been observed. Potential explanations for these findings will be discussed.

No.42D

THE 20 YEAR SYMPTOMATIC COURSE OF BP-I AND BP-II: CHRONICITY, DIMENSIONALITY AND RELAPSE

Lewis L. Judd, M.D., University of California, San Diego, Department of Psychiatry, 9500 Gilman Drive, La Jolla, CA 92093-0603

SUMMARY:

Studies of the longitudinal natural history of the long-term (up to 20 years) course of illness of patients with bipolar I (BP-I) and bipolar II (BP-II) have found that both disorders are highly chronic. BP-l patients were symptomatic from their illness 47% of the weeks and BP-II patients were symptomatic 54% of the weeks. All levels of depressive and manic symptom severity ranging from subsyndromal to syndromal fluctuated frequently within the same bipolar patient over time, indicating that both BP-I and BP-II disorders are symptomatically expressed over time as dimensional illnesses. In disorders, minor and subsyndromal manic and depressive symptoms were 3 times more common than syndromal level symptoms of mania and major depression. Depressive symptoms dominated the course of BP-I patients (M: D ratio = 3:1), however, BP-II is an overwhelmingly depressive illness in which depressive symptoms are over 30 times more common than symptoms in the manic spectrum. Examination of hypomanic episodes in BP-II revealed that hypomanias of short duration (2-6 days) compared to long duration (more than 6 days) are not clinically significantly different and appear to be part of the same disease process. Microanalyses of psychosocial impairment during the course of bipolar illness show that affective symptom severity and psychosocial disability fluctuate together. Depressive symptoms in BP-I and BP-II are equally disabling and sometimes more so than manic/hypomanic symptoms. Subsyndromal depressive but not subsyndromal/hypomanic symptoms are significantly disabling. Subsyndromal hypomanic symptoms in BP-II appear to enhance function. When asymptomatic, BP-I and BP-II patients' psychosocial function normalizes to good levels. In the aggregate, these data indicate that every level of manic and depressive symptom severity is associated with harmful dysfunction and significant risk for early relapse. Therefore all levels of affective symptom severity, even subsyndromal, are legitimate targets for therapeutic intervention. The predominance of depressive symptoms indicates that more emphasis should be placed on the identification and management of depressive symptoms that present in patients with bipolar I and II disorders.

No.42E

DOES MAJOR AFFECTIVE DISORDER CHANGE WITH AGE?

William Coryell, M.D., 2-205 MEB, University of Iowa Carver College of Medicine, Iowa City, IA 52242

SUMMARY:

Little is known of how the manifestations of major affective illness change as individuals age. Efforts to study the effects of age on psychopathology have been limited to cross-sectional analyses and short-term follow-ups but these designs confound the effects of current age with those of age-of-onset.

The NIMH Collaborative Depression Study (CDS) has, for 25 years, followed a large cohort of patients who were recruited as they sought treatment for Research Diagnostic Criteria (RDC) Major Depressive Disorder (MDD), Bipolar Disorder, or Schizoaffective disorder. Follow-up interviews took place at 6-month intervals for the first five years and then at yearly intervals. The following analysis is limited to the 241 patients with unipolar depression and the 237 with bipolar I or II disorder who completed 20 years of evaluations. Patients were grouped by age at intake into "young" (18-29 years), "middle" (30-44 years), and "oldest" (45 years and older). Psychopathology was quantified as the percent of time in each five-year period during which an episode of MDD, mania, hypomania or schizoaffective disorder was present and also as the mean symptom-severity rating in each interval.

Neither unipolar nor bipolar patients showed age group-by-time effects on percent time ill or on severity ratings. However, the "young" and "middle" patients in both unipolar and bipolar groups showed striking declines in the likelihoods of suicidal behavior.

These results indicate that the severity and persitance of affective symptoms in unipolar and bipolar disorders do not change as individuals move from their third to their fifth decade, from their fourth to their sixth decade, or from their sixth to their eight decade. Suicide attempts, though, become much less frequent with age.

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SYMPOSIUM 43

INTERNATIONAL SYMPOSIUM ON BULLYING ACROSS THE LIFESPAN: ASSOCIATED HEALTH RISKS, DETECTION AND PREVENTION

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; (1) understand the nature, epidemiology, ecological aspects and developmental trajectories of bullying along the lifespan; (2) detect associated morbidity; (3) prevent mortality linked to bullying; and (4)Advocate for public health policy for its prevention.

No.43A

WORKPLACE BULLYING: WHAT WE KNOW, WHAT WE THINK WE KNOW AND WHAT WE DON'T KNOW

Loraleigh Keashly, Ph.D., Department of Communication, 585 Manoogian, Wayne State University, Detroit, MI 48225

SUMMARY:

Objective: Workplace bullying (persistent aggression) has recently begun garnering research attention in the US. However, workplace bullying has been examined more extensively in other countries from which valuable insights can be gained. The purpose of this presentation is to bring us up to date on what we know as researchers about the phenomenon (e.g., nature, prevalence, risk factors, and consequences) and what we still need to uncover and examine (e.g., motives of actors; organizational responses).

Method: This talk draws on published and ongoing research globally as well as the results of a NIOSH funded meeting in 2005 of domestic and international researchers to identify the current state of the field and future directions for both research and practice.

Results: Prevalence of workplace bullying globally ranges from 4% - 50% with US studies reporting 10-36% with cross-national differences in who the actors are. In the US coworkers and bosses equally likely to be bullies. Utilizing cross-sectional, longitudinal and physiologically based methodologies, exposure to bullying is consistently linked to poorer mental and physical health, increased stress, decreased job satisfaction and commitment,and decreased organizational productivity. Similar findings are being demonstrated for those who witness bullying. Evidence is also accumulating that exposure to bullying has negative implications for the health of family and friend relationships. While we know a great deal about the costs to victims, less so about the costs to organizations, we know very little about the actors and their motives. Further, there is little published evidence of actions to address bullying and their effectiveness.

Conclusions: Workplace bullying is clearly a pressing public health issue and future research needs to focus on the bully and the organizational factors with an eye to developing actionable data.

No.43B

BULLYING AMONG PRISONERS: THEORETICAL AND PRACTICAL ADVANCES FROM A DECADE OF RESEARCH

Jane Ireland, M.S.C., University of Central Lancashire, UK and Ashworth High Secure Hospital, Mersey Care NHS Trust, Preston, PR1 2HE, United Kingdom

SUMMARY:

Background: Academic interest in bullying has increased in the last ten years, with recognition that bullying is a prevalent problem between prisoners. The impact of bullying on prisons has only recently been explored, with increased interest in prison bullying occurring across different age groups (i.e. juveniles, young offenders and adults).

Objectives: This presentation will enable participants to:

1.) Understand the implications of bullying behaviour within prisons and identify differences across age groups; 2.) Detect the environmental and social risk factors associated with bullying; 3.) Advocate for a 'whole prison' approach to management as opposed to a focus on individual approaches.

Methods: This presentation will outline how the research field has developed by reviewing the published literature, focusing on developments in methods of measurement, theory and application. Attention will be given both to published thought on reactive and preventative approaches.

Results: Estimates of bullying behaviours range from 60% to 80% percent depending on the method employed and prison population studied. This presentation will demonstrate how; a.) Those involved in bullying behaviour should not be psychopathologised with a focus instead on the encouraging and reinforcing role played by the environment; b.) Attention needs to be given to the psychological health impacts both of experiencing and fearing bullying; c.) Behaviours displayed by prisoners can be considered symptom manifestations of victimisation; d.) Groups of 'bully' and 'victim' are by no means mutually exclusive; and e.) Bullying may serve an adaptive function in prisons and thus interventions based on skill deficit models are unlikely to prove effective in the long term.

Conclusion: There is theoretical and empirical evidence to suggest individual psychopathology approaches should not be advocated. The presentation will conclude by outlining the importance of taking a holistic approach.

No.43C

SCHOOL BULLYING AND RELATED HEALTH RISKS: DETECTION, PREVENTION AND ADVOCACY

Jorge C. Srabstein, M.D., 111 Michigan Avenue, NW, Washington, DC 20010

SUMMARY:

Background: There is a progressive recognition of the significant psychosomatic morbidity that affects students who participate in bullying as bullies and/or victims. Participation in bully-

ing incidents is also linked to mortality due to suicide, homicide or accidents.

Objectives:

1) Detect morbidity linked to bullying;

2) Prevent mortality associated with bullying; and

3) Advocate for public health policy for the prevention of bullying

Methods: This presentation will discuss an analysis of the 1996 WHO/US Health Behavior in School Children Survey, to document the frequency of health and educational risks among students who participate in frequent bullying as compared to their peers who are not engaged in this type of victimization. It will also discuss a 20 year newspaper survey of cases of death linked to bullying or hazing. It will finally examine anti-bullying public policy in the United States.

Results: Two to five per cent of US adolescents suffered from a cluster of frequently occurring psychosomatic symptoms, linked to their participation in frequent bullying incidents. These adolescents suffer from a significantly higher frequency of self injuries, substance abuse, absenteeism, poor grades and runaway episodes as compared to their peers who do not participate in bullying.

Conclusion: Psychiatrists have a central public health role in the detection of adolescents and young adults who suffered from significant morbidity and potential mortality linked to bullying

No.43D

BULLYING – IN THE CONTEXT OF WAR & TERRORISM

Paramjit Joshi, M.D., Department of Psychiatry & Behavioural Sciences, Childrens National Medical Center, 111 Michigan Ave NW, Floor 2.5, Room 700, Washington, DC 20010-2978

SUMMARY:

Background: Children are being bullied into socialized violence in ever increasing number world-wide. The most pronounced changes include increased prejudice and social rigidity toward other groups providing an atmosphere where children become victims of being bullied into socialized violence.

Objectives: This presentation will focus on the risk factors that lend themselves to children being bullied into socialized violence in the context of war and terrorism.

Methods: This presentation will review the published literature, focusing on how socialized violence is perpetrated and the secondary consequences on children's mental health including preventative approaches.

Methods: Increased levels of violence leads to decreased sensitivity to violence. Disenchanted adolescents often feel unappreciated leaving them vulnerable to the influence of militant adults and governments that recruit them as pupils of war, glorifying their acts of terror. Children are sometimes armed to fight in insurgent or counter-insurgency forces, exploited and bullied in the labor force, and thrust into political and social spheres not intended for the young. Many of these children remain violent and unaccepted by society long after wars have ended. In post-war South Africa, now-grown children who in the 1980's entered into sustained military action not only must suddenly shed their political military past, upon which so much of their identities have formed, but they also face high risk for substance abuse and criminal activity.

Conclusion: Collectively we bear added burden and responsibility to minimize the moral and ethical dilemmas young people face under such circumstances – for it is only in so doing that we might hope for ending repeated cycles of inter-generational violence

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SYMPOSIUM 44

LIFE WITHOUT PAROLE: SENTENCING FOR JUVENILE OFFENDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the audience will have an (1) increased awareness of the issues and implications of life sentences for juveniles; (2) Appreciate the need to assess developmental issues in juvenile offenders and mitigating factors in their crimes; and (3) understand the historical changes in the legal system and the resulting implications for juveniles.

No.44A

THE INCREASINGLY PARADOXICAL NATURE OF JUVENILE LIFE SENTENCES

David M. Siegel, J.D., New England School of Law, 154 Stuart Street, Boston, MA 02116

SUMMARY:

Legal developments over the past two decades have increased use of juvenile life sentences while forensic psychiatric research has increasingly questioned juveniles' adjudicative competence for developmental reasons. In the early 1990's, 40 states and the District of Columbia made transfer of juveniles for trial as adults easier – by increasing the scope of transferable offenses, decreasing the minimum age for trial as adults, and/or increasing prosecutorial discretion to transfer. This produced a steep increase in the number of juvenile cases transferred through 1994, and then – as crime generally fell through the 1990's – an equally steep decline to the present. A 2005 survey by the New York Times estimated 9,700 persons in the US are serving sentences of life for crimes they committed before age 18, and 2,200 of those are sentences of life without the possibility of parole. Yet in 2005, the US Supreme Court invalidated the juvenile death penalty in Roper v. Simmons, 543 U.S. 551, in part because of juveniles' immaturity and inability to fully recognize the consequences of

their actions. The US Supreme Court has not directly upheld the constitutionality of sentences of life without parole for juveniles, and some lower courts have suggested they may be unconstitutional. Greater clinical skepticism about juveniles' developmental competence, combined with this large group of persons sentenced to life imprisonment for crimes committed as juveniles, will raise the legal significance of this issue in the future.

No.44B
LIFE SENTENCES FOR JUVENILES: DEVELOPMENTAL CONSIDERATIONS

Diane H. Schetky, M.D., P O Box 220, Rockport, ME 04856

SUMMARY:

Dr Schetky will discuss developmental factors in youths such as cognitive immaturity ongoing brain maturation, trauma histories and neglect, which may be mitigating factors when it comes to sentencing juveniles. Expert testimony in helping the court understand developmental issues related to diminished culpability may be invaluable. She will draw upon her experiences in the trail of Lee Malvo, the juvenile sniper. The impact of extreme sentences or life sentence without parole upon juvenile offenders will also be addressed.

No.44C
CYNTOIA: A 16-YEAR-OLD GIRL SENTENCED TO LIFE IN PRISON

William Bernet, M.D., Vanderbilt Forensic Services, 1601 Twenty-Third Avenue South, Suite 3050, Nashville, TN 37212-3133

SUMMARY:

Dr. Bernet will present the case of Cyntoia, a 16-year-old girl who was found guilty of first degree murder and sentenced to life in prison (which means eligible for parole after 51 years). Cyntoia was living on the street and she supported herself through prostitution. She met a man at a fast-food restaurant, who gave her money and said she could stay at his house for the night. At the man's house, it was clear that he expected to engage in sexual activity with Cyntoia. Later, in the man's bedroom, the girl became frightened and shot the man in the back of the head.

Dr. Bernet will summarize the legal issues and explain his role as a forensic child and adolescent psychiatrist. In this case, Dr. Bernet testified in juvenile court regarding the issue of waiver to criminal court. At the hearing in juvenile court, Dr. Bernet's conclusions and recommendations were the following: (1) At the time of the alleged offenses, Cyntoia had serious psychiatric disorders including dysthymic disorder and borderline personality disorder. (2) Cyntoia was physically and sexually abused many times. (3) Cyntoia was intoxicated on marijuana and cocaine at the time of the alleged offense. (4) Cyntoia was very fearful at the time of the alleged offense. (5) Although Cyntoia has never been adequately treated for these mental conditions, appropriate treatment is available through the juvenile justice system.

REFERENCES:

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SYMPOSIUM 45

SAFETY AND RECENT RESEARCH IN NON-CONVENTIONAL THERAPIES

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be familiar with basic safety issues and significant new research findings pertaining to complementary and alternative treatments in mental health care.

No.45A
SAFETY CONSIDERATIONS WHEN CONSIDERING COMPLEMENTARY AND ALTERNATIVE THERAPIES

James H. Lake, M.D., 1015 Cass St., Ste 8, Monterey, CA 93940

SUMMARY:

This presentation will address problems caused by the absence of definitive safety information on alternative treatments used in psychiatry. Following a review of important general safety issues, specific safety issues associated with St. John's Wort, Kava Kava, Ginko biloba and other widely used herbals will be presented including tolerability, contraindications, adverse effects, and potential interactions with other natural products or medications. At the end of the presentation participants will have a general understanding of important safety issues associated with herbals commonly used in the U.S. to treat psychiatric disorders.

No.45B
VITAMINS AND MINERALS IN THE TREATMENT OF PSYCHIATRIC DISORDERS: A REVIEW OF THE EVIDENCE

Garry M. Vickar, M.D., 11125 Dunn Road, Suite 213, St. Louis, MO 63136

SUMMARY:

This presentation will review the historical role of vitamins, minerals and diet in the prevention and treatment of mental illness. Research evidence supporting specific dietary changes, vitamin and mineral supplementation will be critically reviewed for common psychiatric disorders. At the end of this session participants will have a better understanding of the evidence for nutrition and vitamin and mineral supplementation in the management of major depression, bipolar disorder and other psychiatric disorders.

No.45C
ADVENTURE THERAPY COUNSELING IN AT RISK YOUTH

James Fleming, M.D., 540 NE Newport, Lee's Summit, MO

64064

SUMMARY:

Adventure Therapy (AT) is an experiential approach to therapy stemming from the Outward Bound movement which came into prominence in the U.S. in the early 1970s . It includes a wide variety of therapeutically oriented group games and initiatives which rely more on cooperation than on competition. These approaches are commonly used in programs for at-risk and adjudicated adolescents. Settings for implementation of this approach range from classroom to ropes challenge courses to wilderness settings. Young people involved in the juvenile justice system may be more likely to benefit from a structured adventure activity because their often present need for high-risk, thrill seeking activities are satisfied in socially acceptable ways which require individual focus and goal-setting as well as group cooperation and accountability. Another factor which gives AT an advantage over verbally-based therapies in this population is the high prevalence of inattentive, hyperactive and impulsive symptomatology, While learning and psychological insight are difficult if not impossible to achieve in conventional settings due to these problems, AT approaches, which utilize more physical activity as well as direct (experimental) involvement minimize impediments to learning and insight cased by restlessness boredom and understimulation. Because of the large number of variables, research on these approaches are challenging, Yet, reasonably consistent findings have emerged in the case of wilderness therapy, for measure of self-efficacy, confidence, internal locus of control and decision making.

No.45D

USING TECHNOLOGY TO ENHANCE THE EFFECTIVENESS OF HYPNOSIS, ENTRAINMENT AND EEG BIOFEEDBACK

Jonathan H. Holt, M.D., 31 Stonybrook Lane, Williamsville, NY 14221

SUMMARY:

Hypnosis has been recognized as a mainstream medical modality since the mid 19th century. Important technological enhancements of hypnosis have been developed over the past two decades including prerecorded trance induction routines and guided imagery scripts. Controlled research studies have verified specific electrophysiological correlates of clinical improvement using these modalities. More recently, light and sound “entrainment” technologies have been used to amplify beneficial cognitive and behavioral effects of hypnosis and to “pre-package” these on tapes and other recording media. A related technology, EEG biofeedback or neurofeedback, allows training in meditation and hypnosis using validated neurophysiologic benchmarks. Clinical applications in behavioral medicine and psychotherapy will be reviewed and supporting research will be discussed. At the end of the presentation participants will have a general understanding of the history and clinical applications of “entrainment” technologies including EEG biofeedback in the management of common psychiatric disorders.

No.45E

USES OF EXPERIENTIAL THERAPIES IN PSYCHIATRY: A REVIEW OF THE EVIDENCE

Chris C. Streeter, M.D., Boston University School of Medicine, 85 E Newton St, M912E, Boston, MA 02114

SUMMARY:

This presentation will review the findings of a recently completed study demonstrating that regular practice of certain yoga breathing and chanting techniques results in significant increases in brain GABA levels as measured by magnetic resonance spectroscopy imaging (MRSI). The design and findings of this study will be discussed in detail and implications for the regular practice of yoga as an approach to the management of anxiety disorders will be discussed. At the end of the presentation participants will have a general understanding of how to advise patients about appropriate uses of yoga for the management of anxiety.

REFERENCES:

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SYMPOSIUM 46

RECENT ADVANCES IN CROSS-CULTURAL, ETHNIC AND ETHNOPSYCHOPHARMACOLOGICAL ASPECTS OF MOOD DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant should be able to appreciate that culture and ethnicity interact significantly to influence the phenomenology and response to treatment in mood disorders; understand the principles and application of ethnopsychopharmacology and recognize cross-cultural issues in the psychopharmacological and psychotherapeutic treatment of mood disorders.

No.46A

CULTURALLY SENSITIVE TREATMENT OF DEPRESSED CHINESE AMERICANS IN PRIMARY CARE

Albert Yeung, M.D., Suite 401, 50 Staniford St., Boston, MA 02114

SUMMARY:
In European and North American cultures, depression is a well-accepted psychiatric syndrome characterized by specific affective, cognitive behavioral, and somatic symptoms. In many non-European cultures, including Nigerians, Chinese, Canadian Eskimos, Japanese, and Southeast Asians, equivalent concepts of depressive disorders are not found (Marsella et al., 1985). Studies exploring illness beliefs of depressed among depressed Chinese Americans with a low degree of acculturation have shown that many of them were unaware of, or unfamiliar with the concept of major depressive disorder (MDD). The discrepancy of illness beliefs between less acculturated Chinese Americans and their physicians has led to under-recognition and under-treatment of MDD among Chinese Americans. The Culturally Sensitive Treatments were designed to improve recognition, acceptability, and adherence to treatment of depression. They include collaborative care in primary care and culturally sensitive Problem Solving Therapy for Chinese immigrants. The outcomes of these interventions will be discussed.

No.46B
ETHNOPSYCHOPHARMACOLOGY UPDATE

David C. Henderson, M.D., Massachusetts General Hospital, 25 Staniford Street, Boston, MA 02114

SUMMARY:
Understanding basic psychopharmacology principles and the impact of race, sex, and culture on metabolism, response, adverse events, medication interactions and medication compliance. Ethnopsychopharmacology examines biological and non-biological differences across race, ethnicity, sex and culture and is critical for safe prescribing practices. A growing body of published evidence is documenting important inter- and intra-group differences in how patients from diverse racial and ethnic backgrounds experience health and illness, and is affected by pharmacologic treatment. Recommendations will be provided to improve compliance, reduce adverse events and medication interactions, and to improve clinical outcomes. Depression and anxiety are one of the most common medical/psychiatric disorders and occur across all populations, though symptom clusters may vary greatly. Pharmacologic interventions are critical in the treatment of depression. An expanded understanding of the interactions between psychopharmacological treatment and gender, ethnic and cultural diversity informs conceptualizations of psychopharmacological treatments of various populations. Differences in cytochrome P450 enzymes such as the 2D6, 2A6, 2C9/2C19 metabolism rates and their implications for prescribing psychotropic medications will be reviewed. This lecture will also review principles of ethnopsychopharmacology and highlight issues influenced by race, gender, and culture in the pharmacologic treatment of depressive disorders and anxiety disorders. The role of genetic screening for poor and slow metabolizers will be discussed.

No.46C
PSYCHIATRIC MANAGEMENT OF HISPANIC PATIENTS: CROSS-CULTURAL ISSUES AND ETHNOPSYCHOPHARMACOLOGY

David Mischoulon, M.D., 50 Staniford Street, Suite 401, Boston, MA 02114

SUMMARY:
Increasing numbers of psychiatrists nowadays work with Hispanic patients, either on a regular basis through their outpatient clinic, or by serving as consultants to general internists who are called upon to manage psychiatric disorders in patients seen in the primary care setting. This session will review the demographics of the Hispanic-American population; discuss the different challenges and obstacles faced by clinicians who work with Hispanics, including the language barrier, cultural and interpersonal factors, gender roles, and differing beliefs and attitudes about mental health; review difficulties in diagnosis, including the impact of culture-bound syndromes (such as "ataque de nervios", and "susto") on assessment; and review different approaches to treatment, including relevant principles of ethnopsychopharmacology, and the role of natural remedies and folk healing. The topics covered should allow the clinician to effectively diagnose and treat psychiatric disorders in Hispanic patients and communicate more effectively with these patients in the clinical setting.

No.46D
CHALLENGES IN THE TREATMENT OF MOOD AND ANXIETY DISORDERS: CONSIDERATIONS IN THE ASIAN INDIAN POPULATION

Rajesh M. Parikh, M.D., Jaslok Hospital and Research Center, 15, Dr. G. Deshmukh Marg, Bombay, 400 026, India, Shamsah Sonawalla, M.D.

SUMMARY:
The Asian-Indian population is a diverse sub-group of individuals, with their own set of cultural norms, family traditions and religious belief systems, which may influence manifestation of depression and response to treatment. Mood and anxiety disorders are under-diagnosed and under-treated in this population, and mental illness is frequently viewed as an embarrassment or stigma. Young women often face unique pressures in the system, both from the family as well as from society. Family involvement is important in all stages of treatment of mental illness, including interactions with the treating physician and compliance with treatment. Herbal remedies and alternative treatments are widely used. Data on ethnopsychopharmacology, although limited, suggest differences in metabolism, dose requirements and adverse event profiles for antidepressant medications in this population. Cultural sensitivity is important during interactions with patients and their families. Understanding the complex cultural belief systems may allow clinicians to assess some of the cultural factors in treatment and potentially increase treatment acceptability and compliance, particularly with antidepressant medications. Suggested modifications for managing depression in the Indian population will be discussed. Findings from cross-cultural studies comparing depression in college students in the India and the U.S. will be discussed.

No.46E
CULTURAL CONSIDERATIONS IN THE DIAGNOSIS

AND TREATMENT OF MOOD DISORDERS IN WOMEN

Shamsah B. Sonawalla, M.D., Massachusetts General Hospital, 15 Parkman Street, WAC 812, Boston, MA 02114, Albert Yeung, M.D., Ph.D.; Rajesh Parikh, M.D

SUMMARY:

This presentation will discuss mood disorders associated with a woman's reproductive cycle, and will focus on providing a cultural perspective in this area. During periods of increased hormonal variability, women are more prone to depression, e.g. the premenstrual phase, the postpartum and the perimenopausal period. Up to 80% women experience some premenstrual symptoms. Menstruation is viewed differently across different cultures, and the experience of premenstrual symptoms is also affected by culture, in addition to biological and psychological factors. Up to 15% of women experience postpartum depression, a potentially serious condition. Researchers have found a relationship between postpartum depression and factors such as a cultural preference for a male child, lack of social organization of postpartum events and a lack of social recognition of the role transition for the new mother. Menopause is a normal transition in a woman's life; however, every woman's experience with menopause is unique and is influenced by several factors, including culture. Up to 80% of women in western societies suffer from physical and psychological difficulties at menopause. Interestingly, women in some non-western cultures appear to be significantly less affected by menopausal ills, e.g., Rajput women in India, who report minimal or no 'symptoms' of menopause. Studies suggest that women experience greater levels of stress, depression and anxiety when seeking treatment for infertility, which is traditionally viewed as a woman's problem, even if a male factor is responsible for the couple's infertility. Findings from a study on couples undergoing in-vitro fertilization in an assisted reproductive clinic in India will be discussed. The importance of understanding the cultural context and a holistic approach in treating women with mood disorders will be discussed.

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4. Yeung A, Howarth S, Chan R, Sonawalla S, Fava M, Nierenberg AA. Use of the Chinese version of the Beck Depression Inventory for Screening Depression in Primary Care. Journal of Nervous & Mental Disease. 190(2): 94-9, 2002.

SYMPOSIUM 47
HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE: PART 3

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: develop your own individual strategy for launching a successful private practice while maximizing your strengths and interests; identify techniques that that will give you the necessary edge to succeed in a competitive marketplace; and identify ways to balance the functions of manager, technician, and entrepreneur in a small business.

No.47A

HOW TO LAUNCH A PRIVATE PRACTICE: PART 3

William E. Callahan, M.D., 120 Vantis, #540, Aliso Viejo, CA 92656

SUMMARY:

This is the third part in a series organized by Drs. Callahan and Young. The first two parts are workshops covering coding and billing, and risk management and liability issues in launching a successful private practice. Even if you are not in private practice this course will offer lots of useful information that will assist you in launching your career. The third part focuses on the essentials to make it in private practice, and serve your patients well. The following areas will be covered, with plenty of time for questions: biggest risks for failure, individual issues that need to be considered, office location and design features, basic small business principles, streamlining your practice, financial management, marketing, and a summary of how each of the course directors think they succeeded. This course has been given for the last 10 years, and is constantly revised to offer up-to-the-minute ideas to meet the current marketplace. All of the faculty have thriving practices without reliance on managed care.

No.47B

HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE - PART 3

Keith W. Young, M.D., 10780 Santa Monica Blvd. Suite 250, Los Angeles, CA 90025, William E. Callahan, Jr., M.D., Keith W. Young, M.D.

SUMMARY:

This is the third part in a series organized by Drs. Callahan and Young. The first two parts are workshops covering coding and billing and risk management and liability issues in launching a successful private practice. Even if you are not in private practice, this course will offer lots of useful information that will assist you in launching your career. The third part focuses on the essentials to make it in private practice, and serve your patients well. The following areas will be covered, with plenty of time for questions: biggest risks for failure, individual issues that need to be considered, office location and design features, basic small business principles, streamlining your practice, financial management, marketing, and a summary of how each of the course directors think they succeeded. This course has been given for the last 10 years, and is constantly revised to offer up-to-the-minute ideas to meet the current marketplace. All of the faculty have thriving practices without reliance on managed care.

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1. Gerber, Michael E. The E-Myth Revisited: Why Most Small Businesses Don't Work and What to do About It, Harper business, ISBN 0887307280, April 1995.
2. Molloy, Patrick, Entering the Practice of Psychiatry: A New Physician's Planning Guide, Roerig and Residents, 1996.
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SYMPOSIUM 48

TREATING DEPRESSION IN PATIENTS WITH SCHIZOPHRENIA

EDUCATIONAL OBJECTIVES:
At the conclusion of the presentation, participants should be able to discuss;
(1) Treatment outcomes in patients with schizophrenia and depression symptoms and syndromes; and (2)Effect of antidepressant augmentation on depressive symptoms, suicidality, positive and negative symptoms, quality of life and cognitive function in middle aged and older schizophrenic patients who also have subsyndromal depressive symptoms (SSD)

No.48A
EFFECTS OF ANTIDEPRESSANT AUGMENTATION ON SUBSYNDROMAL DEPRESSIVE SYMPTOMS IN OLDER PATIENTS WITH SCHIZOPHRENIA ON POSITIVE AND NEGATIVE SYMPTOMS

Ipsit Vahia, M.D., Stein Institute for Research on Aging, University of California, San Diego,9500 Gilman Drive #0664, La Jolla, CA 92093, Nicole Lanouette, M.D., Sidney Zisook, M.D.

SUMMARY:
Background: Antidepressant medications are frequently prescribed to patients with schizophrenia and schizoaffective disorder, even for symptoms falling short of full major depressive episodes or anxiety disorders. The purpose of this report is to evaluate changes in positive and negative symptoms in middle-aged and elderly adults with schizophrenia/schizoaffective disorder and concomitant symptoms of depression who also receive augmentation treatment with the SSRI, citalopram.

Method: Patients 40 years or older with schizophrenia or schizoaffective disorder and clinically significant depressive symptoms, but not full major depressive episodes, were recruited at each of 2 sites: the University of California San Diego and the University of Cincinnati. Participants were randomized to continued treatment with an antipsychotic plus either citalopram or placebo for 12 weeks.

Results: At end of acute treatment, participants treated with citalopram reduced their PANSS+ mean scores from 14.9 (sd=6.0, n=109) to 14.8 (sd=6.19, n=81) compared to a reduction of 16.3 (sd=4.5, n=103) to 14.6 (sd=4.6, n=79) for participants treated with placebo (p = .049.) Differences in PANSS- mean scores were not significant. Participants whose depressive symptoms responded (> 50 % improvement on Calgary Depression Rating Scale) reported a mean change in PANSS+ score of –1.52 (n=71) vs -0.64 (n=88) for those who did not respond (p = .120); they also reported PANSS- score change of -.99 (n=71) vs -.20 (n=87) for nonresponders (p = .327).

Conclusions: Based on these results, augmentation of antipsychotic medication with the SSRI citalopram may have a negative impact on positive psychotic symptoms. We detected no effects on negative symptoms, or in responders compared to non-responders. These interesting and somewhat unexpected findings bear replication and suggest careful monitoring of positive psychotic symptoms in patients augmented with antidepressant medications.

No.48B
ANTIDEPRESSANT AUGMENTATION IN MIDDLE AGE AND OLDER ADULTS WITH SCHIZOPHRENIA AND DEPRESSIVE SYMPTOMS: EFFECTS ON FUNCTIONING AND SERVICE UTILIZATION

John W. Kasckow, M.D., 1703 Bear Run Dr, Pittsburgh, PA 15237, Thomas Patterson, Ph.D, Ian Fellows, M.S., Shah Golshan, Ph.D., Ellen Solorzano, B.S., S. Zickmund, Ph.D., Somaia Mohamed, M.D., Ph.D., Sidney Zisook, M.D.

SUMMARY:
Background: This study evaluated functioning and mental health utilization in citalopram treated patients as an augmentation to antipsychotic treatment in middle-aged and older adults with schizophrenia and subsyndromal symptoms of depression.

Method: Patients > 39 years with schizophrenia/schizoaffective disorder and subsyndromal depressive symptoms were recruited at U California, San Diego and U Cincinnati. Participants on 4 weeks of stable antipsychotic treatment were randomized to citalopram or placebo for 12 weeks. Outcomes included the SF-12 Health Survey, Medication Management Ability Assessment (MMAA) and the Services Utilization Resource Form.

Results: Of 212 participants, 79% were males and the mean age was 52(7.03) yrs [mean(standard deviation)]. With citalopram treatment, SF-12 Physical scores decreased from 44.6(10.3, n=108) to 42.9(10.3, n=81) compared to an increase of 42.3 (11.4, n=98) to 43.6 (10.6, n=76) with placebo (p=0.238). SF-12 Mental scores in citalopram treated patients increased significantly from 40.5(10.5, n=108) to 47.9(10.2, n=81) compared to an increase of 40.8 (10.7,n=98) to 43.4 (10.0, n=76) with placebo (p =0.002). There were no significant differences between groups on MMAA total error scores (p=0.191). The number of subjects treated with citalopram who had no other psychiatric outpatient visits increased from 14.4%(15/104) to 26.3%(21/80), whereas in the placebo group, the increase was from 12.2%(12/98) to 22.1%(17/77; p=.798). Participants with at least 50% improvement on Calgary Depression Rating Scale scores reported a significant change in SF-12 mental scores from 9.6 (n=70) compared to 1.4 (n=83) for non-responders (p <.001).

Conclusions: In these patients, augmentation of antipsychotics with citalopram had a positive impact on mental functioning. However, citalopram treatment appears to have no statistically significant effect on medication management ability nor on outpatient mental health service utilization.

No.48C
THE SPECTRUM OF DEPRESSIVE SYNDROMES AND TREATMENT OUTCOMES IN PATIENTS WITH SCHIZOPHRENIA

Nicole M. Lanouette, M.D., 9500 Gilman Drive #9116A-13, La Jolla, CA 92093, Ipsit Vahia, M.D., Sidney Zisook, M.D.

SUMMARY:

Depression is a common and clinically significant comorbidity in schizophrenia. The Epidemiologic Catchment Area study found that patients with schizophrenia were 29 times more likely than the general population to have a lifetime diagnosis of Major Depressive Episode (MDE). The National Comorbidity Study reported that 59% of schizophrenic patients met DSM-III criteria for major or minor depression. Comorbid MDEs markedly decrease quality of life, and increase relapse rates and suicide risk.

Although substantially less well studied and understood than co-morbid MDE, subsyndromal depressive symptoms (SDS) are estimated to be present in over 80 percent of patients with schizophrenia. They are so prevalent that some have argued that depression is a core component of schizophrenia. A prospective longitudinal study assessing depression in schizophrenia found only 24% of subjects remained free of depressive symptoms. Another study found more than two-thirds of schizophrenic patients who do not have MDEs have at least mild depressive symptoms (a score of =7 on the 17-item version of the Hamilton Rating Scale for Depression), and over 30% had depressed mood, and feelings of guilt and/or hopelessness. In schizophrenic patients, SDS have been associated with social and financial distress; diminished quality of life; increased health service utilization; overall symptom severity; demoralization; early relapse; and possibly elevated risk for suicide. Despite the prevalence and clinical importance of depression in patients with schizophrenia, and the widespread use of (off-label) antidepressant medications in this population, there is a surprising dearth of systematically obtained, randomized controlled data on either the efficacy or safety of such treatment. This paper will review the published literature on the safety and efficacy of antidepressant medications and psychotherapy for depression in patients with chronic schizophrenia and schizoaffective disorder.

No.48D

COGNITIVE FUNCTIONING IN MIDDLE AGED AND OLDER ADULTS WITH SCHIZOPHRENIA AND DEPRESSIVE SYMPTOMS

Somaia Mohamed, M.D., 950 Campbell Ave., West Haven CT, 06516, West Haven, CT 06516, Shah Golshan, Ph.D., John W. Kasckow, M.D., Ph.D., Thomas Patterson, Ph.D., Ellen Solorzano, M.S., Ian Fellows, M.S., Sidney Zisook, M.D.

SUMMARY:

Background: Cognitive impairment is recognized as a core characteristic of schizophrenia and of depression. The purpose of this study was to report on the relationship between attention and working memory, psychopathology, and everyday functioning, social skills, and medication management in middle aged and older adults with schizophrenia and depressive symptoms.

Methods: Patients with schizophrenia/schizoaffective disorder and a HAMD > 8 were recruited for this study at the University of California, San Diego and the University of Cincinnati. We administered scales assessing attention and working memory, everyday functioning, social skills, medication management quality of life and psychopathology.

Results: A total of 185 patients completed the cognitive measures. Mean age was 52.4 +. 6.95. 78% of the patients were male, 61% were Caucasian, and 64% had a diagnosis of schizophrenia (vs. schizoaffective disorder). There were significant site differences in many of the variables that were controlled for statistically. A multivariate analyses of covariance (MANCOVA) controlling for site revealed significant relationship between the cognitive measures and negative symptoms ($p = 0.02$), medication management ($p = 0.00$), social skills performance ($p = 0.01$), performance based skills assessment ($p = 0.00$), and total errors in medication management ($p = 0.00$). Relationships between individual measures were also examined.

Conclusion: In middle age and older patients with schizophrenia and depressive symptoms, attention and working memory deficits are related to negative symptoms and measures of social functioning and medication management. Thus treatments that enhance attention and working memory could have a positive impact on patient's social functioning and medication management

NO.48E

ANTIDEPRESSANT AUGMENTATIONS OF SUBSYNDROMAL DEPRESSIVE SYMPTOMS IN MIDDLE AGE AND OLDER PATIENTS WITH SCHIZOPHRENIA

Sidney Zisook, M.D., Psychiatry Department, University of California, San Diego, 9500 Gilman Drive, 9116A,, La Jolla, CA 92093, John W. Kasckow, M.D., Ph.D., Somaia Mohamed, M.D., Ph.D., Shah Golshan, Ph.D., Ian Fellows, M.S., Ellen Solorzano, B.S., David Lehman, M.D.

SUMMARY:

Background: Even when the psychotic symptoms have been effectively managed with antipsychotic medications, residual depressive symptoms often remain. These depressive symptoms may profoundly impact the psychosocial functioning, physical health, and long-term course and outcome in schizophrenia. Thus, interventions targeting depressive symptoms could substantially benefit patients with schizophrenia. This study evaluated the effectiveness of citalopram as an augmentation to atypical antipsychotics in middle-aged and elderly adults with schizophrenia and concomitant symptoms of depression.

Method: Patients 40 years or older with schizophrenia and clinically significant depressive symptoms were recruited at 2 sites: the University of California San Diego and the University of Cincinnati. Participants were randomized to continued treatment with an antipsychotic plus either citalopram or placebo for 12 weeks. The primary outcome measures were changes in mean Hamilton Depression Scale (HAM-17) and Calgary Depression Rating Scale (CDR) scores.

Results: The majority of the 212 enrolled participants were males (79%) and the mean age was 52 years. Participants treated with citalopram reduced their HAM-17 scores from 13.71 to 8.48 compared to a reduction of 13.39 to 9.10 for participants treated with placebo (NS). Similarly, participants treated with citalopram reduced their CDR scores from 6.52 to 3.72 compared to a reduction of 6.92 to 5.00 for participants treated with placebo ($p<.05$). Response rates based on the HAM-17 were 49% citalopram vs

29% placebo (p<.05) and on the CDR was 54% citalopram vs 35% placebo (p<.05). The most cfrequent side effects with citalopram were: diarrhea, fatigue, and insomnia.

Conclusions: Augmentation of antipsychotics with the SSRI citalopram is effective in reducing symptoms of depression and is well tolerated in middle-aged and elderly patients with schizophrenia and concomitant symptoms of depression.

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SYMPOSIUM 49

THE VIRGINIA TECH TRAGEDY'S INFLUENCE ON VIRGINIA'S MENTAL HEALTH SYSTEM

AMERICAN ASSOCIATION OF PSYCHIATRIC ADMINISTRATORS

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize potential influences of a tragedy on a state's mental health system, including both the historic setting into which the event occurred and the potential future impact for transformation. The participant should be able to identify different perspectives on mental health system reform and recognize his or her own opportunity to advocate and effect change.

No.49A

THE STATE MENTAL HEALTH AUTHORITY'S ROLE BEFORE AND AFTER A TRAGEDY INVOLVING INDIVIDUALS WITH MENTAL ILLNESS: WHAT IMPACT DO WE HAVE?

James S. Reinhard, M.D., Office of Commissioner, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23218-1797

SUMMARY:

Following the Virginia Tech shootings on April 16th, 2007, much attention turned to the public mental health system when it was determined that the perpetrator of the tragedy had brief contact with local community mental health center during a temporary detention evaluation period and civil commitment proceedings. This contact with the public mental health system and civil commitment courts occurred 16 months prior to the incident. Reviews of the incident have revealed a multitude of findings and recommendations regarding the shortfalls and needed improvements in the public mental health system. The role of the State Mental Health Authority (SMA) in ensuring the provision of critical "safety net" mental health services (such as emergency services, case management, outpatient services, and civil commitment oversight) will be examined. Balancing the responsibilities of providing critical mental health services and helping to ensure public safety will be reviewed from a philosophical, ethical and practical perspective. Criticism, support, and public policy changes related to the SMA in response to a tragedy of this magnitude will be explored. This response varies widely from measured, thoughtful and appropriately helpful changes in the system to reactionary, politically motivated "quick fixes" that further stigmatize those with mental illness and do not improve the system. Attendees will develop a more thorough understanding of at least one SMHA and learn about ways to help support these authorities in becoming more effective change agents in transforming the current mental health system.

No.49B

TAKING ADVANTAGE OF THE OPPORTUNITY FOR REFORM

Richard J. Bonnie, J.D., University of Virginia Law School, 580 Massie Rd,, Charlottesville, VA 22901

SUMMARY:

The Virginia Tech tragedy in April, 2007 highlighted some gaps in community mental health services and deficiencies in the civil commitment process that were already being studied by the Commission on Mental Health Law Reform chaired by Professor Bonnie. The 26-member Commission had been created under the auspices of the Supreme Court in the fall of 2006 to undertake a comprehensive review of the current system and to propose recommendations for reform. The Chief Justice also appointed 5 task forces, involving another 150 participants, to assist the Commission in the areas of access to services, civil commitment, needs of children and adolescents, criminal justice, and empowerment and self-determination. In this presentation, Professor Bonnie will reflect on the impact of the tragic events at Virginis Tech and of the report of the Governor's Virginia Tech Panel on the work of the Commission and on the political process.

No.49C

THE IMPACT OF MENTAL HEALTH TRAGEDIES: A CIVIL RIGHTS PERSPECTIVE

Robert Bernstein, Ph.D., Bazelon Center for Mental Health Law, 1101 15th Street, NW, Suite 1212, Washington, DC 20005

SUMMARY:

Though occurring infrequently, well-publicized tragedies attributed to untreated mental illness have a profound and enduring effect upon public mental health across the nation. These events—often characterized as "wake up calls"—draw attention to the difficulties public systems have in delivering even basic services

to people with serious mental illness. Their repercussions can significantly influence such factors as the allocation of resources to and within states' mental health systems, specific populations prioritized for services, and public expectations about the efficacy of treatment for people who have serious mental illnesses. In their immediate aftermath, there is generally heightened interest in broad mental health reforms, but too often the political will to implement meaningful change dwindles over time. More enduring are cynical perceptions of people with serious mental illness as ticking time-bombs and quick legislative "fixes." Ironically, at a time when there is a substantial body of empirical evidence demonstrating the effectiveness of a variety of treatments and approaches for people with serious mental illness, these episodes have not made quality services commonplace. Rather than spurring the long-overdue infusion of creativity and resources into community mental health that would allow both professionals and the people they serve to demonstrate their true capabilities, the political path has been to find a cheap way out. For instance, the trend has been to turn to the courts, not to clinicians, to promote the narrow goal of treatment compliance among people viewed as difficult to serve. This presentation, from the perspective of a national advocate for the rights of people with mental disabilities, will review how responses to well-publicized tragedies have reinforced the patchwork, crisis-oriented nature of public mental health and how the professional community, in its silence, has been complicit.

NO.49D

SELF-DETERMINATION AND EMPOWERMENT IN THE POST VIRGINIA TECH ENVIRONMENT

Vicky M. Fisher, Ph.D., Catawba Hospital, PO Box 200, Catawba, VA 24070

SUMMARY:

In October, 2006, the Chief Justice of the Virginia Supreme Court appointed a 26 member Mental Health Law Reform Commision (MHLRC). This diverse group of stakeholders was charged with conducting a comprehensive examination of Virginia's mental health laws and services. The work of the Commission was divided among five task forces, including the Task Force on Empowerment and Self-Determination.

In April, 2007, while the Commission's work was in progress, the school shootings at Virginia Tech occurred. These events impacted the nation and the Commission in myriad ways. Public perceptions of fear and misunderstanding reached new heights. Emotional backlash intensified around the central issue of balancing public safety with civil liberties. Some providers questioned the utility of employing the recovery model of care. In many circles, public debate intensified, calling for increased "law and order" responses to mental illness.

The events at Virginia Tech powerfully influenced the work of the full Commission,and in particular the Task Force on Empowerment and Self-Determination. Many ensuing questions emerged, including the following issues. How would the process of system transformation in Virginia's mental health services system continue? How could individuals with mental illness, families, public policy makers, the Department of Mental Health, providers, and the public proceed in ethical and reasoned ways, without reverting to archaic stereotypes regarding mental illness? In examining these issues, this panel presentation highlights the work of the Task Force on Empowerment and Self-Determination in the post Virginia Tech environment.

REFERENCES:

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WEDNESDAY, MAY 7, 9:00 AM-12:00PM

SYMPOSIUM 50

ADVANCES IN EARLY DETECTION, TREATMENT, AND PREVENTION OF PSYCHOSIS: FINDINGS FROM THE NORTH AMERICAN PRODOME LOGITUDINAL STUDY

National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will be able to describe methods for assessing risk for affective and non-affective psychosis in vulnerable youth, understand the association between cannabis misuse and psychosis onset in at-risk individuals, recognize which symptoms of the psychosis prodrome trigger pharmacotherapy in clinical settings, and appreciate the role of psychological interventions for delaying or preventing the onset of psychotic disorders.

No.50A

RISK OF MANIA IN PERSONS AT HEIGHTENED CLINICAL RISK FOR PSYCHOSIS

Diana O. Perkins, M.D., University of North Carolina, Dept of Psychiatry, CB # 7160, Medical School Wing D, Rm 252, Chapel Hill, NC 27599-7160, Scott W. Woods, M.D.

SUMMARY:

While designed to predict risk of schizophrenia psychosis, individuals meeting Structured Interview for Prodromal Syndromes (SIPS) criteria may be at-risk for bipolar disorder, with or without psychosis. We investigated bipolar risk prediction in subjects from the North American Prodrome Longitudinal Study (NAPLS) collaborative database who possessed follow-up diagnostic data. Study subjects included 194 SIPS+ and 67 help-seeking comparison subjects (referred to the study due to suspicion of prodromal symptoms but not meeting prodromal criteria). Twenty-three (12%) of the SIPS+ and 16 (24%) of the help-

seeking comparison subjects met diagnostic criteria for *DSM-IV* mania during the follow-up period (p=0.03). Only five of these had psychotic symptoms despite the study's focus on the psychotic prodrome. Prodromal symptoms that were significantly more severe in at-risk subjects who subsequently developed mania included social anhedonia, avolition, impaired occupational functioning, and dysphoric mood (i.e., irritability, depression). In help-seeking comparison subjects predictive symptoms included suspiciousness, decreased focus and attention, sleep disturbance, and intolerance to stress. Consistent with these findings, most subjects who developed *DSM-IV* mania (20/23 SIPS+ and 16/16 help-seeking comparison subjects) were diagnosed with depression at baseline evaluation. These findings indicate that depressive symptoms at initial assessment may indicate a vulnerability state for later development of *DSM-IV* mania. It is of interest that the development of mania was more common among individuals referred for psychosis prodrome evaluation but who failed to meet diagnostic criteria for the syndrome. It may be that other symptoms or aspects of functional impairment not captured by SIPS criteria prompted clinical referral, and will prove to be better predictors of mood instability and subsequent development of mania.

No.50B

PSYCHOSOCIAL TREATMENTS FOR THE PSYCHOSIS PRODROME

Jean M. Addington, Ph.D., Centre for Addiction and Mental Health, 250 College Street, Toronto, M5T1R8, Canada Irvine Epstein, M.D., Robert Zipursky, M.D.

SUMMARY:

A new development in the prevention of schizophrenia is the potential of psychological interventions for those in the prodromal phase of a psychotic illness. Prior to the diagnosis of a prodromal state, these young people are help-seeking. After diagnosis, although pharmacological treatments seem to be effective, this is not the treatment of choice for most of these young people who generally prefer to engage in psychological treatments. Work emerging in this field is examining the effectiveness of interventions including cognitive-behavioral therapy (CBT), cognitive-remediation, supportive therapy and family work (Addington et al., 2006). A recent British trial suggested that a psychological intervention may delay the onset of psychosis. The aim of the Toronto ADAPT study is to determine the effectiveness of CBT in preventing or delaying the onset of psychosis. Recruitment is now complete with 54 subjects having been randomized to a 6-month course of either CBT or supportive therapy. Participants are followed for one year after therapy to determine the benefits. Symptoms and functioning are monitored monthly for the first 6 months and then at three monthly interviews. Individuals who participate in this study have access to case management and psychiatric management. The CBT approach used is based on an individual case formulation that utilizes change strategies such as normalization, generating and evaluating alternative explanations, safety behaviours, metacognitive beliefs and combating social isolation to address the diverse array of presenting symptoms and problems. Educating communities, recruiting participants, training therapists in this manualized approach and determining outcome with respect to treating young people who appear to be at risk are important issues to be addressed in treating this new population. Follow-up data addresses engagement, adherence and alliance issues. Outcome at end of treatment and 6 months post treatment will be presented.

No.50C

CANNABIS MISUSE AND RISK FOR PSYCHOSIS IN A PRODROMAL SAMPLE

Kristin S. Cadenhead, M.D., Department of Psychiatry 0810, University of California San Diego, 9500 Gilman Drive, La Jolla, CA 92093-0810, Robert Heinssen, Ph.D., A.B.P.P.

SUMMARY:

Background: Recent population based studies have demonstrated an association between cannabis abuse and future risk of chronic psychosis. In a study at UCSD that examined the rate of cannabis misuse and subsequent psychosis among 48 individuals "at risk" for developing a psychotic disorder, 83.3% of those who converted to psychosis at 1 year follow-up had a history of cannabis abuse compared to 26.2% of those who had not converted. To determine whether the cannabis/psychosis association was present in a larger sample, data were analyzed from the NAPLS multi-site database. Methods: The sample included 236 individuals (Mean Age =18.2, 143M/93F) putatively prodromal for psychosis based on subsyndromal psychotic symptoms and/or a family history psychosis and who received at least 1 year of follow-up. Fifty-seven (24%) subjects had a history of cannabis abuse or dependence (misuse) while the rate of other drug misuse was relatively low (range: 0.4% [opiates, N=1] – 3.8% [hallucinogens, N=9]). Thirty-nine subjects (16.6%) reported a history of alcohol misuse. Results: Sixty (25%) of the 236 at risk subjects converted to psychosis within 1 year. One third of those subjects who later converted had a history of cannabis misuse compared to 22% of subjects who had not converted at follow-up (Fisher's Exact: $p<0.05$). Twenty-five percent of the converted subjects had a history of alcohol misuse compared to 14% of non-converters but this was not a significant association. Discussion: The significant association between cannabis misuse and later conversion to psychosis suggests that cannabis represents an important risk factor that might act as a second "hit" in individuals already vulnerable for psychosis. Early identification and intervention programs should screen for cannabis use and provide education about the potential long term consequences of cannabis misuse for anyone with a family history of psychosis or showing prodromal signs of illness.

No.50D

PREDICTING PSYCHOSIS ONSET IN YOUTH AT HIGH CLINICAL RISK: THE EFFECTS OF PRODROMAL SYMPTOMS, NEUROCOGNITION AND FAMILY HISTORY

Larry J. Seidman, Ph.D., Harvard Medical School, MMHC Department of Psychiatry, Landmark Center, 401 Park Drive, 2 East, Boston, MA 02215, Tyrone D. Cannon, Ph.D., Ming Tsuang, M.D.

SUMMARY:

Background. Early detection and prospective evaluation of individuals who will develop schizophrenia or other psychotic disorders is critical to identify mechanisms underlying psychosis onset and to test preventive interventions. Our goal was to determine the risk for conversion to psychosis and to evaluate the predictive power of a number of factors including prodromal symptoms, family history of psychosis and neuropsychological functioning. Methods. A prospective, longitudinal study with 2 and 1/2 years of follow-up of 291 prospectively identified treatment-seeking patients meeting Structured Interview for Prodromal Syndromes (SIPS) criteria, recruited and evaluated across 8 clinical research centers as part of the North American Prodromal Longitudinal Study (NAPLS). Data were pooled across sites. Results. Risk for conversion to psychosis was 35%, with a decelerating rate of transition during the 2.5-year follow-up period. Five features assessed at baseline contributed uniquely to the prediction of psychosis: a genetic risk for schizophrenia with recent deterioration in functioning, higher levels of unusual thought content, higher levels of suspicion-paranoia, greater social impairment, and history of drug abuse. Prediction algorithms combining two or three of these variables resulted in dramatic increases in positive predictive power (i.e., to 68-80%) compared with the prodromal criteria alone. Neuropsychological impairments in the clinical high-risk group were most severe in persons who converted to psychosis, especially those who had a family history of psychosis. Conclusion. These findings demonstrate that prospective ascertainment of individuals at risk for psychosis is feasible. The pattern of predictors suggest that with further refinement, in the near future, clinicians may be able to use these measures to identify very high risk individuals who may benefit from preventive intervention programs.

No.50E

THE RELATION OF ANTIPSYCHOTICS AND SSRIS WITH BASELINE SYMPTOMS AND SYMPTOM PROGRESSION IN PRODROMAL SUBJECTS: A NATURALISTIC STUDY

Elaine Walker, Ph.D., Department of Psychology, Emory University, 532 N Kilgo Circle, Atlanta, GA 30322, Barbara Cornblatt, Ph.D.

SUMMARY:

A substantial number of patients at heightened clinical risk for psychosis receive antipsychotic and/or antidepressant medications. There is evidence that both classes of medication may be effective in reducing symptoms associated with psychosis risk. The present study examined the relation of medication status with prodromal symptom severity, as assessed by the Structured Interview for Prodromal Symptoms (SIPS), at baseline and follow-up evaluation. Symptom ratings and data on atypical antipsychotic and SSRI medication use were obtained at baseline and 6-month follow-up for 252 individuals who met SIPS criteria for the psychosis prodrome. Severity ratings were derived for four symptom dimensions; positive, negative, disorganized and general symptoms. At baseline, those currently and subsequently on antipsychotic medication showed more severe disorganized and general symptoms than those not on medication ($p < .01$). Similarly, those currently or subsequently on an SSRI had significantly higher baseline ratings on general symptom severity than those not on an SSRI ($p < .05$). There were no significant associations between baseline symptom severity and medication status at follow-up. Repeated measures ANCOVA of symptom ratings revealed that all symptom dimensions declined in severity over time, but that the magnitude of decline differed significantly as a function of antipsychotic medication status (medication X time interaction, $p < .005$). Those never on antipsychotic agents showed less reduction in positive and disorganized symptoms over time. The same analyses for SSRIs revealed that they were unrelated to changes in symptom severity, although there was a trend toward improved general symptom ratings ($p < .08$). The findings are discussed in light of the clinical symptoms that precipitate the prescribing of medications, the potential implications for symptom reduction in persons at-risk for psychosis, and the importance of future clinical trials.

No.50F

SHOULD THE PSYCHOSIS PRODROME BE INCLUDED IN *DSM-V*?

Scott W. Woods, M.D., 34 Park Street, New Haven, CT 06519, Thomas H. McGlashan, M.D.

SUMMARY:

Background: This symposium reports findings from the North American Prodrome Longitudinal Study and other datasets of patients meeting diagnostic criteria for the psychosis prodrome. Dr. Seidman reports that risk for conversion to psychosis among prodromal patients is 35% at 2.5 years; other variables increase predictive accuracy to 80%. Neurocognitive function is especially impaired in converters. Dr. Perkins reports that depressive symptoms at initial assessment may indicate a vulnerability state for later development of *DSM-IV* mania. Dr. Cadenhead reports that significantly more subjects who later develop psychosis have a history of cannabis misuse. Dr. Walker reports that at baseline, prodromal subjects on antipsychotic medication show more severe disorganized and general symptoms, but significantly reduced symptoms at follow-up. Dr. Addington reports on a randomized trial of 54 prodromal patients assigned to cognitive behavior or supportive therapy. Methods: In addition to these findings, patients meeting psychosis prodrome diagnostic criteria (n=372) were compared to several comparison groups on cross-sectional measures in multiple domains. Results: Prodromal patients were robustly distinguished from normal controls across all domains, strongly distinguished from clinically-referred help-seeking controls and genetic high risk subjects in many domains, and distinguished from schizotypal patients on multiple measures. Discussion: Diagnostic criteria for the prodromal risk syndrome for psychosis identify a patient group that is distinct at initial evaluation, at high and specific risk for future psychosis, vulnerable to cannabis misuse, and often medicated in the community. These data support the validity of the prodromal risk syndrome for psychosis and suggest the syndome's careful consideration for inclusion in *DSM-V.* Such inclusion would promote more formal study of treatment options for these symptomatic,at-risk, impaired, but understudied patients.

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SYMPOSIUM 51

TREATING PTSD IN A VIOLENT WORLD

National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participants should have: (1) Increased knowledge of the extent and nature of trauma related psychopathology in various populations; (2) Increased knowledge of how integrating neurobiological, genetic, behavioral and social aspects of risk and resilience is leading to improved understanding of pathophysiology, diagnosis and treatment of PTSD; and (3) Increased knowledge of current and evolving intervention practices and evidence of their effectiveness.

No.51A

TREATMENT AND PREVENTION RESEARCH, PART 2: THE JERUSALEM TRAUMA OUTREACH AND EARLY PREVENTION STUDY

Arieh Y. Shalev, M.D., Dept of Psychiatry, Hadassah University Hospital, Jerusalem, 91120, Barbara Rothbaum, Ph.D.

SUMMARY:

Post-traumatic stress disorder (PTSD) has a detectable starting point and typical early symptoms. Early psychological interventions may prevent the occurrence of chronic PTSD. Data on large-scale implementations of early evidence-based therapies for PTSD is missing. We report the design, the implementation, and the outcome of a systematic outreach and early treatment program. We screened 8200 ER admission records for potential trauma, interviewed 5285 survivors by telephone, within 10 days of the event, and invited 1470 symptomatic survivors to clinical assessment, within 20 days of the event. Of those invited, 753 (51.2%) have attended a clinical assessment, 398 had qualifying ASD or PTSD symptoms, and 290 have accepted an offer of early treatment. The latter were randomized (stratified-equipoise randomization) to receive 12 sessions of either cognitive therapy (CT; n=52), or Prolonged Exposure (PE; n=73); or to receive12 weeks of either escitalopram (20mg) or placebo (n=53), or to start PE three months later (WL; n=112). Clinicians who were blind to treatment allocation have assessed all those who were present in the previous interviews, five and eight months following trauma. Structured telephone interviewers assessed the outcome of the larger group seven and 14 months following trauma. The results show short- and long-term efficacy of trauma–focused early therapies, and moderate differences between early and late PE. Reluctance to see a clinician (48.8%) was the major barrier to receiving treatment. Only 5.9% of those approached declined a structured telephone interview, and 27.2% did not attend treatment despite clinicians' recommendations. More subjects declined medication than psychological therapies or a waitlist. The long-term effect of declining help, the error term of interviewers' and clinicians' decisions to offer treatment, and the overall need for treatment resources will be discussed. Systematic outreach is feasible, has reasonable cost, and reduces the rates of PTSD in survivors at high risk.

No.51B

CUTTING EDGE TREATMENT AND PREVENTION RESEARCH

Barbara Rothbaum, Ph.D., Trauma and Anxiety Recovery Program, Emory University School of Medicine, 1841 Clifton Road NE, Atlanta, GA 30329

SUMMARY:

Exposure therapy is considered one of the first line treatments for PTSD based on the clinical and translational literature. Recent advances have been exploring methods to enhance exposure therapy. Two methods being explored include Virtual Reality (Rothbaum, 2006) and augmenting exposure with D-Cycloserine (DCS), a cognitive enhancer that has been found to facilitate the extinction of fear in exposure therapy. DCS is a broad-spectrum antibiotic and a partial agonist at the N-methyl-D-aspartate (NMDA) receptor. NMDA receptors are involved in the process of extinction learning – the gradual decrease in conditioned fear when the conditioned stimulus is presented repeatedly in the absence of the unconditioned aversive stimulus (Myers & Davis, 2002). It has recently been shown in rodents that systemic administration of DCS produces a dose-dependent facilitation of extinction (Myers & Davis, 2002). Importantly, we initially showed that DCS enhances the extinction of fear in humans with specific phobia as well (Ressler et al 2004). Notably, this has now been replicated by several groups treating other anxiety disorders including social phobia and obsessive-compulsive disorders (Kushner 2007; Hofmann 2006; Tolin, 2006; Wilhelm, 2006). We are now performing a double-blind placebo controlled trial examining the role of DCS to augment virtual reality exposure treatment of PTSD in OEF/OIF veterans. In these experiments, DCS is thought to be acting by increasing the neural plasticity involved in the inhibitory learning that takes place with exposure therapy upon reminders of the traumatic events, a process known as extinction of fear.

No.51C

PREVALENCE AND TREATMENT OF PTSD

Charles R. Marmar, M.D., Department of Psychiatry UCSF, Langley Porter Psychiatric Institue, Box F-0984 401 Parnassus Ave, San Francisco, CA 94941

SUMMARY:
Studies of the current and lifetime prevalence of PTSD will be presented including rates in the general population, and in high risk populations including police and other first responders, and in assault, natural disaster and terrorism victims. Findings on the prevalence of warzone related PTSD and associated comorbidities in Vietnam Veterans, veterans of the first Gulf War, and for those who have served in Iraq and Afghanistan will be also be presented. Individual differences in risk and resilience for onset and course of PTSD will be presented, and related to a model of affect regulatory capacities under threat. New data will be presented on the rates of PTSD, depression and substance abuse in 300,000 Iraq and Afghanistan Veterans who have sought treatment at a VA Medical Center following deployment. In this nationwide VA sample the relationship of age, gender, ethnicity, branch of service, active duty, guard and reserve status and time from the onset of hostilities to rates of PTSD and other warzone related mental health problems will be presented. Evidence based treatments of civilian and combat related PTSD will also be presented and discussed in the context of real world practice patterns.

No.51D
DEVELOPING AND IMPLEMENTING PTSD INTERVENTIONS IN REAL WORLD SETTINGS

Douglas F. Zatzick, M.D., 325 9th Avenue, Box 359896, Seattle, WA 98104, Peter Roy-Byrne, M.D., Frederick Rivara, M.D., M.P.H., Gregory Jurkovich, M.D., Joan Russo, Ph.D., Chris Dunn, Ph.D., Amy Wagner, Ph.D., Sandro Galea, M.D. Dr.P.H., Wayne Katon, M.D.

SUMMARY:
Early trauma-focused intervention development targeting PTSD and related disorders has emphasized unidirectional trajectories that begin with basic/efficacy studies followed later by effectiveness/implementation research. This presentation describes how population-based implementation/practice research methods were used to develop a collaborative care intervention for acutely injured trauma survivors that included evidence-based psychotherapy and pharmacotherapy targeting PTSD. A population-based sample of 120 injured surgical inpatients ages 18 or older were recruited from the University of Washington's Harborview level I trauma center. Intervention patients (N=59) received a stepped collaborative care intervention that included: 1) continuous post-injury case management, 2) motivational interviewing targeting alcohol consumption, and 3) evidence-based pharmacotherapy and/or cognitive behavioral therapy targeting PTSD. Control patients (N=61) received care as usual. Random-coefficient regression analyses demonstrated that over time intervention patients were significantly less symptomatic compared to controls with regard to PTSD ($p < 0.02$) and alcohol abuse/dependence ($p < 0.05$). Investigations that incorporate population-based methods early on in the treatment development process have the potential to account for relevant patient, provider, organizational and community contextual factors and thus facilitate the development of feasibly applied, effective early trauma focused interventions.

No.51E
INTEGRATING BIOPSYCHOSOCIAL FACTORS MEDIATING RISK AND RESILIENCY IN PTSD

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

SUMMARY:
In addition to trauma exposure, a number of other factors contribute to the risk for development of posttraumatic stress disorder (PTSD) in adulthood. Both gene and environmental variables are involved, with the genetic heritability for PTSD ranging from 30-40% and developmental experience such as child abuse also providing significant risk liability. Dr. Ressler will discuss studies examining the gene x environment effects of childhood maltreatment, level of trauma exposure and genetic polymorphisms at stress-related genes to predict levels of PTSD and depressive symptomatology in adults. These data suggest that genetic variation at stress-related genes may be critical to sensitization of the stress-response pathway during development placing those individuals with risk polymorphisms who have had significant child abuse at significant risk for PTSD following adult traumatic experiences.

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WEDNESDAY, MAY 7, 2:00 PM- 5:00PM

SYMPOSIUM 52

AN INTERSTATE COMPARISON OF EXCLUSIONS TO INVOLUNTARY CIVIL COMMITMENT LAWS: HAS A BIOETHICS SUCCESS COME UNDONE

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to; (1) explain the moral intent behind the legal protections provided by state statutes governing involuntary commitment; (2) describe the dissonance between the public policy objectives that ground commitment law and the language of the state statutes; and (3) discuss policy options for addressing the legislative ambiguities of the various state laws.

No.52A
ETHICAL AND CONCEPTUAL ISSUES

Claire L. Pouncey, M.D., Belmont Behavioral Health, 4200 Monument Rd., Philadelphia, PA 19131

SUMMARY:

Philosophically, the MHPA raises three significant questions. First, can we identify organizing principles that rationalize senility, mental retardation, and drug dependence as the only three conditions for which one cannot be committed involuntarily? Second, if the excluded conditions are based in the psychiatric theory and nosology in use at the time the statute was written, can they be translated into modern-day equivalents, despite changes in psychiatric theory and terminology? Third, can the judicial problem of strict interpretation be solved by using a carefully worded, universally applicable definition of 'mental disorder' to make commitment decisions? I argue that the statutory language of the MHPA is not, in fact, based in principles, but rather reflects the language of *DSM-II*. As such, the excluded conditions identified in the MHPA do not refer, thus making "strict interpretation" conceptually impossible. Finally, I argue that a strict legal definition of 'mental disorder,' 'mental disability,' or the like, is equally doomed to failure, for reasons practical, historical, and conceptual. I propose that the solution to these conceptual problems and the resultant ethical conundrum is to devise a legal mechanism that would allow commitment court participants some flexibility for referring to contemporary psychiatric terminology while continuing to protect the liberty and autonomy of patients to every extent possible.

No.52B
PSYCHIATRIC LIMITATIONS OF THE MENTAL RETARDATION EXCLUSION

Fayez A. El Gabalawi, M.D., Belmont Behavioral Health, 4200 Monument Road, Philadelphia, PA 19131

SUMMARY:

Pennsylvania's exclusion of persons with mental retardation (MR) from involuntary commitment illustrates a number of conceptual and legal problems. On the one hand, it makes sense to exclude MR, because Pennsylvania law guarantees other treatment and services for these persons. On the other hand, MR frequently co-occurs with other Axis I disorders, obfuscating which disorder caused the behaviors leading to commitment. Conceptually, it is appropriate to exclude MR from involuntary commitment because the disorder is not well defined: prognoses for different kinds of MR are heterogeneous. Furthermore, MR may be conceived better as a developmental descriptor rather than as a discrete mental disorder. However, if a person with MR that co-occurs with another psychiatric diagnoses demonstrates dangerous behaviors, involuntary commitment may be appropriate.

No.52C
LEGAL ISSUES RAISED BY EXCLUSIONS IN CIVIL COMMITMENT STATUTES

Karoline K. Adler, Esq., 7945 Montgomery Ave., Elkins Park, PA 19027

SUMMARY:

State civil commitments laws authorize the state to act for the good of the individual, to mandate necessary treatment, and to commit a mentally ill individual to protect others from harm. Civil commitment statutes traditionally gave doctors a dominant voice in the commitment process. As a result of federal decisions, handed down in the 1970's, all state statutes were repealed and rewritten to conform with due process requirements. The new statutes minimized doctors' authority and instituted standards and procedures now required to protect individual rights. These include definitions of the term "mentally disabled," as well as lists of exclusions from those definitions.

No.52D
POLICY ISSUES

Lawrence A. Real, M.D., Belmont Behavioral Health, 4200 Monument Road, Philadelphia, PA 19131

SUMMARY:

Since the end of the 19th century, there have been scattered but fervent appeals for the states to align their substantive criteria for and the procedural aspects of involuntary commitment. The reforms enacted by most states in the past 40 years have similar emphases on civil liberties and due process. All states shifted from a "need for treatment" justification to one premised on dangerousness. Many states loosened this shift by requiring merely that a patient be "gravely disabled".

REFERENCES:

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SYMPOSIUM 53

DIMENSIONAL MODELS FOR PERSONALITY DISORDER ASSESSMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand various ways in which dimensional assessments of personality psychopathology can be clinically useful.

No.53A
PERSISTENCE OF PERSONALITY DISORDER PSYCHOPATHOLOGY AND FUNCTIONAL IMPAIRMENT OVER TIME

Andrew E. Skodol, M.D., Institute for Mental Health Research, 3300 N. Central Ave., Suite 2380, Phoenix, AZ 85012, Maria E. Pagano, Ph.D., Donna S. Bender, Ph.D.

SUMMARY:

Objective: Previous studies have shown that functional impairment persists in patients with personality disorders despite symptomatic improvement. In addition, the diagnostic criteria for individual personality disorders appear to consist of more stable

pathological traits and less stable symptomatic behaviors. The purpose of this study is to determine whether the stability over time of specific criteria can account for the continuing impairment observed. Method: Patients from the CLPS with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorders were followed annually over 6 years. Manifestations of each individual criterion and impairments in work, social, leisure, and global functioning were assessed on a monthly basis. Relationships between yearly averaged impairment levels and the proportion of months criteria were present were determined using regression analyses, controlling for demographics, comorbidity, and baseline levels of functioning. Results: Functional impairment remained stable over the follow-up period. Complex relationships between the persistence of criteria and functioning were found. For example, both more stable borderline criteria, such as affective instability and impulsivity, predicted impairment, as well as more intermittently expressed criteria, such as self-injury. Different criteria had the stongest effects depending on the type of functioning examined. Conclusions: A hybrid of stable traits and intermittently expressed symptomatic behaviors is necessary to adequately represent the relationship of personality psychopathology to functional impairment over time.

No.53B

SIX-YEAR STABILITY OF *DSM-IV* SCHIZOTYPAL, BORDERLINE, AVOIDANT, AND OBSESSIVE COMPULSIVE PERSONALITY DISORDER CONSTRUCTS

Charles A.Sanislow, Ph.D., Yale Psychiatric Research, P.O. Box CP216 Yale University School of Medicine, New Haven, CT 06520, Todd D. Little, Ph.D., Emily B. Ansell, Ph.D., Carlos M. Grilo, Ph.D., Thomas H. McGlashan, M.D.

SUMMARY:

Objective: To evaluate the stability of *DSM-IV* personality disorder (PD) constructs. Prior factor analytic studies tested PD constructs cross-sectionally but not longitudinally. Using data from the Collaborative Personality Disorders Study, the stability of schizotypal, borderline, avoidant, and obsessive-compulsive PD was examined over six years. Method: PD assessments were obtained from patients in or seeking treatment (N =773) via semi-structured interviews by raters blind to prior diagnostic information at baseline, two, four, and six years. PD criteria were grouped into "parcels" to enhance dimensional properties and control for measurement error, and parcels served as indicators for an omnibus structural model testing the stability and interrelation of the constructs. Correlations over time and across disorders were examined. Results: At baseline PDs were discrete (highest correlation was .42, between STPD and BPD, 17.6% variance shared). Constructs remained discrete at Year 2 (highest correlation.46 between BPD and AVPD, 21.2% shared variance). By Year 4 the constructs were less discrete (highest correlation was .60 between STPD and AVPD, 36% variance shared). At Year 6, the highest correlation between STPD and BPD was .68 (46.2% variance shared). At baseline, OCPD was minimally correlated with the other PDs (highest correlation .17 with STPD, .03% variance shared); by Year 6, it was more correlated with STPD (.44, 19.4% variance shared) and BPD (.50, 25% variance shared). Although the correlation of OCPD with AVPD increased, it remained relatively discrete (.24, 5.6% variance shared). Conclusions: PD constructs were generally stable and discrete. The higher correlation of constructs at six years may reflect wider range of pathology for those with enduring PDs. OCPD appears to stand apart from Cluster C AVPD. Results are considered in light of arguments to dimensionalize *DSM-V* PDs.

No.53C

PREVALENCE AND PERSISTENCE OF CRITERIA FOR SCHIZOTYPAL, BORDERLINE, AVOIDANT, AND OBSESSIVE-COMPULSIVE PERSONALITY DISORDERS AT SIX-YEAR FOLLOW-UP

Emily B. Ansell, Ph.D., Yale University School of Medicine,301 Cedar St., P.O. Box 208098, New Haven, CT 06519, Charles A. Sanislow, Ph.D., Carlos M. Grilo, Ph.D., Robert L. Stout, Ph.D., Thomas H. McGlashan, M.D.

SUMMARY:

Objective: This study tracked individual criteria of four *DSM-IV* personality disorders: Borderline (BPD), Schizotypal (STPD), Avoidant (AVPD), and Obsessive-compulsive personality disorder (OCPD) over 6 years of follow-up. The differential persistence of criteria is important for dimensional considerations of *DSM* PD assessment. Method: Participants were evaluated as part of the Collaborative Longitudinal Personality Disorders Study. PD criteria were assessed with reliably administered diagnostic interviews (including Diagnostic Interview for Personality Disorders) by trained and monitored research-clinicians who were blind to prior diagnostic information at baseline, two, four, and six years. Percent of criteria endorsed were examined. Results: The most prevalent criteria for each disorder were consistent across all four time points: Paranoid ideation in Schizotypal PD, Affective instability in Borderline PD, feeling inadequate/ socially inept for Avoidant PD, and rigidity in Obsessive-Compulsive PD. Two criteria, inflexibility about morality in OCPD and ideas of reference in STPD, showed small increases over 4 year rates at 6 year follow-up. Overall trends were toward remission of criteria but at decreasing rates by year 6. Conclusions: The consistency of prevalence rates of individual criteria over time suggests some criteria remain relatively more common within diagnostic groups over 6 years of follow-up. The rank-order stability suggests a relationship between criteria that is temporally coherent. Their prevalence reflects the diagnostic importance of criteria and informs considerations for *DSM-V* PD definitions.

No.53D

TRAITEDNESS AS AN INDICATOR OF INCREMENTAL VALIDITY IN THE FIVE FACTOR MODEL OF PD ASSESSMENT

Megan B. Warner, Ph.D., Department of Psychology, Room 330, The New School for Social Research, 65 Fifth Avenue, New York, NY 10003, Leslie C. Morey, Ph.D. Tracie M. Shea, Ph.D., Andrew E. Skodol, M.D., Carlos M. Grilo, Ph.D., Charles A. Sanislow, Ph.D., John C. Markowitz, M.D., Mary C. Zanarini, Ed.D.

SUMMARY:
Dimensional trait models are currently under consideration as a component of a hybrid model for assessing personality disorders (PDs). Though the contribution to diagnosis and assessment offered by these models has been met with significant support by many, others have asked that their clinical utility is further demonstrated prior to their inclusion in *DSM-V*. The five factor model (FFM) is a widely researched dimensional model of personality, and prior research demonstrates significant relationships between FFM traits and Axis II diagnoses. One method for testing the utility of the FFM model in predicting diagnostic outcome and stability is to evaluate if the model has differential validity for different individuals. Traitedness assessment measures the salience of specific traits to individuals. An assumption is that a measure of the degree of salience, or behavioral relevance, that a trait has can function to improve upon the measurement of trait-behavior relationships. Thus, outcome prediction will be best for those patients for whom FFM traits are most salient (who are thus more "traited" on psychopathology-relevant traits). Different indicators of traitedness have been proposed in the personality literature. The convergence of these indicators was investigated in a clinical sample of individuals diagnosed with borderline PD (BPD). To further explore the idea that maladaptive traits are a principal underlying etiological factor in the maintenance of BPD, we evaluated whether the inclusion of measures of traitedness of specific, BPD-relevant traits could incrementally improve the ability of FFM traits to predict the stability of the BPD diagnosis at a later time point. The greatest predictors of diagnostic stability were BPD-relevant trait levels and diagnostic status. Traitedness on certain traits (Neuroticism, Anxiousness, and Impulsivity) incrementally improved the prediction of diagnostic stability after trait level was addressed.

No.53E
PREDICTORS OF CHANGE IN PERSONALITY TRAITS

Sara E. Lowmaster, M.S., Department of Psychology, Texas A&M University, MS 4235, College Station, TX 77840, Leslie C. Morey, Ph.D.

SUMMARY:
Previous research has suggested that personality traits are relatively stable with some degree of malleability possible. Warner, et al. (2004) demonstrated that changes in personality traits can lead to changes in personality disorder. Therefore, it is important to examine the mechanisms that lead to changes in personality to develop a better understanding of disorder. The current study identified diagnostic and life event variables relationship to changes in personality. More specifically, these variables were examined in relation to changes in the Revised NEO Personality Inventory (Costa & McCrae, 1992) domain scores at designated intervals for a period of six years. Data were collected as part of the Collaborative Longitudinal Personality Disorder Study. Results suggest that the most significant changes in personality occurred on the neuroticism, extroversion, and conscientiousness domains. In addition, it was found that the corresponding facets changed together; however, there were some exceptions. Furthermore, findings also revealed the importance of life events as moderators for change in personality traits.

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SYMPOSIUM 54

GENE-ENVIRONMENT-DEVELOPMENTAL INTERACTIONS: IMPLICATIONS FOR PSYCHIATRIC AND ADDICTIVE DISORDERS

National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:
Attendees of the workshop will learn how inherited characteristics can be modified by early experience interact to produce different behavioral outcomes and alters psychopathology in humans, non-human primates, and rodents. The workshop attendees will acquire knowledge of the epigenetic mechanisms by which the environment alters inherited characteristics. Attendees will gain knowledge of what chromatin is and how of modification of chromatin produces gene-environment interactions.

No.54A
ROLE OF MEF2 IN COCAINE-INDUCED SYNAPTIC AND BEHAVIORAL PLASTICITY

Christopher W. Cowan, Ph.D., Department of Psychiatry, UT Southwestern Medical Center, 5323 Harry Hines Blvd, Dallas, TX 75390-9070, Suprabha Pulliparacharuvil, Ph.D., William Renthall, Carly Hale, M.D., Colleen Dewey, Arvind Kumar, Ph.D., Eric Nestler, M.D., Ph.D.

SUMMARY:
Repeated exposure to cocaine results in behavioral sensitization, which can persist long after drug abstinence. One of the best-described correlates of this behavioral sensitization to psychostimulants is a robust increase in synaptic spines found on medium spiny neurons (MSNs) in the nucleus accumbens (NAc). However, the mechanisms governing cocaine-induced dendritic spine formation, as well as the role of increased spine density in cocaine-induced behaviors, are not known. MEF2 transcription factors negatively regulate excitatory synapse number, suggesting that they might function in the NAc to regulate cocaine-in-

duced dendritic spine formation and cocaine-related behaviors. We found that chronic cocaine administration regulates MEF2 phosphorylation in the NAc in vivo, consistent with a decrease in MEF2-dependent transcription. Similarly, we observed that D1 dopamine receptor signaling (i.e. elevated cAMP) attenuates calcium-induced MEF2 activity in cultured primary striatal neurons, a signaling process involving suppression of calcineurin and CaMK activities. To determine the functional importance of MEF2-dependent transcription in vivo, we used adeno-associated viruses to reduce (via shRNAs) or increase (via MEF2-VP16) MEF2-dependent transcription in the mouse NAc. We found that manipulating MEF2 activity in the NAc alters cocaine-induced NAc synapse density and behavioral sensitization. Using a ChIP on chip approach, we have identified a number MEF2 target genes that are regulated by chronic cocaine exposure. Together, our data suggest that chronic cocaine exposure suppresses MEF2-dependent transcription to facilitate an increase in NAc spine density and behavioral plasticity associated with repeated cocaine exposure. Moreover, our data suggest that dopamine signaling serves to modify the cellular response to excitatory synaptic input by integrating cAMP (dopamine) and calcium (glutamate) signaling pathways to generate distinct transcriptional programs.

No.54B
EPIGENETIC INFLUENCE OF THE EARLY ENVIRONMENT

Frances A. Champagne, Ph.D., 406 Schermerhorn, Department of Psychology Columbia University, 1190 Amsterdam Avenue, New York City, NY 10027

SUMMARY:
Recent evidence suggests the long-term epigenetic influence of environmental experiences on offspring gene expression and behavior. In particular, mother-infant interactions have been found to alter levels of DNA methylation of steroid receptor genes with consequences for stress responsivity, response to reward, and reproductive behavior. The role of maternal care in regulating epigenetic changes in gene expression has primarily been studied in a rodent model. However, there is certainly evidence that the quality of mother-infant interactions in primates and humans can have sustained effects on development. Moreover, due to the effects on maternal care on offspring reproductive behavior there is a transmission of these epigenetic effects across generations. This behavioral transfer of characteristics from parents to offspring and grand-offspring is also influenced by environmental experiences beyond infancy. Thus, exposure to social enrichment or isolation during the juvenile period or a severe stressor in adulthood can alter the pathway of development and in some cases reverse the effects of early maternal care. These findings suggest that a Lamarckian mode of inheritance is possible and mediated by the effects of early and later environmental conditions on mother-infant interactions.

No.54C
MAOA BY MALTREATMENT GENE X ENVIRONMENT INTERACTION AND CHILDREN'S BEHAVIOR PROBLEMS

Julia Kim-Cohen, Ph.D., Department of Psychology, Yale University, P.O. Box 208205, New Haven, CT 06520

SUMMARY:
Aims: Although many physically maltreated children develop behavior problems, some maltreated children are resilient and avoid maladaptive outcomes. This study evaluated the role of a genetic variant in the monoamine oxidase A (MAOA) gene in predicting which children are vulnerable or resilient to the effects of physical abuse.

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SYMPOSIUM 55

STALKING INTERVENTIONS AND TREATMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: understand the etiology of stalking; identify the consequences to the victim; treat stalking victims and offenders; and identify approaches that may end stalking and facilitate treatment.

No.55A
STALKING: OVERVIEW AND TREATMENT OF VICTIMS

Gail E. Robinson, M.D., Toronto General Hospital 8-231 E.N., 200 Elizabeth St,, Toronto, ON, M4W 3M4, Canada, Karen Abrams M.D., F.R.C.P.C.

SUMMARY:
Stalking is a serious offence perpetrated by disturbed offenders. It can cause major mental health consequences that are often poorly understood by society. The majority of victims are female. Up to 1 in 20 women will be stalked during her lifetime. Victims may experience anxiety, depression, guilt, helplessness and symptoms of post-traumatic stress disorder. Victims also suffer from a lack of understanding by family, friends, society, police and the legal system, all of which may minimize the behaviour or not enforce laws. Victims may also blame themselves for the stalker's behaviour. Treatment of stalking victims requires a comprehensive approach including education, supportive psychotherapy and a discussion of practical measures. Education to victims about the nature of stalking, including common emotional reactions helps to validate the patient's feelings, reduce self-doubt, and mobilize her. It is important for victims to receive the message that this is not their fault. Supportive therapy will increase the woman's self-esteem by helping her to assert herself with the stalker and, if necessary, the authorities. Therapists can

empower the victim to take control through (1) documentation and collecting evidence and (2) taking safety precautions.

No.55B
STALKING INTERVENTIONS AND TREATMENT

Karen M. Abrams, M.D., F.R.C.P.C. Department of Psychiatry University Health Network 200 Elizabeth Street, Suite 8EN-212 Toronto, Ontario, M5G 2C4, Canada, Gail E. Robinson, M.D., F.R.C.P.C.

SUMMARY:
Healthcare workers are especially vulnerable to being a victim of stalking, most often from stalkers who are intimacy seeking, resentful or incompetent. They regularly see lonely or mentally unstable individuals who may misconstrue sympathy and attention as romantic interest. Therapists may be vulnerable as a result of erotic transference. Stalking occurs in both outpatient and inpatient settings. The limited literature on this subject suggests that a significant number of clinicians experience some type of stalking and suffer adverse consequences yet most lack any type of training to deal with this. To assess the prevalence and consequences of stalking of physicians, the authors sent out questionnaires to over 3000 randomly chosen physicians in the Greater Toronto Area. Return rate was over 35%. Prevalence and types of stalking identified will be discussed as well as the psychological impact on the physicians harassed. Increased awareness of this phenomenon and appropriate interventions could reduce escalation of harassing behaviours. Suggestions for management of stalkers in the healthcare setting will be discussed.

No.55C
THREAT MANAGEMENT BY MULTI-AGENCY JOINT COOPERATION

Sgt. Totti Karpela, P.O.Box 112, Helsinki, 00140 Finland

SUMMARY:
As part of Finland's goal to be the safest country in the EU, the Helsinki police department has trained 60 of its officers in threat assessment and management. Every police district has an inter-agency response group that includes representatives from the police, social services, district attorneys office, youth services, victim support groups, local school districts, the church, and health care services. Officers work as liaisons between the police, community, government and county organizations. In stalking cases, the victim has an initial consultation with a threat management officer. Information is gathered and primary instructions given. A booklet is given with information about: security recommendations; restraining orders; how to manage encounters with the suspect; and possible psychological consequences. A security survey of the victim's place of employment and home is conducted. Security recommendations and a management strategy is recommended and a decision re follow-up procedures is made. If necessary, the victim is assisted in applying for a restraining order. To help the inter-agency information exchange, a social service worker with experience in child welfare or family crises is assigned to each police district. Frequently the social services representatives work in police patrols, responding to suitable calls. With the presence of social services at the scene, Helsinki police department has received excellent results in handling of various family related emergencies. By combining the efforts of various organizations, resources have been used more effectively, the information exchange between various organizations has become more effective, the amount of false information has decreased tremendously and each organization's has been able to share their "best practices".

No.55D
TREATMENT OF STALKERS: CHALLENGING THE INTERVENTION DILEMMA

Werner Tschan, M.D., PO Box 52, Basel, 4012 Switzerland

SUMMARY:
The "Intervention Dilemma" is a term used to describe the risk of any form of intervention in stalking cases. This means, that any intervention might contribute to a dramatic escalation in the situation and lead to a violent outburst. On the other hand if you do not intervene in protecting those affected there is a considerable risk of continued suffering. Therefore, in some stalking cases it is better not to intervene directly but, rather, focus on counseling the victim about how to manage the situation. This approach is addressed as a "defensive" strategy, in which, although the stalker usually does not realize the intervention, it could contribute to a de-escalation of the entire situation.

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SYMPOSIUM 56

UPDATE ON NEUROLEPTIC MALIGNANT SYNDROME WITH CASE REVIEWS

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to (1) know how to contact the NMSIS Hotline, (2) be aware of the typical clinical features of neuroleptic malignant syndrome [NMS], and (3) identify basic differential diagnosis and management strategies for NMS.

No.56A
COMPLICATIONS OF NEUROLEPTIC MALIGNANT SYNDROME (NMS)

Dora D. Kohen, M.D., Lancashire Postgraduate School Of Medicine, Preston, PR1 2HE United Kingdom

SUMMARY:
NMS is recognized as a potentially dangerous but generally reversible complication of psychotropic medication. Raised aware-

ness of NMS, better symptom recognition, more responsible use of psychotropic medication, probably the increase of atypical antipsychotic usage and better management in the first two days following the episode of NMS have all contributed to the decrease in the rates of fatality rates associated of NMS. With reduction of fatality rates, possible persistent complications of NMS have become part of the medico-legal climate. NMS Database –UK established in 1991 is a UK – wide naturalistic collection of NMS cases referred to the author for comments on treatment and management. It contains over 250 cases with well described episodes of NMS. The database also contains rare cases with irreversible complications as follows: Neurological complications of NMS (seizures, prolonged hypoxia and CNS ischemia, Parkinson's disease), metabolic complications (diabetes), cognitive deficits (difficulties in people who have no baseline assessment of their cognitive deficits and established on people who already had learning disability), psychiatric complications (e.g., worsening of the course of the pre-existing psychotic illness). The paper will present some of the data in the recognition and assessment of cases with irreversible complications of NMS.

No.56B

THE PATHOPHYSIOLOGY AND TREATMENT OF NMS: CURRENT PERSPECTIVES

Ronald J. Gurrera, M.D., 940 Belmont Street (116A), Brockton, MA 02301

SUMMARY:

Purpose: The pathophysiology of NMS remains enigmatic due to its sporadic, unpredictable and often sudden emergence, and the absence of established vulnerability markers. This presentation will survey proposed pathophysiological models and current treatment "best practices" to provide a foundation for the case-based discussion to follow. Content: A variety of mechanisms have been proposed to account for the clinical characteristics of NMS, including reduced central dopamine transmission, sympathetic nervous system dysregulation, disordered muscle metabolism, and altered central GABAergic function. These models have distinct implications for improving risk prediction and treatment strategies. Methodology: Relevant published clinical research will be summarized and critically reviewed with respect to proposed models of pathophysiology. The NMS Information Service Advisory Group expert consensus recommendations for diagnosis and best-practice management will be reviewed. Results: Participants will increase their knowledge of the most likely causes of NMS, its potential risk factors, and current expert consensus recommendations for clinical management. Importance: NMS typically occurs in the setting of acute medical and/or psychiatric illness and often requires immediate intervention in order to prevent serious morbidity or mortality. Clinicians often feel unprepared to meet this challenge because they lack confidence in their knowledge of current strategies for diagnosing and managing this disorder. This presentation is designed to provide clinicians who treat patients receiving antipsychotic medications with the most up-to-date information regarding the recognition and management of NMS.

No.56C

A NATURALISTIC, PROSPECTIVE STUDY OF 53 PATIENTS WITH NEUROLEPTIC MALIGNANT SYNDROME (NMS) SECONDARY TO TYPICAL AND ATYPICAL ANTI-PSYCHOTIC DRUGS.

Patricia Rosebush, M.D., Department of Psychiatry, McMaster University, Hamilton, Ontario, L8N 3Z5, Canada, Michael Mazurek, M.D.

SUMMARY:

Purpose: To update clinicians on the clinical features, course of illness and treatment in patients with NMS secondary to both typical and atypical anti-psychotic agents. Methods: We prospectively diagnosed NMS in 53 patients, using stringent criteria and closely followed 51 over the course of illness. We believe this represents the largest such series in the world. Typical agents alone precipitated the episode in 33; atypical alone, in 7. Results: Demographic profile: 27M, 26F; mean age 44.1 yr. Key clinical features included elevated temperature (mean=102F) and pulse (mean=116); rigidity (98%), delirium (96%), and diaphoresis (88%); biochemical abnormalities included high CPK in 97% (mean=9,677SI) and WBC in 93% (mean=15.5); low serum iron (>2 SD below normal in 34 of 35 patients (97%) without concurrent infection). There was no significant difference in any key clinical or biochemical feature between those treated with typical vs. atypical agents. Seventeen of the 53 patients received Dantrolene (D) and/or bromocriptine (B), in addition to benzodiazepines (BZP) and 33 received BZPs alone. Mean duration of illness was 9.19 (SD 5.7) days for those who received D and/or B; 7.23 (SD 4.9) days for those treated only with BZP. One of the 53 died and another was left with permanent sequelae. In both cases, anti-psychotic agents were not immediately discontinued. Complications (excluding 2 who died) were: respiratory failure in 12 (22 %); renal failure in 10 (18%); extreme muscle weakness in 5 (9%); contractures in 2 (3%) and deep vein thrombosis in 2 (3%). The likelihood of complications did not differ between those who received D and/or B vs. BZP alone. Conclusion: NMS remains a serious complication of anti-psychotic agents, both typical and atypical, requiring their immediate discontinuation. D and/or B do not confer an advantage over BZP alone in the treatment of NMS.

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4. Rosebush PI, Mazurek MF: Neuroleptic malignant syndrome: differential diagnosis, treatment and medical-legal implications. Essential Psychopharmacol 2003; 5:187-215.

SYMPOSIUM 57

DEMORALIZATION AND PSYCHOTHERAPY: RESEARCH ADVANCES AND CLINICAL IMPLICATIONS

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the proposed definitions, criteria, and measures of demoralization; recognize the manifestations of subjective incompetence as the clinical hallmark of demoralization; follow the longitudinal course of distress in PTSD; diagnose demoralization in the medically ill patient; and review the psychotherapeutic interventions for restoration of morale by building hope, sense of purpose, and personal meaning.

No.57A

PSYCHOTHERAPY FOR DEMORALISATION IN THE PHYSICALLY ILL

David M. Clarke, M.B., Department of Psychological Medicine, Monash Medical Centre, 246 Clayton Road, Clayton VIC, 3168 Australia

SUMMARY:

At the conclusion of this session, the participant should be able to identify the proposed definitions, criteria, and measures of demoralization; recognize the manifestations of subjective incompetence as the clinical hallmark of demoralization; follow the longitudinal course of distress in PTSD; diagnose demoralization in the medically ill patient; and review the psychotherapeutic interventions for restoration of morale by building hope, sense of purpose, and personal meaning.

No.57B

PSYCHOTHERAPEUTIC INTERVENTIONS FOR MOBILIZING HOPE IN DEMORALIZED PATIENTS

James L . Griffith, M.D., Department of Psychiatry 8th Floor, George Washington University Medical Center, 2150 Pennsylvania Avenue, N.W., Washington, DC 20037

SUMMARY:

Mobilization of hope operates as a specific antidote for demoralization in medically- and psychiatrically-ill patients. This lecture presents a review of recent empirical research and clinical theory on hope in psychotherapy. Based upon these studies, a clinical approach is presented that conceptualizes hope as the product of agency-thinking (perceptions and beliefs about one's capabilities for acting effectively) and pathways-thinking (perceptions, strategies, and the planning of routes to goals). Hope is regarded in terms of intentional thoughts and actions, rather than solely as a feeling-state that in response to life circumstances. Psychotherapeutic interventions to mobilize hope in a demoralized patient do so by: (1) helping the patient to envision a desired future, (2) conceptualizing goals more clearly and concretely, (3) generating multiple possible pathways for goal attainment, (4) recruiting sufficient energy to make a strong effort, (5) reframing obstacles as surmountable challenges, and (6) therapist modeling of a hopeful attitude. A patient is helped to engage in agency-thinking and pathways-thinking both through personal acts as an individual and through accessing relational resources within family and social networks. When adversities are overwhelming and goals unachievable, hope can be recast as a spiritual practice not reliant upon expectations for achieving goals, but rather as a way to sustain one's chosen identity as a person and quality of relatedness with others. Clinical vignettes will illustrate interview methods for mobilizing hope by activating agency-thinking and pathways-thinking at both individual and relational levels.

No.57C

DEMORALIZATION AND THE COURSE OF PTSD: TWO YEARS AFTER HURRICANE MITCH

Robert Kohn, M.D., Butler Hospital, 345 Blackstone Blvd., Providence, RI 02906, Itzhak Levav, M.D.

SUMMARY:

Objectives: A wide range of scales measure demoralization. Whether these scales differ in predicting the course of psychopathology is not well understood. This study examines prospectively two measures of demoralization at baseline following a category 5 hurricane among community respondents and two years later.

Methods: Individuals 15 years and older in Tegucigalpa representing high, middle and low income groups of high and low exposure were selected. A group of respondents in shelters was also investigated. The 800 individuals interviewed completed the PTSD section of the CIDI and two demoralization screens, the SRQ and PERI-D.

Results: The initial interview was completed by 781 respondents, of which 84 (10.5%) had PTSD. Two years later 590 persons participated; 116 had PTSD (19.7%). Those with higher demoralization had a higher risk for PTSD at time 1 (PERI-D: OR = 7.67; $p < 0.0001$; SRQ: OR = 1.30; $p < 0.0001$). Having PTSD two years after the hurricane was predicted by increased demoralization (PERI-D: OR = 3.63, $p < 0.0001$; SRQ: OR = 1.21; $p < 0.0001$). Individuals with chronic PTSD, being diagnosed at time 1 and 2, had elevated psychological distress (PERI-D: OR = 2.74, $p < 0.02$; SRQ OR = 1.16, $p < 0.03$). Likewise, those who did not have PTSD at baseline, but develop PTSD two years later were a highly demoralized group at time 1 (PERI-D: OR = 3.09, $p < 0.0001$; SRQ: OR = 1.16, $p < 0.0001$). Those who had PTSD at time 1 but recovered were less likely to be demoralized than those who did not recover (PERI-D: OR = 0.32, $p < 0.02$; SRQ: OR = 0.83, $p < 0.02$). The highest demoralization scores were among those with chronic PTSD.

Conclusions: Demoralization predicted the course of PTSD two years following exposure to a highly traumatic life event. No differences were noted between two different measures of demoralization with regard to their relationship to the outcome of PTSD.

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3. Clarke DM, Kissane DW: Demoralization: its phenomenology and importance. Austr and New Zealand J Psychiatry 2002; 36: 733-742.
4. Griffith JL, Gaby L: Brief psychotherapy at the bedside: countering demoralization from medical illness. Psychosomatics 2005; 46(2): 109-116.

SYMPOSIA

SYMPOSIUM 58

DRUG ABUSE, HIV, HCV, AND THE BRAIN

National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should understand experimental paradigms used to assess decision making, should know the CNS pathways associated with decision making as well as interoceptive system, which may be a new treatment target for reward-dysfunction disorders such as substance abuse. Participants will learn how drugs of abuse, HIV, and HCV alter the brain and behavior and how drugs to treat HIV may also lead to psychiatric and neurological complications.

No.58A

PATHOGENESIS OF HEPATITIS C VIRUS CO-INFECTION IN THE BRAINS OF PATIENTS INFECTED WITH HIV

Eliezer Masliah, M.D., UCSD Neurosciences, Mail Code 0624, 9500 Gilman Drive, La Jolla, CA 92093

SUMMARY:

Involvement of the nervous system by HIV continues to be a serious problem. Among individuals with HIV, those with a history of drug abuse and co-infected with the hepatitis C virus (HCV) are a fast growing population. However, few studies have addressed the affects of HCV on the central nervous system (CNS) and its impacts on HIV-infected individuals with a history of methamphetamine (METH). In HIV patients with a history of METH use selective damage to interneurons occurs. For this purpose, the distribution of HCV was investigated in the brains of HIV patients. The presence of HCV RNA and HCV antigens were detected, particularly noted in astrocytes and microglial cells. The HCV Core protein was specifically detected among these cells of the HIV patients. Previous studies have indicated that the HCV Core protein is secreted from the cell and can be found in the surrounding plasma. Therefore this study focused on how the HCV Core protein could affect the surrounding neurons and there signaling pathways. Treatment of neuronal cells with HCV Core protein with METH resulted in a rapid and sustained chronic activation of extracellular signal-related kinase (ERK) that was accompanied by alterations in the tubulin cytoskeleton and neurite retraction without causing overall cell death. This pathway is known to have significant roles in a number of functions in the cell. Via the activation of many transcription factors particularly CREB, the ERK signaling pathway has been shown to play a role in the cytoskeletal integrity. When blocking ERK and the TLR receprots the neurotoxic effects of HCV core were reduced. In conclusion this study suggests that HCV proteins might interact with HIV proteins and METH and contribute directly to the neurotoxic phenotype in infected patients by dysregulating signaling pathways in selected neuronal populations of HIV patients.

No.58B

NEUROECONOMICS: NEW APPROACHES TO RISKY DECISION MAKING

Gregory S. Berns, M.D., Emory University, Atlanta, GA 30322

SUMMARY:

Within the last 5 years, neuroeconomics has matured as a new approach of using brain imaging to both test and expand economically based theories of decision making. In this talk, the basic principles of expected utility and prospect theory will be described. Recent brain imaging experiments based on these theories suggest common neural substates in the brain that weigh the costs and benefits of potential decisions as well as the risk an individual places on them. These experiments suggest promising approaches to using brain imaging to predict future decisions.

No.58C

NEUROLOGIC AND PSYCHIATRIC COMPLICATIONS OF ART AND DRUG INTERACTIONS

Glenn J. Treisman, M.D., Meyer 119 Johns Hopkins Hospital, Baltimore, MD 21287

SUMMARY:

There are several infectious diseases associated with specific behavioral risks, including Human Immunodeficiency Virus (HIV), Hepatitis C, Hepatitis B, and the common sexually transmitted diseases. Psychiatric disorders including addiction, major depression, personality disorder, cognitive impairment, and major mental illness have been implicated or directly shown to be a risk factor for infection with some of these conditions. Vulnerable people are less able to modify risk behaviors and therefore are at increased risk for getting and spreading infection. The development of effective treatments for these conditions has also revealed that the same psychiatric barriers to effective prevention operate to make treatment less effective or ineffective, and promote the development of resistance. The medications used to treat Hepatitis C and HIV have psychiatric and neurologic side effects which further complicate care. The treatment of HIV and Hepatitis C in patients with psychiatric disorders is made more complex by conditions such as neuropathic pain produced by antiviral medications, depression caused by interferon, and delirium caused by ancillary medications. Lastly, polypharmacy required for successful treatment of substance abuse disorders, affective disorders, schizophrenia, Hepatitis C and HIV create a variety of complex drug interactions that can undermine effective treatment for all these conditions. Key elements of treatment include communication of all medications to all treating clinicisans, and emphasis on collaborative efforts at adherence to regimens, and careful surveillance for side effectgs, drug interactions, treatment non-adherence, and the emergence of treatment related complications. Several model programs have demonstrated that integrated care improves outcomes and effectiveness of treatment. Coherent treatment of psychiatric, nuerologic, and substance abuse disorders improves outcome for patients and may decrease the risk of spreading infection and the development of viral resistance.

No.58D

METHAMPHETAMINE AND HIV: CNS EFFECTS

Igor Grant, M.D., UCSD Dept of Psychiatry,9500 Gilman Drive, La Jolla, CA 92093-0680

SUMMARY:

Methamphetamine and HIV infection each can produce brain disease, and there is evidence that their co-occurrence may produce additive effects on neural injury. Approximately 40% of methamphetamine (METH+) abusers who are HIV uninfected (HIV-) have some neurocognitive impairment; and a similar proportion of HIV infected individuals (HIV+) who are not methamphetamine abusers are also impaired. Over 60% of persons who are HIV+ METH+ have cognitive disturbance, suggesting an additive effect. While there may be some common pathways (e.g., induction of neuroinflammatory cascades) which underlie this apparent synergy, there are also differences in neuropathogenic mechanisms. For example, while atrophy of selected brain regions is a common correlate of HIV disease of the brain, one sees increases in volumes of certain brain structures with methamphetamine. Furthermore, neuropathologic studies indicate that in addition to the generally accepted effect of methamphetamine on dopaminergic circuitries, there may be selective loss of calbindin immunoreactive interneurons in the brains of those with both HIV and METH. Disturbances in neurocognitive functioning associated with methamphetamine may also be associated with declines in everyday functioning, and deficits in decisional abilities could influence likelihood of engaging in risk behaviors or non-adherence to treatment which could affect HIV disease progression and transmission. Learning objective: At the conclusion of this talk participants should be able to understand the effects of methamphetamine and HIV on the human brain.

No.58E

A NEW BASIC APPROACH TO UNDERSTAND DYREGULATION OF REWARD SYSTEMS IN SUBSTANCE USE

Martin P. Paulus, M.D., 3350 La Jolla Village DR., San Diego, CA 92113, Kathryn L .Lovero B.S., Jennifer Aron, B.S.

SUMMARY:

The interoceptive system, which provides information about the subject's internal state and is integrated in the insular cortex, and not the subcortical ventral striatum, is the critical neural substrate for reward related processes. Understanding the internal state of the individual, which is processed via this system makes it possible to develop new intervention that are aimed to treat reward-dysfunction disorders, i.e., substance and alcohol dependence. Although the ventral striatum is important for signaling the degree to which rewarding stimuli are predicted to occur, this system alone cannot account for the complex affective, cognitive and behavioral phenomena that occur when individuals come in contact with potentially rewarding stimuli. Instead, the interoceptive system is able to connect between all cortical, subcortical and limbic systems to orchestrate a complex set of responses. Social interactions are an important means of stimulation the interoceptive system. Importantly, specific receptors in the skin have evolved to signal gentle touch and other human-to-human interactions that carry important reward-related information. This alternative formulation of reward processing enables one to examine new therapeutic directions.

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SYMPOSIUM 59

TREATMENT OF ADOLESCENT DEPRESSION: RESULTS FROM RECENT TRIALS AND IMPLICATIONS FOR PRACTICE

National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the implications of results from clinical trials regarding: (1) the utility of medication, psychotherapy, and combination approaches for treating adolescent depression; (2) strategies for treating youth who do not respond to initial, first-line pharmacotherapy; and (3) models for improving access to evidence-based interventions for youth who present in primary care settings.

No.59A

THE TREATMENT OF SSRI-RESISTANT DEPRESSION IN ADOLESCENTS (TORDIA)

David A. Brent, M.D., Western Psychiatric Institute and Clinic 3811 O'Hara Street, 315 Bellefield Towers Pittsburgh, PA 15213, Graham Emslie, M.D., Greg Clarke, Ph.D., Karen Wagner, M.D., Joan Asarnow, Ph.D., Marty Keller, M.D., Ben Vitiello, M.D., Louise Ritz, Ph.D.

SUMMARY:

In a 6-site NIMH-sponsored clinical trial, 334 depressed adolescents who did not respond to an adequate trial of an SSRI were randomized to one of four conditions in a 2 by 2 balanced design: (1) switch to another SSRI (either paroxetine, citalopram, or fluoxetine); (2) switch to another class of medication (venlafaxine); (3) switch to another SSRI + cognitive behavior therapy (CBT); or (4) switch to venlafaxine plus CBT. The primary outcomes were: (1) a rating on the Clinical Global Impressions- Improvement Subscale (CGI-I) LE 2 (much or very much improved) and Child Depression Rating Scale- Revised (CDRS-R) decline over baseline >50% and (2) change in CDRS-R over time. There was a significantly greater rate of clinical response and improvement in functional status in the CBT cells over medication alone, but no difference between the SSRI and venlafaxine conditions, nor were there any interactions. While all treatments caused a reduction of CDRS-R, self-reported depression, and suicidal ideation over time, there were differential treatment effects, nor were there treatment differences with regard to the rate of suicidal adverse events. There was considerable variability in both medication and

CBT response across sites, although the findings were robust to removal of one site at a time, and persisted in logistic regression even after a site by CBT interaction was added. The site differences appear to be in part due to differences in subject make-up, which in turn affected CBT response. In this clinical trial of depressed adolescents who have not shown an adequate clinical response to an SSRI, a combination of a switch in antidepressant and CBT was superior to a medication switch alone, but a switch to a second SSRI was just as efficacious as a switch to venlafaxine, and resulted in fewer side effects.

No.59B

DELIVERING EVIDENCE-BASED PSYCHOTHERAPY FOR TEEN DEPRESSION IN PRIMARY CARE, WITH AND WITHOUT PHARMACOTHERAPY: APPROACHES, ISSUES, AND OUTCOMES

Greg Clarke, Ph.D., Center for Health Research, Kaiser Permanente Northwest, 3800 N. Interstate Ave., Portland, OR 97227

SUMMARY:

Many depressed youth first present for treatment in primary care, mostly pediatric clinics. In many situations access to specialty care is limited or unacceptable to youth or family. Following the trends first observed with the collaborative care of depressed adults, depressed youth are increasingly being treated in primary care. In many cases this is antidepressant pharmacotherapy by itself, but the 2004 SSRI black box warning and parent-adolescent ambivalence about drugs often result in many youth unwilling to adhere to a full course of medication. We have been conducting a series of studies examining the primary care delivery of brief cognitive-behavioral therapy (CBT) for depressed adolescents. We will present the results of our 2005 study comparing usual care SSRI antidepressants alone versus SSRIs plus brief CBT. We will also present the design, rationale and current progress of an ongoing study primary care CBT for depressed youth who either declined antidepressant medication or rapidly discontinued them. We will review barriers encountered in implementing this program and the solutions we have tried. Finally, we present preliminary data on the effectiveness of Internet-delivered, self-help CBT for depression in youth and young adults otherwise being treated in primary care, illustrating an alternative and low-cost method of delivering evidence-based psychotherapy in settings where mental health specialists may not be present.

No.59C

EXPORTING EVIDENCE-BASED DEPRESSION TREATMENT TO PRIMARY CARE CLINICS: IMPACT ON ADOLESCENT DEPRESSION OUTCOMES

Joan R. Asarnow, Ph.D., Semel Institute for Neuroscience & Behavior, University of California, Los Angeles, 760 Westwood Plaza, Los Angeles, CA 90024-1759, Lisa Jaycox, Ph.D., Jeanne Miranda, Ph.D., Kenneth Wells, M.D, M.P.H.

SUMMARY:

This paper presents results from Youth Partners in Care, an effectiveness trial aimed at evaluating a service delivery strategy for improving access to evidence-based depression treatment (particularly cognitive-behavior therapy (CBT) and antidepressant medication) for adolescents in primary care practices. This randomized effectiveness trial, enrolled 418 depressed primary care patients (aged 13-21) from 5 health care organizations. Youth were randomly assigned to usual care (UC) or a 6-month quality improvement (QI) intervention which included: expert leader teams at each site, care managers trained to deliver manualized CBT for depression and support primary care clinicians with patient treatment, and patient and clinician choice of treatment modality.

No.59D

THE TREATMENT FOR ADOLESCENTS WITH DEPRESSION STUDY (TADS): IMPLICATIONS FOR PRACTICE

John S. March, M.D., P.O. Box 3527, Durham, NC 27710, TADS Team

SUMMARY:

This presentation reports on the 36-week clinical outcomes of the Treatment for Adolescents with Depression Study (TADS) and discusses implications of the findings for clinical practice. TADS was a publicly funded multisite clinical trial that randomized 439 youths (age 12-17 years, 55% female, 74% Caucasian) to receive fluoxetine, cognitive-behavioral therapy, a combination of these two treatments, or clinical management with pill placebo for 12 weeks. A consolidation phase, from week 12 to 18, was followed by maintenance treatment through week 36. Patients were then referred for community treatment, and a follow-up assessment was conducted 12 months later. Based on random assignment, 327 adolescents with major depressive disorder were treated with fluoxetine (FLX), cognitive-behavioral therapy (CBT), or a combination of the two (COMB) for 36 weeks. The primary outcome measures, rated by a blinded independent evaluator, were the Children's Depression Rating Scale-Revised total score (CDRS-R) and response rate defined by a Clinical Global Impressions-Improvement score of much or very much improved. Rates of response were: COMB 73%, FLX 62%, and CBT 48% at week 12; COMB 85%, FLX 69%, and CBT 65% at week 18, and COMB 86%, FLX 81%, and CBT 81% at week 36. Suicidal ideation decreased with treatment, but more so with COMB or CBT than with FLX. More suicidal events occurred in FLX (14.7%) than with COMB (8.4%) or CBT (6.3%). In adolescents with moderate to severe depression, treatment with fluoxetine alone or in combination with CBT accelerates response as compared to CBT monotherapy. Combined treatment presents the most favorable benefit/harm balance.

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SYMPOSIUM 60

RESEARCH UPDATE: CURRENT PROSPECTS FOR ENHANCED TREATMENTS FOR SCHIZOPHRENIA, MOOD DISORDERS, ANXIETY DISORDERS AND SUBSTANCE ABUSE

National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

We will show the current state of pharmacological development and treatment for anxiety and addictive disorders, refractory mood disorders, and schizophrenia. At the end of this session participants should be able to identify the issues of response, side effect tolerability and patient adherence with respect to limiting treatment efficacy, and be able to articulate novel strategies and targets for future treatment development that adheres to a rational process of drug discovery and development.

No.60A

TREATMENTS FOR SCHIZOPHRENIA: CURRENT LIMITATIONS AND FUTURE PROMISES

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

SUMMARY:

The discovery of antipsychotic drugs was one of the great breakthroughs in medical therapeutics of the 20th Century. First-generation antipsychotics, called neuroleptics, alleviated psychotic symptoms and prevented their recurrence. However, they had high rates of neurologic side effects. Second-generation atypical antipsychotics have fewer neurologic side effects, but may have other potentially serious side effects. Thus, there is an urgent need for new drug development, particularly, using novel pharmacologic strategies.

No.60B

TRANSLATIONAL STUDIES IN ANXIETY DISORDERS: NEW INSIGHTS AND TREATMENTS

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

SUMMARY:

Dr. Ressler's presentation will focus on new rationally-designed psychiatric treatments for anxiety disorders derived from preclinical human and animal studies. Non-pharmacological treatments that differentially affect disrupted emotion circuits include vagal nerve stimulation, rapid transcranial magnetic stimulation, and deep brain stimulation, all of which have been borrowed from neurological interventions which attempt to target known pathological foci. A second set of new approaches includes pharmacological agents that, when given specifically in relation to specific learning events, may enhance or disrupt endogenous emotional learning processes. Interestingly, recent imaging data suggests that some common regions of brain activation are targeted with pharmacological and somatic treatments as well as with the emotional learning in psychotherapy. Although many of these approaches are still experimental, the rapidly developing understanding of emotional circuit regulation is likely to provide exciting and powerful future treatments for debilitating mood and anxiety disorders.

No.60C

GENOMIC APPROACHES TO THE TREATMENT OF ALCOHOLISM

Charles O'Brien, M.D., 232 Beech Hill Rd, Wynnewood, Philadelphia, PA 19104

SUMMARY:

Numerous studies have demonstrated a role for heredity in the vulnerability to psychiatric disorders. The heredity factor in addictive disorders is among the highest for all psychiatric disorders. There are demonstrated genetic influences on response to abused drugs as well as to medications used in their treatment. Recent progress has been made in the study of alcoholism. Family history positive participants have been found to show greater alcohol stimulation, greater alcohol plasma endorphin response and greater response to naltrexone treatment. A variant of the gene for the mu opiate receptor has been found to be associated with higher risk for alcoholism and greater stimulation from a given alcohol blood level. This stimulation is blocked by the opiate receptor antagonist naltrexone which has also been reported in clinical trials to block alcohol high in alcoholics. Most importantly, two studies have now reported significantly better treatment outcome when patients with this allele are treated with naltrexone. Should we begin genotyping our alcoholic patients?

No.60D

DEVELOPING IMPROVED THERAPEUTICS FOR REFRACTORY MOOD DISORDERS

Carlos Zarate, M.D., 10 Center Drive, CRC, Unit 7 SE, Rm. 7-3465, Bethesda, MD 20892-1282, Husseini K. Manji, M.D.

SUMMARY:

For a number of patients with recurrent mood disorders, current pharmacotherapy is generally ineffective. Despite adequate treatment, many patients continue to have recurrent mood episodes, functional impairment, psychosocial disability, and significant medical and psychiatric comorbidity. Newer "AMPA throughput enhancers" or "synaptic plasticity enhancing" strategies may have utility in the treatment of mood disorders and include inhibitors of glutamate release, non-subunit and subunit selective NMDA antagonists, AMPA potentiators, and glutamate reuptake enhancers. Other targets for the development of novel therapeutics include intracellular signaling cascade modulators. This presentation will review recent findings in treatment-resistant mood disorder research.

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SYMPOSIUM 61

CARDIOMETABOLIC RISK DURING TREATMENT WITH ANTIPSYCHOTIC MEDICATIONS

National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

Increase attendees' knowledge of the adverse effects of antipsychotic medications (AM's) on metabolic & cardiovascular (CV) endpoints in the adult & geriatric populations; strategies for treating and/or preventing adverse metabolic & CV side effects associated with certain AM's; what & how often psychiatric clinicians should be monitoring potential adverse metabolic & CV effects associated with certain AM's; awareness of clinicians responsibilities regarding medication choice and referral.

No.61A

EFFECTS OF ANTIPSYCHOTIC MEDICATIONS ON METABOLIC ENDPOINTS IN THE ADULT POPULATION

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

SUMMARY:

The most frequent cause of mortality among patients with severe mental illness is cardiovascular disease, explained in part by the prevalence of modifiable cardiovascular disease risk factors in this population. Prevalent risks factors include overweight and obesity, dyslipidemia, hyperglycemia, hypertension, and smoking. A number of agents used to treat severe mental illness can promote increases in weight and adiposity, further increasing cardiometabolic risk. Antipsychotic medications are well-studied, with individual medications offering a wide range of liability for weight gain and adverse metabolic effects such as insulin resistance and dyslipidemia. Treatment with individual antipsychotics can contribute to significant increases or decreases in body weight, as a function of individual medication effects and pretreatment conditions. For example, the largest observed weight increases occur in drug-naïve patients or patients switching from lower risk to higher-risk drugs, while weight loss is observed in patients switching from higher-risk to low risk medications. Various levels of evidence support the association of some antipsychotic medications with risk for dyslipidemia and diabetes, with treatment-related changes in insulin sensitivity apparently contributing to the majority of observed effects on glucose homeostasis. In addition, most adverse effects on insulin sensitivity and lipid metabolism appear to be adiposity-dependent, although effects with some agents can potentially occur without observed changes in weight. Given the elevated risk status of many patients requiring treatment with antipsychotic medications, careful monitoring of adverse effects, and careful balancing of potential risks and benefits during treatment decisions, should be a routine component of good patient care.

No.61B

ANTIPSYCHOTIC MEDICATIONS AND METABOLIC AND CARDIOVASCULAR RISK IN OLDER PATIENTS

Dilip V. Jeste, M.D., VA La Jolla Village Drive, 116A-13, San Diego, CA 92161

SUMMARY:

Since their introduction during the past 15 years, the newer atypical antipsychotics have been increasingly used for the management of a variety of psychotic disorders and severe behavioral disturbances in older patients. The main reason for this common off-label use of atypical antipsychotics is their lower risk of extrapyramidal symptoms and tardive dyskinesia compared to conventional neuroleptics. However, in the last few years there has been a growing concern that these medications present a different set of potentially serious adverse effects, especially long-term metabolic, cardiovascular, and cerebrovascular effects resulting in weight gain, type 2 diabetes mellitus, dyslipidemia, strokes, and mortality. Recently, based on meta-analyses of double-blind randomized placebo-controlled trials among elderly people with dementia, the FDA has added 'black box' warnings regarding strokes and mortality to the prescribing information for these agents in patients with dementia. We have been conducting an NIMH-funded randomized controlled trial of the effects of long-term use of four atypical antipsychotics (aripiprazole, olanzapine, quetiapine, and risperidone) in middle-aged and elderly psychiatric patients. This is a longitudinal, prospective study with serial clinical and laboratory assessments. The strengths of this study include use of equipoise-stratified randomization (which is scientifically, ethically, and practically superior to the conventional randomization), and state-of-the-art clinical and laboratory assessments of adverse effects. We will present preliminary results from this ongoing study at the APA conference, and discuss their therapeutic implications as well as limitations. We stress shared decision making and caution in using pharmacotherapy for elderly patients, especially those with dementia.

No.61C

CLINICIAN LEVEL APPROACHES

Michael J. Sernyak, M.D., Psychiatry Service/116A, VA Connecticut Healthcare System, 950 Campbell Avenue, West Haven, CT 06516

SUMMARY:

Concerns about the cardio-metabolic side effects of second-generation antipsychotics have resulted in many issues being raised that may be unfamiliar to psychiatrists. However, frequently psychiatrists are called upon to play a central role in the medical

monitoring of patients receiving these medications. This component of the workshop will address several key issues for mental health providers associated with the use of second-generation antipsychotics. First, what are the recommendations for the screening of patients for the development of disorders such as obesity, diabetes mellitus, metabolic syndrome, dyslipidemia, and hypertension? Second, when these disease are observed, what interventions are available, when should they be instituted, and by whom? Third, what role does antipsychotic medication selection play in response to the development or avoidance of these diseases?

No.61D

TREATMENT STRATEGIES TO PREVENT WEIGHT GAIN, PRODUCE WEIGHT LOSS OR IMPROVE INSULIN SENSITIVITY IN RESPONSE TO PSYCHIATRIC MEDICATIONS

Tony A. Cohn, M.B., 1001 Queen St. West, Toronto, Ontario, M5S2M8 Canada

SUMMARY:

It is now well established that commonly prescribed, contemporary, psychotropic medications cause significant weight gain and associated cardio-metabolic risk. Psychiatrists and mental health systems are now challenged to develop strategies for monitoring, preventing, and treating metabolic risk in these patients.

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SYMPOSIUM 62

MOOD DISORDERS THROUGH THE LIFE CYCLE IN FRANCE AND THE US: "VIVE LA DIFFERENCE!"

French Federation of Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize, diagnose and treat mood disorders throughout the life-cycle, from infancy to old age utilizing information from two nations.

No.62A

FROM THE FRENCH PARADOX TO THE FRENCH PROGRAM AGAINST DEPRESSION

Frederic Rouillon , M.D., Clinique Des Maladies Mentales et De L'Encephale 100, Rue de la Sante, Paris, 75674, France,

SUMMARY:

Depression cause over 12% of the years lived with disability globally and ranks as the third leading contributor to the global burden disease in the world. Despite a good quality of life and one of the best social welfare in the world, epidemiological data show that the prevalence rates of mood disorders are higher in France (6.7 % for one year prevalence rate and 24.1% for life time prevalence rate) in comparison to other European countries (respectively 4.2 and 14%) according to the ESEMed Study included in the WHO WMH surveys. Moreover the French suicide rate is amongst the highest in Europe and even in the world (20 deaths per 100,000 inhabitants).

No.62B

HOW WELL DO WE KNOW HOW TO RECOGNIZE AND ADDRESS INFANT AND EARLY CHILDHOOD DEPRESSION ?

Gisèle Apter-Danon, M.D., 121 bis Avenue du Général Leclerc, Bourg-La-Reine, 92340 France

SUMMARY:

Mood disorders in infancy and early childhood are still an enigma in many ways. Mood disorders in infancy and early childhood are still an enigma in many ways.

Are they specific entities? And, if so how do we assess and address them.

For many years, it was denied that mood and affect disorders existed in childhood. Depression as a disorder in the very young raised refusal by parents and professionals alike (as did other childhood issues such as pain for example). Today it is admitted that very young children even infants and toddlers can be depressed. However, age-specific symptoms, masked symptoms and often lack of variety of symptoms due to developmental constraints contribute to difficulties in diagnosis and therefore in assessment and treatment management. Diagnostic classifications, such as *DSM-IV* and the Diagnostic Classification O to Three give comprehensive guidelines for diagnosis of very early childhood diagnosis of depression. Seemingly, infant early developmental capacities, parent-infant relationships and environmental factors all contribute to the emergence of depression during the early years. Management needs to take into account infant symptomatology, parental response and long-term cognitive and affective development. Multidisciplinary teams and environmental support need to be implemented. These diagnostic challenges and therapeutic issues will both be discussed. Mood disorders in infancy and early childhood are still an enigma in many ways.

No.62C

REDUCING SUICIDAL IDEATION AND DEPRESSION IN OLDER PRIMARY CARE PATIENTS: TWO-YEAR OUTCOMES OF THE PROSPECT STUDY

George S. Alexopoulos, M.D., Weill Medical College of Cornell

University, Westchester Division, 21 Bloomingdale Road, White Plains, NY 10605, Martha L.. Bruce, Ph.D., Ira R. Katz, M.D., Ph.D., Charles F. Reynolds III, M.D., Thomas Ten Have, Ph.D., and the PROSPECT group

SUMMARY:

Introduction: Older adults are twice more likely to commit suicide than the general population. Most elderly suicide victims see their physicians within a few months of their death. Suicidal ideation and depression are risk factors for suicide and each occurs in at least 7% of older primary care patients. We report 2-year outcomes of the Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT), which compared the course of suicidal ideation and depression in practices offering a care management model to usual care. Care management was provided by masters level clinicians who assisted physicians in making on-time, on-target interventions based on an algorithm.

No.62D

STAR*D: WHAT ARE THE TAKE HOME MESSAGES FOR CLINICIANS?

A. John Rush, M.D., 5323 Harry Hines Boulevard, Dallas, TX 75390-9066

SUMMARY:

The STAR*D trial was designed to determine whether different treatment options (either switch treatments or augmentation treatments) would be more effective and or better tolerated then others in depressed patients who do not remit with the first or several subsequent treatment steps. This presentation will highlight the most clinically relevant bottom line, take home findings from the trial that inform clinicians and patients about how to deliver high quality care, how to select among different switch or augmentation treatment options, and for who the chance of acute treatment remission might be lower or for whom the chances of relapse might be higher. Results to date indicate that those with more current anxious symptoms or greater current general medical burden will be less likely to remit and more likely to relapse. Furthermore, longer acute trial durations seem to be needed, especially for those with substantial general medical or psychiatric comorbidity. Implications for future trials will be discussed.

No.62E

FUNCTIONAL NEUROIMAGING FINDINGS IN YOUTH WITH BIPOLAR DISORDER

Ellen Leibenluft, M.D., Section on Bipolar Spectrum Disorders Mood and Anxiety Program NIMH Building 15K, Room 203, MSC 2670, Bethesda, MD 20892, Brendan Rich, Ph.D., Melissa Brotman, Ph.D., Eric Nelson, Ph.D., Ken Towbin, M.D., Daniel Pine, M.D.

SUMMARY:

Neuroimaging data implicate prefrontal-amygdala-striatal circuitry in the pathophysiology of bipolar disorder (BD) in youth. Specifically, fMRI studies indicate abnormalities in youth with BD when they process the emotional content of faces, when they inhibit a prepotent motor response, and when they perform a task requiring cognitive flexibility. fMRI studies of face emotion processing in this population are motivated by data indicating that BD youth have difficulty labeling face emotion accurately. Neuroimaging data indicate that BD youth, compared to controls, see neutral faces as more angry, are more scared of the faces, and have increased amygdala activation when viewing neutral faces and rating their emotional response to them. When failing to inhibit a prepotent motor response, youth with BD, compared to controls, have decreased striatal activation, suggesting that they may fail to experience a striatal "error signal'. Finally, when performing a task requiring cognitive flexibility, youth with BD have decreased dorsolateral prefrontal cortical activation relative to controls. Continuing research is designed to ascertain the impact of medication, mood state, and comorbidities on these findings, and to determine the extent to which they are specific to BD. In particular, it is important to compare youth with BD to those with non-episodic, impairing irritability, and to those with ADHD, and such studies are ongoing.

No.62F

TREATING MENTAL DISORDERS OF THE ELDERLY IN FRANCE: A DARING FIGHT OR A LOST CAUSE?

Thierry Gallarda, M.D., Service Hospitalo-Universitaire, Centre D'Evaluation Des Troubles Psychiques et Du Vieillissement, Hôpital Sainte-Anne, 1 Rue Cabanis, Paris, 75014 France

SUMMARY:

Some may point out that the title of this article has both a belligerent and pessimistic tone. But after some years spent in the field of elderly psychiatry, I would gladly assume this attitude. In an ageing society where, paradoxically, the youth is made increasingly sacred, providing care which answers in an equalitarian way the psychological needs of the people without any discrimination of age, still seems a utopia to me. Within Europe, France accumulated a certain delay in adopting mental health policies in favour of the elderly. One only has to look back to the summer of 2003 when a fatal heat wave claimed the life of thousands of elderly people, bringing to light the fate of the most vulnerable segment of the population. This event catalysed a certain number of political decisions in favour of the elderly. However, besides the fact that such a natural disaster was needed to accelerate the implementation of these measures, we may still be afraid that their application was late and their modesty disproportionate with the scale of the announced stakes in public health. Without a doubt we shall retort that the French society is no longer in a position to complain or act in disillusionment. There are indeed some reasons to hope. Tributes must be paid here to our geriatric colleagues. Their precursor commitment and their work with our elders, in the most modest material conditions, without recognition from the most "noble" medical-surgical specialists, deserve the biggest respect. Psychiatry constitutes another "marginal speciality". Since the 70's, the capacity of the French sector-based organisation to care for mentally ill patients was unanimously recognised. The principles of this organization could be applied to provide care intended specifically for the elderly suffering from mental disorders. If the French psychiatry really wishes to improve its service of care towards our elders then the confession

of ignorance, the disaffection or the ambivalence which ch

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SYMPOSIUM 63

STOP IT: YOU'RE MAKING ME SICK REVISITED: LANDMARKS IN THE STRUGGLE TO NORMALIZE LESBIAN AND GAY LIVES

Association of Gay and Lesbian Psychiatrists

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able: (1)To understand historical and contemporary perspectives on psychiatric diagnosis and homosexuality.; (2)To appreciate the need to make changes in nosology concerning sexual orientation in *DSM-V* and ICD-11; and (3)To understand the clinical issues that face Lesbian, Gay, Bisexual and Transgender people today that were misconstrued to be pathology in years past.

No.63A
SEXUAL ORIENTATION AND PSYCHIATRIC DIAGNOSIS: CURRENT ISSUES IN DSM-IV AND MOVING TOWARDS *DSM-V*

Benjamin H. McCommon, M.D., 300 Central Park West, Suite 1K, New York, NY 10024

SUMMARY:
When the American Psychiatric Association removed homosexuality as a psychiatric disorder from the *DSM-II* in 1973, this began a movement towards a relative lack of consideration of the impact of sexual orientation on psychiatric diagnosis in the *DSM*. This paper will review the few mentions of sexual orientation in the current *DSM-IV-TR*, including possible problems in diagnoses such as gender identity disorder and sexual disorder not otherwise specified and alternatives available such as identity problem or phase of life problem. Also, the movement being encouraged in developing *DSM-V* to better include cultural factors, including sexual orientation, relevant to psychiatric diagnosis will be discussed. Some of the important diagnostic considerations relevant to sexual orientation will be highlighted, including the central place of the clinical interview in determining psychiatric diagnoses and factors that assist in optimizing the clinical interview with GLB patients. Also, a brief review of the epidemiology of psychiatric disorders and treatment seeking in GLB populations will be included as an example of what might be included in the text portions of the upcoming *DSM-V*. Lastly, this paper will discuss a white paper being prepared by the Committee on Gay, Lesbian, and Bisexual Issues of the American Psychiatric Association, "A Research Agenda for *DSM-V*: Gay, Lesbian, and Bisexual Populations." Not only will this white paper emphasize the importance of sexual orientation as a cultural factor relevant to psychiatric diagnosis in the *DSM-V*, it will give an overview of future research pathways that will help improve the understanding of sexual orientation and psychiatric diagnosis.

No.63B
STRIKE WHILE THE IRON IS HOT! SCIENCE AND SOCIAL FORCES AND EGO-DYSTONIC HOMOSEXUALITY

Robert P. Cabaj, M.D., 1380 Howard Street, San Francisco, CA 94103

SUMMARY:
In 1986, scientific knowledge and social forces that looked at the rights people had to make about their own bodies and behavior (abortion, sodomy, safer sex and so on), combined to foster an alliance of organizations and individuals to meet with the APA *DSM* decision making body and seek the removal of a diagnosis that, even as it was created, was acknowledged to be a political compromise and not a scientific entity--ego-dystonic homosexuality (EDH). By the early 1980's, the view of homosexuality as pathology had shifted to looking at the impact of externalized homophobia or anti-gay bias on the lives of LGBT people. Many clinicians saw a phase of development in many LGBT in which the person wished they were not LGBT but saw this concern as a normal developmental step in a homophobic society verses evidence of psychopathology. As APA looked at revising the *DSM-III*, EDH stood out (with several other diagnoses) as without scientific merit and a possible prejudicial tool to use against troubled LGBT people. An alliance of the APA Committee and Gay, Lesbian and Bisexual Issues, the Assembly Caucus of Lesbian, Gay and Bisexual Psychiatrists, the Association of Gay and Lesbian Psychiatrists and researchers on LGBT issues formed and demanded a meeting with the *DSM* revision group. At first there was resistance to the meeting, but APA leaders recognized a need to be heard and representatives from each body appeared before the *DSM* panel and presented their arguments. There were quite vocal protests against the removal but there were no valid scientific arguments--as will be discussed. Scientific knowledge and best clinical care prevailed and EDH was removed from the *DSM-III-R.*

No.63C
HOW IT ALL STARTED

Franklin Kameny, Ph.D., 5020 Cathedral Ave, NW, Washington, DC 20016

SUMMARY:
As the early 1960s gay activism got under way it became clear that the psychiatric categorization of homosexuality as pathological would be an insuperable obstacle to full progress, necessitating a critical examination of that categorization. It failed that

examination upon numerous bases, triggering a formalized effort to reverse it, which continued to a successful conclusion in 1973. Following an initial declaration about 1963, which technically reversed the burden of proof, the effort lay largely fallow until 1970. At that time the gay movement, having abruptly become a "grass roots" one, commenced an intensive push on the issue which resulted in disruptions of the 1970 APA meeting in San Francisco, an invited presence and disruption at the 1971 meeting in Washington, DC, a symposium and gay-sponsored exhibit booth at the 1972 meeting in Dallas, a full discussion at the 1973 meeting in Honolulu, and the final action by the APA Board of Trustees in December 1973, followed by a failed effort at reversal of the Board action in 1974, settling the issue, aside from the collateral matter of Ego-dystonic Homosexuality, resolved some years later.

No.63D

ELIMINATING ANTI-GAY DIAGNOSES IN THE WHO'S INTERNATIONAL CLASSIFICATION OF DISORDERS (ICD)

Gene A. Nakajima, M.D., CSP, 1700 Jackson St, San Francisco, CA 94109

SUMMARY:

In 1973, the APA became the first psychiatric organization to declare that homosexuality was not a mental illness. In 1980, egodystonic homosexuality replaced sexual orientation disturbance in *DSM-III*, but the APA deleted it in *DSM-IIIR* because there was no empirical research supporting its use and because the diagnosis was rarely made. In 1992, the WHO deleted homosexuality as a mental illness following the practice in many countries, which had already deleted it in their versions of ICD-9. In ICD-10, three new diagnoses were added: egodystonic sexual orientation, 1) hetereosexual (F66.10), 2) homosexual (F66.11), and 3) bisexual (F66.12). These diagnoses were probably added for political rather than scientific reasons. A search of Medline and Psychinfo, two major databases of worldwide medical and psychological journals produced no research or clinical reports using any of these new diagnoses. In addition, ICD 10 added two other problematic diagnoses, Sexual Maturation Disorder (F66.0) and Sexual Relationship Disorder (F66.2), which appear to be targeted toward gay, lesbian, and bisexual people. Sexual maturation disorder may be geared toward gay adolescents who have concerns about their sexuality. Sexual Relationship Disorders may impact gay people in relationships with heterosexuals who are having difficulty in those relationships because of their sexual orientation. If countries delete these flawed diagnoses from their versions of ICD-10, their actions might generate momentum for their elimination from ICD-11. It is also important for psychiatric organizations to study these diagnoses and come up with position statements calling on WHO to eliminate them. Working with delegates who serve on ICD-11 committees will also be essential.

No.63E

FROM DISORDER TO DISTONIA: DSM-II AND DSM-III

Richard C. Pillard, M.D., 6 Bond Street, Boston, MA 02118

SUMMARY:

The revision of psychiatric nomenclature that became *DSM-III* took place in the charged atmosphere of social protest that surrounded the Vietnam War in the early 1970's. The very concept of psychiatric diagnosis was under attack. Critics of psychiatry saw mental disorders merely as codifications of social prejudice. Their position was reinforced by certain Russian doctors who "diagnosed" political dissidents with "sluggish schizophrenia" which justified confining them to a mental hospital. Official psychiatry needed to show that mental disorders were not just cultural prejudices but entities as clearly defined as somatic disorders: cross-culturally valid, and with causes and treatments. In this arena, homosexuality became a hotly contested issue.

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SYMPOSIUM 64

DEPRESSION AMONG EMERGENCY DEPARTMENT PATIENTS IN LATIN-AMERICAN COUNTRIES

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify symptoms and correlates of depression associated with medical conditions in Emergency Department patients.

No.64A

CHALLENGES IN THE DIAGNOSIS OF DEPRESSION IN EMERGENCY DEPARTMENTS

Arturo P. Grau, M.D., Jorge VI 414 -Las Condes, Santiago de Chile, Santiago, 5620008 Chile

SUMMARY:

Despite the evidence of the important role of depression in chronic medical illnesses, it is estimated that fewer than 50% of cardiac and diabetic patients with major depression (MDD) are diagnosed, and only about one half of them receive treatment for depression. Depression may be undiagnosed and untreated in emergency department (ED) patients because many symptoms of the disorders overlap, (such as fatigue, low energy, sleep disturbances, weight loss or gain, elevated glucocorticoids and concentration or memory problems) and may be diagnosed as symptomatic only of the physical diseases. The more severe the medical condition, the more likely a patient will experience clinical depression. For example, the current prevalence rates of depression in congestive heart failure patients range from 10% to 25%, from 11% to 15% in patients with diabetes, from 15% to 25% in stroke patients and from 6% to 39% in cancer patients. Our data suggest that MDD is prevalent in ED in Latin-American countries and the

integration of depression screening into routine emergency care merits serious consideration, especially if such screening can be linked to psychiatric treatment. As depression continues to be a leading cause of untreated disability, further studies to evaluate the potential benefits of ED-based depression screening should become a public health priority.

No.64B

THE BURDEN OF COMORBID DEPRESSION IN EMERGENCY DEPARTMENTS IN LATIN-AMERICA

Carlos Sanchez-Russi, Ph.D., INSA-Colombia; Rincon de la Floresta # 208, Duitama, Boyaca, Columbia, Jorge Calle, M.D., Nuri Pena, M.D., Wilma Castilla, M.D., Sandra Castilla, M.D., and Ivan Gomez, M.D.

SUMMARY:

Alone, major depressive disorder is an incapacitating, prevalent and costly chronic disease. It produces debilitating symptoms that inhibits help seeking and is associated with poor self-care and poor adherence to medical treatment recommendations. Several studies have shown that major depression disorder (MDD) is associated with 50% to 100% higher costs in medical patients in all facets of medical care, including emergency room visits, primary care visits, prescriptions, laboratory tests, hospital days and mental health visits. In a multisite study of 1,835 emergency department patients in five Latin-American countries (Argentina, Chile, Colombia, Mexico and Brazil) the prevalence for MDD range from 23.0% to 35.0%..Compared to non-MDD patients, MDD patients were more likely to be middle-aged, female, smokers, of lower socioeconomic status, and to report a diagnosis of asthma or arthritis/rheumatism. Multivariate analysis identified lower level of education, smoking, and self-reported anxiety, chronic fatigue, and back problems to be independently associated with MDD. Our results not only demonstrate that the prevalence of MDD is elevated among ED patients in Latin-American countries, but it also identifies several factors associated with MDD.

No.64C

DEPRESSION AND MEDICAL COMORBIDITY IN EMERGENCY DEPARTMENTS IN LATIN-AMERICA

Ricardo Secin, M.D., Hospital Angeles Pedregal, CmNo. Sta Teresa 1055-602, Mexico, 010700 Mexico

SUMMARY:

Major depressive disorder (MDD) has been linked to many medical conditions, including cancer, chronic obstructive pulmonary disease (COPD), asthma, cardiac disease, stroke, hypertension, arthritis, rheumatism and diabetes. Of 1,835 eligible patients, 83% of patients were interviewed, and 1,505 patients had information on both interview and CES-D scores. Among these emergency department (ED) patients, 451 (30%; 95%CI, 23-35%) exhibited MDD symptoms. Our study suggests that ED patients with asthma, compared to those without asthma, are more likely to have MDD and that anxiety may, partially, mediate this association(OR 1.71; 95%CI 1.00-2.92; p=0.05). The asthma-MDD association may indicate that the portion of the total asthmatic population presenting to the ED is more likely to suffer from severe or poorly managed asthma, which has been correlated with MDD. Additional factors were associated with MDD: insomnia (OR 2.09; 95%CI 1.31-3.34; p=0.002), headaches (OR 1.83; 95%CI 1.16-2.88; p=0.009), and chronic pain (OR 1.66; 95%CI 1.02-2.70; p=0.04). In this session we present results from our study in ED in Latin-American countries and the analysis of the significant association between MDD with diagnosed medical conditions.

No.64D

UNDERLYING DIFFERENCES BETWEEN DEPRESSED AND NON-DEPRESSED PATIENTS IN EMERGENCY DEPARTMENTS

Roxana B. Galeno, M.D., O. Andrade 290, Mendoza, 5500, Argentina, Ruby Castilla, M.D., Ricardo Secin, M.D., Arturo Grau, M.D., Marcelo de Mello, M.D., Nuri Pena, M.D.

SUMMARY:

Several studies have shown that major depression is associated with 50% to 100% higher costs in medical patients in all facets of medical care, including emergency department (ED) visits, primary care visits, prescriptions, laboratory tests, hospital days and mental health visits. Of 1,835 eligible patients in five latinamerican countries, 1,523 (83%) patients, 451 (30%; 95%CI, 23-35%) exhibited MDD symptoms (>=16 in CES-D and a DSM-IV based interview). Significantly more MDD patients than non-MDD patients experienced a variety of self-reported health problems, anxiety (60.9%). In addition, MDD patients are current smokers as compared to non-MDD patients (42% of 20%, p<0.001). MDD patients report on self-reported health problems as MDD and non MDD patients were significantly likely to have been diagnosed with Osteoarticular, Gastrointestinal, and Cardiovascular problems. After controlling for age and sex, factors independently associated with depression included lower level of education, current smoking, anxiety, chronic fatigue, and back problems. Because depression and anxiety were so strongly associated (OR 9.26), we repeated the multivariate model excluding anxiety. Omission of anxiety yielded nearly identical results for several factors: lower level of education, current smoking, and chronic fatigue.

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SYMPOSIUM 65

COGNITIVE DYSFUNCTION IN BIPOLAR DISORDER

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to define and evaluate core neurocognitive domains in patients with bipolar disorder and their stability across mood states; understand the genetic and functional neuroanatomic correlates of impaired attention, memory or executive function; recognize the potential adverse and beneficial effects of mood-stabilizing agents on cognitive function; and incorporate knowledge of basic neurocognitive deficits in treatment planning.

No.65A
A CLINICIAN-FRIENDLY APPROACH TO NEUROCOGNITIVE ASSESSMENT

Katherine E. Burdick, Ph.D., Department of Psychiatry Research, The Zucker Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004

SUMMARY:
Clinicians often encounter patient complaints regarding problems with thinking or memory, but may at times feel ill-equipped to properly evaluate them. Deficits in attention, memory and executive function have been increasingly documented in patients with bipolar disorder, independent of mood states, although for many practitioners it may be difficult to recognize and characterize the nature of neurocognitive deficits, and differentiate them from psychopathologic manifestations of bipolar illness. Prior findings suggest that while most individuals with bipolar disorder report subjective cognitive complaints, patients themselves often inaccurately identify problems that reflect objective neurocognitive deficits.

No.65B
NEUROCOGNITIVE DEFICITS ACROSS ILLNESS PHASES IN BIPOLAR DISORDER

Eduard Vieta, M.D., Hospital Clinic, University of Barcelona, Villarroel 170, Barcelona, 08036, Spain Anabel Martinez-Aran, Ph.D., Carla Torrent, Ph.D.

SUMMARY:
Cognitive dysfunctions and their neurochemical correlates play a central role in the pathophysiology of bipolar disorder, but this fact has been neglected for many years as manic-depressive illness was supposed to be a "good-prognosis" condition, as compared to schizophrenia. Recent studies suggest that bipolar patients show subtle but clinically relevant neuropsychological disturbances, which go beyond acute episodes, but it is still unclear whether those dysfunctions actually precede or follow the development of the disease. Cognitive changes during acute episodes of mania or depression include attentional abnormalities in measures of sustained attention and inhibitory control, verbal and visuo-spatial memory deficits, processing information and psychomotor speed changes, and executive dysfunctions (1). During remission, although general intellectual function is preserved, there are enduring deficits in executive functions, verbal memory and sustained attention in a substantial proportion of patients. Some dysfunctions may be influenced by residual symptoms and by medication, but other appear to be intimately connected to the condition itself. Cognitive dysfunctions have been reported to be the main factor explaining poor functional outcome in bipolar illness (1).

No.65C
NEUROCOGNITION AS AN ENDOPHENOTYPE IN BIPOLAR DISORDER

David Glahn, Ph.D., University of Texas Health Science Center at San Antonio, Mail Code 7792, 7703 Floyd Curl Drive, San Antonio, TX 78229-3900, Carrie E. Bearden, Ph.D.

SUMMARY:
Although bipolar disorder is strongly influenced by genetic factors, the imprecision of categorical psychiatric diagnoses may be a limiting factor in understanding the genetic basis of the illness. The genetic investigation of hidden or "endo"phenotypes –quantitative traits hypothesized to lie intermediate between the gene and the disease syndromes –offers a promising alternative or complement to studies of the categorical disease phenotype. This presentation will review the criteria for identifying neurocognition as an endophenotype – namely, its heritability, association with disease state, independence from clinical psychopathology symptoms, and impairment within families. Data will be reviewed on genetic and functional neuroanatomic correlates of executive dysfunction, declarative memory impairment, and other potential neurocognitive deficits in patients with bipolar disorder and their unaffected relatives as a means to help clinicians refine clinical diagnostic subtypes.

No.65D
BENEFICIAL AND ADVERSE COGNITIVE EFFECTS OF PSYCHOTROPIC MEDICATIONS FOR BIPOLAR DISORDER

Joseph F. Goldberg, M.D., 128 East Avenue, Norwalk, CT 06851

SUMMARY:
There exists much uncertainty about the extent to which atypical antipsychotics, traditional mood stabilizers, and other compounds used to treat bipolar disorder produce either beneficial or adverse cognitive effects. Differentiating iatrogenic from illness-specific cognitive deficits represents a substantial challenge for clinicians, as does recognizing the potential for additive pharmacodynamic effects in polypharmacy regimens. Most existing studies of cognition with anticonvulsants derive from patients with epilepsy or migraine, while those assessing cognition during atypical antipsychotic therapy focus mainly on patients with schizophrenia. Extrapolation about drug-related cognitive effects to other clinical groups, such as individuals with bipolar disorder, carries unknown validity. Similarly, there has been little systematic study of adverse cognitive effects from medications used to treat bipolar disorder relative to dose-dependency, titration schedules, or the potential for attenuation of cognitive impairment with habituation.

No.65E
ATTENTION AND COGNITIVE DYSFUNCTION IN

PEDIATRIC BIPOLAR DISORDER

Paula Shear, Ph.D., Dept. of Psychology, Univ. of Cincinnati, 429B Dyer Hall, Cincinnati, OH 45221-0376, Melissa P. DelBello, M.D.

SUMMARY:
There is extensive research to suggest that, in addition to their cardinal symptoms of mood dysregulation, many adult patients with bipolar disorder also exhibit cognitive dysfunction, particularly during abnormal mood states. Despite the fact that bipolar disorder has a prevalence rate in children and adolescents that is similar to that in adults, there have been only a few studies that have examined cognitive abilities in this pediatric population. This presentation will include a discussion of our current knowledge about cognitive abilities in children and adolescents with bipolar disorder. Attention Deficit Hyperactivity Disorder (ADHD) commonly co-occurs in children with bipolar disorder, but there is only limited existing information about the relative contributions of bipolar disorder and ADHD to the observed cognitive presentations of these patients. Accordingly, this presentation will review data and clinical implications of studies that directly address the impact of comorbid ADHD on cognitive dysfunction in children and adolescents with bipolar disorder.

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SYMPOSIUM 66

THE SCIENTIFIC BASIS OF INTERPERSONAL DYSFUNCTION IN BORDERLINE PERSONALITY DISORDER

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to understand the; 1) clinical; and 2) neurobiologic correlates of the disturbed interpersonal relatedness symptom sector in BPD.

No.66A
THE INTRAPSYCHIC AND NEUROCOGNITIVE BASIS OF INTERPERSONAL DYSFUNCTION IN BPD PATIENTS

John F. Clarkin, Ph.D., New York Presbyterian Hospital-Cornell Medical Center,21 Bloomingdale Road, White Plains, NY 10605

SUMMARY:
An object relations approach to personality organization posits that both subjective experience and behavior are organized by an internal psychic structure composed of a representation of self and other, linked by affect. In this paper, object relations theory concerning borderline personality disorder is linked to research on attachment organization and neurocognitive functioning in these patients. We discuss attachment and neurocognitive functioning of BPD patients in light of treatment development

No.66B
A PROSPECTIVE LONGITUDINAL VIEW OF GENETIC VULNERABILITY AND QUALITY OF EARLY CARE AS CONTRIBUTORS TO BORDERLINE FEATURES

Karlen Lyons-Ruth, Ph.D., Department of Psychiatry, Cambridge Hospital, 1493 Cambridge St., Cambridge, MA 02139

SUMMARY:
In retrospective reports, borderline patients report high rates of childhood abuse or neglect. However, there is almost no prospective longitudinal data to evaluate the contribution of childhood and developmental factors to the emergence of borderline symptomatology. In addition, advances in molecular genetics have made new tools available for examining genetic influences on young adult borderline features. Short variants of the serotonin transporter gene (5HTT) have been shown to correlate with vulnerability to major depression and suicidality (Caspi et al., 2003). Borderline personality disorder also has substantial comorbidity with major depression. In this presentation, we will examine the prospectively assessed contributions of quality of early care, later abusive experiences, and presence of the short form of the serotonin transporter polymorphism to the prediction of borderline traits in young adulthood.

No.66C
INTERPERSONAL STRESS REACTIVITY, ATTACHMENT, AND BORDERLINE PERSONALITY DISORDER

Lois W. Choi-Kain, M.D., 115 Mill Street, Belmont, MA 02478

SUMMARY:
Borderline Personality Disorder(BPD) has been associated both clinically and empirically with insecure and disorganized forms of attachment. Clinically, BPD is distinguished by an intense and dysregulated interpersonal style that is resonant with the clingy, intensely distressed, difficult to soothe, resistant, and conflicted qualities of anxious/ambivalent and disorganized forms of attachments observed in infants and small children on Ainsworth's Strange Situation. Empirically, a number studies have demonstrated associations between BPD and 1) biparental failures during childhood (i.e. abuse and neglect) as well as 2) preoccuppied and disorganized states of mind regarding attachment. Early attachment relationships between children and primary caregivers is critical to the child's regulation of stressful arousal. Both animal and human studies have shown that sensitive and responsive caretaking influences the development and functioning

of the hypothalamic-pituitary-adrenal (HPA) axis. This current study examines the relationship between BPD, attachment, and the functioning of the HPA axis. Female subjects aged 18-25 are recruited from the larger Family Study of Personality Traits (PI JG Gunderson, NIMH R01 MH070377-01A2) in which they are rigorously and reliably diagnosed into BPD and non-BPD comparison groups. Subjects and their mothers participate in a facilitated conflict discussion which is videotaped and coded for attachment. Salivary cortisol samples are collected at three points in the study visit designed to represent baseline, reactive, and recovery phases. Data from this study will be presented. The relationships between BPD, attachment strategies, and stress reactivity as reflected in the functioning of the HPA-axis will be examined and clinical implications will be discussed.

No.66D

CAN A DEFICIT IN MENTALIZATION EXPLAIN THE INTERPERSONAL DYSFUNCTION IN BPD?

Peter Fonagy, Ph.D., Sub-Department of Clinical Health Psychology,University College London, Gower Street, London, WC1 6BT United Kingdom

SUMMARY:

Whilst clinicians have long recognised that interpersonal dysfunction is a key facet of borderline personality disorder, research in this domain has lagged behind work on affect dysregulation, impulsivity and self-harm. The capacity to envision mental states is developmentally as well as neurophysiologically linked to the quality of attachment relationships and the activation of brain systems mediating attachment relationships. This presentation will explore evidence that suggests that deficits of social understanding may be critical to understanding some of the most distressing aspects of the disorder and may represent a key focus for psychosocial intervention. Evidence will be presented from a randomized controlled trial that suggests that the mentalization-focused approach to psychological therapy can be effective in reducing suicidality, self-harm and the costs of the comprehensive management of the disorder.

No.66E

BPD RELATIONSHIPS AS A PHENOTYPE

John G. Gunderson, M.D., McLean Hospital, 115 Mill Street, Belmont, MA 02478

SUMMARY:

The borderline patients pattern of disturbed interpersonal relationships are their most discriminating and most clinically troublesome characteristics. While this pattern has traditionally been considered to be the product of disturbed early caretaking experiences, often confounded by trauma, this presentation proposeds a more complicated etiology. Drawing upon evidence from the genetic, family history, and attachment literature, the thesis is proposed that the preborderline child's disturbed relationship to early caretakers and the disturbed relational patterns that evolves after trauma are products of a genetically organized psychobiological disposition. This disposition is manifest in interpersonal hypersensitivity and in the misinterpretation of normal interpersonal stress -- features that aggravate rather than diminish the angry or avoidant responses by others. Rather than developing from particularly poor early caretaking, the borderline patients disturbed pattern of relationship might only have been prevented by particularly good caretaking -- of types that might eventually be designed for special needs children. Implications are discussed.

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SYMPOSIUM 67

DSM V: PHILOSOPHICAL AND CLINICAL CONSIDERATIONS

APA Council on Global Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the conceptual underpinnings of several alternative applications of diagnostic rules to evolving psychiatric conditions.

No.67A

ARE RELATIONAL PROBLEMS MENTAL DISORDERS AND SHOULD THEY BE IN *DSM-V*?

Christian D. Perring, Ph.D., Department of Philosophy, Dowling College, 150 Idle Hour Blvd, Oakdale, NY 11769

SUMMARY:

Wakefield (2006) argues against Perring (2005) that relational problems do count as disorders on his harmful dysfunction analysis, and he argues that relational disorders in a strict medical sense can exist even when none of the individuals in the relationship (couple or family) has a mental disorder. In this presentation, I address the issues raised by Wakefield's arguments. The argument proceeds by analysis of theories of disorder and disease. First, I argue that his claim that we should understand relationship disorders as dysfunctions in evolutionarily designed relationships is problematic given the great cultural variability in family function, and even the infant-mother relationship which he holds to be one of the clearest examples. Second, I argue that even if relationship disorders do exist, it is a separate question whether they should be categorized as mental disorders and listed among other disorders in *DSM-V.* The harmful dysfunction analysis does not by itself answer this question. We can see this more clearly by showing that the harmful dysfunction analysis can also be applied to larger social entities: if a community self-destructs due to internal conflict, we can equally conclude there is a dys-

function in the evolutionarily designed community. However, it clearly does not follow that community disorders should be in *DSM-V*. Thus I argue that we need to pay more careful attention to what sorts of disorders should be in the domain of psychiatry, and this requires more careful attention to the place of psychiatry in modern society. The conclusion is that deciding whether to include relational disorders in *DSM-V*, the harmful dysfunction account of disorder, and clinical utility are insufficient; rather, we need to pragmatically take into consideration the social role of psychiatry and to what extent it is the business of psychiatry to be diagnosing relationships.

No.67B
VICE IN *DSM-IV* DIAGNOSTIC CRITERIA

John Sadler, M.D., 5323 Harry Hines Boulevard, Dallas, TX 75390-9070

SUMMARY:
"Vice" is a term that refers to the broad domain of wrongful conduct and criminality. Using the methods of philosophical values analysis, the author presents selected *DSM-IV-TR* categories which employ vice concepts as clinical descriptors in diagnostic criteria. For example, many of the diagnostic criteria for the categories of Conduct Disorder, Pedophilia, Antisocial Personality Disorder, and Intermittent Explosive Disorder exhibit vice-laden meanings. The use of vice-laden diagnostic criteria will be related to the classical "mad/bad" debate in the philosophy of psychiatry, whether mental disorders represent mad (illness) or bad (wrongful) conduct. The author argues that use of vice concepts in diagnostic criteria poses serious problems in psychiatric classification and practice, with implications for public policy, public understanding of mental illness, stigma, and allocation of both mental health, educational, and criminal justice services. A conceptual-analytic method for dealing with vice concepts in diagnostic criteria is presented, with implications for development and refinement of categories, as well as empirical validation efforts. The systematic investigation of vice concepts in mental disorder categories may contribute to a beneficial shift in mental health care away from the domains of social control and more towards the doctoring of the sick.

No.67C
WHAT IS MOODY? WHAT IS BIPOLAR?

S. Nassir Ghaemi, M.D., Bipolar Disorder Research Program Emory University, Department of Psychiatry, 1841 Clifton Road, 4th Floor, Atlanta, GA 30322

SUMMARY:
Bipolar disorder – or perhaps better put, manic-depressive illness – is an old concept, described in some way or another since antiquity. Yet it remains a controversial diagnosis, some thinking it is under diagnosed, others that it is over diagnosed. This controversy has especially taken on emotional valence with children. The recent death of a four year old child diagnosed with bipolar disorder and treated with multiple psychotropic agents has brought out fierce criticism, as well as some defense, of the concept of childhood bipolar disorder.

No.67D
ARE PERSONALITY DISORDERS INFECTED WITH MORAL NORMS? CONSIDERATIONS FROM VIRTUE THEORY

Peter Zachar, Ph.D., P. O. Box 244023, Montgomery, AL 36124

SUMMARY:
Are category B personality disorders really disliked and/or immoral behaviors that have been inappropriately medicalized as has been claimed by philosophers such as Charland? Some categories of PD are clearly morally-saturated. For example, narcissistic personality traits such as grandiosity, rage and envy are three of the seven deadly sins. The relationship between the antisocial diagnosis and criminality is well known. Furthermore, the problem of moral norms and personality disorders would be accentuated, not alleviated with the adoption of a dimensional model. For example, in addition to neuroticism, a large majority of personality disorders (not only category B disorders) are associated with high levels of agreeableness on the five-factor model. In virtue ethics, agreeableness (friendliness) is a virtue. It is also a dimensional construct lying between the vices of ingratiation and antagonism.

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SYMPOSIUM 68

PHARMACOTHERAPY OF UNIPOLAR PSYCHOTIC DEPRESSION: RESULTS FROM THE NATIONAL INSTITUTE OF MENTAL HEALTH STOP-PD TRIAL

Institute of Mental Health

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: (1) identify delusions among patients with major depression (MDPsy); (2) understand the efficacy of pharmacotherapy for psychotic major depression and factors that influence treatment response; (3) know factors that contribute to attrition of patients with MDPsy during systematic pharmacotherapy; and (4) understand disturbances in neuropsychological functioning associated with MDPsy and how they change during treatment.

No.68A
DESIGN ISSUES RELATED TO RECRUITING, PROTECTING, AND RETAINING PATIENTS WITH PSYCHOTIC DEPRESSION IN A RANDOMIZED CONTROLLED PHARMACOTHERAPY TRIAL

Alastair J. Flint, M.B., Toronto General Hospital, 200 Elizabeth

St, 8 Eaton North, Room 238, Toronto, M5G 2C4, Canada Barnett Meyers, M.D., Benoit Mulsant, M.D., ,Anthony Rothschild, M.D., Ellen Whyte, M.D., Ayal Schaffer, M.D., Shelley Brook, M.D., Nathan Herrmann, M.D., Jose Silveira, M.D., Kate Peasley Miklus, Ph.D., Moonseong Heo, Ph.D., Sonja Kasapinovic, M.Sc., Camila Andrade, B.A., for the STOP-PD Study Group

SUMMARY:
This presentation will describe the design of the Study of the Pharmacotherapy of Psychotic Depression (STOP-PD), and discuss the rationale for various aspects of the design. In addition to a discussion of the overall study design, the following specific issues will be addressed: a)the methods that were used to minimize the risk of attempted suicide and suicide among study participants, nearly 20% of whom had previously attempted suicide during the index episode of depression; b)the assessment of participants' decision-making capacity and the methods used to obtain informed consent from participants or, when applicable, surrogate decision-makers; c) the procedures used to maximize retention of participants in the study, especially older persons with severe functional impairment; and d)the methods that were used to ensure that reasons for discontinuation from the study, including clinical worsening and poor response to treatment, were accurately described and captured.

No.68B
TOLERABILITY OF INTENSIVE PHARMACOTHERAPY AND PREDICTORS OF ATTRITION

Benoit H. Mulsant, M.D., CAMH 1001 Queen Street West, Toronto, M6J 1H4, Canada Alastair Flint, M.B., Anthony J. Rothschild, M.D., Ellen Whyte, M.D., Ariel Gildengers, M.D., Nancy McLaughlin, R.N., B.S.N., Kate Peasley Miklus, Ph.D., Moonseong Heo, Ph.D., Barnett Meyers, M.D., for the STOP-PD Study Group

SUMMARY:
This presentation will report on the rates and causes of attrition and adverse events associated with the two treatment arms (olanzapine + sertraline vs. olanzapine + placebo) in the Study of the Pharmacotherapy of Psychotic Depression (STOP-PD). Predictors of adverse events and attrition, including age, treatment assignment and clinical response will be discussed. The frequency of treatment-emergent suicidality and the relationship between increased suicidality and assignment to sertraline or placebo will also be described.

No.68C
THE EFFICACY OF COMBINATION PHARMACOTHERAPY COMPARED TO ATYPICAL ANTIPSYCHOTIC MONOTHERAPY FOR MAJOR DEPRESSION WITH PSYCHOTIC FEATURES

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SUMMARY:
Results of the primary efficacy analyses comparing remission rates associated with combination treatment versus olanzapine monotherapy are reported for the 259 randomized subjects. Results of intent to treat and completer analyses are reported. Predictors of remission among study subjects in the two treatment arms are described. Data on the stability of remission and predictors of stability during three months of continued double-blind treatment following completion of the acute phase are reported.

No.68D
CHALLENGES IN THE DIAGNOSIS AND TREATMENT OF PSYCHOTIC DEPRESSION

Anthony J. Rothschild, M.D., University of Massachusetts Medical School, Department of Psychiatry, 361 Plantation Street,Worcester, MA 01605, Alastair Flint, M.B., Benoit Mulsant, M.D., Ellen Whyte, M.D., Barnett Meyers, M.D., Jayendra Patel, M.D., Eric Smith, M.D., Nancy Byatt, M.D., Richard Cook, M.D., Kristina Deligiannidis, M.D., Philip Burke, M.D., Catherine Peasley-Miklus, Ph.D., Moonseong Heo, Ph.D., Susan Fratoni, B.A., R.N., Michelle Martin, B.A,. Constance Wood, M.S.W., for the STOP-PD Study Group

SUMMARY:
Major depression with psychotic features (MDPsy) is a severe mental illness associated with poorer outcomes, including increased mortality, compared to non-psychotic major depression. The rationale for the STOP-PD trial, including a review of previous studies of the epidemiology, course and treatment of MDpsy is presented. Evidence from the STOP-PD trial demonstrating that MDPsy continues to be under-treated in the community and that the presence of delusions in patients with major depression is commonly missed by treating clinicians is presented.

No.68E
NEUROPSYCHOLOGICAL FUNCTIONING IN PATIENTS WITH PSYCHOTIC MAJOR DEPRESSION

Ellen M. Whyte, M.D., Western Psychiatric Institute and Clinic University of Pittsburgh School of Medicine, 3811 O'Hara St, BT-766, Pittsburgh, PA 15213, Alastair Flint, M.B., Benoit H. Mulsant, M.D., Anthony Rothschild, M.D., Kate Peasley Miklus, Ph.D., Moonseong Heo, Ph.D., Eros Papademetriou, Faith Gunning-Dixon Ph.D., Barnett Meyers, M.D., for the STOP-PD Study Group.

SUMMARY:
This presentation will describe the neuropsychological profile of subjects in the Study of the Pharmacotherapy of Psychotic Depression (STOP-PD) both at baseline and after treatment. We will describe correlates of baseline and post-treatment neuropsychological performance considering subject (e.g., age), illness (e.g., depression severity), and treatment characteristics. We will also describe the predictors of change in cognitive function over time. We will discuss our findings in context of previously published reports of cognitive deficits in psychotic major depression.

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1. Andreescu, C; Mulsant BH, Peasley-Miklus C, Rothschild AJ, Flint, AJ, Heo, M, Caswell M, Whyte EM, Meyers, BS: Persisting Low Use of Antipsychotic the Treatment of Major Depression with Psychotic Features. J. Clin Psychiatry 2007; 68:194-200.
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4. Rothschild AJ, Williamson DJ, Tohen MF, Schatzberg A, Andersen SW, Van Campen LE, Sanger TM, Tollefson GD: A double-blind , randomized study of olanzapine and olanzapine/fluoxetine combination for major depression with psychotic features. J Clin Psychopharmacol 2004; 24:365-373.

SYMPOSIUM 69

PRIVACY AND FRAUD POLICIES AND ELECTRONIC HEALTH RECORDS

EDUCATIONAL OBJECTIVES:
Educational objectives: At the conclusion of this symposium, participants will be able to describe a) how electronic health record policies on privacy and fraud detection are evolving, b) the definitions and roles of the National Committee on Vital and Health Statistics, the Office of the National Coordinator on Health Information Technology, the Certification Commission on Health Information Technology, privacy advocates, contracted studies, and other national bodies.

No.69A
MODEL ANTI-FRAUD REQUIREMENTS FOR ELECTRONIC HEALTH RECORDS

Colleen McCue, Ph.D., Innovative Analytics and Training, LLC, 1050 Connecticut Ave, NW, 10th Floor, Washington, DC 20036

SUMMARY:
Electronic Health Record (EHR) systems promise to significantly improve health care by enhancing the quality of care, increasing patient safety, reducing medical errors, and controlling health care costs. The move to EHR systems also represents a unique opportunity to improve billing accuracy and reduce health care fraud and improper payments, while creating additional opportunities to protect the privacy of health information through secure mechanisms, authorized access and control procedures, and audit functions and features. Currently, most billing errors, improper payments and fraud are detected post payment, which makes addressing these claims very inefficient. The ability to detect errors at the time the record is created affords the opportunity to not only eliminate improper payments, but also improve the quality of care. As part of an effort to realize the promise of EHR systems to identify and prevent health care fraud and improper payments, the Office of the National Coordinator on Health Information Technology (ONCHIT) supported the development of model functionalities and requirements for health care anti-fraud features, functions and data collection in EHR systems. This effort was designed to reduce the growing number of fraudulent claims and other improper payments against public and private health care plans by developing model anti-fraud requirements for electronic health records designed to prevent and detect improper payments, while minimizing the opportunities to perpetrate fraud. As part of the process, a panel of experts was convened that included health care providers, health insurers, health care fraud investigators, and federal agencies. This team worked with other industry stakeholders, including health information technology certification and standards groups, as well as health information technology industry representatives.

No.69B
PRIVACY AND ELECTRONIC HEALTH RECORDS

Deborah C. Peel, M.D., 2905 San Gabriel #207, Austin, TX 78705

SUMMARY:
The RTI Report is bad policy: insurers will be given access to American's longitudinal health recrods to stop fraud. The way to end fraud is to restore consent, so patients can prevent unauthorized users from using their EHR data from fraud.

No.69C
PSYCHIATRIC HEALTH RECORDS AS SENSITIVE INFORMATION

Mark A. Rothstein, J.D., Institute for Bioethics, Health Policy and Law, University of Louisville School of Medicine, 501 East Broadway #310, Louisville, KY 40202

SUMMARY:
Psychiatric records are among the most sensitive health records. The HIPAA Privacy Rule has special protections for "psychotherapy notes," but the exception is quite limited. An important issue is whether additional protections should be given to a wide class of sensitive health information, including reproductive health, substance abuse, domestic abuse, and genetic information, as well as mental health records. If so, should the exception be based on provider or service provided? What does it mean to give the records "special" protection? Finally, if sensitive information, including mental health information is treated separately, is there a risk that doing so will be a self-fulfilling prophecy whereby the stigma and sensitivity of the conditions are increased because of their different treatment?

No.69D
NATIONAL HEALTH IT AGENDA: PRIVACY AND SECURITY

Robert Kolodner, M.D., Dept of Veterans Affairs, 810 Vermont Ave NW, Washington, DC 20420-0001

SUMMARY:
Privacy is an absolutely crucial component of the national

health information technology (health IT) agenda. Confidentiality, privacy and security protections are critical for moving toward increased electronic health record (EHR) adoption and interoperability to enable electronic health information exchange. The Office of the National Coordinator for Health IT (ONC) is in the process of developing a Confidentiality, Privacy and Security Framework to provide guidance for establishing the policies that will create the necessary trust among consumers and providers that will facilitate health information exchange. ONC has, and will continue, to progress policies in concert with technological advances.

No.69E

WHAT THE CERTIFICATION COMMISSION FOR HEALTH INFORMATION TECHNOLOGY MIGHT DO

Zebulon Taintor, M.D., Nathan Kline Institute for Psychiatric Research., Orangeburg, NY 10962

SUMMARY:

The Certification Commission for Health Information Technology (CCHIT, www.cchit.org) was created in 2004 to accelerate the adoption of health information technology by creating an efficient, credible, and sustainable certification program. A certified product can help potential electronic health record (EHR) users get a well-vetted product. CCHIT has a small staff and relies heavily on unpaid volunteers who are appointed to serve on its various panels, which usually have about 16 members, representing clinicians, payers, EHR vendors, quality improvement organizations, and patients. Panels work by conducting environmental scans in their areas and trying to discern consensus about what should be in an electronic health record. The consensus is then turned into a testable standard. EHR vendors are encouraged to apply for certification, which was granted first to some outpatient EHRs. The certification process has two stages: a review of submitted software followed by a site visit with jurors (also volunteers drawn from the field). The practical effect of the procedure is to limit requirements to about 250 standards, the number that can be reviewed in the allotted time.. It's expected that standards will evolve by adding new requirements to the list to replace others that have been met.

REFERENCES:

1. McCue, Colleen (project director): Recommended Requirements for Enhancing Data Quality in Electronic Health Records. (115p)Research Triangle Park, NC, Research Triangle International,, August 25, 2007.
2. Rothstein Mark (Privacy Subcommittee Chair) Privacy and Confidentiality in the National Health Information Network,. Washington, D.C., National Committee on Vital and Health Statistics, 2006.
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4. Following the Digital Trail: Weak Auditing Functions Spell Trouble for an Electronic Health Record. Rosenfeld S, Koss S, Siler S: Privacy, Security and the Regional Health Information Organization. Avalere Health LLC, prepared for California HealthCare Foundation, June 2007.
5. http://www.chcf.org/topics/view.cfm?itemID=133288.

SYMPOSIUM 70

DOES PEER SUPPORT HAVE A ROLE IN PSYCHIATRY?

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; (1) Demonstrate knowledge of three peer support programs based within YPRCH; (2) Recognize the special gifts, skills and experience peer support workers bring to their work with persons in recovery; (3) Recognize how people in recovery may benefit from peer support workers; and (4) Employ strategies for incorporating and supporting peer workers in community based care settings.

No.70A

PARTNERS IN PLANNING: PERSON-CENTERED CARE AS A PATHWAY TO COMMUNITY LIFE

Chyrell Bellamy, M.S.W., Program of Recovery and Community Health, YSM Department of Psychiatry, 319 Peck Street Bldg 6 W Ste 1 C, New Haven, CT 06811

SUMMARY:

This presentation will offer an innovative culturally competent peer support model which aims to facilitate recovery for African Americans and Latino/as, and further, eliminate disparities in mental health service delivery. The involvement of peer-support to facilitate the process of recovery in those living with mental health and substance use issues has been linked to decreased hospital utilization, decrease symptom severity, enlarged social networks, and improved quality of life It is anticipated that the number of programs utilizing some form of peer-facilitated services will continue to grow in the upcoming decade. While these services have the potential to radically re-shape current paradigms, careful consideration is needed while establishing such programs, particularly assisting people in recovery as they transition into these various roles.

No.70B

PEER OUTREACH AS AN ALTERNATIVE TO OUTPATIENT COMMITMENT

Dave Sells, Ph.D., Yale School of Medicine, Yale Program on Recovery & Community Health, 319 Peck Street, Bldg 6, Ste 1C, New Haven, CT 06515

SUMMARY:

This presentation will offer an overview of the Peer Engagement Specialist project as an alternative to involuntary outpatient commitment (IOC), a court order mandating specified treatment for individuals with severe mental illness who refuse treatment is a professionally and politically contested public health issue in contemporary American society. Proponents argue IOC is a humane approach to treatment for individuals whose judgment is impaired by mental illness. Opponents argue IOC is an unneces-

sary infringement on individual autonomy and undermines the provider-client relationship. While several studies have assessed the effectiveness of IOC, none has studied the effectiveness of community-based outreach encouraging voluntary participation in outpatient treatment. We consider a "Peer Engagement Specialist Initiative" as a prospective alternative to IOC in Connecticut, one of the few states without an IOC law. This initiative builds on the unique capacity of peer outreach workers to engage people in psychiatric services through a gradual process of trust-building, role modeling, and persuasion. A group of adults with serious mental illness were randomly assigned to one of two treatment conditions: "Peer Engagement" or "Treatment as Usual." Rate of participation in voluntary outpatient treatment, homelessness, hospitalization, quality of life, perceptions of the therapeutic relationship, as well as qualitative findings will be presented. Implications for mental health treatment and policy will also be discussed.

No.70C
FOUNDATIONS OF PEER SUPPORT

Larry Davidson, Ph.D., P.R.C.H., Erector Square, 319 Peck Street, New Haven, CT 06513, William Sledge, M.D.

SUMMARY:

This presentation will offer an overview of the historical perspective and philosophical foundations of the peer support movement, as well as ideas for future directions for the field. Peer support involves people with histories of mental illness who have experienced significant improvements in their psychiatric condition offering support to other people with mental illness who are not as far along in their personal recovery. This kind of support, in which one designated person—the peer specialist—helps another peer, differs from mutual support and consumer-run programs, on the one hand, because in both of these formats people voluntarily come together to help each other address common problems. Peer support also differs from case management and other mental health services, on the other hand, because the experience of having "been there" and having made progress in one's own personal recovery comprises a major part of the support that peer specialists provide. While people in recovery can provide conventional services as well, peer support per se is made possible by the provider's own history of disability and recovery and his or her willingness to share this history with others.

No.70D
THE RECOVERY MENTOR STUDY

Martha Lawless, 319 Peck Street, Building 6W, Suite 1C, New Haven, CT 06511

SUMMARY:

This presentation will explore the Recovery Mentor Study, in which 120 people with psychosis who have been in the hospital at least three times in 18 months will be recruited. Sixty participants will be randomized to a treatment as usual condition, and sixty will receive Recovery Mentor services. The Recovery Mentor works with a maximum of 10 study participants and will meet with each no less than once per week for 9 months. The Recovery Mentor is e available to the intervention participants to assist in recovery efforts and in gaining a fuller life in the community. Recovery Mentors are hired and trained through the Yale Program on Recovery and Community Health (PRCH) and study personnel provide supervision on a weekly and as needed basis. We will present the primary participant outcome measures which is utilization rates of mental health services, both inpatient and outpatient. We will also include various other assessments, completed at baseline, three months and nine months, including considerations of participant demographics, symptom severity, and treatment satisfaction, as well as qualitative interviews upon a randomly selected subsample. Though the project is still in the beginning phases, the presentation will focus on the preliminary findings from these assessments, as well as challenges and lessons learned in the course of developing the project.

REFERENCES:

1. Davidson L, Chinman M, Kloos B, Weingarten R, Stayner D, Tebes JK: Peer support among individuals with severe mental illness: A review of the evidence. Clinical Psychology: Science and Practice 1999; 6:165-187.
2. Davidson L, Chinman M, Sells D, Rowe M: Peer support among adults with serious mental illness: A report from the field. Schizophrenia Bulletin 2006; 32: 443-450.
3. Mowbray CT, Moxley DP, Thrasher S, Bybee D, McCrohan N, Harris S, Glover G: Consumers as community support providers: Issues created by role innovation. Community Mental Health Journal, 1996; 32:47-67.
4. Sells D, Davidson L, Jewell C, Falzer P, Rowe M: The treatment relationship in peer-based and regular case management services for clients with severe mental illness. Psychiatric Services, 2006; 57(8):1179-1184.

SYMPOSIUM 71

FEATURES OF AUTISM IN ADULTHOOD

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to explain the difficulties and opportunities related to diagnosis and management of autism spectrum disorders in adulthood.

No.71A
MANAGEMENT OF INTELLECTUALLY ABLE ADULTS WITH AUTISM SPECTRUM DISORDERS

Bram B. Sizoo, M.D., Postbus 110, Zwolle, 8000 AC, Netherlands

SUMMARY:

Autism spectrum disorders in adulthood are characterized by a heterogeneous presentation of symptoms, and by variation in time. Much depends on whether the diagnosis has been made in childhood or later on in life, for how well individuals and their environment have adapted to the disorder. Despite a seemingly stable family life and work environment, sudden changes in the external structure can lead to a paralysing imbalance, followed by mandatory admission in an emergency mental health facility. The nature of these interventions is often in itself destabilizing for people with autism, aggravating problems even more. Examples are given of preventive measures and psycho-education, aimed

at early detection of derailment. Social skills training in group therapy is useful for raising awareness among patients of their own symptoms, but generalization of lessons-learned to everyday life situations appears to be less successful. Marital therapy or relations therapy in general can be very rewarding as problems are put into the context of autism, and negative stigmatisation is reduced. Practical help by a regular coach or therapist in dealing with administrative issues and everyday choices in virtually all fields of social life is a high-yield intervention, as is consultative mediation between patients and employers. It is a challenge for mental health providers to ensure that problem-guided and appropriate care is offered at the right time, preventing ensuring a continuity of care as much a possible.

No.71B

AN ANALYSIS OF THE CONCEPT OF EMPATHY AND ITS RELEVANCE FOR THE UNDERSTANDING OF AUTISM

Gerrit G. Glas, M.D., Zwolse Poort, P.O. Box 110, Zwolle, 8000AC Netherlands

SUMMARY:

In this presentation it will be shown that Theory Theory (TT) and Simulation Theory (ST), both dominant theories in research of empathy and other forms of affective/intersubjective understanding, in a critical way depend on a Cartesian and Humean view of the human person. Both theories are Cartesian in the sense that they implicitly conceive the mental as something that is enclosed in a private mind. They are Humean in the sense that they implicitly suggest that intersubjective recognition is based on perception (of bodily activities) and inference on the basis of these bodily activities. This is not only of theoretical interest. It also leads to underestimation of the practical, embodied, and embedded nature of empathy and interactive understanding. I will briefly investigate some possible alternatives, such as the so-called neurophenomenological approach. Then, I will sketch the outline of a multi layered conceptual framework that does justice to the pragmatic, embodied and embedded nature of empathy. Finally, the implications of this approach for the (scientific) understanding of autism are explored.

No.71C

COMORBIDITY ISSUES IN AUTISM SPECTRUM DISORDERS IN ADULTS

Patricia J. van Wijngaarden-Cremers, M.D., PO Box 110, Zwolle, 8000 ac, Netherlands Van Wijngaarden-Cremers, Patricia J.M. M.D., Bram Sizoo, M.D., Cees Kan M.D., Ph.D., Van der Gaag Rutger Jan M.D., Ph.D.

SUMMARY:

Autism Spectrum Disorders are currently often diagnosed in adults. Not only do “adult” psychiatrist treat individuals in whom the diagnosis was made in infancy, childhood and adolescence, but more over are they confronted with adults who seek diagnosis and treatment for ASD. These are often fathers of children with ASD, who are referred under pressure of their spouses. But also individuals in whom the suspicion of an ASD diagnosis arouses in their employers. These are so called straight forward referrals in which the likelihood of the diagnosis is present at referral.

No.71D

ASSESSMENT AND DIAGNOSIS OF AUTISM SPECTRUM DISORDERS IN ADULTS

Rutger Jan van der Gaag, M.D., UMCN Nijmegen & Karakter University Centre for Child & Adolescent Psychiatry Nijmegen, Reinier Postlaan 12, Nijmegen, 6525GC, Netherlands Patricia J. M. Van Wijngaarden-Cremers, M.D. , Bram Sizoo, M.D., Cees Kan, M.D Ph.D.

SUMMARY:

People with Autism Spectrum Disorders (ASD) grow up to become adults. But more and more adults (often parents of children with as ASD Diagnosis) are referred to services for assessment and diagnosis. In our country teams of adult and child & adolescent psychiatrists have joined forces to elaborate a comprehensive assessment programme (CASD18+) to ascertain the quality of the diagnostic process in this yet only shortly recognised group of individuals. In line with the Practice Parameters in use at younger age the assessment procedure involves the patient and his family and is performed by a well-trained multidisciplinary team.

REFERENCES:

1. Dawson G, Webb S, Schellenberg GD, Dager S, Friedman S, Aylward E, Richards T: Defining the broader phenotype of autism: genetic, brain, and behavioral perspectives. Dev Psychopathol 2002; 14(3):581-611.
2. Klin A, Jones W, Schultz R, Volkmar F, Cohen D: Defining and quantifying the social phenotype in autism. Am J Psychiatry 2002; 159(6):895-908.
3. Gallagher S: Understanding Interpersonal Problems in Autism: Interaction Theory as an Alternative to Theory of Mind. Philosophy, Psychiatry, & Psychology 2003; 11(3):199-217.
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SYMPOSIUM 72

TRANSFORMING THE PROVISION OF MENTAL HEALTH SERVICES: THE CALMEND PROJECT

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Recognize the current quality chasm in mental health and how the Institute of Medicine (IOM) aims can address it; (2) Understand the CalMEND strategy to transform the provision of mental health services using the IOM aims; and (3) Describe the framework for shared decision making and apply it mental health services.

No.72A

CALMEND: AN INITIATIVE TO RATIONALIZE CARE FOR MENTALLY ILL PERSONS ACROSS STATE SYSTEMS IN CALIFORNIA

Barry E. Handon, M.D., 1501 Capitol Ave., MS4606, PO Box 997413, Sacramento, CA 95899

SUMMARY:

CalMEND, the California Mental Health Care Management Program, is a joint quality improvement initiative by the California Department of Mental Health (DMH), the state's Medicaid agency (Medi-Cal), and the California Institute for Mental Health (CiMH). The work of CalMEND draws heavily on the participation of all stakeholders, including clinicians, consumers, family members, physicians, pharmacists, and recovery specialists.

No.72B

IDENTIFYING ANTIPSYCHOTIC POLYPHARMACY AND THE COLLABORATIVE PERFORMANCE IMPROVEMENT PROJECT

Douglas Del Paggio, Pharm.D., 2000 Embarcadero Cove Suite #400, Oakland, CA 94606, Pauline Chan R.Ph.

SUMMARY:

California County Medical and Pharmacy Directors were initially brought together in Oct 2006 to identify pressing psychotropic prescribing concerns. These consisted of: polypharmacy, multiple psychotropic agents and medication adherence. Antipsychotic polypharmacy was selected to be the starting point of the performance improvement project.

NO.72C

ANTIPSYCHOTIC TREATMENT DECISIONS: WHO DETERMINES RECOVERY OF FUNCTION?

Pauline Chan, R.Ph., 1501 Capitol Ave., Suite 71.5155, Sacramento, CA 95814, Neal Adams, M.D., Ahn Thu Bui, M.D., Kim Tallian, Pharm.D.

SUMMARY:

There are a wide range of services, supports and activities that can help clients, including relapse prevention and recovery promotion, psychosocial rehabilitation, case management, psychological services, pharmacotherapy and other biomedical treatments, activities of personal meaning to the individual, supported employment and education, and housing. The resources or providers of these services and activities are also varied, ranging from the community at large, to primary care providers, peers, mental health service system, and the individual and family.

No.72D

INCORPORATING BOTH FAMILY SUPPORT AND EVIDENCE BASED PRACTICES IN TREATMENT FOR CHILDREN

Penelope K. Knapp, M.D., CA Dept. Mental of Health, 1600 9th St, Suite 151, Sacramento, CA 95814

SUMMARY:

Children and adolescents with severe emotional disturbances (SED) are best treated via access to a comprehensive array of evidence-based services that address the child's physical, emotional, social, and educational needs within the clinically appropriate least restrictive and normative environment. Challenges to realizing this goal in the public mental health system include (a) declining funding for systems of care, (b) prescriptions for psychotropic medication may only be available outside the mental health system, (c) psycho-education and family participation in decision making about treatment planning may be lacking (d) treatments may not be evidence-based.

No.72E

DEVISING A DURABLE TREATMENT PLAN: WHO DECIDES?

Thu A. Bui, M.D., PMB#233, 1717 E. Vista Chino Road, Suite A7, Palm Springs, CA 92262, Neal Adams, M.D.

SUMMARY:

CalMEND in its several workgroups has focused on the delivery system design. This effort resulted in the creation of a process map that has become central to communicating the work of CalMEND, as well as organizing the project's structure and further work.

REFERENCES:

1. Institute of Medicine, Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. Improving the Quality of Health Care for Mental and Substance-Use Conditions. Washington, D.C. National Academy Press, 2006
2. Adams N, Grieder D: Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery. Elsevier Academic Press, 2005.
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4. National Collaborating Centre for Mental Health, National Institute for Clinical Excellence. Schizophrenia: Full clinical guideline on core interventions in primary and secondary care. The Royal College of Psychiatrists & The British Psychological Society, 2003. http://guidance.nice.org.uk/CG1/?c=91523

SYMPOSIUM 73

AFFECTIVE INSTABILITY IN BORDERLINE PERSONALITY DISORDER

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the biological and psychological correlates of affective instability in BPD.

No.73A

NEURAL CORRELATES OF AFFECTIVE INSTABILITY IN BORDERLINE PERSONALITY DISORDER

Harold Koenigsberg, M.D., Mount Sinai School of Medicine, James J. Peters VA Medical Center, 130 W Kingsbridge Rd,116 A, Bronx, NY 10468, Larry J. Siever, M.D., Hedok Lee, Ph.D., Antonia S. New, M.D., Marianne Goodman, M.D., Hu Cheng, Ph.D., Janine Flory, Ph.D., Isak Prohovnik, Ph.D.

SUMMARY:

Affective instability is a core feature of borderline personality disorder (BPD) and is associated with many of its most disabling symptoms, such as suicidality, inappropriate anger, stormy relationships and identity disturbances. Yet its biological underpinnings are poorly understood. We employed functional MRI to compare patterns of regional brain activation in BPD patients and healthy volunteers as they processed emotional stimuli. Method: BOLD fMRI images were acquired while 19 BPD patients and 17 healthy volunteers viewed emotion inducing pictures of negative and positive emotional valence. Activation data were analyzed with SPM5 ANCOVA models to derive the effects of diagnosis and stimulus type. Results: BPD patients demonstrated greater differences in BOLD activity than controls, when viewing negative pictures compared to rest, in the amygdala, fusiform gyrus, primary visual areas, superior temporal gyrus (STG), and premotor areas, while healthy controls showed greater differences in activation than BPD's in the insula, middle temporal gyrus and dorsolateral prefrontal cortex (BA46). When viewing positive pictures compared to rest, BPD patients showed greater differences in BOLD signal compared to HC's in the STG, premotor cortex, and ventrolateral prefrontal cortex more than HC's, and HC's activated the caudate more than BPD's. Conclusions: These findings suggest that BPD patients show greater amygdala activity and heightened activity of visual processing regions than HC's, when processing negative emotional pictures compared to rest. BPD patients activate neural networks in emotion processing that are phylogenetically older and more automatic and reflexive than healthy controls, who tend, in contrast, to activate higher level cognitive regions that are capable of reflective functioning. These differences in patterns of neural activity may account for the heightened emotional reactivity of borderline patients.

No.73B

STABILITY AND VARIABILITY OF AFFECTIVE EXPERIENCE AND INTERPERSONAL BEHAVIOR IN BORDERLINE PERSONALITY DISORDER

Jennifer Russell, Ph.D., Dept of Psychology, McGill University, 1205 Dr Penfield Ave., Montreal, H3A 1B1, Canada Moskowitz, D.S., Ph.D., David C. Zuroff, Ph.D., Debbie Sookman, Ph.D., Joel Paris, M.D.

SUMMARY:

This study examined both mean levels and intraindividual variability in the mood and interpersonal behavior of individuals with borderline personality disorder (BPD) and non-clinical controls over a 20-day event-contingent recording period. Individuals in the BPD group experienced more unpleasantly valenced affect and were less dominant, more submissive, more quarrelsome, and more extreme in overall levels of behavior than control participants. In addition to these mean level differences, individuals with BPD also reported more intraindividual variability in overall affect valence and in pleasantly valenced affect, displayed greater variability in dominant, quarrelsome, and agreeable behaviors, and exhibited an increased tendency to "spin" among interpersonal behaviors relative to non-clinical controls. The findings document behavioral and affective manifestations of BPD in the context of naturally occurring interpersonal situations.

No.73C

THE INTERFACE BETWEEN BPD AND BIPOLAR DISORDER

Joel Paris, M.D., Institute of Community and Family Psychiatry, 4333 Cote Ste-Catherine Rd,, Montreal, H3T 1E4, Canada John Gunderson, M.D., Igor Weinberg, Ph.D.

SUMMARY:

Objective: This presentation will examine whether borderline personality disorder (BPD) should be considered part of the bipolar spectrum.

Method: Literature review of studies of co-occurrence, phenomenology, family prevalence, medication response, longitudinal course, and etiology.

Results: BPD and bipolar disorder co-occur, but the relationship is neither consistent nor specific. There are a few overlaps but important differences in phenomenology and in medication response. Family studies suggest distinctions, and BPD rarely evolves into bipolar disorder. It is not known whether these disorders have a common etiology.

Conclusions: Existing data fails to support the conclusion that BPD and bipolar disorders fall within a spectrum.

No.73D

CLARIFYING THE NATURE OF AFFECTIVE INSTABILITY IN BORDERLINE PERSONALITY DISORDER

Paul Links, M.D., 30 Bond St., Rm 2010d Shuter St., Toronto, M5B 1W8, Canada Rahel Eynan, M.A., Marnin J. Heisel, Ph.D., Rosane Nisenbaum, Ph.D., Denise Sum, B.A.

SUMMARY:

Objective: This paper clarifies the nature of affective instability in Borderline Personality Disorder (BPD) addressing two issues: 1) what elements of affective instability were associated with an increased likelihood of impulsivity and did these element relate to an increased occurrence of suicidal behavior and 2) what were the most prevalent triggers of mood states reported by BPD patients with a history suicidal behavior.

Method: We prospectively followed 82 individuals with BPD and a history of recurrent suicidal behavior who recorded their impulsivity, suicidal ideation and using Experience Sampling Methodology, their current mood states and triggers 6 times daily over three weeks.

Results: Our results suggested mood amplitude was correlated with impulsivity and that four subgroups defined by mean scores on mood amplitude and negative mood intensity significantly differed on the number of suicidal behaviors reported in the last year. The most prevalent triggers of mood change were current: interpersonal relationships, daily life or situational stress, and internal psychological states. However, physical states and media stimuli were also common triggers.

Conclusions: Affective instability in BPD has to be understood as having several elements including variability in mood amplitude that correlates with impulsivity and increased sensitivity to current environmental stimuli and external events.

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SYMPOSIUM 74

COGNITIVE EFFECTS OF SECOND GENERATION ANTIPSYCHOTICS: EXPERIENCES FROM FIRST EPISODE STUDIES

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand how much second generation antipsychotics may improve the cognitive deficits found with first episode psychosis, the magnitude of cognitive improvement in comparison with improvements in other domains with treatment, and the extent to which practice effects may underly the cognitive improvements noted in studies.

No.74A

USING TRANSLATIONAL COGNITIVE NEUROSCIENCE PARADIGMS TO EXPLORE THE EFFECTS OF SECOND GENERATION AGENTS

John A Sweeney, Ph.D., Center for Cognitive Medicine,University of Illinois Hospital, 912 S. Wood St., MC 913, Chicago, IL 60612, Margret S. H. Harris, M.S., Scot K. Hill, Ph.D., James L. Reilly, Ph.D.

SUMMARY:

Objective: Cognitive deficits are a major cause of functional morbidity in schizophrenia, and have become recognized as an important treatment target in new drug development. Traditional clinical neuropsychological measures have been used in most prior studies assessing the cognitive impact of antipsychotic drugs. The present study included a battery of translational cognitive neuroscience tasks with known robust sensitivity to drug effect in monkey studies to examine their utility for assessing cognitive outcomes of antipsychotic treatment.

Method: Thirty first episode antipsychotic naïve patients who met *DSM-IV* criteria for schizophrenia were recruited and studied before treatment, and again at 4-6 weeks, 26 weeks and 52 weeks with a battery of neuropsychological tests and a series of oculomotor neurophysiology paradigms. Thirty matched controls were studied in parallel. Clinical change was monitored with SAPS and SANS scales, but was not significantly correlated with cognitive change.

Result: Increase in neuropsychological test scores of patients were moderate after treatment, and paralleled change over time in healthy individuals. Changes in visually guided saccades were present at the first follow-up period, and were stable over time in the form of slowed response initiation and reduced accuracy of responses, consistent with psychomotor slowing. On the oculomotor delayed response test of spatial working memory, performance was impaired before treatment, but was further and persistently impaired after treatment initiation, consistent with observations in animal models. On a test of the ability to voluntarily suppress context-inappropriate responses, gradual improvement over the 1-year follow-up period was observed.

Conclusion: Translational cognitive neuroscience paradigms may provide a sensitive and discriminating approach for evaluating cognitive effects of antipsychotic and other drugs. They provide data that can be validated and mechanistically explored in animal models. And, they may better separate beneficial and adverse cognitive effects of treatment, perhaps by providing measures closer to specific drug effects on neuron populations that control specific cognitive abilities.

No.74B

THE COGNITIVE EFFECTS OF RISPERIDONE, OLANZAPINE AND QUETIAPINE IN PATIENTS WITH FIRST EPISODE PSYCHOSIS

Richard S Keefe, Ph.D., Box 3270, Duke University Medical Center, Durham, NC 27710

SUMMARY:

Objective: To compare the effects of olanzapine, quetiapine, and risperidone on neurocognitive function in patients with first-episode psychosis.

Methods: A 52-week, double-blind, multicenter study of first-episode patients randomized to olanzapine (2.5 to 20 mg/day), quetiapine (100 to 800 mg/day), or risperidone (0.5 to 4 mg/day). The mean (SD) modal daily dose (mg) of olanzapine, quetiapine, and risperidone in the 400 randomized patients was 11.7 (5.3), 506 (215), and 2.4 (1.0), respectively. Two hundred twenty-four patients completed neurocognitive assessments at baseline and 12 weeks, and 81 patients also completed them at 52 weeks. Neurocognitive composite scores were calculated from a neurocognitive battery used in the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) schizophrenia trial and the Brief Assessment of Cognition in Schizophrenia (BACS).

Results: At week 12, there was significant improvement in neurocognition for each treatment ($p<0.01$), but no significant overall difference between treatments. CATIE composite z-score improvements were 0.17 for olanzapine, 0.33 for quetiapine, and 0.32 for risperidone. BACS composite z-score improvements were 0.19 for olanzapine, 0.34 for quetiapine, and 0.22 for risperidone. At weeks 12 and 52, there were statistically significant relationships between improvements in neurocognition and functional outcome. Conclusions: In first-episode patients, olanzapine, quetiapine, and risperidone all produced significant improvements in neurocognition.

Although cognitive improvements were modest and may not have surpassed the changes expected with placebo, their clinical

importance was suggested by relationships with improvements in functional outcome.

No.74C

MULTI-DIMENSIONAL OUTCOMES OF TREATMENT OF FIRST EPISODE SCHIZOPHRENIA WITH SECOND GENERATION ANTIPSYCHOTICS

Delbert Robinson, M.D., The Zucker Hillside Hospital, Research Department, 75-59 263rd Street, Glen Oaks, NY 11004

SUMMARY:

Patients with first episode schizophrenia may have multiple symptoms as well as deficits in cognition and social and vocational functioning. Second generation antipsychotic treatment is associated with substantial improvements in positive symptoms but more modest improvements in negative symptoms. In a recent first episode study (Robinson et al 2006) comparing olanzapine and risperidone with 112 subjects, about half of the subjects after 4 months of treatment met criteria for response, which required an absence of delusions, hallucinations, or significant thought disorder. Only modest improvements were found in avolition-apathy and asociality-anhedonia; other negative symptom domains did not improve. First episode studies have consistently found that first episode patients have cognitive deficits at illness onset. The severity of these deficits are correlated with important outcomes. Robinson and colleagues (2004) examined recovery among 118 FE patients treated for 5 years. Better cognitive functioning was associated with more likelihood of achieving symptom remission, adequate social/vocational function and meeting full criteria for recovery.

No.74D

COGNITIVE CHANGE WITH TREATMENT: REAL OR PRACTICE EFFECTS?

Terry E. Goldberg, Ph.D., 75 59 263rd St, Glen Oaks, NY 11004

SUMMARY:

It is generally accepted that cognitive impairment accounts for a significant share of the social and vocational morbidity associated with schizophrenia. Numerous recent studies have suggested that second generation antipsychotic medications significantly enhance cognition in schizophrenia. None of these studies included healthy controls undergoing repeated testing to assess the possibility that "improvements" actually reflect simple practice effects. In this study of 104 first episode (FE) schizophrenia patients we were able to address several sources of bias or problematic methodologies which made interpretation of earlier results complex. Critically, a healthy control group (N=84) was employed and assessed over repeated visits to measure practice effects. Fifty one FE patients were randomized to olanzapine (modal dose 12.7 mgs) and 53 to risperidone (modal dose 3.7 mgs). Assessments occurred at baseline, six weeks later, and 16 weeks later. Neurocognitive tests included multiple measures of working memory and attention, speed of processing, episodic memory, and executive function. No differential drug effects were observed. Of 16 cognitive measures, nine demonstrated improvement over time. Of these only two (visual memory for designs, trailmaking speed) demonstrated greater rates of change than that observed in the HC group undergoing repeated assessment. The composite effect size in the HC group was .33, in the FE patients, .36. Results suggest that cognitive change was consistent in magnitude to practice effects and thus does not reflect cognitive enhancement per se. We believe that these findings have important implications for drug discovery and the design of registration trials that attempt to demonstrate cognitive enhancement.

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SYMPOSIUM 75

MOOD DISORDERS AND MEDICAL COMORBIDITY: CAUSES AND CONSEQUENCES

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; (1) To understand the health outcomes of medically ill patients with mood disorders; (2) To understand the underlying neurobiology of mood disorders which may predispose patients to development of diabetes, heart disease, and possibly stroke; and (3) To learn strategies for the prevention and treatment of depressive symptoms in medically ill patients at high risk for affective disorders.

No.75A

MOOD DISORDERS AND MEDICAL COMORBIDITY: CAUSES AND CONSEQUENCES

Claus H. Sørensen, M.D., Department of Psychiatry, Odense University Hospital, Odense, DK 5000 Denmark

SUMMARY:

Recent research find that conceptions such as bipolar patients are only ill when hospitalized, they are well-functioning and maintain cognitive functioning, and they only have an increased mortality from suicide are wrong. Bipolar patients are much more likely to have somatic comorbidity, and they have at least twice

the mortality rate for cardiovascular disease, endocrine disease and respiratory disease compared with the background population. Furthermore, somatic comorbidity predicts longer time to recovery from a mood episode. Somatic comorbidity is related to early debut of bipolar illness, duration of depressive episodes and female gender.

No.75B

DEPRESSION AND DIABETES: CURRENT CHALLENGES AND FUTURE DIRECTIONS

Dominique L. Musselman, M.D., 1639 Pierce Drive, Suite 4000, Atlanta, GA 30322

SUMMARY:

This lecture will address the epidemiology linking onset of diabetes in patients with depression, as well as the onset of depression in those individuals diagnosed with type 2 diabetes. The neurometabolic consequences of stress and depression will also be reviewed, as well as the cognitive impact of diabetes upon brain function. Treatment modalities addressing depression in patients with Type 2 diabetes, as well as the mood effects of effective glycemic control will be contrasted. Lastly, novel interventions to address both these chronic, disabling, and coexisting "psychiatric" and "medical" conditions will be presented.

No.75C

POST STROKE DEPRESSION

Grethe Andersen, M.D., Department of Neurology, Aarhus University Hospital, Århus, DK 8000 C Denmark

SUMMARY:

Purpose: To update current scientific knowledge of post stroke depression (PSD) and implications for every day practice.

Content: Review of frequency, course, aetiology and treatment of PSD and daily practice in a stroke ward.

Methodology: Literature review from the last two decades combined with a study of practice in an experienced centre with about 1,000 acute stroke admissions per year and documented scientific interest in this field.

Results: Post stroke depression and/or emotionalism are the most frequent complications after stroke occurring in approximately 30% and clearly related to the acute stroke event. PSD is frequently overlooked as symptoms of depression are difficult to separate from the neurological symptoms. The frequency of PSD varies between different studies due to selected study populations and criteria for the depression diagnose used. About half the post stroke depressed patients have chronic symptoms lasting for more than one year. The cause of PSD is related to the lesion in the brain per se and probably also the size of the lesion, although this is not shown in the literature. Also social factors, genetic factors and a history of past depression are risk factors for PSD. The clinical presentation of depression symptoms varies according to side of brain lesion. The left sided brain lesion may cause catastrophic reactions while the right sided brain lesions may cause apathy, loss of coherence and delusions. Although there was no clear evidence for antidepressant treatment, we have for years treated about 30% of patients in the acute phase and it is our clear impression that such treatment strategy has great impact on the process of rehabilitation as well as quality of life, and therefore is now almost standard treatment for patients with specific stroke syndromes. Examples of such treatment strategy for specific stroke syndromes will be presented.

Conclusion: PSD is common and important but often overlooked in clinical practice and patients are not treated. It is however possible to change attitude towards an aggressive antidepressant treatment strategy with overall good results in respect to decreased depression symptoms, increased well being and motivation.

NO.75D

CAN TREATMENT OF DEPRESSION REDUCE CARDIAC RISK

Steven P. Roose, M.D., 1051 Riverside Drive, New York, NY 10032

SUMMARY:

There is a much-replicated finding that major depression or the presence of depressive symptoms in a patient post-MI or in a patient with unstable angina significantly increases the risk of cardiac mortality. The greatest period of increased risk appears to be six to nine months following the cardiac event.

The compelling clinical question is whether treatment of depression reduces cardiac risk, and if so does it depend on the modality of treatment, (e.g., antidepressant medication or psychotherapy?) To date, there are a number of completed studies that address this issue. The results suggest a reduction in cardiac mortality associated with SSRI treatment, but whether the reduction is also associated with anti-depressant response is not clear, Furthermore there are some interventions that clearly do not decrease cardiac risk. This talk will review the data from these studies as well as methodological problems specific to each clinical trial. Special attention will be paid to the physiological issues related to cardiac risk that may also be associated with depression, and subsequently effected by treatment, (e.g. platelet aggregability and inflammatory status).

REFERENCES:

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SYMPOSIA

THURSDAY, MAY 8, 9:00 AM-12:00PM

SYMPOSIUM 76

TRANSLATIONAL RESEARCH ON OBSESSIVE COMPULSIVE DISORDER

National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; (1) Genetic and phenotypic approaches can advance understanding of obsessive compulsive disorder (OCD) dimensions; (2) Animal models have both promise and limitations in advancing OCD treatment; (3) Effects of deep brain stimulation in otherwise intractable OCD, and the brain circuitry implicated; and (4) Brain glutamate systems are potential therapeutic targets in OCD.

No.76A

DEEP BRAIN STIMULATION OF THE VENTRAL INTERNAL CAPSULE/VENTRAL STRIATUM FOR OBSESSIVE COMPULSIVE DISORDER: EXPERIENCE, EFFECTS AND POTENTIAL MECHANISMS

Benjamin D Greenberg, M.D., Butler Hospital 345 Blackstone Blvd., Providence, RI 02906, Loes Gabriels, M.D., Ph.D., Donald Malone, M.D., Nathan A. Shapira, M.D., Ph.D., Michael Okun, M.D., Ph.D., Gerhard Friehs, M.D., Ali Rezai, M.D., Kelly Foote, M.D., Ph.D., Paul Cosyns, M.D., Cynthia Kubu, Ph.D., Paul Malloy, Ph.D., Stephen Salloway, M.D., Ph.D., Wayne Goodman, M.D., Bart Nuttin, M.D., Ph.D., Steven Rasmussen, M.D.

SUMMARY:

Since 1998, psychiatric neurosurgery teams in Europe (Leuven/Antwerp) and the U.S. (Butler Hospital/Brown, Cleveland Clinic, University of Florida) have investigated deep brain stimulation (DBS) of the ventral anterior limb of the internal capsule and adjacent ventral striatum (VC/VS) for severe, otherwise intractable obsessive compulsive disorder (OCD). Patients (N=26) selected had mean OCD duration of 22 years and baseline Yale-Brown OCD Scale (YBOCS) severity of 34.0 (severe OCD), judged intractable to conventional treatment using rigorous criteria. Team psychiatrists led selection and long-term followup (mean: 24.0 months). Results reveal meaningful symptom reductions and functional improvement in about two-thirds of patients after open treatment. Results improved in patients implanted more recently. The percentages of patients meeting the full response criterion (35% YBOCS severity decrease) at last followup were 33.3%, 77.8%, and 75.0% of patients in the first, second, and third groups implanted, respectively. The improvement in outcomes ("learning curve") appears mainly due to target refinement to a more posterior location. This procedure can be successfully implemented by dedicated interdisciplinary teams, and has therapeutic promise. Neuroimaging data on response prediction and mechanisms of action will be discussed.

No.76B

THE UTILITY OF GENETIC RESEARCH TO IDENTIFY ETIOLOGICALLY DISTINCT SYNDROMES AMENABLE TO ADVANCING TREATMENT OPTIONS

Gerald Nestadt, M.D., Meyer 109, Johns Hopkins Hospital, 600 N. Wolfe St, Baltimore, MD 21287

SUMMARY:

Advances in the development of more effective treatments for obsessive compulsive disorder (OCD) may be limited by etiological, and potentially pathophysiological, heterogeneity. Efforts in several research domains are in progress to elucidate subclasses or dimension which may provide insight into this issue. Important among these is the likely genetic heterogeneity of this disorder. Compulsive hoarding will be employed to illustrate this approach.

Identification of genetic susceptibility variants for OCD dimensions is critical. The status of genetic research in OCD will be discussed. From that vantage point, efforts that have been initiated to identify etiologically homogeneous subgroups or dimensions of OCD, will be discussed. Furthermore the evidence to date of pharmacogenetic studies that are in progress to dissect out syndromes amenable for specific treatment strategies will be reviewed.

No.76C

THE POTENTIAL AND PITFALLS OF ANIMAL MODELS OF OCD: A CLINICAL PERSPECTIVE

Helen Blair Simpson, M.D., New York State Psychiatric Institute, 1051 Riverside Drive, Unit 69,, New York, NY 10032, Stephanie Dulawa, Ph.D., Abby Fyer, M.D., Rene Hen, Ph.D., David Leonardo, M.D., Ph.D., Michael Liebowitz, M.D., Susanne Ahmari, M.D., Ph.D.

SUMMARY:

There are two established first-line treatments for obsessive compulsive disorder (OCD): pharmacotherapy with serotonin reuptake inhibitors (SRIs) and cognitive-behavioral therapy consisting of exposure and response/ritual prevention (EX/RP). Although both treatments are efficacious, less than half of patients achieve an excellent outcome even when these treatments are delivered optimally. To improve the outcome of patients with OCD, researchers have applied a variety of scientific approaches to better understand the biological basis of obsessions and compulsions, with the hope of identifying new targets for treatment. One promising approach is the use of animal models to examine the cellular and molecular basis of obsessions and compulsions. However, this approach is complicated by the difficulty of finding an animal model that reproduces the mental features of OCD, as well as some of the overt repetitive behaviors. This talk will describe how animal models have been applied to the study of OCD to date, using examples from the literature as well as from the recent work of Dr. Simpson and her collaborators. The potential and pitfalls of translating animal data to OCD phenomenology will be discussed.

No.76D

TARGETING GLUTAMATE: NOVEL TREATMENT INTERVENTIONS FOR OBSESSIVE COMPULSIVE DISORDER

Vladimir Coric, M.D., Yale University, CMHC 329B, 34 Park St., New Haven, CT 06519-1187

SUMMARY:

Treatment refractory obsessive compulsive disorder (OCD) remains a significant and debilitating disorder despite the introduction of serotonin reuptake inhibitors, neuroleptic augmentation strategies, and cognitive behavioral therapy. Accumulating preclinical and clinical evidence suggests that glutamate, an excitatory amino acid neurotransmitter, plays an important role in the pathophysiology of OCD. Dr. Coric will review recent preclinical, neuroanatomical, genetic and clinical studies implicating dysfunctional glutamatergic neurotransmission in OCD. Dr. Coric will also describe the use of riluzole (Ritulek™), a glutamate modulating agent, in the treatment of SRI-refractory OCD. Pharmacological approaches that modulate glutamatergic neurotransmission may hold promise as novel treatment interventions for anxiety and mood disorders.

REFERENCES:

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SYMPOSIUM 77

ASSESSING AND REDUCING RISK OF VIOLENCE AMONG PEOPLE WITH SCHIZOPHRENIA AND OTHER MENTAL DISORDERS

National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; (1) Understand the complex link between violence and mental disorders, and the challenges to interpreting evidence for such a link; (2) Demonstrate knowledge of empirical research on violence risk assessment; (3) Apply findings from the NIMH CATIE study to clinical practice of violence risk management of schizophrenia; and (4) Understand the role of legal mandates to promote treatment engagement and to reduce violence risk.

No.77A

FACILITATING TREATMENT ENGAGEMENT TO LOWER RISK OF VIOLENCE

Eric B. Elbogen, Ph.D., Forensic Psychiatry Program and Clinic, UNC-Chapel Hill School of Medicine, Dept of Psychiatry, CB #7160, Chapel Hill, NC 27599,

SUMMARY:

This presentation will describe the role of treatment engagement as a point of intervention to reduce violence risk among persons with schizophrenia and other mental disorders. Continuing discussion from the previous presentation, while some legal mechanisms such as outpatient commitment could lead to reduced violence risk, other legal mechanisms such as representative payeeship may inadvertently increase violence risk, particularly among families of people with mental disorders. While these external pressures to adhere to treatment have been shown to affect violence risk in schizophrenia, relatively less research has examined internal motivation to engage in psychiatric treatment. N=1010 adults with mental illness were interviewed and data were analyzed to test the hypothesis that patients' treatment engagement lowers risk of aggression and violence. Multivariate regression analysis showed that people with schizophrenia and other mental illnesses who are less engaged in psychiatric treatment are more likely to report having been recently violent; these results were controlled for relevant clinical and demographic covariates. Specifically, patients who were nonadherent with treatment and did not think treatment was needed or effective were nearly five times more likely to have engaged in violence compared to patients who were adherent, thought they needed treatment, and perceived it was effective (39% vs. 8%). As such, interventions to improve patient's treatment engagement, such as motivational interviewing or dialectical behavior therapy, hold promise as potentially effective means of managing and reducing risk of violent behavior among people with schizophrenia or other mental disorders. The presentation will synthesize findings on the roles of external motivation (e.g., legal mechanisms) and internal motivation (e.g., perceived treatment need) for promoting treatment adherence and reducing violence risk.

No.77B

SCHIZOPHRENIA AND RISK FACTORS FOR COMMUNITY VIOLENCE: DOES ANTIPSYCHOTIC TREATMENT REDUCE RISK?

Jeffrey W. Swanson, Ph.D., Dept of Psychiatry and Behavioral Sciences Box 3071, Durham, NC 27514

SUMMARY:

This presentation will examine new evidence for: (1) violence risk factors in persons with schizophrenia; (2) possible alternative pathways to violent behavior in subgroups of schizophrenia patients; and (3) effectiveness of antipsychotic medications in reducing violence risk. Findings will be presented from the NIMH CATIE study. N=1,493 patients with schizophrenia were

randomly assigned to double-blinded treatment with one of five antipsychotic medications: olanzapine, perphenanize, quetiapine, risperidone, or ziprasidone. Patient self-report of violence was assessed prospectively using the MacArthur Community Violence Interview, supplemented with family report. At baseline, about 18% of participants were found to have engaged in violent behavior in the past 6 months; about 4% committed serious violent acts involving weapons or causing physical injury. Prevalence of violence was much higher in a subgroup of participants with a history of childhood antisocial behavior (28% vs. 14%); the profile of risk factors differed in these patients as well. Overall, positive psychotic symptoms increased violence risk, while negative psychotic symptoms decreased risk. Social and environmental factors may contribute to violent behavior independently of psychopathology. Across assigned medication groups, violence declined significantly from study initiation to 6-months follow-up. Compliance with medication significantly reduced violence, except in patients having a history of antisocial conduct in childhood. No differences in violence by medication group were found for the intention-to-treat sample. A large proportion of participants stopped taking their assigned study medication. Violence risk assessment and management should focus on modifiable clinical and nonclinical risk factors. Treatment with antipsychotic medications may help reduce community violence risk, but psychosocial interventions are needed to help patients stay engaged in treatment.

No.77C
VIOLENCE RISK AND MANDATED COMMUNITY TREATMENT

Marvin S. Swartz, M.D., Box 3173, Duke University Medical Center, Durham, NC 27710

SUMMARY:
Rare but tragic acts of violence by person with serious mental illness have fueled public support for policies of involuntary outpatient commitment or "assisted outpatient treatment." Statutes providing court-mandated treatment in the community have been named after victims of violent acts committed by persons with serious mental illness--Kendra's Law in New York and Laura's Law in California. More recently, the Virginia Tech tragedy has focused national attention and debate on the use and effectiveness of legal leverage to ensure adherence with mental health treatment. Involuntary outpatient commitment should be understood in the broader context of a range of legal mandates and other types of leverage intended to reduce nonadherence and prevent violence by mentally ill individuals in community care. This presentation will review the prevalence and use of involuntary outpatient commitment along with other forms of leverage, derived from the criminal justice system (e.g., mental health courts) and the social welfare system (e.g., subsidized housing and representative payeeship.) The effectiveness of involuntary outpatient commitment in reducing violence will be critically examined.

REFERENCES:
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THURSDAY, MAY 8, 2:00 PM- 5:00PM

SYMPOSIUM 78

AIDS PSYCHIATRY IN 2008

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to: (1) Understand the latest challenges that face persons with HIV and AIDS and how psychiatric care can help to meet those challenges; (2) Learn about the current causes of morbidity and mortality in persons with HIV and AIDS and their relevance for psychiatrists; and (3) Understand the sources of distress in HIV and AIDS.

No.78A
METHAMPHETAMINE AND HIV TREATMENT

Antoine Douaihy, M.D., 372 S. Highland Ave., #602, Pittsburgh, PA 15206

SUMMARY:
Rates of methamphetamine use have increased significantly. Methamphetamine use has acute physical and psychological effects. This session will review the interconnectedness of methamphetamine use and HIV and will explain how methamphetamine use affects the immune system. This session will review the relationship between methamphetamine, HIV and the brain specifically cognitive deficits. The presenter will share information on populations disproportionately affected by the epidemics and provide intervention and treatment recommendations.

No.78B
UPDATE ON HIV TREATMENT IN SEVERELY MENTALLY ILL

Francine Cournos, M.D., 5355 Henry Hudson Pkwy, # 9F, Bronx, NY 10471

SUMMARY:
This presentation will offer an update on HIV among people with severe mental illness, including global epidemiology and risk behavior; substance abuse and hepatitis comorbidities; approaches to primary and secondary prevention; and strategies for providing HIV-related medical care, including adherence to antiretroviral treatment.

No.78C
HIV-ASSOCIATED SLEEP DISORDERS: A COMPREHENSIVE APPROACH

Harold W. Goforth, M.D., Duke University Medical Center, Duke Insomnia and Sleep Research Program DUMC 3309, Durham, NC 27710

SUMMARY:
Sleep disorders are highly prevalent in the HIV seropositive population, and have been demonstrated to be a primary contributor to non-adherence to HIV retroviral regimens. Importantly, sleep has been demonstrated to be a powerful predictor of both co-morbid psychiatric illnesses as well as medical co-morbidities. Emerging evidence links impaired sleep quality to inflammatory cytokines that may contribute negatively to overall health status. This symposium will review common disorders of sleep initiation and sleep maintenance including primary insomnia, sleep related breathing disorders, and sleep disorders secondary to either HIV or other co-morbid medical and psychiatric conditions. The symposium will also review evidenced based treatments for various sleep disorders with a particular emphasis upon pharmacology and behavioral aspects of treatment. Tentative recommendations for treating sleep disorders in HIV seropositive patients will be offered to conference attendees.

No.78D
A BIOPSYCHOSOCIAL APPROACH TO AIDS: THE 27TH YEAR

Mary Ann Cohen, M.D., 1 Gustave L. Levy Place - Box 1009, New York, NY 10029

SUMMARY:
Psychiatrists are in a unique position to help prevent the transmission of HIV infection, diagnose HIV, provide care for persons with HIV and AIDS, improve adherence to medical care and antiretroviral therapy, and alleviate suffering. As we approach the end of the third decade of the AIDS pandemic, the biopsychosocial approach to AIDS has taken on new significance. Psychiatrists and other mental health professionals now provide integrated care and work with HIV clinicians and other specialists to provide persons with HIV and AIDS comprehensive care in ambulatory settings. Persons with HIV and AIDS may have severe distress from psychiatric symptoms both related and unrelated to HIV infection and its treatments. Persons with AIDS who are treated with antiretroviral therapy are dying of non-AIDS-related causes. Sources of distress are multifactorial and multidimensional with medical, psychological, social, cultural, and societal determinants. They are complex in nature and may result in psychiatric symptoms or psychiatric disorders that require psychiatric care. Psychiatric disorders can result in transmission of HIV infection and to problems with retention in and adherence to care. Psychiatric care including both psychotherapy and appropriately selected psychotropic medications can alleviate suffering, prevent transmission, and improve adherence to care. A biopsychosocial approach maintains a view of each person with AIDS as an individual who is a member of a family, community, and society and who deserves comprehensive, compassionate care and treatment with respect and dignity.

No.78E
PSYCHOTHERAPEUTIC ASPECTS OF LIPODYSTROPHY IN PERSONS WITH AIDS

Marshall Forstein, M.D., 24 Olmsted St., Jamaica Plain, MA 02130

SUMMARY:
The remarkable progress of medical science in the treatment of HIV and AIDS has been found to have a price tag attached. Physicians are encountering a litany of heretofore-unrecognized metabolic abnormalities and body-composition changes in patients receiving the antiretroviral therapy that has so greatly improved their lives. One of the most distressing observations includes visible changes in body shape and appearance as a result of lipodystrophy. HIV lipodystrophy syndrome, which includes metabolic complications and altered fat distribution, is of major importance in HIV therapy. Lipodsytrophy has significant physical and psychological effects on the individual including, but not limited to, metabolic issues, cardiovascular disease, bodily discomfort, low self esteem, depression, sexual dysfunction, social isolation, and reduced treatment adherence. During this session participants will review metabolic syndrome, discuss the impact of lipodystrophy on HIV management, diagnosis and treatment, steroid use, mental health, and quality of life.

No.78F
HIV-ASSOCIATED NEUROCOGNITIVE DISORDERS: AN UPDATE

Steve Ferrando, M.D., New York Presbyterian Hospital, Payne Whitney Clinic, 525 E 68th St., Box 181, New York, NY 10021

SUMMARY:
Since the beginning of the HIV epidemic, the neurocognitive manifestations of HIV infection have been widely recognized. HIV infection is associated with a range of cognitive and behavioral symptoms that become more frequent and severe as the immune system declines and symptomatic illness and AIDS ensue. Moreover, functionally significant neurocognitive problems may develop or persist despite effective combination antiretroviral treatment. This talk will cover the current epidemiology, diagnostic nosology, clinical manifestations, differential diagnosis, pathogenesis and treatment of HIV-associated neurocognitive disorders, including HIV-associated minor neurocognitive disorder and HIV-associated dementia.

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SYMPOSIUM 79

RELIGION THAT HEALS, RELIGION THAT HARMS: WHAT IS THE PLACE OF PSYCHIATRY?

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, participants will be able to: (1) Distinguish between spirituality that diminishes suffering and sociobiological religious behaviors that can amplify it; (2) Describe the psychology of cultic behavior and how it manifests in both harmful and beneficial contexts; (3) Articulate how religious principles can be used to justify sacred violence; and (4) Recognize religious contributions to patients' moral struggles, identify options, and how to choose among them.

No.79A
WHEN RELIGION DOES HARM: HOW DO I RESPOND AS A CLINICIAN?

James L Griffith, M.D., Department of Psychiatry 8th Floor, George Washington University Medical Center, 2150 Pennsylvania Avenue, N.W., Washington, D.C. 20037

SUMMARY:
Many feel baffled when religious faith that is a powerful source of comfort and compassion for one person propels another person towards aggression, suicide, self-neglect or other exacerbations of suffering. Evolutionary psychology can bring a clinical understanding to this conundrum, distinguishing the suffering reduction, resilience building, and compassion enabling aspects of religion, referred to commonly as spirituality, from religious behaviors that can exacerbate suffering because they mainly express either sociobiological behaviors or psychopathology. Spirituality grounded in ethical concerns for the individual bears similar features across different religious traditions: (1) person-to-person ("I-Thou") relatedness; (2) commitment to an ethic of compassion; (3) nurturing of such existential states as hope, purpose, communion, gratitude, joy. Religious behaviors, however, also express sociobiological behaviors for attachment, peer affiliation, social hierarchy, kin recognition, or social exchange-reciprocal altruism, as specialized psychological systems that evolved over the course of human history for non-religious reasons. Such sociobiological agendas can co-opt religions life, dominating it to the exclusion of spirituality. Religion also can become an expression of psychopathology, as a mood, anxiety, dissociative, or psychotic disorder whose symptoms exclude spirituality. Clinical assessment organized along these lines can guide interventions that facilitate personal spirituality, while countering sociobiological behaviors that exacerbate suffering or treating psychiatric disorders for which religious behaviors express symptoms of illness. Clinical examples will illustrate how such an assessment and interventions can be conducted.

No.79B
KILLING IN THE NAME OF GOD

Jerrold M. Post, M.D., 1957 E Street, NW #600F, Washington, D.C. 20052

SUMMARY:
This paper addresses the manner in which hate-mongering leaders from all faiths have used religious justification to sanction violence. While the current international focus is on Islamist fundamentalist terrorism, radicals within in fact all of the major faiths have invoked religious principles to justify striking out violently against enemies of the faith. This is found not only in Sunni and Shi'a Islam, but also in in Judaism, in Christianity, in Sikhism, and the millenarian "new religions" faith, espoused by the Guru Shoko Asahara for his cult Aum Supreme Truth. The paper will stress the relationship between the "true believer" followers and the leader, stressing the uncritical manner in which the followers accept the dictate of their leaders with whom they are in a destructive charismatic relationship and are persuaded that their acts are in a sacred cause. Examples will be given from each of the faiths identified above, emphasizing the challenge of combating this faith based radicalism which has such deadly consequences.

No.79C
WORKING WITH THE RELIGIOUS ASPECT OF PATIENTS' MORAL CONCERNS

John Peteet, M.D., 75 Francis St, Boston, MA 02115

SUMMARY:
Patients regularly bring into treatment moral concerns such as whether to forgive a childhood abuser, or how much to sacrifice for an aging parent. Religion can be an important element in the patient/therapist discourse, and this presentation suggests a strategy for taking it into account. A psychiatrist's initial task is to understand the ways that religion functions in the patient's moral life – for example, in helping to shape his ideals, guide his moral decision-making, deal with his own and others' moral failures (e.g. via forgiveness), or develop morally admirable character traits (virtues). A second task is to clarify ways that the patient's faith is a source of positive guidance and trusted support, as well as the ways it may be a harshly judgmental, immature or even an abusive force. A third task is to identify possible roles of a psychiatrist, for example focusing on the psychological implications of the question, referring the patient to a religious resource, or addressing the issue within the therapy using the patient's own, or a shared world view. A final task is to decide among these roles, taking into account the importance of the issue to the patient's functioning, the goals and nature of the work, the availability of outside resources, the need for informed consent, and the influence of therapist's own world view. Case examples will illustrate this approach.

No.79D
CULTS: FAITH, HEALING AND COERCION

Marc Galanter, M.D., Department of Psychiatry, NYU School of Medicine, 550 First Avenue, Room NBV20N28, New York, NY 10016

SUMMARY:
This lecture will present illustrations of cultic behavior with a discussion of the underlying social psychology of cult members, followed by a description of a systems model that clarifies how such groups exert their influence on individuals. It will close with an illustration of cultic behavior as evident in positively oriented healing groups. On the basis of recent studies, it is possible to formulate a model of cult affiliation whereby respective members' compliance with group norms is operantly reinforced by the relationship between their affective status and the intensity of their affiliation toward the group. This psychological model is compatible with a sociobiological approach, wherein close ties between individuals are fostered by the adaptive advantage lent genetically-related members of a species by traits such as reciprocal altruism. Such intensely affiliative groups may appear in modified form in spiritually-oriented healing movements, as in Twelve-Step programs for addiction such as Alcoholics Anonymous.

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SYMPOSIUM 80

BEHAVIORAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA (BPSD): AN UPDATE

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; (1) Identify and evaluate various types of behavioral and psychological symptoms of dementia (BPSD), including inappropriate sexual behaviors; (2) Treat patients with BPSD utilizing evidence-based psychological and pharmacological treatment modalities; and (3) Discuss, based on published data, the risk of stroke and death in patients with dementia who are treated with atypical antipsychotics.

No.80A

INAPPROPRIATE SEXUAL BEHAVIORS IN DEMENTIA: A REVIEW

Karin E.Kerfoot, M.D., LV-121 Yale-New Haven Psychiatric Hospital, 184 Liberty Street,, New Haven, CT 06519

SUMMARY:
Dementias are the most common type of neurodegenerative disorder. Behavioral disturbances are seen in more than 80% of patients suffering from these disorders.

Sexually inappropriate behaviors should be seen as part of the symptom cluster of behavioral disturbances of dementia which are disruptive, distressing, and impair care of the patient. These behaviors are estimated to occur in 7% to 25% of demented patients and present a major challenge to psychiatric clinicians. There are currently no randomized trials for the treatment of these behaviors, but the available data suggest efficacy for some commonly used treatment modalities. In this presentation, we will systematically review and discuss various aspects of these behaviors and available treatments. Content will include the nature and prevalence of inappropriate sexual behaviors in dementia, their underlying neurobiology, and evidence-based treatment of such behaviors.

No.80B

BEHAVIORAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA: AN EVIDENCE-BASED REVIEW

Kirsten M .Wilkins, M.D., VA CT Healthcare System, 950 Campbell Ave 116A, West Haven, CT 06516

SUMMARY:
Behavioral and psychological disturbances are commonly seen in patients with dementia, affecting up to 65% of such patients in the community and up to 90% in nursing homes. These behaviors may begin as early as three years prior to the diagnosis of dementia, and frequently cause significant distress to both patients and their caregivers. There are no FDA-approved medications for the treatment of behavioral and psychological symptoms of dementia (BPSD), and recently published data suggest that the overall effectiveness of commonly used pharmacological treatments may be limited by their adverse effects. This presentation will begin with a discussion of the prevalence, specific categories, and clinical relevance of BPSD. We will then offer ways to evaluate and conceptualize BPSD, followed by an evidence-based review of psychological, psychosocial, and pharmacological treatment approaches.

No.80C

RISK OF STROKE AND DEATH IN ELDERLY DEMENTED PATIENTS TREATED WITH ATYPICAL ANTIPSYCHOTICS: A REVIEW OF PUBLISHED DATA

Rehan Aziz, M.D., Department of Psychiatry, 300 George Street, New Haven, CT 06511

SUMMARY:
Several concerns have been raised regarding the use of atypical antipsychotic agents in the elderly. Any potential benefit of these agents must be balanced against potential risks associated with their use. The U.S .Food and Drug Administration has placed a black box warning on all atypical agents cautioning against their use in elderly patients with dementia-related psychosis because of increased risk of cerebrovascular adverse events (CVAEs) and increased mortality. There appears to be a risk of death in drug-treated patients of between 1.6 to 1.7 times that seen in patients receiving placebo. The FDA examined 17 placebo controlled trials performed with olanzapine, aripiprazole, risperidone, or quetiapine in elderly demented patients with behavioral disorders. Of these, 15 showed numerical increases in mortality in the drug-treated group compared to the placebo-treated patients. These studies enrolled a total of 5106 patients. The rate of death in drug-

treated patients was ~4.5% compared with a rate of ~2.6% in the placebo group. Most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Advanced age and the presence of vascular dementia appeared to increase this risk. No drug appeared to be individually responsible for the effect but rather each contributed to the overall effect. Potential mechanisms proposed to explain an association between atypical antipsychotics and cerebrovascular adverse events include thromboembolic effects, cardiovascular effects (e.g. orthostatic hypotension, arrhythmias), excessive sedation resulting in dehydration and hemoconcentration, and hyperprolactinemia. This lecture will review current literature addressing the risk of stroke and death in elderly demented patients treated with atypical antipsychotics, as well as treatment strategies.

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SYMPOSIUM 81

MENTALIZING AS A FRAMEWORK FOR EFFECTIVE PSYCHOTHERAPY

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to distinguish mentalizing from related terms such as psychological mindedness and empathy; understand factors that influence the development of mentalizing in attachment relationships; appreciate how social-cognitive neuroscience informs mentalizing; recognize the pervasive role of mentalizing in psychotherapy and its therapeutic value; employ fundamental principles to promte mentalizing in a range of psychotherapies.

No.81A

PROMOTING MENTALIZING IN INDIVIDUAL AND GROUP PSYCHOTHERAPY

Anthony W. Bateman, M.D., F.R.C.Psych Halliwick Unit, St Ann's Hospital, St Ann's Road, London, N15 3TH, United Kingdom

SUMMARY:

In this talk I will argue that mentalizing is the foundation of any therapeutic work. In conducting psychotherapy, you construct and reconstruct in your own mind an image of your patient's mind. You label feelings, explain cognitions, and spell out implicit beliefs. It has generally been agreed that psychotherapy invariably activates the attachment system and thus generates secure-base experience. In our view, the attachment context of psychotherapy is essential in creating the synergy between the recovery of mentalizing capacity and secure-base experience. That is, you provide the experience of being understood, which generates an experience of security, which in turn facilitates mental exploration. That mental exploration includes your patient's exploration of your mind—and finding himself or herself in the process. This typically rapid, non-conscious implicit process enables the patient to apprehend what he or she thinks and feels. Although your mind is likely to be focused on the content, the therapeutic value of the interchange stems from the joint focus on the patient's subjective experience in the context of one mental content after another. This joint attentional process enhances mentalizing capacity and, concomitantly, strengthens the patient's sense of self which is necessary if patients with borderline personality disorder are to improve. Examples will be given of mentalizing interventions in group and individual psychotherapy during treatment for borderline personality disorder. More importantly an outline will be provided of interventions likely to undermine mentalizing and therefore to hinder recovery. Some empirical evidence will be presented in support of the hypothesis that the process of change in recovery from borderline personality disorder requires a change in mentalizing.

No.81B

WHAT IS DISTINCTIVE ABOUT MENTALIZING?

Jon G. Allen, Ph.D., The Menninger Clinic, P.O. Box 809045, 2801 Gessner Drive, Houston, TX 77280

SUMMARY:

his presentation makes the case that mentalizing, the natural human capacity to interpret behavior in relation to mental states, can be construed as the most fundamental common factor across diverse psychotherapies, ranging from psychodynamic to interpersonal to cognitive-behavioral approaches. Mentalizing is an umbrella term, and its multiple facets will be articulated, for example, as it pertains to self versus others and implicit versus explicit processes. Mentalizing is distinctive from a range of overlapping terms, including psychological mindedness, empathy, metacognition, mindfulness, insight, and theory of mind. Central to engaging in a therapeutic change process is mentalizing emotion, which entails mentalizing in the midst of emotionally aroused states; this entails identifying, modulating, and expressing emotion. In the context of emotional arousal, a range of mentalizing failures and non-mentalizing modes of subjective experience come into play that challenge the psychotherapist to restore mentalizing. With our without the concept of mentalizing, effective psychotherapists mentalize and engage their patients in doing so; yet understanding the developmental processes that promote and undermine mentalizing in attachment relationships, coupled with sharpened attention to the activity of mentalizing in the conduct of psychotherapy, can enable psychotherapists to refine what is perforce a central psychotherapeutic process.

No.81C

WHAT DOES MENTALIZING LEAVE OUT? A COGNITIVE-BEHAVIOR THERAPIST'S PERSPECTIVE

Thröstur Björgvinsson, Ph.D., The Menninger Clinic, 2801 Gessner Drive, Houston, TX 77080, John Hart, M.A.

SUMMARY:
This presentation highlights some of differences between current conceptualization of mentalizing and the practice of cognitive behavioral therapy (CBT). Allen, Bateman and Fonagy explicitly note that there may be many roads to facilitate mentalizing capacity and that facilitating mentalizing may be a common thread throughout effective psychotherapeutic interventions. Perhaps CBT promotes mentalizing but more importantly, we contend that mentalizing may, at times, promote the goals of CBT.

No.81D
MENTALIZATION AND DEVELOPMENTAL PSYCHOPATHOLOGY

Peter Fonagy, Ph.D., Sub-Department of Clinical Health Psychology, University College London, Gower Street, London, WC1 6BT. United Kingdom

SUMMARY:
The field of social cognition in general and mentalization in particular has been one of the major growth areas of developmental psychology. Increasingly problems of social cognition are recognised as core aspects of a range of psychopathologies that make their first appearance in childhood or adolescent years. This presentation will summarise evidence relating to the role of mentalization in developmental psychopathology, particularly problems of conduct, mood disorder, eating disorder and borderline personality disorder. Whilst the nature of deficits of social cognition are somewhat different in each of these areas, social cognitive deficits have been shown to mediate core aspects of symptomatology. Evidence will be presented that suggests that social cognitive deficits may be key mediators of the impact of the quality of childhood relationships on developing psychopathology. The paper will draw out implications from these research findings for psychosocial treatments.

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2. Allen JG, Fonagy P, Bateman AW: Mentalizing in Clinical Practice. Washington, DC, American Psychiatric Publishing, 2008.
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SYMPOSIUM 82

PARASOMNIAS, VIOLENCE AND THE LAW

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; (1) Describe clinical features of various parasomnias in adult and pediatric populations; (2) Distinguish among the various parasomnias based on history and the sleep state during which they occur; (3) Recognize common comorbidities in patients with parasomnias; (4) Identify risk factors associated with violent behavior due to parasomnias; and (5) Describe potential legal consequences associated with violence and parasomnias

No.82A
OVERVIEW OF PARASOMNIAS I: A REVIEW FOR PSYCHIATRIC PRACTICE

Dimitri Markov, M.D., 1020 Sansom St Suite 1652, Philadelphia, PA 19004, Karl Doghramjii, M.D.

SUMMARY:
Parasomnias, defined as undesirable behavioral, physiological or experiential events that accompany sleep, are common in the general population. This presentation will describe the clinical presentation, diagnostic criteria and medical treatment of parasomnias in the general population and in psychiatric patients. We will also describe the phenomenon of aggression and violence associated with parasomnias, as well as, the various risk factors that may lead to such behaviors in affected individuals. Case examples will be used to illustrate our points.

No.82B
SEXSOMNIA: PHENOMENOLOGY AND FORENSIC IMPLICATIONS

Elena delBusto, M.D., Thomas Jefferson University Hospital, Department of Psychiatry, 833 Chestnut Street, Suite 210, Philadelphia, PA 19107

SUMMARY:
Sexsomnia or sexual behavior during sleep (SBS) has for a long time been classified as a variant of sombalism. Recent data has shown sexsomnia to be distinctly different from sombalism as well as all other parasomnias. This talk seeks to illustrate the distinctions as outlined by the clinical studies. The presentation will outline the definition and diagnostic criteria of sexsomnia. Additionally, risk factors leading to this parasomnic activity, it's treatment, medical-legal issues and a case report will be presented.

No.82C
EVALUATION OF CHILDHOOD PARASOMNIAS AS A PREDICTOR FOR FUTURE SLEEP VIOLENCE

Nicole Foubister, M.D., NYU Medical Center, 550 First Avenue, HCC 10, New York, NY 10016

SUMMARY:
This presentation will provide an overview of childhood parasomnias, including etiolology and clinical interventions. Further, factors associated with "sleep violence" will be outlined. Clinical case examples of a 14-year-old who rose from his bed and severely stabbed his five year old cousin; and a 16-year-old, who shot and killed family members during a dream state will be presented. Lastly, a clinical approach to the assessment of a patient presenting with a parasomnia defense to violent behavior will be outlined.

No.82D
OVERVIEW OF PARASOMNIAS II: A REVIEW FOR PSYCHIATRIC PRACTICE

Karl Doghramji, M.D., 211 South Ninth Street, Suite 500, Philadelphia, PA 19107, Dimitri Markov, M.D

SUMMARY:
Parasomnias, defined as undesirable behavioral, physiological or experiential events that accompany sleep, are common in the general population. This presentation will describe the clinical presentation, diagnostic criteria and medical treatment of parasomnias in the general population and in psychiatric patients. We will also describe the phenomenon of aggression and violence associated with parasomnias, as well as, the various risk factors that may lead to such behaviors in affected individuals. Case examples will be used to illustrate our points.

No.82E
SLEEP DISORDERS, VIOLENCE AND CRIMINAL RESPONSIBILITY

Kenneth J. Weiss, M.D., Two Bala Plaza, Suite 300, Bala Cynwyd, PA 19004

SUMMARY:
Violence which occurs in the setting of a sleep disorder not only raises significant concerns regarding medical intervention, but may also bring about serious legal consequences in the form of criminal charges. This presentation will address situations in which such criminal charges have arose; the legal requirements of the mental state for criminal culpability (mens rea) in general; and various considerations for legal defenses for violence associated with parasomnias. Considerations that must be accounted for during the psychiatric evaluation of criminal defendants claiming their violent behavior was due to a sleep disorder will also be addressed.

REFERENCES:
1. Markov D, Jaffe F, Doghramji K. Update on parasomnias: A review for psychiatric practice. Psychiatry 2006 3:69-76.
2. Cartwright, R. Sleepwalking Violence: A Sleep Disorder, a Legal Dilemma, and a Psychological Challenge. Am J Psychiatry. 2004 Jul;161(7):1149-58.
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SYMPOSIUM 83

QUALITY AND OUTCOME ASSESSMENT IN DIVERSE CLINICAL SETTINGS

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) understand the clinical and measurement properties of the OQ and the HoNOS; (2) understand who to use web-based technology like the OQ-Analyst to improve psychotherapy; (3) recognize critical factors for implementation of outcome measures; (4) know how to use outcomes measures to enhance quality of treatment and care; and (5) understand facilitators and barriers to effective quality improvement.

No.83A
IMPLEMENTATION AND USE OF OUTCOME ASSESSMENTS AS QUALTIY INDICATORS IN LONG TERM MENTAL HEALTH CARE

Annet A. Nugter, Ph.D., GGZ Nootd-Holland-Noord, PO Box 18, Heiloo, 1850 BA, Netherlands, W. Teer, M.D.

SUMMARY:
Five Dutch multidisciplinary community based mental health care teams offer individual case management and Function Assertive Community Treatment (FACT, Van Veldhuizen, 2007) to about 800 patients with enduring and severe psychiatric illnesses. Outcomes are assessed in terms of symptomatology, functioning and quality of life. Instruments used are: the Health of the Nation Outcome Scales (HoNOS, Wing e.a., 1998) and The Manchester Short Assessment of Quality of Life (MANSA; Priebe e.a., 1999). These outcomes assessments are used to improve the quality of care of individual patients and of the teams and the organization in general.

No.83B
HEALTH OF THE NATION OUTCOME SCALES AND QUESTIONNAIRE: TOOLS FOR ROUTINE CLINICAL OUTCOME MEASURES FOR MODERATE TO SEVERE MENTAL ILLNESSES

Victor J. Buwalda, M.D., Parnassusweg 28-III, Amsterdam, 1076 AR, Netherlands Jan H. Smit, Ph.D.,Jan A. Swinkels, M.D., Ph.D., Willem van Tilburg, M.D., Ph.D.

SUMMARY:
Objective: to study the characteristics and usefulness of the HoNOS, and the OQ, in routine clinical practice for patients with moderate to severe mental illnesses.

Content: more transparency is needed during the treatment of mentally ill patients, not only for patients but also for professionals and managers. To enhance the quality of treatment there is need for routine outcome assessment with measures that are easy to use and that give insight into treatment response. The HoNOS and OQ are two of these measures.

Methods: Instruments The HoNOS is a 12 item staff-rated assessment of clinical problems and social functioning (Wing e.a., 1998). The OQ is a 45 items self-assessment of symptom distress, interpersonal relations and social role (Lambert, e.a. 2004).

Procedure: 500 patients in a rural clinical setting were routinely assessed with the HoNOS and the OQ every 6-12 weeks, for a time period of 2 years

Results: psychometric characteristics of the HoNOS and OQ will be presented as their usefulness for monitoring clinical symptoms in terms of reliability, validity and the ability to show clinical significant improvement and reliable change.

Importance: To enhance quality of care we have to find outcome measures that can help the professional to evaluate treat-

ment results in a short time frame. It also benefits the patient and manager.

No.83C
IS THE EFFECTIVENESS OF QUALITY IMPROVEMENT ASSOCIATED WITH ORGANIZATIONAL FIT?

Richard C Hermann, M.D., Tufts-New England Medical Center, 750 Washington Street, NEMC #345, Boston, MA 02111, Susan Stockdale, Ph.D., Jeff Chan, B.A., Debra Lerner, Ph.D., Paul Barreira, M.D., Gail Tsimprea, Ph.D.,Benjamin Liptzin, M.D., Paul Summergrad, M.D.

SUMMARY:
Measurement-based quality improvement (QI) has been increasingly adopted by provider organizations and encouraged by external groups, such as accreditors, managed care organizations and payers. However, QI results vary widely. Why do some hospitals achieve measurable change in the course of their QI activities, while other hospitals do not? Why do successful hospitals achieve improvement toward some of their QI objectives but not others? This report describes the conceptual model, study design and preliminary findings of the NIMH-funded Mental Health QI-Fit Study. The study posits that more-successful QI activities result from greater fit between a hospital's QI objectives and the hospital's culture, leadership, structure and resources. The study model and instruments (a leadership interview protocol and clinician survey) can be applied across objective topics and clinical settings. This report will feature findings from inpatient psychiatric units in 32 hospitals in Massachusetts and California. Findings from the QI-Fit Study can inform the selection of QI objectives by hospitals and by national standard-setting organizations. The findings can also be used by hospitals to identify potential causes of ineffective QI, and to inform their efforts to improve performance.

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SYMPOSIUM 84

PHARMACOGENETICS IN PSYCHIATRY

National Institute of Mental Health

EDUCATIONAL OBJECTIVES:
Increase attendees' knowledge of basic methods and terminology of the field of molecular genetics, with a particular emphasis on the application of these new approaches to dissecting the heterogeneity of drug response in psychiatric disorders; of pharmacogenetic studies of antidepressant drugs, including an association between the SSRI, citalopram, and genetic variation in the serotonin re receptor systemthe molecular genetics of response to agents commonly used to treat bipolar disorder.

No.84A
PHARMACOGENETICS IN BIPOLAR DISORDER

John R Kelsoe, M.D., University of California, San Diego, Department of Psychiatry, 0603, La Jolla, CA 92093

SUMMARY:
The pharmacogenetics of bipolar disorder is an emerging area of interest for researchers and clinicians. Bipolar disorder presents special challenges as multiple classes of agents are commonly utilized in the treatment of the disorder, and differentiation must be made between treatment of manic versus depressive episodes, as well as long term maintenance with mood stabilizers. In this presentation, we will review early work aiming to identify molecular predictors of treatment response in bipolar disorder. This work includes family based linkage studies that utilize lithium responsiveness as an affected phenotype in studies aiming to identify chromosomal regions implicated in bipolar illness, as well as work from our group identifying several candidate genes directly or indirectly involved in lithium response. Finally, we will discuss new technological innovations that may transform the field – including the use of the whole genome association paradigm to detect susceptibility loci, and the application of this paradigm to the problem of treatment variability in bipolar disorder. At the end of the presentation, it is hoped that audience participants will have an understanding of the current status of this rapidly developing field, as well as an appreciation of the rapid pace of change and future prospects for pharmacogenetic approaches in the treatment to this complex disorder.

No.84B
OVERVIEW OF GENETIC AND PHARMACOGENETIC APPROACHES IN PSYCHIATRY

Todd Lencz, Ph.D., Psychiatry Research, The Zucker Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004

SUMMARY:
Individual differences in clinical response to psychotropic drugs have long been recognized as a fundamental problem in the treatment of mental illness. As a generalization, only about one-third of patients with psychotic or affective disorders experience rapid or robust treatment response, while as many as 40-50% can be labeled as partially or completely treatment refractory. There is also marked variability in susceptibility to adverse drug effects, leading to excess morbidity and treatment nonadherence. A priori identification of the patients who will respond well to a particular psychotropic drug, or be at a higher risk for development of side effects, has the potential to help clinicians avoid lengthy, ineffective medication trials and limit patients' exposure to adverse events. The field of pharmacogenetics offers the potential for providing readily accessible, immutable biomarkers -- DNA sequence variants -- that might be predictive of an individual's

propensity for both positive and adverse effects of pharmacologic agents. This presentation is designed to introduce the basic conceptual and methodological framework of this rapidly evolving field. Recent technological developments, including whole genome association and sequencing, as well as copy number variation, will also be discussed.

No.84C
PHARMACOGENETICS OF SCHIZOPHRENIA

Anil K Malhotra, M.D., The Zucker Hillside Hospital Psychiatry Research, 75-59 263rd Street, Glen Oaks, NY 11004

SUMMARY:
Pharmacogenetic strategies offer the prospect of individualization of treatment in psychiatric disorders. To date, the majority of pharmacogenetic studies of antipsychotic drug response have focused on a candidate gene approach, which may be limited in scope. Newer approaches, termed whole genome association or WGA however, provide the first opportunity to comprehensively scan the entire genome to detect genes influencing treatment response.

No.84D
PHARMACOGENETICS OF ANTIDEPRESSANTS

Francis McMahon, M.D., 9000 Rockville Pike, Bethesda, MD 20892

SUMMARY:
The long-standing promise of pharmacogenetics is beginning to be realized, thanks to new genetic technologies and large samples for study. Pharmacogenetic studies of the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) sample are beginning to uncover genetic markers of treatment response and risk for side effects. However, what we need in the clinic is a panel of genetic tests that offer high predictive power to guide treatment decisions. This talk will focus on the near future of pharmacogenetics in the treatment of depressive disorders and discuss some of the challenges that clinicians will soon face as they try to translate genetic discoveries into improved patient care and outcomes.

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2. Paddock S, Laje G, Charney D, Rush AJ, Wilson AF, Sorant AJ, Lipsky R, Wisniewski SR, Manji H, McMahon FJ. Association of GRIK4 with outcome of antidepressant treatment in the STAR*D cohort. Am J Psychiatry 2007, 164:1181-8.
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SYMPOSIUM 85

APA'S GOLDWATER RULE: ETHICS OF SPEAKING PUBLICLY ABOUT PUBLIC FIGURES

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant will be able to; (1) recognize the legal and ethical implications of the Goldwater decision and its relevance for psychiatry; and (2) discuss the extent to which the APA's Code of Ethics addresses those issues; and (3) address the limitations of formalized moral codes to identify all professional responsibilities.

No.85A
THE PSYCHIATRIST IN THE COMMUNITY: A BROADER ETHICAL PERSPECTIVE

Claire L. Pouncey, M.D., Belmont Behavioral Health, 4200 Monument Rd., Philadelphia, PA 19131

SUMMARY:
he Goldwater case forces us to recognize our public moral responsibilities as well as those that apply in our professional practices. Many of these responsibilities are codified in the APA's principles of ethics, but some obligations are more situationally-dependant than can be addressed by a finite set of moral principles. Principles of ethics can attune us to unambiguous obligations. However, it is the responsibility of each practitioner to remain alert to the more nuanced situations in which overt duties don't direct action, but sensitivity to our multiple roles in our various communities might. I argue that the broader moral questions raised by the Goldwater Rule are best addressed by an ethical perspective that goes beyond discrete principles of moral conduct.

No.85B
LEGAL ISSUES BEHIND THE GOLDWATER RULE

Lisa Dagostino, M.D., Kline and Specter, PC, The Nineteenth Floor, 1525 Locust Street, Philadelphia, PA 19102

SUMMARY:
I will examine the facts and legal principles behind the original Goldwater decision. A published examination of the mental health status of Presidential candidate Barry Goldwater led to a successful libel suit, and the appeal of the jury verdict led to a landmark opinion that has significant repercussions for today's psychiatrist. Using the original 1969 Goldwater decision, and its subsequent history in the courts, I will provide a basic understanding of the torts of libel and slander with respect to of both private and public figures. By understanding the difference between the legal and moral concepts of malice, mental health practitioners will be able to protect themselves against spurious accusations.

No.85C
WHEN PSYCHIATRISTS SPEAK OUT ABOUT PUBLIC FIGURES: LEGAL LIABILITY, MEDICAL ETHICS, AND PRIVATE CONSCIENCE

Jerome L. Kroll, M.D., University of Minnesota Medical School,

Community-University Health Care Center, 2001 Bloomington Avenue South,, Minneapolis, MN 55404

SUMMARY:
Section 7.3 of the APA code of ethics, stating that it is professionally unethical for psychiatrists to make public statements about public figures whom they have not formally evaluated, raises many intriguing issues. The technical objection of the APA is that it is a violation of professional standards to offer opinions about the psychiatric diagnoses and psychodynamics assessment of persons who have not been formally assessed by direct interview. The broader objection is that psychiatrists as members of the medical profession have a responsibility to recognize that the public does not distinguish between remarks a psychiatrist may make as a private individual versus as a representative of the psychiatric profession.

No.85D
A PRUDENT AND PROFESSIONAL POSITION IS OFTEN CHALLENGING

William Arroyo, M.D., 4034 Witzel Dr., Sherman Oaks, CA 91423

SUMMARY:
The general public is too often baffled by seemingly inexplicable atrocities and tragedies, especially those that are man-made or executed by another human being. It is natural for anyone to attempt to explain such acts, in part because the acts at least temporarily cause intense fear and anxiety in those who are exposed to them, either directly or indirectly. The general public depends on an increasingly wide array of informational sources; these include the traditional media sources and, of course, the internet. Each of these sources competes for "experts" to inform the general public because such individuals are believed to have the credentials and knowledge about human behavior. Such so-called experts are often psychiatrists. The various media often vie for "first" release because their economic success depends on it.

REFERENCES:
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2. Shore MF: How psychiatrists and political scientists have grown up since 1938. Psychiatry 2001; 64: 192-196.
3. Post JM (ed): Psychological Assessment of Political Leaders. Ann Arbor: University of Michigan Press, 2003.
4. Hermann MG (ed): Political Psychology as a Perspective on Politics. Amsterdam: Elsevier, 2004.

SYMPOSIUM 86

NEUROETHICS: ETHICAL CHALLENGES AT THE CUTTING EDGE OF NEUROSCIENCE

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to identify the emerging ethical issues in the application of neuroscience findings to treatment and in the courts, and with regard to their use to enhance human functioning.

No.86A
ETHICAL ISSUES IN RESEARCH ON DEEP BRAIN STIMULATION FOR TREATMENT-RESISTANT DEPRESSION

Laura B. Dunn, M.D., 9500 Gilman Drive, 0603-R, La Jolla, CA 92093-0603, Paul Holtzheimer, M.D., Helen Mayberg, M.D., Laura Weiss Roberts, M.D., M.A.., Paul Appelbaum, M.D.

SUMMARY:
Major Depressive Disorder (MDD) is highly prevalent and frequently disabling. Up to 70% of patients do not achieve symptomatic remission despite appropriate treatment, and up to 20% have a limited response to multiple treatments. There remains an unmet need for treatment options for many people with depression who do not experience adequate relief with currently available treatments. Recently, deep brain stimulation (DBS) has begun to be studied in early trials as a potential treatment for severe, treatment-resistant depression (TRD) and obsessive-compulsive disorder. Preliminary safety and efficacy data have been reported for DBS of the white matter adjacent to the subgenual cingulate cortex as a treatment for TRD. Other targets currently under investigation include the anterior internal capsule and the nucleus accumbens. Risks of DBS include (1) surgery-related adverse events, and (2) risks associated with acute and chronic stimulation. Serious risks of DBS surgery are infrequent but include intracranial hemorrhage, infection and death. In early phase studies of such novel, potentially risky treatments for serious and disabling illnesses, numerous ethical questions arise, some common to research involving any seriously ill population, and others unique to this population. This presentation will focus on several of these issues as they pertain to intervention studies targeting TRD: informed consent procedures, decision-making capacity, conflict of interest, and investigator, industry, and media responsibilities. Also described will be available empirical evidence that can help illuminate specific areas of discussion. Specific recommendations for a research agenda focusing on ethical issues in the study of novel interventions for TRD.

No.86B
THE NEW LIE DETECTORS: NEUROSCIENCE IN THE COURTS

Paul S. Appelbaum, M.D., New York State Psychiatric Institute 1051 Riverside Drive, Unit 122, New York, NY 10032

SUMMARY:
lthough a primary goal of the legal process is the ascertainment of truth, courts have long been skeptical of evidence based on technology that purports to detect lies. Polygraph evidence is barred in most jurisdictions, and expert witnesses are restricted from testifying about the credibility of parties and witnesses in the case. Two new techniques, however, are being promoted as more accurate than traditional lie detection: brain-wave analysis (sometimes called "brain fingerprinting") and fMRI neuroimaging. Analysis of brain-wave patterns is based on the "guilty knowledge test," in which a familiar scene or piece of information elicits a recognition spike not present when unfamiliar information is presented. fMRI approaches are rooted in the observation that lying is an active process that engages areas of the brain not involved when a person responds truthfully. The leading brain-wave approach is proprietary, and hasn't been subjected to peer

review. The fMRI studies, though promising, have yet to demonstrate validity in real-world contexts. It is unclear whether either technique can resist countermeasures undertaken by evaluees (e.g., alterations in attention) that complicate polygraph analyis, and neither is likely to be broadly admissible in the near future. But both techniques raise the question of whether the state or an adverse party might compel suspects or defendants to undergo such examinations, and at this point, it's not clear that the law would preclude such uses. Hence, the ethics of using an approach that violates what has always been presumed to be the sanctity of thought will be at the forefront of debate as these techniques, and others like them, are refined.

No.86C

GENES, BLAME, RESPONSIBILITY AND THE BRAIN: VIEWS OF PATIENTS

Robert L. Klitzman, M.D., 1051 Riverside Dr., New York, NY 10025

SUMMARY:

Background: Genetic markers are increasingly being sought for psychiatric disorders, yet numerous ethical dilemmas can arise as a result for patients, family members and providers.

Methods: in-depth semi-structured interviews were conducted with 25 individuals who have or are at risk of Huntington Disease (HD). Questions concerned their views and approaches toward testing, privacy, reproductive decision making and other related areas. Interviews were analyzed by two coders, informed by grounded theory.

Results: Interviewees confronted many issues of blame and responsibility in struggling to make sense of the disease in their family. Individuals described feeling compelled to ponder to what degree genes explain and are to blame for the behavior, at times erratic, violent or psychotic, of family members with HD. Adult children often grew up with a parent who was erratic, and demonstrated "poor" parenting skills, but turns out to have HD. These offspring were thus forced to wrestle with difficult ethical and moral questions of to what degree these parent were or could be held responsible, and what that means. The fact that psychiatric symptoms may be either biological (and hence potentially beyond the patient's conscious control) or psychological (and hence seen as somewhat volitional) readily led to uncertainty and confusion, making these issues and decisions difficult.

Conclusions: These findings have critical implications for understanding the complexities that arise from a psychiatric disorder that is associated with a genetic marker. These issues mirror those posed by other neurotechnologies (e.g., fMRI) concerning blame and responsibility, and have profound implications given the rise of behavioral genetics, and of searches for genetic markers for a wide variety of other psychiatric disorders (e.g., depression). Hence, providers, patients and family members will increasingly need to be prepared to confront these conundrums.

No.86D

DETERMINISM AND THE DEATH OF FOLK PSYCHOLOGY: TWO CHALLENGES TO RESPONSIBILITY FROM NEUROSCIENCE

Stephen J. Morse, J.D., University of Pennsylvania Law School, 3400 Chestnut St., Philadelphia, PA 19104-6204

SUMMARY:

The new neuroscience poses two challenges to traditional conceptions of responsibility. The first is the familiar threat that if determinism is true, responsibility is impossible. The second, which is potentially more radical, is that the new neuroscience undermines the view of the person upon which responsibility depends, namely, the view that mental states play a crucial role in explaining human behavior and are the foundation for ascriptions of moral and legal responsibility. This submission contends that neither challenge succeeds. As a deterministic explanation, the new neuroscience poses no truly new challenge to responsibility because such challenges have been mounted in the past based, for example, on genetics or psychodynamic psychology. So-called "free will" plays no genuine role in our positive moral and legal responsibility practices, however. Moreover, there is a standard, plausible philosophical position, compatibilism, which holds that determinism is compatible with responsibility. The second challenge, the death of folk psychology or "the illusion of conscious will," suggests that our mental states play no causal role in explaining our behavior. In its strongest form, this challenge claims that our mental states are simply post-hoc rationalizations for what our brains have already "decided." If this is true, or nearly so, traditional responsibility conceptions would be unjustified. Compatibilism cannot deflect this challenge because compatibilism accepts the traditional view of the person as an intentional agent. This submission claims on conceptual and empirical grounds that the second challenge has not yet been demonstrated and it is not likely to be. For the present, then, responsibility seems secure despite astonishing advances in our knowledge of how the brain affects behavior.

No.86E

BUILDING BETTER BRAINS: THE ETHICS OF NEUROENHANCEMENT

Paul R. Wolpe, Ph.D., Ctr for Bioethics, University of PA, 3401 Market St, Suite 320, Philadelphia, PA 19102

SUMMARY:

With the advent of implantable brain chips, neural tissue transplants, brain-computer interfaces, and psychopharmaceutical advances, human beings will soon be able to micromanage their moods, enhance cognitive and affective skills and traits, "mind-read" through brain scanning, and replace brain functions with brain prosthetics. While millions have been spent exploring genetic enhancements, far less attention has been placed on brain enhancement, which has more immediate and perhaps profound implications. Considered one of the founders of the field of neuroethics, Dr. Wolpe will introduce these new technologies and explore their profound ethical and social implications.

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1. Morse S: Brain overclaim syndrome and criminal responsibility: a diagnostic note, Ohio State Journal of Criminal Law 2006;3:397-412.
2. Appelbaum PS: The new lie detectors: neuroscience, deception and the courts. Psychiatric Services 2007;58:460-462.

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4. Klitzman K, Thorne D, Williamson J, Chung W, Marder K: Disclosures of Huntington's Deisease risk within families: patterns of decision-making and implications. American Journal of Medical Genetics (in press).

SYMPOSIUM 87

INDIGENOUS MODELS OF MIND AND MENTAL HEALTH

EDUCATIONAL OBJECTIVES:

At the conclusion of this course the participant should be able to: l) define integrative psychiatry; 2) enumerate three principles of an indigenous approach to mental health; 3) describe three ways in which indigenous ideas of mental health are similar to integrative ideas and are different from those of conventional psychiatry; and 4) list three ways in which environments modify genes and contexts influence behavior.

No.87A

HUICHOLE IDEAS OF MIND AND MENTAL HEALTH

Bruce W. Scotton, M.D., 322 Clement St., San Francisco, CA 94118

SUMMARY:

Indigenous healers around the world have developed techniques for transformation that are not unlike psychotherapy. The Huichols are no exception. The first transformation occurs within the consciousness of the individual and within his or her family and community groups. Through storytelling, the healer cultivates ideas of faith, hope, and possibility of healing. Through testimonials, he or she reinforces those ideas and the belief in them. We will review examples of stories that teach transformation, and will explore to what extent our personal beliefs and our social system's beliefs actually guide the directions in which biology will flow. Huichol healers hold a playful consideration of our own aches, pains, and illnesses, and create healing stories to guide personal transformation. Traditional wisdom for social roles, social behavior, perspective on life, and more is contained within these stories which inculcate the wisdom of healing without the person even recognizing what has happened. Ceremony provides an opportunity for the enact of the changed values and roles provided by the stories with an audience of community members and the spirit realm. The social support engendered by ceremony facilitates life changes to continue in daily interactions.

No.87B

MIND AND MENTAL HEALTH WITHIN THE MAYAN CULTURES: COMPARISONS WITH CONVENTIONAL PSYCHIATRIC MODELS

Anne-Marie Chaisson, M.D., Program in Integrative Medicine, University of Arizona, Tucson, AZ 85721

SUMMARY:

Mayan cultures emphasize the spiritual aspect of illness, which is not separated in contemporary categories of mental or physical. Mayan elders believe that they heal both the body and soul, as well as restore harmony to the community and nature. Healers communicate with spirits in order to help heal. Some healers say they can heal spiritual, psychic, and physical wounds as well as communities and global conditions. Healers work in cultures that include other specialists such as herbalists, diviners, bonesetters, and midwives. Some healers are very selective in choosing which people they will treat because if they fail, they lose stature. Mayan healers enter a trance to figure out what is wrong with the patient and what to do about it. The healer or an assistant may pray, sing, chant, dance, or drum around the patient. Storytelling and other art forms may also be used. During the trance, the healer's soul is believed to leave the body and travel to the spirit world in a search to help the sick person. This is where the healer communicates with the spirits thought to be responsible for the illness. Although the healer is in a state of trance, he is still conscious and aware. This allows him to bargain with the spirits who can help the patient's illness. The healer returns and shares his or her vision with the sick person. Each healer must complete rigorous training, especially in the ability to achieve the controlled trance required for communication with the spirits. Healers work both with individual patients and with groups. Traditional healing of this type may date back as far as 40,000 years and is believed to have begun in the Altai and Ural Mountains of western China and Russia, probably in the form of a religion. In the Tungusu-Manchurian language, the word shaman means, "one who knows."

No.87C

MODELS OF MIND AND HEALTH FROM THE SOUTHEASTERN U.S.: WHAT CAN WE LEARN?

Robert Crocker, M.D., Fellow, Program in Integrative Medicine, University of Arizona College of Medicine,Tucson, AZ 85721

SUMMARY:

This presentation looks at concepts of mind and mental health from the indigenous cultures of the southeastern U.S., especially Choctaw, Creek, Seminole, and Cherokee, the first tree representing a common language group, while Cherokee represents an Algonquin language. Within these cultures mind was not perceived as an indepedent construct pre-existing relationship but as a result of relationship, while awareness was seen as predating relationships -- similar to what has been called primary process thinking. Relationships forces upon both partners the need to communicate which occurs through language and shapes the development of identity construction of both parties into an ongoing and perpetually changing dialogue that parallels as verb what conventional psychiatry calls personality (noun). Given these conceptual differences, we will consider how different it is to work within these cultures and for non-indigenous peoples to practice psychiatry or psychotherapy with these peoples.

No.87D

NARRATIVE PHILOSOPHY: A BRIDGE BETWEEN CONVENTIONAL PSYCHIATRY AND ABORIGINAL IDEA OF MIND AND MENTAL HEALTH

Lewis Mehl-Madrona, M.D., Departments of Family Medicine and Psychiatry, University of Saskatchewan College of Medicine, West Winds Primary Health Centre, 3311 Fairlight Dr., Saskatoon, S7M3Y5 Canada

SUMMARY:

A narrative approach coupled with social constructionism allows us to view medicine from other vantage points, most productively those of indigenous cultures and their healing systems. From these vantage points we can consider aspects of medicine that have been lost as it became scientific. Extensive information is lost when people are only considered in accordance with an anatomically based diagnosis related to individual organs. Indigenous models of mental health emphasize the person of the illness and the community/context in which the illness arose. When we question people more deeply, we discover that everyone has a story to explain their illness. This story is more or less shared by family members and may or may not relate to the medicine's official story of the illness. Nevertheless, within these stories lie radical possibilities for restoring balance and harmony, an indigenous concept of healing which is largely neglected by medicine. People's stories about their illness contain the seeds for stories about their healing. What we do with these seeds can make all the difference for healing and transcendence and sometimes even for curing disease.

No.87E

INDIGENOUS MENTAL HEALTH WITH PARTICULAR REFERENCE TO AKADIAN AND MIKMAC CULTURES

Margaret Williams, M.D., Dept. of Psychiatry, Texas A & M, P.O. Box 64107, Pipe Creek, TX 78063

SUMMARY:

Seven principles about healing emerge: 1) They spend time and they recognize that time is in itself healing (time). 2) Healers recognize that healing only can occur within the context of a quality relationship (holding environment). 3) Healers listen to the client's story of the illness, making sure that the client knows that the healer has understood, and then use their methods to transform the story toward one that ends with wellness (Deconstruction-reconstruction). 4) Healers recognize that major life changes are required for recovery from chronic diseases (2nd and 3rd order changes). 5) Healers enroll and enlist the community in supporting and facilitating the healing process (ceremony). 6) Healers call upon spiritual resources for help with healing, serving as a channel or conduit for the patient to recognize and encounter this dimension (prayer and shamanism), holding an unshakeable belief that the client can get well (faith). 7) Healers recognize and work with the interconnectedness and inter-relatedness of all beings (systems theory). These are all aspects of Micmaq (Nova Scotia) and Akadian (Micmaq who were relocated to Louisiana) belief systems. In this presentation, we will consider how modern medicine might change so that it can be more compatible with indigenous cultures.

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2. Kirmayer et al (nd). Chs 1 & 2 Emerging trends in research on mental health among Canadian Aboriginal Peoples. Montreal: McGill University, Culture and Mental Health Research Unit, Institute of Community and Family Psychiatry, Sir Mortimer B. Davis-Jewish General Hospital, and Division of Social and Transcultural Psychiatry. Available free on-line at http://www.mcgill.ca/tcpsych/research/cmhru/working-papers/
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SYMPOSIUM 88

TECHNOLOGIES TO IMPROVE PSYCHOTHERAPY TRAINING AND OUTCOMES

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should know how to improve psychotherapy outcomes for patients in their clinical practice. Steps include an evaluation of trainees for suitability for psychotherapy; the innovative use of simple-to-use websites, webcams, and webcam-based supervision; and computer -enhanced cognitive therapy. Evidence suggests that these steps can significantly improve psychotherapy training as well as patient outcomes.

No.88A

COMPUTER-ASSISTED COGNITIVE-BEHAVIOR THERAPY IN CLINICAL PRACTICE

Jesse H. Wright, M.D., Department of Psychiatry and Behavioral Sciences, University of Louisville, 200 E Chestnut Street, Norton Psychiatric Clinic, Louisville, KY 40202

SUMMARY:

Recent developments in use of computer-assisted cognitive-behavior therapy have focused on programs for enhancing the delivery of empirically tested psychotherapy for depression and anxiety disorders. Multimedia programs have been shown to reduce requirements for therapist time while retaining efficacy; and in some cases, to have a greater impact on patient learning than standard CBT. Virtual reality programs have been used effectively in exposure therapy for a variety of anxiety disorders. This presentation details methods for integrating computer-assisted CBT into clinical practice and presents data from an outcome study on depression to illustrate treatment strategies.

No.88B

THROUGH THE LOOKING GLASS WITH SUPERVISION: VIDEO RECORDING TWO

John Manring, M.D., University Hospital, 750 East Adams Street, Syracuse, NY 13210

SUMMARY:
In the past 10 years we have witnessed a significant increase in the use of technology in medical education. Updated electronic equipment can facilitate various aspects of learning. Web-cams, DVD recorders, MP3 players, CD-ROMS, and other electronic devices have become common place in learning environments, although less so in psychotherapy training of residents. These devices can be creatively utilized to record therapy sessions, which can then be reviewed with the resident in supervision permitting more accurate feedback to the resident about content, process and specific therapeutic interventions. Supervision can in turn be recorded to provide both supervisor and trainee access to aspects of the supervisory process which may prove helpful to patient outcome. Like Alice, once through the looking glass of video recording, the supervisor can find herself feeling like a pawn in a chess game.

No.88C
SIMULATION BASED ASSESSMENT AND TRAINING IN PSYCHOTHERAPY

Usha Satish, Ph.D., Department of Psychiatry, 750 East Adams Street,, Syracuse, NY 13104, Manring John, M.D., Dewan Mantosh, M.D., Gregory Robert, M.D.

SUMMARY:
Successful resident training must include both the acquisition of required knowledge as well as the ability to use that knowledge appropriately and adequately. In other words, measurement of the needed competence must not only focus on "content" based skills or knowledge, but also on the process of decision making abilities. The SMS (Strategic Management Simulations) is a validated tool used to assess and train professionals worldwide. We employed the technology to assess resident decision-making abilities along several parameters and compared simulation performance assessments to faculty evaluations of actual real world performance of these residents.

No.88D
WEB-BASED LEARNING IN PSYCHOTHERAPY: A DEMONSTRATION!

Priyanthy Weerasekera, M.D., M.Ed., McMaster University, St.Joseph's Hospital, 301 James Street South, Fontbonne 415, Hamilton, Ontario, L8P 3B6, Canada

SUMMARY:
The past 10 years has witnessed a significant increase in the use of technology in medical education. Web-based learning (WBL) offers numerous advantages with universal accessibility, ease in updating content, and hyperlink functions that permit cross-referencing to other resources. Proponents of WBL consider this method of learning superior to more traditional forms given that the learner is actively searching out and enhancing his/her knowledge base through hyperlink functions. Application of this technology to psychotherapy training suggests potential benefits to various components of training such as demonstration of therapy specific skills through clinical vignettes, interactive learning experiences, and testing of knowledge base.

REFERENCES:
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SYMPOSIUM 89

CHILDREN OF IMMIGRANTS: DEVELOPMENTAL AND MENTAL HEALTH NEEDS

American Academy of Child and Adolescent Psychiatry

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to;(1) Understand the impact of adverse socioeconomic risk factors on the rapidly growing U.S. population of children of immigrants; (2) Better understand the problems with identity development that affect children of immigrants and how they impact on their development and risk for psychopathology; and 3) Learn about how these sociodemographic and psychological risk factors compound acculturation and affect the children of two key immigrant groups: Latinos and South Asians.

No.89A
CULTURE AND IDENTITY DEVELOPMENT OF ASIAN INDIAN CHILDREN

Aradhana Sood, M.D., Virginia Commonwealth University, 515 North 10th Street, Richmond, VA 23298

SUMMARY:
This presentation describes developmental issues and impact of stress on second-generation children of Asian Indian origin. The Asian Indian population has grown from 815,447 in 1990 to 1,670,725 in 2000 in the U.S. (U.S. Bureau of the census, 2000) and 30 % of this population is under the age of 18. This presentation presents the impact of the immigration experience on the identity development of children of Asian Indians. The cultural identity of Asian Indian children is shaped by parental adjustment to the U.S. and assimilation within the majority culture (Phinney, 1990). Secular trends in the waves of immigration also have an impact on the adjustment of Asian Indian children. (Chandrashekhar, 1982) Individual, familial and environmental influences determine whether the adjustment and functionality of the offspring will be optimum. This presentation will focus on children and adolescents of immigrants from the Indian subcon-

tinent. The data is drawn from clinical work and focus groups with the Asian Indian community and supported by extant literature. As the cultural diversity of the US population increases, it is imperative that clinicians become educated about and skilled at working with diverse populations of which the Asian Indian population is one.

No.89B
MENTAL HEALTH OF CHILDREN OF LATINO IMMIGRANTS IN THE U.S.

Andres J. Pumariega, M.D., The Reading Hospital and Medical Center, 6th Avenue and Spruce Street, Reading, PA 19611

SUMMARY:
A number of studies have indicated that Latino youth have a higher risk of significant psychopathology and mental health morbidity. The 2005 Youth Risk Behavior Survey from the CDC demonstrated that Latino youth are at highest risk amongst all U.S. youth for suicidality. There are multiple stressors that aggravate any biological vulnerability that Latino youth may have towards psychopathology. Methods: This presentation will review the current knowledge and the literature on the mental health status of Latino children and youth, and particularly immigrant youth. It will focus on the contribution of such risk factors such as immigration trauma, acculturation, adverse socioeconomic, family, and community environments, and lack of access to child mental health and culturally competent services to the development of psychopathology and mental health morbidity in this growing population. The presentation will also present evidence for how the service needs of immigrant Latino children are best addressed through community-based programs in the context of community-based systems of care, which have been associated with improved access and outcomes for Latino youth. The evidence-base for specific pharmacological and psychological modalities, particularly those that address cultural needs, will be presented. More research into the use of specific treatment modalities with Latino youth (both medications and psychological therapies) is showing promise and effectiveness.

No.89C
THE HEALTH AND WELL-BEING OF CHILDREN OF IMMIGRANTS

Randolph Capps, Ph.D., The Urban Institute, 2100 M Street, N.W., Washington, D.C. 20037

SUMMARY:
The number of U.S. children of immigrants has more than tripled over the past 35 years. Immigration-led demographic change is being felt acutely by child serving agencies, including schools, health providers, and social service agencies. This presentation draws on findings from more than a dozen studies by the Urban Institute and other research organizations. The findings are based on analyses of data from the U.S. Census, various years of the Current Population Survey (CPS), and the 1999 and 2002 National Survey of America's Families (NSAF). While high poverty, low parental education, and limited English proficiency leave immigrants' children less prepared for school, they are less likely to be enrolled in formal child care programs and public benefit programs that could make up developmental gaps and provide familial assistance. Though children of immigrants were more likely to live in two-parent families (82 versus 70 percent), children of immigrants in two-parent families are twice as likely to be low-income (47 versus 22 percent). Limited parental English skills are a predictive factor for child poverty and other forms of economic hardship. as well as a risk factor for poor school performance. The combination of lower SES, lack of legal status, limited English proficiency, and barriers to accessing services may lead to greater incidence of poor mental health for children and their parents. Mental health providers should take these factors into account when planning and delivering services for this important and growing group of children.

No.89D
IDENTITY FORMATION IN CHILDREN OF IMMIGRANTS

R. Rao Gogineni, M.D., One Bala Ave,Suite #118, Bala Cynwyd, PA 19004

SUMMARY:
Erik Erikson defined a healthy identity as a fundamental task of adolescence. This task is more difficult, but vital in children of immigrants. Identity formation is influenced by socio-economic status, family factors, peer group, language, parent-child interactions, individual psychology, educational level of parents, country of origin, race, ethnicity, acculturation, discrimination, ethnic socialization, regional location and others.

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1. Capps, Randy, and Karina Fortuny. 2006. "Immigration and Child and Family Policy." Assessing the New Federalism Children in Low-Income Families Paper No. 3. Washington, DC: The Urban Institute.
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3. Mehta, P. (1988). The emergence, conflicts, and integration of the bicultural self: psychoanalysis of an adolescent daughter of South Immigrant parents. In S. Akhtar & S. Kramer (Eds) Colors of Childhood: Separation-Individuation across cultural, racial, and ethnic differences, pp. 129-168. North Vale, New Jersey: Jason-Aronson.
4) Suarez-Orozco, C. & Suarez-Orozco, M.M. (2001). Children of Immigration. Cambridge: Harvard University Press.

SYMPOSIUM 90

DSM V: FROM RESEARCH TO CLINICAL ISSUES

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to identify several direct consequences of nomenclature changes, including public health controversies, changes in the appreciation of neuropathology, new views on the validity of common diagnoses, and more realistic application of practice guidelines.

No.90A

MENTAL DISORDER VERSUS UNDERSTANDABLE MENTAL SUFFERING: IS THE DIFFERENCE CLEAR? IS IT RELEVANT TO TREATMENT DECISIONS?

Mario Maj, M.D., Department of Psychiatry, University of Naples SUN, Largo Madonna delle Grazie, Naples, 80138 Italy

SUMMARY:

There was a time when it seemed that the target of psychiatric treatment could be easily defined: "Psychiatry treats people who are sick and who require treatment for mental illness"; "There is a boundary between the normal and the sick". These were two items of the "neo-kraepelinian credo", articulated in 1978. A corollary to these items was the statement that "Depression, when carefully defined as a clinical entity, is qualitatively different from the mild episodes of sadness that everyone experiences at some point in his life". Apparently in line with this statement was the observation that tricyclic antidepressants were active only in people who were clinically depressed; when administered to other people, they did not act as stimulant and did not alter their mood. Today, the picture appears much less clear, and this is certainly in part a consequence of the evolution of psychiatric treatments. Guidelines for treatment of major depression often contain contradictory statements in this respect: on the one hand, the warning that "antidepressant medications are effective even in the presence of significant life stress, such as a serious medical illness or job loss; they should not be withheld solely because the condition is understandable", on the other, the assertion that "it is important to clearly differentiate clinical depression from normal adaptive responses to stress, frustration and loss". Why is the latter distinction so important, if it has no treatment implications (i.e., if the decision whether to treat or not the condition is based only on its severity and duration)? Moreover, are we really able to distinguish between a "dysfunctional" and an "adaptive" response to an adverse life event? These are questions with significant political, ethical, scientific and clinical implications, which involve the credibility and the future itself of our discipline and our profession.

No.90B

INCREASING THE VALIDITY IN *DSM-V*

Roger Peele, M.D., P O Box 1040, Rockville, MD 20849-1040, Enrico Suardi, MD., M.I.T.

SUMMARY:

About fifty percent of the entities in *DSM-IV-TR* have some validity. The majority of this fifty percent are *DSM* entities associated with substances. Others are neurological disorders, general medical disorders, stress/trauma, season of onset, and the postpartum period. Except for sleep disorders laboratory results, there has been no expansion of diagnoses with validity since *DSM-III* [1980]. As to increasing the validity in *DSM-V*, there may soon be new developments as to phenotypes that are related to signs and symptoms of mentally illness that would be the major breakthrough the field has anticipated for the past two decades. If that fails to materialize, it appears that, of the present validities, the one that is most ripe for expansion is mental conditions associated with stress and trauma. A great deal of information has evolved since the late 1970s when Post Traumatic Stress Disorder was conceptualized. Working from that information seems, both our increased knowledge as to recent trauma as well as childhood trauma, is the most promising area to increase *DSM* validity. This paper will include suggestions on how that increased knowledge can be captured in *DSM-V* entities.

No.90C

PUBLIC HEALTH IMPLICATIONS OF CHANGING CLASSIFICATION OF MENTAL DISORDERS

Norman Sartorius, M.D., 14 Chemin Colladon, Geneva, 1209 Switzerland

SUMMARY:

The forthcoming revision of the World Health Organization (WHO) ICD and APA *DSM* will require considerable amounts of work to review the evidence that might require a change in the classification and to find the best way of introducing the change. While engaged in this process the drafters of the proposals for the changes will have to take public health implications of such changes into account. These include the consequences in relation to the prevalence of mental disorders (and subsequent planning of services), forensic implications and consequences for reimbursement practices. Changes of classifications also have an impact on licensing medications, on the organisation of mental health information systems and the education and training of health personnel at all levels. The paper will review these issues and propose ways of optimising the public health implications of changes in the ICD and *DSM.*

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3. Zimmerman, M, Rothschild, l.:The Prevalence of DSM-IV Personality Disorders in Psychiatric Outpatients. Am J Psychiat, Oct 2005; 162: 1911- 1918.
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SYMPOSIUM 91

STUCK IN THE BLACK BOX: A PATIENT SAFETY APPROACH TO PRESCRIBING ANTIDEPRESSANTS

APA Committee on Patient Safety

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) The audience will learn how to systematically perform safety assessments prior to prescribing antidepressants; (2) The audience will evaluate special groups of patients proactively to eliminate risk of errors in prescribing; and (3) Members in training and early career psychiatrists will incorporate error reduction strategies to avoid or minimize adverse events in their practices.

No.91A

MAKING IT TO MORNING: A RESIDENT'S PERSPECTIVE

Jason G. Roof, M.D., Department of Psychiatry & Behavioral Sciences, University of California, Davis Medical Center, 2230 Stockton Blvd, 2nd Floor, Sacramento, CA 95817

SUMMARY:

In an academic training facility, a resident of psychiatry will often be the first physician to come into contact with a new patient. Residents in such situations evaluate and determine an initial framework of treatment for the patient's care. Many therapeutic options are available at this point and may include further care at the facility itself or referral to an outside source. Included with the various other difficulties to be overcome in this environment are information gathering problems such as incomplete histories from the presenting patient and their family as well as incomplete, inaccessible, or non-existent medical records. Additionally, a recent study regarding resident error suggests excessive work hours, inadequate supervision and problems with communication between residents and staff may contribute to errors in care. Although this may be a less-than-optimal evaluation point to begin a treatment regimen, the initial treatment framework constructed by a resident can influence the direction of care of the patient for the duration of their inpatient stay and may well affect the direction of treatment for years to come. This presentation will explore characteristic and typical experiences of a resident physician as they assess patients and create treatment plans in the face of these multiple difficulties. Particular attention will be paid to starting, continuing or discontinuing medication regimens and how stabilization of the patient in an acute state of their illness can differ from later maintenance therapies.

No.91B

USES OF GENETIC TESTING

John W. Goethe, M.D., Institute of Living, 200 Retreat Avenue,, Hartford, CT 06106

SUMMARY:

Overview: This part of the symposium will discuss the use of available genetic tests to inform clinician prescribing and present data from a pilot program at the Institute of Living.

Summary: Genetic testing as applied to psychiatry is still in its infancy.1) We remain far from predicting which patients will tolerate or respond to which antidepressant. 2) However, the field of genetic testing has progressed sufficiently to be able to determine which patients will be fast or slow metabolizers of a given antidepressant. 3) This presentation will describe a variety of results from genetic testing in psychiatric patients and how this information was useful.

REFERENCES:

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2. Sood N. Treglia M. etal. Determinants of antidepressant outcome. Am J of Managed Care 2000: 6:1327-1336.
3. The Management of Suicidality: Assessment and Intervention. Randon S.Welton. Psychiatry 2007. May 2007, Vol 4., No.5.
4. A Computerized Clinical Decision Support System as a Means of Implementing Depression Guidelines Madhukar H. Trivedi, M.D., Janet K. Kern, Ph.D., Bruce D. Grannemann, M.S., Kenneth Z. Altshuler, M.D. and Prabha Sunderajan, M.D. Psychiatr Serv 55:879-885, August 2004.

SYMPOSIUM 92

POVERTY AND MENTAL ILLNESS AROUND THE WORLD

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should know how and to what extent poverty affects mental illness and child development; how these effects are mediated and how they differ in different countries; and how they can be mitigated with fairly simple interventions; and for example how poverty in the Caribbean may have followed the ravages of indigenous genocide and African slavery and have led to the increase in schizophrenia in the Caribbean diaspora.

No.92A

THE EFFECTS OF POVERTY ON MENTAL ILLNESS AROUND THE WORLD: THE AFRICAN PERSPECTIVE

Frank G. Njenga, M.D., Upper Hill Medical Centre Third Floor, Suite 3C P.O. Box 73749, Nairobi, 00200, Kenya Njenga Frank, M.D., F.R.C.Psych.(UK)

SUMMARY:

Africa is a continent ravaged by wars, natural and man made disasters, epidemics, including malaria and HIV AIDS, and up to 60% of her inhabitants live on less than a dollar a day. This presentation will explore the relationship between poverty and mental illness in Africa. There is for example increasing evidence that poverty predisposes to certain mental disorders , just as there is evidence that mental illness leads to poverty. Special attention will be paid to marginalized populations including refugees, women, children and survivors of wars in Africa. These populations suffer high prevalence of mental disorders in part due to the interplay between poverty and displacement both within and outside national boundaries. Post traumatic stress disorder in these regions is highly prevalent but often poorly recognized.

No.92B

THE HIGH COST OF POVERTY: MENTAL HEALTH PERSPECTIVES FROM THE CARIBBEAN DIASPORA

Frederick W. Hickling, D.M., University of the West Indies, Mona, Kingston, 7 Jamaica

SUMMARY:

A Caribbean Diaspora has emerged worldwide after five hundred years of European colonial exploitation of the Caribbean geopolitical region separating into a two-tiered social legacy of the 'haves' and the 'have-nots' characterized by poor educational achievement, underdevelopment and unemployability of the many, amidst opulent wealth and luxury of the few. The Caribbean Diaspora is a product of ever increasing fantasies of escape from poverty by migration to greener first-world pastures. A plethora of studies reveal higher risk ratios of schizophrenia

in African Caribbean migrants to the UK, the USA, Canada and Europe, confined mainly to the lower socioeconomic classes. A contemporary Jamaican study indicates that matched native-born developed schizophrenia at a significantly higher rate than white immigrants, and that white first-generation migration to the Caribbean is characterized by immediate and marked upward social mobility. Studies of first contact schizophrenia in the Caribbean identify that the majority of these patients originate from the poorest classes of those societies. A study of condemned murders in Jamaica indicated that 83% had originated from very low socioeconomic developmental conditions, but had significantly higher IQ's than the norm. It is suggested that the political/economic system in post-colonial countries of the Caribbean engenders severe mental illness in the poorest native-born socioeconomic classes, but protects white immigrants from the social stress of migration; contrarily, the political structure of white first-world countries seems to create psychosocial stress factors that predispose the development of schizophrenia in Caribbean migrants. It is advanced that existing poverty in people of the Caribbean Diaspora follows the ravages of indigenous genocide and African slavery in the Caribbean, and has emerged as a dialectic antipode of European colonization and wealth-creation that has now become socioeconomically unaffordable.

No.92C

A PILOT INTERVENTION TO PROMOTE MENTAL HEALTH AMONG WIDOWS OF INJECTING DRUG USERS IN NORTH-EAST INDIA

Helen E. Herrman, M.B., ORYGEN Research Centre, University of Melbourne, 35 Poplar Road, Parkville, Melbourne, Victoria, 3052, Australia, Michelle Kermode Ph.D., Alexandra Devine B.Sc., Prabha Chandra M.B.B.S, M.D., Bernadette Dzuvichu B.Sc., Thomghood Gilbert B.Sc.

SUMMARY:

Background. HIV prevalence is high in Manipur and Nagaland. The major route of HIV transmission is injecting drug use. Most injecting drug users (IDUs) are male and about 40% are married. The widows of IDUs are among the most disadvantaged people. Many are HIV infected, and experiencing poverty, poor health, social isolation and discrimination, all factors likely to be compromising their mental health. Some widows are engaging in HIV risk behaviours. Links between HIV prevalence, mental health status and poverty are recognised increasingly, as is the possibility of effective interventions for promoting mental health for individuals and communities. Aims. To evaluate the use of participatory action groups to promote the mental health of IDU widows as a strategy for HIV prevention. Method. A pilot intervention over 20 weeks included 74 widows in 6 peer-facilitated participatory action groups, with a focus on promoting mental health. Changes in quality of life (WHOQOL-BREF), mental health (GHQ12), somatic symptoms and HIV risk behaviours were assessed. The value of the intervention from the perspective of the participants was captured using a qualitative evaluation method (Most Significant Change). Results. The women told stories about 'significant changes' with the themes of economic participation, social inclusion, discrimination, physical health and future orientation. The questionnaire responses indicated that their quality of life, mental health and physical health improved over the course of the intervention. Information about HIV risk behaviours was limited by inhibitions about reporting sexual behaviours. Conclusions. A participatory approach to mental health promotion can have a positive impact on the lives of vulnerable women, and the potential to contribute to HIV prevention. Poverty alleviation through economic participation is likely to be a mediating factor, as well as a consequence of improved mental health. Further investigation is warranted.

No.92D

POVERTY, MATERNAL DEPRESSION AND INFANT MORBIDITY IN THE DEVELOPING WORLD: CAN THE VICIOUS CIRCLE BE BROKEN?

John L. Cox, M.D., Department of Psychiatry, Keele University, Staffordshire, ST5 5BH United Kingdom

SUMMARY:

In the last decade there has been a burgeoning of research on the effect of poverty and impaired early attachment on infant brain development. It will be argued that what is required now is for this new knowledge to influence public policy.

This paper will bring together evidence from Developmental Psychology (Lancet 2007 vol 369), Clinical Psychiatry (WPA Parent and Infant Mental Health Programme) and Public Health that the reduction of infant and maternal mortality, as well as optimal school performance, can be achieved only with multi - sector child development programmes, and by health workers trained in developmental paediatrics and Maternal Infant Child Health (MNCH).

Examples of successful programmes from Asia and South America will be given; and the need to take full account of local beliefs emphasised.

No.92E

EVERYDAY EMOTIONAL DISTURBANCES IN MEXICAN URBAN POPULATIONS WITH LOW FINANCIAL RESOURCES

Maria Elena Medina Mora, Psy.D., Calzada Mexico Xochimilco 101 San Lorenzo Huipulco Tlalpan, Mexico City, 14370, Mexico, Shoshana Berenzon Ph. D., Jazmín Mora-Ríos Ph.D.; María A. Lara Ph.D., María Elena Medina-Mora Ph.D.

SUMMARY:

The purpose of this study is to find-out the interpretations that the adult population of poor urban communities attribute to their experiences of health and suffering in the context of everyday life, the way they deal with these situations and the forms of assistance to which they resort. The information analyzed in this paper is drawn from three research projects undertaken in Mexico City. The studies used qualitative research methods for collecting and analyzing the information. Some of the main results indicate that: 1) Concepts and Beliefs Concerning Health and Illness: Health is conceived of as a state of balance between mind, body and spirit. It is also associated with the possibility of carrying out everyday activities and having the ability to solve conflicts. Mental illness was defined in terms of "being crazy" while "madness" is acknowledged as behavior that transgresses the norms of social interaction, such as violence. 2) Suffering and malaise: The main

sources of malaise include financial and familial problems, drug consumption and domestic violence. 3) Treatment resources: The resources used, which are extremely varied, include members of the person's family of origin and other significant figures such their children's godparents, friends and bosses. They also use home remedies and self-care. They consult traditional doctors, use alternative therapies, visit GPs and in some exceptional cases, consult psychologists or psychiatrists. These different forms of treatment coexist and there is no contradiction between the choice of a particular form of treatment. The meanings the interviewees attribute to health and diseases reflect the fact that the knowledge generated is closely linked to their socio-economic and cultural context. In this respect, it is important to propose professionals the use of a more integral definition of health, since the meanings the subjects themselves give their ailments shed light on their own conceptual definitions of health, which may prove useful in developing intervention strategies that are better tailored to their treatment needs.

No.92F
IMPACT OF POVERTY ON MENTAL HEALTH IN THE MIDDLE EAST

Nasser N. Loza, M.D., 32 El-Marsad St, Helwan, Cairo, 11421, Egypt, Nael Hasan, M.D.

SUMMARY:
Poverty can endanger mental health of adults and children, through exposing them into many risk factors. Those risk factors van be poor housing, lack of appropriate health insurance, stress of living in poor conditions, physical illnesses, poor education, poor nourishment, and difficult employment opportunities. On the National and International levels, poverty may lead to wars, such as the Sudan war, with resulting in refugee status, complicating the poor living situation.

REFERENCES:
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2. Hickling FW. Psychopathology of White Mentally Ill Migrants to Jamaica" J of Molecular and Chemical Neuropathology 1996; 28:261-267.
3. Jolly R. Early childhood cevelopment: the global challenge. Lancet 2007; 369:8-94) Devine A, Kermode M, Chandra P, Herrman H. A participatory intervention to improve the mental health of widows of injecting drug users in north-east India as a strategy for HIV prevention. BMC International Health and Human Rights 2007; 7:3 www.biomedcentral.com/1472-698X/7/3.

SYMPOSIUM 93

BEYOND THE WALLS: CAN PRINCIPLES OF MORAL TREATMENT BE APPLIED TO CONTEMPORARY MENTAL HEALTH SYSTEMS?

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to;(1) To understand the history of moral treatment; (2) To recognize the later treatment approaches which were derived from moral treatment; and (3) To appreciate the challenges facing psychiatrists and contemporary health care settings in sustaining the core values and in practicing according to the principles of moral treatment.

No.93A
MORAL TREATMENT IN CONTEMPORARY PRACTICE

Christopher J. Holman, M.B., The Retreat, York, YO10 5BN United Kingdom

SUMMARY:
Moral treatment emerged in the context of enlightenment ideas about the nature of man, which saw rationality as the defining feature of humanity. It became a critique of the inhumane practices meted out to disturbed people in response to the perception that by losing their reason, they had lost of what defined them as human.

No.93B
ALL THINGS OLD ARE NEW AGAIN: THE IMPACT OF MORAL TREATMENT ON CONTEMPORARY PSYCHIATRY

Gregory A.. Miller, M.D., 98 Old Goshen Rd, Williamsburg, MA 01096

SUMMARY:
The moral treatment movement in the United States was nothing short of a revolution in societal perspectives toward the treatment of severe mental illness. Prior to this era, deficits in reason, judgment and behavior, currently understood as mental illness, were treated as disordered behavior often requiring control or punishment. The age of Enlightenment, beginning in the latter 18th century, heralded a philosophical perspective that valued rational thought as the most salient aspect of humanity. Paradoxically, the ideas of enlightenment initially served to perpetuate inhumane treatment of the mentally ill, but ultimately concepts of mental illness emerged that demanded the "insane" be treated as ill human beings, with compassion and caring.

No.93C
THE PARADOX OF MORAL TREATMENT IN MODERN TIMES

Harold I. Schwartz, M.D., Institute of Living, 200 Retreat Avenue, Hartford, CT 06106

SUMMARY:
The principles of "moral treatment," requiring attention to the psychological, social and spiritual needs of the patient, in addition to appropriate medical care, delivered in a humane manner and setting, have become increasingly difficult to maintain in modern psychiatric systems that are bureaucratized, heavily regulated and underfunded. While the biopsychosocial model can be considered a contemporary reflection of "moral treat-

ment" principles, the changing conception of hospitalization, from provision of asylum (the extended treatment of an episode of illness) to allowance of only the shortest admission that will ensure safety, has contributed to a fragmentation of the biological, psychological and social components of treatment such that the evolution of autonomous functioning can rarely be the focus of institutional care.

No.93D

ECHOES OF MORAL TREATMENT IN THE PLANETREE MOVEMENT

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

SUMMARY:

The Planetree movement was begun thirty years ago by a patient who experienced hospitalization as traumatic and disempowering. Planetree has evolved into a successful foundation which guides health care organizations along a so-called journey toward delivering patient-centered care with attention to mind, body, and spirit. Key elements of the Planetree approach are creation of a restorative environment, emphasis on patient education, and through that education, empowerment for patients and families as full partners in their own care.

REFERENCES:

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2. Sederer, L. Moral Therapy and the Problem of Morale. Am. J. Psychiatry 1977 134: 267-272.
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SYMPOSIUM 94

HORMONES, IDENTITIES AND CULTURES: CLINICAL ISSUES IN TRANSGENDER YOUTH

American Academy of Child and Adolescent Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better understand transgender issues in prepubertal youth, gain knowledge in ways to help transgender youth and their families, and become familiar with resources for transgender youth and their families.

No.94A

TRANSGENDER CHILDREN: CLINICAL AND ETHICAL ISSUES IN PRE-PUBERTAL PRESENTATIONS

Edgardo J. Menvielle, M.D., 111 Michigan Avenue, NW,, Washington, D.C. 2001

SUMMARY:

Objective/Background: Transgender, transsexual and gender variance issues are very important but poorly understood by most clinicians especially with children and adolescents. When these issues present in children before puberty they raise even more questions. Methods: This presentation will be organized around two clinical cases of children who have transitioned genders, including individual and group interventions to support these children and their families. The presenter will provide handouts with clinical and support resources for these children. Results: Differentiating transgenderism from other presentations of gender variant behaviors in pre-pubertal children is particularly challenging. A few studies have shown that gender variance in young boys often does lead to transgenderism in adolescents in adults, although sometimes it does. The long term outcome of girlhood gender variance is less well established. A clinical case of a 11 year old child with female physical phenotype who consistently self identifies as a boy will be presented. Another clinical case will be presented, that of a 9 year old child with a male physical phenotype who self-identifies as, and presents to consultation as, a girl. The family dynamics as well as the therapeutic processes will be examined. Educational, ethical and legal issues will be discussed. Conclusions: Issues of childhood gender variance are extremely challenging for clinicians. Old assumptions about family dysfunction being the culprit for most gender variance, especially for cross-gender identification, are increasingly being discredited. A shift in the ethical stance of psychiatrist towards an ethic of embracing the patient's subjectivity is increasingly displacing an ethic of regulating, restricting and enforcing the gender and sexuality normative hierarchy. This presentation is intended to bring up these complex issues for examination and discussion.

No.94B

AN ENDOCRINE PERSPECTIVE ON THE CARE OF TRANSGENDER ADOLESCENTS

Norman Spack, M.D., Endocrine Division, Children's Hospital Boston/Harvard Medical School, 300 Longwood Avenue, Boston, MA 02115

SUMMARY:

Objectives: This presentation covers endocrine interventions for transgender adolescents.

Background: Increasingly, endocrinologists are called to treat teens who are carefully screened by experienced mental health evaluators. These adolescents self-identify as transgender and wish to shape the physical effects of puberty to match their deeply experienced sense of gender.

Methods: This presentation will include clinical examples and the results of protocols involving initial pubertal suppression and subsequent cross-gender hormones. One protocol is ongoing in the Netherlands and the other has recently begun in the USA.

Results: Endocrine treatment is essential to enable transgender adolescents to achieve appropriate physical development and to prevent irreversible pubertal effects of their genotypic sex. However, philosophical and fiscal barriers, among others, prevent patients from receiving pubertal suppressive therapy.

Conclusions: The development of secondary sexual characteris-

tics has life-long consequences for transgender persons. Research and clinical cases underlie the importance of peri-pubertal endocrine interventions on their long-term psychological adjustment and life satisfaction. A close collaboration with mental health care providers is essential to maximize benefits.

No.94C
FORMATION OF TRANSGENDER IDENTITIES IN ADOLESCENCE

Richard R. Pleak, M.D., Long Island Jewish Medical Center Zucker Hillside Hospital, ACP, Glen Oaks, NY 11004

SUMMARY:
Children with substantial gender atypical behavior are fairly rare, and adults who are transsexual are also not common; however, as these individuals become more open and acknowledged, more clinicians are asked to help with their issues and concerns. These concerns include developmental issues, and most clinicians feel unprepared to deal with transgender youth. Some, but not most, children with gender atypical behavior and wishes identify as transsexual in adulthood, and most, but not all, transsexual adults report gender atypical behavior and wishes in their childhoods. There has been an unfortunate tendency to lump these populations and oversimplify these differences. This paper will review theories and research findings on the formation of transgender identities including transsexuality and the controversial topic of autogynephilia. The ways the *DSM* and ICD diagnoses have changed over the past three decades will be documented and explored.

No.94D
ISSUES IN WORKING WITH FEMALE TO MALE TRANSGENDER YOUTH

Sarah E. Herbert, M.D., Morehouse School of Medicine, Department of Psychiatry, 41-A Lenox Pointe N.E., Atlanta, GA 30324

SUMMARY:
Objectives: To understand gender variance in female youth, appreciate how this differs from gender variant male youth, become familiar with approaches to working with these young people and their families, and aware of available resources. Background: Much written about gender variant children and transgender adolescents is based on males, as they traditionally outnumbered females by 4 or 5:1 in specialty gender clinics. Gender variance may be less prevalent in girls than boys; less stigma may be attached to stereotypically masculine behaviors in girls than to feminine behaviors in boys; or there may be less interest in pursuing sex reassignment due to surgical limitations. Methods: This presentation will use case material, interviews with youth in community organizations, internet communications, and videos to describe issues pertinent to female youth with gender variance and transgender identity. Results: Despite presenting to clinics later and less frequently than boys, there are girls with significant gender variance and transgender identities. Their social adjustment appears to be less impaired than that of boys with gender variant behaviors. As with boys, gender identity issues in girls may not persist into the adolescent years. For some, there is a consolidation of masculine identity in adolescence, but for others, there may need to be more exploration of transgender identity. The ways in which youth self-identify may be confusing to clinicians, which may reflect identity confusion and conflict. Conclusions: When the clinician encounters a young person with gender variance or transgender identity, it is not always possible to know what the ultimate outcome will be. Familiarity with gender variance in girls, knowledge of how it is different from that of boys, and understanding how transgender youth identify themselves in their adolescent years, are important skills in helping clinicians approach evaluation and treatment of these individuals and their families.

No.94E
AFRICAN-AMERICAN AND LATINO TRANSGENDER YOUTH

Vernon A. Rosario, M.D., 10850 Wilshire Blvd. Suite 1210, Los Angeles, CA 90024

SUMMARY:
Objectives: To appreciate how diverse cultural and socioeconomic factors affect gender identity development, understand life-course and outcomes of gender atypical Latino and African-American (A-A) youth, and learn culturally-sensitive approaches to working with these teens and their families. Background: The medical study of transsexualism or gender identity disorder (GID) has largely focussed on white, middle-class male-to-female transsexuals. Only recently has non-Euro-American gender atypicality been studied. Studies of American transgender youth of color have largely centered around HIV prevention, which have found that this population has high rates of HIV seroprevalence and sex work, as well as high rates of depression, suicide attempts, substance abuse, psychiatric hospitalization, and self-administration of hormones. Methods: Relying on case material from inner-city A-A and Latino gender-atypical adolescents in the dependency and delinquency systems, this presentation examines the culturally-specific risks and coping mechanisms of these youth. Results: Cultural, religious, and family values are often anti-gay and anti-transgender. Expressions of sexuality are shaped by stereotypes of gender as well as the visibility of transsexual sex work. Culturally-shared beliefs shape gender-atypical teens' psychosexual development and complicate psychiatric diagnosis. Their psychosexual development frequently does not follow the typical life course of GID as described in the *DSM* and their transgender identity is sometimes fluid. Conclusions: A-A and Latino gender atypical adolescents in the poor inner-city struggle with culturally-specific challenges in their psychosexual development. These complicate the application of *DSM* GID criteria and the evaluation for gender-reassignment hormones and surgery. Social and cultural stressors can lead to major mental illness and substance abuse. Familiarity with such diverse cultural factors is important for effective treatment.

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SYMPOSIUM 95

IMPULSIVE-COMPULSIVE SPECTRUM DISORDERS: RECOGNITION AND CLINICAL MANAGEMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; (1) understand the conceptual basis supporting a spectrum of impulsive and compulsive disorders; (2) recognize the symptoms of these disorders and their differential diagnoses; and (3) be familiar with both psychotherapeutic and pharmacological treatment strategies for these disorders.

No.95A

OBSESSIVE-COMPULSIVE DISORDER, ITS RELATIONSHIP TO IMPULSIVITY, AND AVAILABLE TREATMENTS

Dan J. Stein, M.D., University of Cape Town Department of Psychiatry, Groote Schoor Hospital, Anzio Road, Cape Town, 7925 South Africa

SUMMARY:

One approach to compulsivity and impulsivity has been to consider these constructs as lying on opposite ends of a single spectrum, with each end of the spectrum characterized by opposing psychobiological characteristics. However, studies of patients with obsessive compulsive disorder demonstrate that a significant proportion suffer from impulse control disorders. The existence of patients with comorbid compulsive and impulsive symptoms and disorders raises the question of whether a more complex model is needed, perhaps viewing compulsivity and impulsivity as orthogonal dimensions. In this paper, an A-B-C model of compulsive-impulsive symptoms, such as hair-pulling, is proposed. In a range of patients, affective dysregulation (A), behavioral addiction (B), and cognitive dyscontrol (C) may play a role in accounting for the phenomenology and psychobiology of compulsive-impulsive symptoms. Various treatments, acting on each of these domains, may be useful in the treatment of the obsessive-compulsive spectrum of disorders.

No.95B

IMPULSIVE-COMPULSIVE SPECTRUM DISORDERS: DIAGNOSTIC ISSUES

Eric Hollander, M.D., One Gustave L. Levy Place, Box 1230, New York, NY 10029, Heather Berlin, Ph.D., Daphne Simeon,

Related Disorders. In order for a specific disorder to be included in the Obsessive Compulsive Related Disorders category, at least 3 of the following 5 criteria must be similar to that seen in OCD: 1. phenomenology and course of illness, 2. comorbidity, 3. family history, 4. brain circuitry (frontostriatal brain circuitry, with caudate hyperactivity), and 5. treatment response. In addition, at least one of the following two criteria that reflect etiology (family history) or pathophysiology (frontostriatal brain circuitry with caudate hyperactivity) must also be met. Disorders that met these criteria included somatoform (body dysmorphic disorder, hypochondriasis), grooming/impulse control (trichotillomania), tic/motor (Tourette's syndrome, PANDAS/Sydenham's chorea), and certain eating disorders.

No.95C

UPDATE ON THE CLINICAL FEATURES AND TREATMENT OF TRICHOTILLOMANIA AND PATHOLOGIC SKIN PICKING

Jon E. Grant, M.D., Department of Psychiatry, University of Minnesota, 2450 Riverside Avenue,Minneapolis, MN 55454

SUMMARY:

Trichotillomania and pathologic skin picking are relatively common and often disabling disorders that share commonalities with both compulsive and impulsive disorders. These behaviors often go unrecognized in clinical practice, and even when recognized, clinicians are often unaware of treatment options. This presentation will review the clinical features of these behaviors, including similarities with obsessive complusive disorder (OCD) and addictive disorders. The presentation will also emphasize recent research findings on effective pharmacologic and psychotherapeutic treatments, and will offer practical advice on how to successfully treat patients with these often difficult-to-treat disorders.

No.95D

BODY DYSMORPHIC DISORDER

Katharine A. Phillips, M.D., Butler Hospital, 345 Blackstone Blvd., Providence, RI 02906

SUMMARY:

For more than a century, body dysmorphic disorder (BDD) has been hypothesized to be related to obsessive compulsive disorder (OCD), and BDD is currently widely conceptualized as an OCD-spectrum disorder. BDD, a distressing or impairing preoccupation with an imagined or slight defect in physical appearance, affects approximately 1-2% of the population. BDD is characterized by time-consuming obsessional preoccupations about perceived appearance flaws as well as compulsive behaviors such as excessive grooming, mirror checking, reassurance seeking, and skin picking. Patients with BDD typically have markedly poor functioning and quality of life, as well as high rates of suicidal ideation, suicide attempts, and completed suicide. However, BDD often goes unrecognized and untreated in clinical practice, despite the availability of efficacious treatments. This presentation will discuss the challenges of recognizing BDD and engaging these patients in treatment, which can be complicated by their poor insight and

M.D., Stefano Pallanti, M.D., Jennifer Bartz, Ph.D., Andrea Allen, Ph.D.

SUMMARY:
The Research Planning Agenda for *DSM-V* Workgroup on Obsessive Compulsive Behaviors Spectrum supported the creation of two broad and parallel categories. These included 1. Behavioral and Substance Addictions, and 2. Obsessive Compulsive desire for cosmetic treatment (e.g., surgical, dermatologic) rather than psychiatric treatment. Recent research findings on BDD's treatment will be presented, with a focus on serotonin-reuptake inhibitors and cognitive-behavioral therapy, which are currently considered the first-line treatments for BDD. This presentation will also discuss similarities with OCD (e.g., obsessions and compulsive behaviors) as well as differences between BDD and OCD (e.g., poorer insight in BDD), including their relevance for BDD's diagnosis and treatment.

No.95E
CLINICAL ADVANCES IN UNDERSTANDING AND TREATING IMPULSE CONTROL DISORDERS

Marc N. Potenza, M.D., Yale School of Medicine, Department of Psychiatry, 34 Park St, New Haven, CT 06519,

SUMMARY:
Background: Impulse control disorders (ICDs), including pathological gambling, intermittent explosive disorder, kleptomania and others, are relatively common, particularly amongst individuals with other psychiatric disorders. An emerging understanding of the etiologies of ICDs is leading to advances in behavioral and pharmacological treatments for these disorders.

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SYMPOSIUM 96

PSYCHIATRIC EMERGENCY SERVICES: MEDICO LEGAL ISSUES IN CRISIS CARE

American Association for Emergency Psychiatry

EDUCATIONAL OBJECTIVES:
At the end of the symposium, the audience will: (1) Recognize potential medicolegal issues that are currently present in emergency psychiatric services and interventions; (2) Identify some potential medicolegal issues that the audience may face in their clinical practices; (3) Evaluate potential strategies to implement to mitigate some of the medicolegal issues identified; and (4) Incorporate some of the above identified strategies into the improving the care of their patients

No.96A
MEDICOLEGAL ISSUES FACED BY PSYCHIATRIC EMERGENCY PHYSICIANS

Avrim B. Fishkind, M.D., 1611 Missouri Street, Houston, TX 77006

SUMMARY:
A Psychiatric Emergency Service (PES)is a high risk environment due to many factors. First is the use of coercive interventions including restraint, seclusion and forced medications. Second, PES physicians make critical decisions as to the necessary level of care for suicidal and homicidal patients. Issues such as duty to warn are inherent in making decisions about patients who are dangerous to themselves or others. Physicians also face questions relating to the appropriateness of involuntarily committing patients, privacy of information, and adequateness of assessment, especially with regards to medical clearance. Each PES physician should be aware of such risks, be able to develop a risk management plan, and learn to work in the least coercive and restrictive fashion.

No.96B
THE LIVED EXPERIENCE OF MEDICO LEGAL ISSUES IN ER'S

Edward L. Knight, Ph.D., 7150 Campus Dr, Suite 300, Colorado Springs, CO 80911

SUMMARY:
Dr. Knight will report his and others experiences with emergency room treatment. He will also report on qualitative research on use of psychiatric services when people are feeling suicidal. This research shows that people avoid such services turning instead to family, peers, friends. One of the reasons is the fear of force which is a problem in emergency room use. He will review consumer qualitative research on what changes consumers would like to see to more fully use psychiatric services when feeling suicidal.

No.96C
LEGAL LIABILITY PITFALLS IN PSYCHIATRIC EMERGENCY CARE AND PRACTICAL SUGGESTIONS TO AVOID THEM

Steven R. Smith, B.A., Ober Kaler, 1401 H. Street, N.W., Suite 500., Washington, D.C. 20005, Steven R. Smith, Esq.

SUMMARY:
The submission will discuss various legal theories of liability that have been applied in the context of providing emergency psychiatric services to patients. These theories will include a general discussion of the negligence standard that applies to all conduct and how that standard has been applied in specific factual situations such as patient suicide, disclosure of threats by patients towards others, restraints (chemical and physical) and other similar matters. The submission will then discuss how risk management principles, and specific factual suggestions, can be used by providers of emergency psychiatric services to reduce the likelihood of their being involved in an action seeking to impose liability on them as a result of their professional services.

NO.96D
PSYCHIATRIC EMERGENCY SERVICES: MEDICO LEGAL ISSUES IN CRISIS CARE

Susan Stefan, J.D., Center for Public Representation, 246 Walnut St., Newton, MA 02460

SUMMARY:
Many emergency department physicians and psychiatrists report that liability concerns sometimes tip the balance toward inpatient admission when they are assessing patients with behavioral problems, especially patients who are suspected to be suicidal. Such dispositions sometimes preclude alternative community based crisis interventions. While such dilemmas are often faced by emergency department physicians and psychiatrists, many psychiatrists in non-emergency settings may find themselves in similar situations at some point in their clinical practice.

REFERENCES:
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SYMPOSIUM 97

ADHD UPDATE: MANAGEMENT OF NEW COMPLEXITIES AND ONGOING CHALLENGES

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to (1) Recognize challenges and improve the differential diagnosis of AHDH and Bipolar Illness as well as Substance Abuse; and(2) Better identify and manage side effects and risks of stimulant medications.

No.97A
MINIMIZING GROWTH EFFECTS OF ADHD MEDICATION IN CLINICAL PRACTICE

Christopher Kratochvil, M.D., 515 S 26th St., Omaha, NE 68105-5584

SUMMARY:
Clinicians who treat children and adolescents with ADHD are often confronted with patients who experience diminished appetite, weight loss, and at times growth suppression. Attempts to address this include a wide variety of techniques, ranging from dose reductions to caloric supplementation. However, there has been limited specific guidance for those in practice on how to optimally address these issues. This presentation will provide an overview of various approaches which have been implemented in clinical practice, along with a review of available data on these practices.

No.97B
NEUROBIOLOGY AND MANAGEMENT OF TIC DISORDERS

Robert D. Hunt, M.D., The Center for Attention and Brain Function, 2129 Belcourt Ave., Nashville, TN 37212

SUMMARY:
Research has helped define subgroups of tics and greater specificity of treatment. Tics can be classified by patterns of severity, frequency, age of onset and relationship to precipitating agent and therapeutic treatments. The neurobiology of tics appears to be under genetic control and linked to specific neurotransmitters in localized brain structures. The emergence of tics has been associated with ADHD and OCD, and may be precipitated or exacerbated by medications. While the majority of tics are relatively non-intrusive, the term Malignant Tourette Syndrome characterizes severe, frequent and disruptive tics occurring in 5% of cases. Tics are frequently most severe around or following puberty, and may be influenced by hormonal and neurotransmitter alterations associated with development. Neurotransmitter mechanisms include modulation through both DA and 5HTA2 activity are implicated in the regulation of tics. Several agents have been found effective in treatment of tics. The alpha-2 agonists are frequently used to decrease overall arousal, hyperactivity and tics in ADHD. Current research found the mechanism of action of these agents to include modulation of CAMP activity. In our clinical experience, patients often become calmer, more resilient, and demonstrate enhanced capacity for both behavioral inhibition and selective attention; the decrease in tics is specific, not secondary to overall sedation. Other agents, including tetrabenazine, and atypical neuroleptics or anticonvulsants such as levetiracetam can diminish tics. Non-pharmacological interventions including relaxation, meditation and hypnosis have also demonstrated some efficacy and can enhance coping strategies. While there is no consensus algorithm for treating tics, a clinical model for intervention will be proposed for testing and validation. The most obvious intervention is to reduce the dose or discontinue a precipitating agent. In some cases, such as treating severe ADHD, the relative severity and disruption of the tic must be weighed against the functional disturbance of the primary disorder. Pharmacologic amelioration of the tics though adjunctive treatment frequently allows continuation of effective treatment.

No.97C
CHILDHOOD ADHD AND RISK FOR ADOLESCENT SUBSTANCE ABUSE

Iliyan Ivanov, M.D., One Gustave L. Levy Place, Dept of Psychiatry Box 1228, New York, NY 10029

SUMMARY:
Longitudinal studies have linked childhood Attention Deficit/ Hyperactivity Disorder (ADHD) to heightened risk for substance abuse disorders (SUD) in mid-late adolescence and early adult-

hood, however, the nature of this relationship is not fully understood. This relationship could be directly mediated by shared neurobiological correlates of ADHD and addiction – possibly involving dopaminergic and/or cholinegic neurotransmission in brain structures comprising reward and attention systems. Alternatively, it could be mediated by the severity and degree of persistence of impulsive symptoms in individuals with ADHD. The latter model is supported by the findings that deficient response inhibition is associated with increased drug self-administration in animals. Similarly, human studies have demonstrated that individuals suffering from addiction exhibit high levels of inhibitory control deficits. The clinically relevant question is: if stimulant treatment of ADHD indeed decreases risk for SUD, is this attributable to pharmacological control of impulsivity symptoms? This presentation will review the relationships among ADHD, adolescent SUD and exposure to stimulants in animals and humans. It will specifically focus on findings suggesting that: i) the purported relationship between ADHD and SUD is mediated via inhibitory control deficits, and ii) that reduction of SUD risk following stimulant treatment is mediated by adequate treatment of inhibitory control deficits. Implications of this model for prevention and treatment of early onset SUD will be discussed using clinical case material to augment the review of published and emerging research findings.

No.97D
DIAGNOSIS AND TREATMENT OF ADHD AND BIPOLAR SPECTRUM DISORDERS IN YOUTH

Jeffrey H. Newcorn, M.D., Mount Sinai School of Medicine, Department of Psychiatry, Box 1230, One Gustave L. Levy Place, New York, NY 10029

SUMMARY:

Children and adolescents with ADHD + bipolar disorder (BPD) are among the most challenging to diagnose and treat. Prevalence estimates vary greatly, with some investigators suggesting that as many as 15% of patients with ADHD have BPD and others stating that the condition is relatively rare. This is not surprising, since ADHD and BPD are each conditions with uncertain boundaries, and different clinical and research groups use different approaches to collecting and/ or interpreting clinical data. Children with ADHD + BPD are generally extremely hyperactive and disruptive, highly irritable, and have clear lability of mood. They do not cycle in the sense that adults with BPD do. And they may or may not have symptoms that are typically thought of as "bipolar," such as euphoria. However, the extent to which such features are present may, in fact, define biologically and clinically distinct subgroups, with implications for directing treatment choice. There is disagreement in the field as to when it is possible to treat ADHD symptoms in children with BPD, which medication(s) is (are) least likely to aggravate mania, when to use anti-psychotic and/ or mood stabilizing agents, and which one(s) to use once the decision has been made. This symposium will present the various points of disagreement regarding diagnosis and treatment of children with ADHD plus bipolar spectrum disorders, offering the practitioner an algorithmic approach to thinking through key issues in the context of expert opinion and emerging professional guidelines.

No.97E
STIMULANT USE AND CARDIOVASCULAR ISSUES

Stephen E. Kimmel, M.D., M.S.C.E., University of Pennsylvania School of Medicine, 423 Guardian Drive, 717 Blockley Hall, Philadelphia, PA 19104

SUMMARY:

This talk will discuss the cardiovascular effects of stimulants, focusing on adults. Stimluant medications can increase heart rate and blood pressure and have been associated with reports of myocardial infarction, stroke, and sudden death. Most data come from case reports which do not provide a sufficient level of scientific evidence to document an association between these drugs and serious cardiovascular events. Recent literature has focused on studies trying to measure if there is an association between stimulant drugs and cardiovascular events. These studies will be reviewed.

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SYMPOSIUM 98

ADVANCES IN DIAGNOSIS AND TREATMENT OF FREQUENTLY ASSOCIATED COMORBID CONDITIONS IN YOUTH WITH

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; (1) demonstrate an increased awareness of risk for co-morbid mental health problems in youth with pervasive developmental disorders (PDD); (2) address the challenges of recognizing symptoms of ADHD, mood disorders, and psychosis in youth with PDD;(3) understand the heterogeneous genetic architecture of PDD and existing susceptibility genes related to comorbid disorders ; and (4) appreciate potential differences in tolerability and response of PDD youth to medications considered for the treatment of comorbid conditions.

No.98A
TREATING ATTENTION-DEFICIT/HYPERACTIVITY DISORDER SYMPTOMS IN PERVASIVE DEVELOPMENTAL DISORDERS

David J. Posey, M.D., Riley Hospital Room 4300, 702 Barnhill Dr., Indianapolis, IN 46202, Craig A. Erickson, M.D., Christopher J. McDougle, M.D.

SUMMARY:
Objective: To review recent clinical drug studies that has focused on the treatment of attention-deficit/hyperactivity disorder (ADHD) symptoms in pervasive developmental disorders (PDD). Methods: Many clinical drug trials have focused on ADHD symptoms in PDD. Results: Methylphenidate is the best studied ADHD treatment in PDD with as many as 50% of children with PDD responding favorably to treatment. Short-term tolerability is problematic with as many as 18% of children with PDD being unable to tolerate it due to irritability or other adverse effects. Clonidine treatment has been helpful in small placebo-controlled trials. In an open-label, prospective trial of guanfacine in children with PDD who did not respond favorably to methylphenidate (n=25), symptom reduction and a response rate of 48% was seen. Atomoxetine was also recently shown to be efficacious in two open-label and one placebo-controlled crossover study. Antipsychotics, including risperidone, may be helpful for the treatment of moderate to severe hyperactivity especially in the presence of significant irritability or lack of response to more traditional medications. In a clinic sample of youth with PDD, memantine had beneficial effects on both inattention and social impairment. Conclusions: ADHD symptoms occurring in PDD can be effectively treated by medications.

No.98B

GENETIC STUDIES OF PERVASIVE DEVELOPMENTAL DISORDERS AND RELATED DISORDERS OF COGNITIVE DEVELOPMENT

Eric M. Morrow, M.D., Massachusetts General Hospital Psychiatry, WACC 812, 15 Parkman Street, Boston, MA 02114, Seung-Yun Yoo, Ph. D., Russell J. Ferland, Ph.D., Robert Sean Hill, Ph.D., Adria Bodell, M.S., C.G.C., Kira A. Apse, M.S., Samira Al-Saad, Ph.D., Asif Hashmi, M.D., Soher Balkhy, M.D., Generoso Gascon, M.D., Sabri Herguner, M.D., Nahit Motavalli Mukaddes, M.D., Christopher A. Walsh, M.D., Ph.D.

SUMMARY:
Objectives: To identify autosomal recessive genes for familial PDD by conducting homozygosity mapping approaches in large, multiplex families who share common ancestors (i.e., have cousin-marriages). Previous studies have shown that homozygosity mapping in pedigrees with cousin-marriages is a viable approach to identify autosomal recessive genes that cause neurodevelopment disease. Methods: Families with cousin-marriages and children affected by autistic disorder, with or without mental retardation, were ascertained through an international collaborative in multiple international centers. Affymetrix 500K SNP microarrays were used for both a copy number analysis and homozygosity mapping. Results: Seventy-five pedigrees have been analyzed to date. Similar to other studies, de novo deletions were discovered, thereby implicating loci. However, homozygosity mapping identified additional loci either by virtue of implicating a region with strong support for linkage (LOD 2.1 to 2.8) or by revealing a homozygous deletion within a region of identity by descent segregating with disease. Regions with support for linkage overlapped some known autism linkage peaks such as 7q, 6q or 3q, however, several regions are novel. The region on 6q overlaps a known region from meta-analyses in bipolar disorder. Conclusion: The identification of diverse loci supports the notion of profound heterogeneity of genetic mechanisms in PDD. Overlapping genomic intervals between PDD, ADHD, and bipolar disorder support some common genetic susceptibilities but further progress is necessary to establish this.

No.98C

COMORBIDITY IN ASPERGER'S DISORDER AND HIGH FUNCTIONING AUTISM

Fred R. Volkmar, M.D., PO Box 207900, New Haven, CT 06520

SUMMARY:
Objective: To review available literature on the issue of co-morbidity of Asperger's disorder and high functioning autism (HFA) with other psychiatric conditions. Methods: Available literature on this topic was reviewed. Much of the literature is limited to case reports or cases series. Lack of standard assessments and differences in approach also limit available data. Results: The available data do strongly support a strong and significant connection between these problems and affective disorders (particularly depression) and anxiety disorders. The data supporting other increases in co-morbidity (notably in Tourette's syndrome, OCD, and psychosis) is much more limited. Most of the literature suggesting an increased risk for conduct problems or violence is limited. Conclusion: Available evidence strongly suggests a connection between higher functioning social disability and both depression and anxiety disorder.

No.98D

RESPONSE TO SECOND GENERATION NEUROLEPTICS IN YOUTH WITH COMORBID PERVASIVE DEVELOPMENTAL DISORDERS AND BIPOLAR DISORDER

Gagan Joshi, M.D., 10-F Locust Lane, Watertown, MA 02472, Joseph Biederman, M.D., Robert Doyle, M.D., Nora Sullivan, B.A., Paul Hammerness, M.D., Eric Morrow, M.D., Janet Wozniak, M.D., and Eric Mick, Sc.D.

SUMMARY:
Objective: Compare symptom characteristics and treatment response to second generation neuroleptics (SGN) in youth with bipolar disorder (BD) based on presence and absence of comorbidity with pervasive developmental disorders (PDD).

Methods: Secondary analysis of identically designed and concurrently conducted 8-week open-label flexible dosing trials of SGN monotherapy (risperidone, olanzapine, quetiapine, ziprasidone, or aripiprazole) for the treatment of BD in youth. Severity of mania assessed with the Young Mania Rating Scale (YMRS). Severity of PDD assessed by developing a "proxy-rating scales" for PDD from items in YMRS and Brief Psychiatric Rating Scale (BPRS) that distinguished in severity BD youth with from without PDD comorbidity.

Results: Of the 151 BD subjects (65% male and mean age 9.1±3.0 years) enrolled in SGN trials 15% (n=23) met criteria for comorbid PDD (BD+PDD) on structured diagnostic interview. At baseline compared to BD subjects without PDD comorbidity (BD-PDD) BD+PDD subjects were significantly more impaired on YMRS (35.4±7 vs. 28.4±8; $p<0.001$), BPRS (48.6±12 vs. 42.5±13; $p=0.04$), and global assessment of functioning (48.5±5

vs. 51.2±6; p=0.01). No differences reported between BD+PDD and BD-PDD subjects on the rate of response (=30% reduction on YMRS or CGI-Improvement =2: 65% vs. 69%; p=0.7), drop out (43% vs. 26%; p=0.08), or side-effects. In BD+PDD subjects compared to other SGNs risperidone is associated with significantly higher anti-manic response (effect size of 1.0 vs. 0.2) and improvement in PDD prototypical symptoms.

Conclusion: PDD comorbidity is relatively common in clinically referred youth with BD. Presence of PDD is associated with increased severity of mania and of certain symptoms prototypical of PDD. Rates of anti-manic response and adverse-effects to SGNs are unaffected by the presence of PDD comorbidity with BD. In PDD youth with BD, compared to other SGNs risperidone has preferentially superior anti-manic response and superior response for particularly those symptoms that are prototypical of PDD.

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PRESIDENTIAL AACAP INSTITUTE PRACTICALPEDIATRIC PSYCHOPHARMACOLOGY

Chair: Christopher J. Kratochvil, M.D., 985581 Nebraska Medical Center, Omaha, NE 68198-5581; A. Robb, M.D.; L. Greenhill, M.D.; J. Prince, M.D.; J. Walkup, M.D.

EDUCATIONAL OBJECTIVE:

Overall Symposium Objective: The primary objective of this institute is to provide practical information to clinicians on the use of psychotropic medications in the treatment of children and adolescents in their practices. Methods: The presentations will include discussions of clinically relevant aspects of pediatric psychopharmacology for the treatment of ADHD, depression, and anxiety disorders. Additionally, management of medications for bipolar disorder, schizophrenia, pervasive developmental disorders, and aggression will be addressed. Recent literature will be reviewed, and discussions will focus on medication selection, initiation, titration, and management. Following the more formal didactics, brief vignettes will allow for the application of information from earlier presentations, and audience involvement in practical clinical discussions. Conclusion: Awareness of recent research and the application of practical clinical information pertaining to pediatric psychopharmacology can inform and positively impact patient care.

A. EVIDENCE-BASED PHARMACOTHERAPY FOR ADHD

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

SUMMARY:

Objective: This presentation will provide attendees the opportunity to expand their knowledge base regarding ADHD pharmacotherapies, with a focus on positively impacting management of medications for the treatment of children and adolescents with ADHD. Methods: An overview of current research will provide an update on evidence-based pharmacotherapies for ADHD. Currently available medications will be discussed, followed by recent developments and clinical studies that may impact ADHD treatment in the near future. This information will be presented in the context of what would be useful for the clinician in practice to know, and how it might relate to the treatment of pediatric ADHD in their own patients. Recent regulatory activities will also be reviewed, as will potential implications for clinical practice. Conclusion: ADHD is a common neuropsychiatric disorder, and one primary care clinicians are often called upon to manage pharmacologically. Recent and ongoing research can help to inform practice, but must be done so in the context of the current regulatory environment.

B. MANAGEMENT OF PEDIATRIC DEPRESSION

Jefferson B. Prince, M.D., Massachusetts General Hospital, Yawkey Center 6A, 55 Fruit Street, Boston, MA 02114

SUMMARY:

Objective: This session will provide attendees the opportunity

to become more familiar with the identification and management of pediatric depression. Methods: Data on the epidemiology and impact of depression on children and adolescents will be reviewed, stressing the importance of early identification and intervention. An overview of assessment, evaluation, and diagnosis of pediatric depression, including comorbid disorders, will provide clinical tips and guidance useful for everyday practice in the primary care setting. After discussing assessments, a variety of interventions will be addressed. The potential role of pharmacological as well as non-pharmacological treatments will be presented, with a special emphasis on the risks and benefits of antidepressant medications. This will include important information to be shared with patients and their families on the efficacy and safety of antidepressants. Conclusion: The ability to identify and manage treatment for pediatric depression is important for clinicians who treat children. It is a common disorder, with significant morbidity and mortality, but also one that responds to available interventions.

C. THINGS A CLINICIAN NEEDS TO KNOW ABOUT BIPOLAR, SCHIZOPHRENIA, AUTISM AND AGGRESSION IN CHILDREN & ADOLESCENTS

Adelaide Sherwood Robb, M.D. Children's National Medical Center, 111 Michigan Avenue, N.W., Washington, D.C. 20010-2970

SUMMARY:
Objective: The objective of this institute presentation is to teach primary care clinicians the key elements about the diagnosis, treatment and short and long term clinical management of children with bipolar disorder (BD), schizophrenia (SZ), autism (AUT) and aggressive behavior (AGG). As more children with these disorders are being treated in the community, it is important for clinicians to recognize these disorders and be able to manage them with psychotropic medications.
Methods: For each disorder, we describe the *DSM-IV-*TR diagnostic criteria, common presenting symptoms, pharmacologic treatments including mood stabilizers and second generation antipsychotics, strategies for initiating treatment, monitoring regimens, and recommendations for length of treatment, and discontinuation strategies. The talk covers important side effects, studies in children supporting the use of these medications for BD, SZ, AUT and AGG, and FDA concerns. Conclusion: This talk teaches clinicians the basics about diagnosis, treatment and management of BD, SZ, AUT, and AGG in their pediatric outpatients.

D. PEDIATRIC ANXIETY DISORDERS

John T. Walkup, M.D., Johns Hopkins Hospital, CMSC 314, 600 N. Wolfe St., Baltimore, MD 21287

SUMMARY:
Objective: To provide attendees with the skill set necessary to complete a basic assessment of childhood anxiety, and an understanding of available treatment options. Methods: The session will begin with an overview of the basic elements of an assessment for an anxiety disorder in a pediatric patient. Treatment options will then be reviewed, providing a discussion of pharmacological treatments as well as cognitive behavioral therapy. Relevant recent studies and literature will be presented, providing a rationale for use of these treatments, as well as a foundation for treatment selection. The strengths and weaknesses of the treatment interventions will be discussed, along with suggestions for how to decide upon the most appropriate treatment modality for an individual patient. Conclusion: Anxiety disorders are common in children and adolescents, but are also commonly overlooked. Data clearly demonstrates that treatment can significantly lower distress and improve functioning.

E. PEDIATRIC PSYCHOPHARMACOLOGY CASE PRESENTATIONS: PRACTICAL APPLICATIONS

Christopher Jon Kratochvil, M.D., University of Nebraska Medical Center, 985581 Nebraska Medical Center, Omaha, NE 68198-5581

Objective: This session will allow the attendee to apply information from the didactic presentations as well as clinical experience to a series of patient vignettes, providing an opportunity for a practical application of the data presented earlier in the institute. Method: Vignettes will be presented by the faculty, followed by an interactive format with discussion of patient management by faculty and attendees. Cases will focus on typical patient presentations, simple as well as complex. The use of concomitant medications, comorbidities, side effect management, and issues pertaining to the extended use of psychotropic medications will be addressed. Time will also be allotted for attendees to discuss challenges to using pediatric psychopharmacology in their own practices. Conclusion: The practical application of the data will demonstrate how the information presented on pediatric psychopharmacology can impact the attendee's clinical practice.

SYMPOSIA

INTERNATIONAL SYMPOSIUM

THE EMERGENCE OF SUBTHRESHOLD PSYCHIATRY

Chair: Ahmed Okasha, Ph.D.
Co-Chair: Hagop S. Akiskal, M.D.

EDUCATIONAL OBJECTIVES

At the purpose of this session, is to discuss (1) The feasibility of the emergence of a new category of subthreshold psychiatry; (2) The burden of subthreshold psychiatric symptoms (3) Is there a place in the future psychiatric classifications for the inclusion of subthreshold disorders in a more specific way and not "NOS"; (4) Examples of subthreshold disorders e.g. in Unipolar and Bipolar disorders, Schizotypal disorder and Schizophrenia, PTSD, etc…; (4) The ethics of management in the absence of longitudinal studies of outcome and evidence-based therapy should be evaluated.

A. PERSONALITY TRAITS VERSUS PERSONALITY DISORDERS

Juan J. Lopez-Ibor, M.D., Institute of Psychiatry & Mental Health, Hospital Clinico San Carlos, Complutense University of Madrid, Avda, Madrid 28035 Spain

SUMMARY:

Axis II of *DSM* was introduced in order not to forget in the diagnostic process the personality of patients. This is very important in classification systems based on the symptoms of diseases because although useful for communication and scientific interchange they are reductionistic as they do not consider the origin of these symptoms. The problem with Axis II of *DSM* is that it considers only personality disorders and clinicians should also take into account personality characteristics which are not morbid. It is therefore necessary to use two diagnostic approaches: one for psychiatric disorders including personality disorders and another one based on personality traits to describe personality of patients in the same way as normal personalities are described. This approach is embedded in ICD-10 multiaxial version but this has unfortunately not been used very much. The suggestion is made that future systems should consider these two perspectives. This leaves open the relationship between normal and abnormal personalities and from present research in this field one can anticipate that future research will be highly interesting.

B. CLINICAL STAGING OF THE SCHIZOPHRENIA PRODROME TO IMPROVE DIAGNOSTIC ACCURACY AND INFORM TREATMENT

Kristin S. Cadenhead, M.D., Department of Psychiatry 0810, University of California San Diego, 9500 Gilman Drive, La Jolla, CA 92093-0810

SUMMARY

Early identification of the prodromal phase of a psychotic illness can lead to earlier treatment and perhaps prevention of the devastating effects of a first psychotic episode. International research efforts have demonstrated the success of community outreach and education regarding the schizophrenia prodrome and it is now possible to use clinical and demographic criteria to identify individuals at a substantially increased risk for a psychotic illness. Up to 35% of 12-30 year old individuals with a family history of psychosis plus a recent deterioration in functioning and/or new subsyndromal psychotic symptoms become psychotic within 2-3 years, suggesting that these criteria have important diagnostic implications. Preliminary psychosocial and pharmacologic treatment studies report initial success in reducing the rate of psychotic conversion and the severity of symptoms in "at risk" samples but further work is needed to both refine the prodromal criteria and replicate the treatment studies in adequately powered samples. The use of biological markers for psychosis such as imaging, electrophysiology and genetic techniques show promise in understanding the neuropathological mechanism by which psychosis develops (thus informing preclinical studies of neuroprotective factors)and providing additional tools to identify psychosis early. The development of clinical staging criteria for psychosis that incorporates severity of clinical symptoms, functional status, family history, substance abuse, neurocognitive performance, could help to specify appropriate treatment for vulnerable individuals. Treatment algorithms can then be tailored to presenting symptoms, number of risk factors present, and evidence of progression of the illness, as assessed by biological and neurocognitive measures, to assure appropriate, safe and effective interventions in the early stages of psychosis.

C. THE BURDEN OF SUB-THRESHOLD DISORDERS

Norman Sartorius, M.D., 14 Chemin Colladon, Geneva, 1209, Switzerland.

SUMMARY:

The currently most widely used systems of diagnosis aver that persons who show some but not all the symptoms selected for the definition of mental disorders do not have the disorder: yet they come forward seeking help from health services because they are distressed and often fail to perform in their personal and social roles. Since they do not have a mental disorder as defined in the prevailing systems of classification they do not benefit from their health insurance and are not supposed to be receiving treatment offered to people who have well defined mental disorders. Their distress and disability reduces their quality of life and their capacity to fully contribute to the lives of their family and community: their condition thus creates a burden to society.

The estimation of the total size of the social burden produced by disorders that do not reach the thresholds defined in the classification systems is difficult to estimate. The main reason for this difficulty is the often forgotten need to distinguish between definitions used in comprehensive systems of classification of disorders useful for public health purposes and research and the systems of defining the need for care used in clinical practice. The presentation will address the differences between these two systems of classification and the possible ways of reducing the difficulties that arise because of these differences.

D.THE EMERGENCE OF SUBTHRESHOLD PSYCHIATRY

Ahmed Okasha, Ph.D., 3, Shawarby Street, Kasr El Nil, Cairo 11411, Egypt

SUMMARY:

Many studies have shown that we are faced in our daily clinical practice with many patients, who do not fulfill the criteria of either ICD10 or *DSMIV.* They may be included under atypical , unspecified or not elsewhere classified. Subthreshold cases or prodromata of psychotic or non psychotic clinical cases are encountered frequently in clinical practice , and because of some ethical and nosological issues their needs are unmet. Pharmacological intervention in such conditions are denied in some countries especially with Managed care , where maximization of profit and minimization of cost is the main objective. It has been reported that early treatment of many clinical diagnosis ensures a better outcome and better assimilation in society and reduce residual manifestations. This presentation will discuss and clarify the ethics of treating patients suffering from prodromata or subthreshold diagnosis in psychiatric disorders. Recent data suggest that the impairment and disability caused by subsyndromal disorders are almost equal to the syndromal ones. Our current classifications have no room for such disorders in spite of the suffering of those patients. This creates an ethical dilemma to clinicians who would like to help but restricted by the fact that there are no guidelines for the treatment course or outcome of these disorders. The objective of this presentation is to discuss the ethics of managing subsyndromal disorders inspite of lack of evidence based informations about such a category. We need more scientific data and research studies to evaluate the value of treating such disorders. Are we in need in our diagnostic systems to include a new category of subthreshold psychiatry?

REFERENCES

1. Pincus H, et al Subthreshold Mental Disorders: Nosological and Research Recommendations in Advancing DSM Dilemmas in Psychiatric Diagnosis. Ed. by Phillips K., First M., Pincus H., 2003 Pub. by American Psychiatric Association Washington D.C.

E. AFFECTIVE TEMPERAMENTS AS PRECURSORS OF MOOD DISORDERS

Hagop S. Akiskal, M.D., VA Psychiatry Services (116-A)
3350 La Jolla Village Dr., San Diego, CA 92161

SUMMARY:

Although dysthymia and cyclothymia have been introduced into the *DSM* and ICD diagnostic schemas as "subthreshold" mood disorders, their boundaries with normal temperaments and under what circumstances they merit therapeutic interventions, including pharmacotherapy, remain unclear. These are extremely important questions for public health because affective disorders more often than not arise from antecedent temperaments. A new instrument, the Temperament Evaluation of Memphis, Pisa, Paris and San Diego Autoquestionnaire (TEMPS-A), has been validated (10 languages), generating sufficient research to help in formulating data-based answers to the foregoing questions. The temperament about which a great deal of relevant data exists is the cyclothymic, which is in some ways paradigmatic of the dilemmas faced by the clinician-scientist because many artistically talented individuals seem to benefit from this temperament, yet affectively ill individuals with this temperament appear at some risk for suicide. This temperament also predisposes to bipolar II, mixed states, rapid cycling, alcohol and substance abuse, is often "comorbid" with multiple anxiety disorders, and may be a precursor of bulimia and HIV infection. New, provocative data suggest that this temperament can serve as a behavioral endophenotype for bipolar disorder. Indeed, suggestive linkage to chromosome 18p11 locus has been reported by our group.

WORKSHOPS

MONDAY, MAY 5, 2008

MEDIA WORKSHOP 01

WHITE LIGHT, BLACK RAIN: THE DESTRUCTION OF HIROSHIMA AND NAGASAKI

Chairperson: David Rothstein, M.D., 2851 West Bryn Mawr, Chicago, IL 60659

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) recognize the physical and emotional effects of nuclear weapons on survivors; (2) know the views of some who were involved in dropping the bombs; (3) understand the medical and psychological needs of survivors, and how they can be met; (4) appreciate how the existence of nuclear weapons affects us all currently; (5) be more able to deal with present nuclear threats.

SUMMARY:

Through the powerful recollections of atomic bomb survivors, this HBO film by an Academy Award-winning filmmaker, presents a deeply moving look at the painful legacy of the first - and hopefully last - uses of nuclear weapons in war. Featuring interviews with 14 atomic bomb survivors - many who have never spoken publicly before - and four Americans intimately involved in the bombings, it provides a detailed exploration of the bombings and their aftermath. A succession of personal accounts reveals both unimaginable suffering and extraordinary human resilience. It portrays the physical injuries and the emotional and psychological effects on the survivors, and on the entire societies involved. It shows both the positive and negative aspects of the efforts to meet the survivors' medical/surgical and psychological needs. The film also shows a disturbing lack of knowledge in the current generation. The film is especially relevant in view of current concerns about nuclear proliferation, "loose nukes," and potential terrorist access to nuclear weapons. Dr. Rothstein has been the co-chair of the APA Committee on Psychological Aspects of Nuclear Issues, was a national board member of Physicians for Social Responsibility (American affiliate of International Physicians for the Prevention of Nuclear War, which received the Nobel Peace Prize) and was president of the Chicago chapter of PSR. He was a consultant to the Warren Commission and National Commission on the Causes and Prevention of Violence, and has published papers on psychiatric aspects of violence. Dr. Benedict is the executive director of the Bulletin of the Atomic Scientists, established by Manhattan Project scientists in 1945 to inform the public about the dangers of nuclear weapons. Previously, she was director of the International Peace and Security Area at the John D. and Catherine T. MacArthur Foundation, and established and directed the foundation's initiative in the former Soviet Union.

REFERENCES:

1. Rothstein DA: Ethnic Conflict in the Post-Cold-War Era. Journal for Psychoanalysis of Culture and Society 3:131-144, Fall, 1998;
2. Rothstein DA: Psychological Effects of the Nuclear Age. Presented at NEIS "Know Nukes" session: The Effects of the Nuclear Age on Society, Commemorating the 60th Anniversaries of the Atomic Bombings of Hiroshima and Nagasaki. Chicago, Thursday, August 11, 2005.
3. Lifton RJ: Death in Life: Survivors of Hiroshima. University of North Carolina Press, 1991.

MEDIA WORKSHOP 02

TSOTSI: TOWARD AN UNDERSTANDING OF THE ROOTS OF VIOLENCE, ITS MAINTENANCE, AND ITS TRANSFORMATION

Chairperson: Roslyn Seligman, M.D., 231 Albert Sabin Way, Cincinnati, OH 45267-0559

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: Understand the roots of rage and violence, the maintenance of rage and violence, diagnose the personality/character issues, and know the necessary therapeutic ingredients for a healthy transformation of the character and the violent ways.

SUMMARY:

Tsotsi (meaning thug) won the 2006 Best Foreign Film Academy Award. The filming takes place in Johannesburg, South Africa, and the neighboring shantytown Soweto. The plot could occur in any city worldwide dealing with similar issues. All actors are African-American except for one white official. It portrays six days in the life of one male about 20 years of age. Early parts of the film are violent. The remainder of the film offers an opportunity to understand better rage/violence, its maintenance, and what may be needed for a healthy transformation. The film is a psychological thriller that has been described as a character study. It is rich psychologically. One could transpose aspects of the director Gavin Hood's genius to an empathic and difficult psychotherapeutic process. The discussion will focus on the roots of Tsotsi's character and rage and on his psychological transformation and violent ways.

REFERENCES:

1. Ornstein PH, Ornstein A: Assertiveness, Anger, Rage, and Destructive Aggression: A Perspective From the Treatment Process. In Rage, Power, and Aggression, edited by Glick RA, Roose SP, New Haven and London, Yale University Press, 1993, pp 102-117.
2. Dargis M: Tsotsi (2005). Movie Review. New York Times, 2006.
3. http://movies.nytimes. com/2006/02/24/movies/24tsot.html.

TUESDAY, MAY 6, 2008

MEDIA WORKSHOP 03

GHOSTS OF ABU GHRAIB

Chairperson: David Rothstein, M.D., 2851 West Bryn Mawr, Chicago, IL 60659

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand: (1) "atrocity producing situation" development; (2) deleterious effects of torture and abuse on perpetrators and victims; (3) challenges and obligations facing military physicians regarding treatment of detainees and reporting signs of abuse or torture; (4) how organizations and ethical principles can help military physicians/psychiatrists fulfill their obligations; 5) how

such issues can be communicated by film.

SUMMARY:

This Emmy Award-winning HBO film explores, through pictures and interviews, the torture at Iraq's Abu Ghraib prison. It looks beyond the headlines to investigate the psychological and political context in which torture occurred, including effects on perpetrators as well as on victims. The workshop will discuss questions raised: How did torture become an accepted practice at Abu Ghraib? How did it relate to interrogation practices? Did U.S. government policies create what Lifton has called an atrocity-producing situation? What challenges face military physicians regarding the treatment of detainees and reporting signs of abuse or torture? How can professional organizations help them deal with these challenges (e.g., by means of the APA and AMA position statements concerning participation in interrogation)? How much damage has the aftermath of Abu Ghraib had on America's credibility as a defender of freedom and human rights around the world? This film is for mature audiences only. The images and some of the interviews are extremely intense. The film contains numerous photos with male nudity. Dr. Rothstein was a consultant to the Warren Commission and National Commission on the Causes and Prevention of Violence, and has published and delivered papers on psychiatric aspects of violence, and ethical responsibilities regarding torture and abuse. Dr. Xenakis, Brigadier General, U.S. Army (retired), is former commander of the U.S. Army's Southeast Medical Command, commanded a military hospital at Ft. Campbell, and has written concerning actions and inactions of medical personnel at Abu Ghraib and Guantanamo. Dr. Post, Professor of Psychiatry, Political Psychology and International Affairs, directs the political psychology program at the George Washington University, founded and directed the Center for the Analysis of Personality and Political Behavior at the CIA, and has published extensively concerning political psychology.

REFERENCES:

1. Basoglu M, Livanou M, Crnobaric C: Torture vs other cruel, inhuman, and degrading treatment: Is the distinction real or apparent? Arch Gen Psychiatry, 2007; 64:277-285;
2. Rothstein DA: Terrorism and Medical Ethics: Conflicting Loyalties for American Psychiatrists. American Psychiatric Association 159th Annual Meeting, May 20-25, 2006, Toronto, Ontario, Canada, May 22, 2006.
3. Allen S, Xenakis S: Our Duty to War Detainees. Boston Globe, January 22, 2007; Post JM, Panis LK. Crimes of Obedience. Democracy and Security 2005, Vol. 1: 33-40;

MEDIA WORKSHOP 04

ADDICTION AND SEX: "SPUN" OUT OF CONTROL

APA Corresponding Committee on Treatment Services for Patients With Addictive Disorders

Chairperson: Petros Levounis, M.D., 357 West 29th Street, #3A, New York, NY 10001; Petros Levounis, M.D., Jose Vito, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) list three psychological and three medical effects of crystal methamphetamine; (2) discuss the complex interconnection of stimulant dependence and sexual addiction, and (3) identify one promising pharmacological treatment and one psychosocial intervention for crystal methamphetamine dependence.

SUMMARY:

SPUN (2002) is a film about a group of young crystal methamphetamine users struggling to get their next "fix" and eventually manufacturing the methamphetamine that everyone is desperate for. The characters live out extreme sexual, paranoid, and exploitive situations as they make their descent into the psychotic world of speed addiction. Are the drugs primarily responsible for the psychological fallout and the concomitant behaviors that we encounter, or does the causal flow run primarily in the opposite direction? In 2004, the National Institute on Drug Abuse awarded SPUN a Prism Commendation, which "recognizes accurate depictions of drug, alcohol and tobacco use, and addiction in television, feature film, music, and comic book entertainment." In this media presentation, we will explore the complexities of drug addiction (primarily stimulant addiction) from the interpersonal, cultural, and political perspectives. The conundrums of polysubstance dependence and dual diagnosis; the self-medication hypothesis; the unique biological properties of crystal methamphetamine; and the catastrophic triangle of: (1) psychostimulant use; (2) unsafe sex; and (3) HIV transmission among young adults will form the basis of our discussion. We will also review novel psychopharmacological and psychosocial approaches to the treatment of crystal methamphetamine addiction and sexual addiction, including current research findings. The workshop is open to all psychiatrists who would like to explore the interplay of addiction and sex from a psychiatric perspective, but is particularly targeted toward members in training and early career psychiatrists.

REFERENCES:

1. Levounis P, Ruggiero JS: Outpatient management of crystal methamphetamine dependence among gay and bisexual men: how can it be done? Primary Psychiatry 2006; 13(2):75-80.
2. Lee SJ: Overcoming Crystal Meth Addiction: An Essential Guide to Getting Clean. New York, Marlowe, 2006.

WEDNESDAY, MAY 7, 2008

MEDIA WORKSHOP 05

MICHAEL MOORE'S SICKO

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this film and the discussion that follows, the participants will be able to more fully appreciate the challenge of health system reform in the United States and the various proposals, including single payer, and other methods designed to achieve universal coverage.

SUMMARY:

Michael Moore is the nation's premier documentarian whose controversial and thought-provoking films have stimulated

public debate on a variety of highly-charged subjects, including unemployment, gun control, the War on Terror, and most recently, health care in the United States. In his stimulating, controversial film Sicko, Mr. Moore takes on the deficiencies and defects in the U.S. health care system, interviewing affected individuals and families as well as insurance executives, providing "witness" to the broken system of health care in the U.S. He goes abroad to contrast the U.S. non-system with other systems, including Cuba. This film is a wonderful launching pad to debate the wisdom of the American medical marketplace, as it exists today: high cost, questionable quality, poor access. Dr. Steven Sharfstein, former APA President, will lead a discussion after this film.

REFERENCES:

1. Barlett DL, Steele JB: Critical Condition. New York, Doubleday, 2004.
2. Cohn J: Sick: The Untold Story of America's Health Care Crisis-and the People Who Pay the Price. New York, Harper Collins, 2007

MEDIA WORKSHOP 06

RED WITHOUT BLUE: A FILM ABOUT GAY AND TRANSGENDER IDENTICAL TWINS

American Academy of Child and Adolescent Psychiatry

Chairperson: Richard R. Pleak, M.D., Long Island Jewish Medical CenterZucker Hillside Hospital, ACP, Glen Oaks, NY 11004; Richard R. Pleak, M.D., Edgardo J. Menvielle, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize family and individual issues in the development of gay and transgender identities.

SUMMARY:

Red Without Blue is a multiple award-winning documentary portraying sexuality, gender, identity, and the unswerving bond of twinship despite transformation. A true portrayal of a family in turmoil, Red Without Blue follows a pair of identical twins as one transitions from male to female. Captured over a period of three years, the film documents the twins and their parents, examining their struggle to redefine their family. The twins' early lives were quintessentially all-American: picture-perfect holidays, supportive parents who cheered them on every step of the way. By the time they were 14, their parents had divorced, they had come out as gay, and a joint suicide attempt precipitated a forced separation of Mark and Alex for two and a half years. Through candid and extensive interviews with the twins and their family, Red Without Blue recounts these troubled times, interweaving the twins' difficult past with their efforts to find themselves in the present. The film follows the painful steps of Clair's transition, including electrolysis and the difficult decision to proceed with surgery. Through its portrayal of these articulate and independent twins, each haunted by the painful experiences of their adolescence, the film questions normative standards of gender and identity, as Mark and Clair reassert their indescribable bond as identical twins. Red Without Blue, whose title refers to the colors the twins wore as children to distinguish between the two, provides a heartbreaking, but ultimately optimistic look at the tribulations of growing up gay and transgender in rural America and maintaining strong family bonds in the face of adversity. Following the screening of the film, there will be ample time for discussion with the audience, led by two child psychiatrists with expertise in gay and gender issues.

REFERENCES:

1. Pleak RR: Ethical issues in the treatment of gender atypical children and adolescents. In Sissies and Tomboys, Gender Nonconformity & Homosexual Childhood, edited by Rottnek M, New York, New York University Press, 1999; pp 34-51.
2. Menvielle E, Tuerk C: A support group for parents of gender non-conforming boys. Journal of the American Academy of Child & Adolescent Psychiatry 2002; 41(8):1010-1013.

MEDIA WORKSHOP 07

SHAME AND SILENCE: UNDERSTANDING THE STIGMA OF MENTAL ILLNESS IN ASIAN AMERICANS

Chairperson: Francis G. Lu, M.D., Department of Psychiatry, 7M8, San Francisco General Hospital, 1001 Potrero Ave., San Francisco, CA 94110; Francis G. Lu, M.D., Elizabeth J. Kramer, S.M.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize how Asian-American patients and in their families present their stigma of mental illness and how skilled therapists manage stigma, incorporating patients' explanatory models and treatment pathways.

SUMMARY:

This media workshop will show a 2007 DVD entitled, "Shame and Silence: Understanding the Stigma of Mental Illness in Asian Americans," followed by discussion using the *DSM-IV TR* Outline for Cultural Formulation. The DVD consists of five simulated interviews between clinicians and actors who play the roles of simulated patients The cases include: (1) a South Asian-American woman with bipolar disorder; (2) a Vietnamese-American man with somatic presentation of depression and PTSD; (3) a Chinese-American man with the culture-bound syndrome of neurasthenia; (4) the parents of a Philipino-American child with ADHD; and (5) a Korean-American woman with major depression and substance abuse. The clinicians are three psychiatrists, a psychiatric social worker, and a psychologist. The interviews show how the stigma of mental illness manifests in Asian-American ethnic subgroups in the individual, family, and community. The interviews demonstrate how clinicians can empathize with patients' and their families' perspectives: (1) the idioms of distress that patients and families use to describe their distress; (2) the impact of symptoms on the patients' lives; (3) the explanatory models and treatment pathways that patients and families may use that may be different from those known to the clinician; and (4) the profound stigma and shame of mental illness. Finally, the interviews show how the clinician can work in partnership with patient, family, and traditional providers to negotiate and implement a treatment plan that is acceptable to the patient. An introduction precedes and a commentary follows each interview. The DVD was co-directed by Elizabeth Kramer, ScM., and Francis Lu, M.D., and sponsored by the New York Coalition for Asian- American Mental Health.

REFERENCES:
1. Department of Health and Human Services, U.S. Public Health Services: Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General, 2001, http://www.surgeongeneral.gov/library/mentalhealth/cre.
2. Lim RF: Clinical Manual of Cultural Psychiatry. Washington, DC, American Psychiatric Press, Inc., 2006.

MONDAY, MAY 5, 2008

COMPONENT WORKSHOP 01

THE BIGGER PICTURE: PSYCHIATRISTS AS PHYSICIAN ADVOCATES

APA Committee of Residents and Fellows

Rachel A. Davis, M.D., 4455 E. 12th Avenue, Denver, CO 80220; Jeremy Lazarus, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) become aware of current medical issues and the impact on psychiatry as well as the impact on the field of medicine in general; and (2) gain an understanding of how to become involved in the APA and AMA, and how to use this involvement to improve the political climate for healthy wins for our patients and profession.

SUMMARY:

In order to provide quality psychiatric care, psychiatrists must carry current community competencies in coping with the challenges facing the bigger field of medicine. One cannot remain effectively up-to-date if only aware of topics directly related to psychiatry. Dr. Jeremy Lazarus, Past Speaker of the American Psychiatric Association (APA) Assembly and now Speaker of the American Medical Association (AMA) House of Delegates, will articulate the threats impacting not only physicians who specialize in psychiatry, but all physicians. They include covering the uninsured, Medicare/Medicaid changes, quality of care, pay for performance, patient safety, risk management, and public health issues. Dr. Lazarus will also articulate how political advocacy via the APA and the AMA provide opportunities to mitigate and overcome those threats.

REFERENCES:

1. Gruen RL, Campbell EG, Blumenthal D: Public roles of US physicians: Community participation, political involvement, and collective advocacy. JAMA 2006; 296:2467-2475.
2. Lazarus J: Entering Private Practice: A Handbook for Psychiatrists. APPI 2006

COMPONENT WORKSHOP 02

EARLY CHILDHOOD FEEDING DISORDERS: CROSS-CULTURAL LESSONS IN US AND CHINA COLLABORATION

APA Corresponding Committee on Infancy and Early Childhood

Chairperson: Jean M. Thomas, M.D., Children's National Medical Center, Department of Psychiatry, 111 Michigan Avenue, NW., Washington, DC 20010; Jean M Thomas, M.D., Irene Chatoor, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to become familiar with cross-cultural treatment challenges across childhood disorders. In addition, they should be able to better understand and treat early feeding disorders. They should also better understand specific Chinese cultural challenges and how they guide understanding and treatment of challenges across other cultures.

SUMMARY:

Purpose: To share lessons from an ongoing U.S,-China early feeding disorders collaboration that informs cross-cultural understanding and treatment. Content: U.S.-China collaboration on early feeding disorders is informing cross-cultural understanding and treatment pertinent across other cultures within and beyond the U.S. Dr. Zhu, a young Chinese child psychiatrist studied with U.S. colleagues. She quickly became interested in Irene Chatoor, M.D.'s interdisciplinary feeding team. Before she returned home, her mentor agreed to help develop a similar feeding team in Shanghai. In adapting Dr. Chatoor's treatment guidelines for Shanghai families, Dr. Zhu's first concern was that Chinese families would quickly reject "time-out" management for inappropriate behaviors during feeding. In China, cultural expectations of early feeding follow traditional teachings of "duty" and "honor." The child has a duty to accept family spoon-feeding over his first seven years. In general, the child's fulfillment of his duties brings honor to the family. Drs. Zhu, Chatoor, and Thomas brainstormed culturally appropriate intervention strategies for early food refusal in China, based on Chess and Thomas's "Goodness of Fit" model that concludes that behavioral problems are not caused by mothers or by the child's temperament, but by difficulties in the "goodness of fit" between the parents' expectations of the child and the child's temperament. Methods: Dr. Chatoor will describe her feeding intervention research. Dr. Thomas will provide an overview of the ongoing U.S.-China collaboration and her research on understanding and treating early disruptive disorders. Dr. Chen will present a feeding intervention with a Chinese family and discuss how cultural challenges were overcome. Summary and Discussion: The "goodness of fit" model has shaped the strategies now used in Shanghai and are applicable across other cultures.

REFERENCES:

1. Chatoor I, Hirsch R, Persinger M: (1997). Facilitating internal regulation of eating: a treatment model for infantile anorexia. Infants and Young Children, 9, 12-22.
2. Thomas J. Guskin K: (2001). Disruptive behavior in young children: what does it mean? Journal of the American Academy of Child & Adolescent Psychiatry 40, 44-51.

COMPONENT WORKSHOP 03

FROM BEDSIDE TO BALANCE SHEET: THE MANY FACETS OF ADMINISTRATIVE PSYCHIATRY

APA Committee on Psychiatric Administration and Management

Chairperson: L. Mark Russakoff, M.D., 701 North Broadway, Sleepy Hollow, NY 10591; L. Mark Russakoff, M.D., L. Mark Russakoff, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this session, participants should be able to describe the multiple opportunities that are available for psychiatric administrators. They will learn how one might pursue career paths in differing domains: clinical, public, private, research, industry. They will understand the value of seeking additional training and experiences, such as fellowship training, an MBA, and Certification in Psychiatric Administration and Management by the APA.

SUMMARY:

There are multiple opportunities for careers in administrative psychiatry. Brief presentations will be made by individuals who have successfully pursued differing paths. Presenters have experience in public and private clinical settings, government, managed care, pharmaceutical industry, academia, and research areas. They will briefly describe their activities and the choices they made along the way. The focus will be on discussion from the audience about choices they may make and how those choices will forward their careers in administrative psychiatry.

REFERENCES:

1. Rodenhauser P, Ed.: Mental Health Care Administration. Ann Arbor: Univ. of Michigan Press, 2000.
2. Reid WH Silver SB, Eds.: Handbook of Mental Health Administration and Management. New York: Brunner-Routledge, 2003.

COMPONENT WORKSHOP 03

THE RIPPLE EFFECT OF PSYCHIATRIC STIGMA IN MEDICAL EDUCATION AND STRATEGIES TO COMBAT IT

APA Corresponding Committee on Medical Student Education

Chairperson: Linda F. Pessar, M.D., Department of Psychiatry, University at Buffalo, SUNY School of Medicine and Biomedical Sciences; Erie County Medical Center; 462 Grider Street, Buffalo, NY 14215; Lowell Tong M.D., Mark Townsend M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be able to define two components of stigma and formulate strategies that can be adopted in their own institutions or work settings to diminish social distance between patients with psychiatric illnesses, psychiatrists, mental heath workers, and others.

SUMMARY:

Societal attitudes toward psychiatric illnesses ripple into medical education. The social impact of stigma is a product of attribution of characteristics that are deeply discrediting, as well as social rejection or distance. Psychiatric education has combated stigma largely by addressing faulty attitudes and beliefs through clinical teaching. These interventions have produced real, but modest gains. This workshop proposes methods to combat stigma by reducing social distance. The first is to include mental health concerns within a framework of healthy function. We will discuss the importance of integrating psychiatrists across the entire spectrum of medical student curriculum and student affairs and supporting a diversity of student interest groups. A second strategy is to enhance tolerance by encouraging introspection. Patients with psychiatric illnesses are often perceived of as "other" by medical students because they disobey professional norms of continence in emotional, psychological, and behavioral responsiveness. Social distance is threatened during the clerkship when students experience intense feelings generated by clinical encounters. We will present a conference for psychiatry clerks that encourages controlled exploration of student responses to patients. A third strategy is to demonstrate the universal nature of psychological suffering and need for care. In New Orleans, a medical class of 2007, made homeless and emotionally altered by Hurricane Katrina, had more students enter psychiatry than previously. The psychiatry interest group flourished and tied itself to the mental health of the community. We will abstract from this event ways that other schools might raise psychiatric prestige. Psychiatry education has well-formulated teaching approaches to counter false attributions of stigma. Effective measures must also address the social isolation that allows patients with psychiatric illnesses and psychiatrists to be dismissed as "other."

REFERENCES:

1. Feldman DB, Crandall CS: Dimensions of mental illness stigma: What about mental illness causes social rejection? J of Soc and Clin Psychol 2007; 26:137-154.
2. Zalar B, Strbad M, Svab V: Psychiatric education: does it affect stigma? Academic Psychiatry 2007; 31:245-246.

COMPONENT WORKSHOP 04

SCHOOL MENTAL HEALTH: CLINICAL ESSENTIALS AND COLLABORATIVE INTERVENTIONS

APA Corresponding Committee on Mental Health and Schools

Chairperson: Marcia J. Slattery, M.D., University of Wisconsin School of Medicine and Public Health, Department of Psychiatry, 6001 Research Park Boulevard, Madison, WI 53719
Lina Lopez M.D., Jodi Star M.D., Hong Shen M.D., Edgardo Menvielle M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Identify symptoms and behaviors commonly associated with social anxiety, depression, and self-harm, Asperger's Disorder, and ADHD in children and adolescents; (2) Discuss how these problems commonly present in the school setting; and (3) Describe a collaborative assessment and intervention model that incorporates school and office-based interventions to maximize academic and psychosocial outcomes in each of these disorders.

SUMMARY:

Psychiatric problems commonly occur in the school setting. Mental health care professionals are frequently asked to address school-related academic, emotional, and behavioral concerns. The purpose of this workshop is to review childhood mental

health problems frequently encountered in the school setting. A collaborative model of school mental health care involving mental health professionals and school personnel will be presented with emphasis on interventions to maximize positive academic and psychosocial outcomes in school and related settings. Methods/ Content: Four commonly encountered school mental health problems will be discussed with emphasis on school-based difficulties and collaborative interventions: (1) Social anxiety disorder: beyond school shyness. Social anxiety symptoms/ behaviors frequently encountered within the school setting will be reviewed. Cognitive-behavioral interventions will be emphasized; (2) Depression in youth: self-injurious and suicidal behavior. Developmental differences in depressive symptoms in children and adolescents will be addressed, with particular focus on assessment and interventions for self-harm behaviors; (3) Asperger's Disorder: clinical presentation and interventions in the school setting. Emotional and behavioral correlates of Asperger's Disorder will be highlighted, with focus on school-related manifestations and interventions; and (4) ADHD: medications and classroom interventions. Pharmacological and school-based behavioral strategies will be reviewed. Presentations on topics will be followed by small group discussions that include clinical vignettes and audiovisual clips. Attendees may rotate among small-groups to maximize topic exposure. This workshop will pragmatically focus on four commonly encountered school mental health problems and the role of primary mental health providers. A collaborative model of care is emphasized.

REFERENCES:

1. Walter HJ, Berkovitz IH: Practice parameters for psychiatric consultation to schools. J Am Acad Child Adolesc Psychiatry 2005; 44:1068-1083.
2. Rones M, Hoagwood K: School-based mental health services: a research review. Clin Child Fam Psychol Rev 2000; 3:223-24.

COMPONENT WORKSHOP 05

PRACTICAL TIPS ON HOW TO BE A SUCCESSFUL AUTHOR

American Psychiatric Publishing Inc. Editorial Board

Chairperson: Robert E. Hales, M.D., Department of Psychiatry and Behavioral Sciences, University of California, Davis School of Medicine, 2230 Stockton Blvd., Sacramento, CA 95817
Presenters: Glen Gabbard, M.D., John Oldham M.D., Katharine Phillips M.D., Donna Stewart M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to list five practical strategies that will improve a person's skills to be a successful book author.

SUMMARY:

The workshop is designed for psychiatrists who are interested in becoming an author or editor. The participants are all senior editors of the American Psychiatric Publishing, Inc. Editorial Board and are accomplished authors and editors with extensive publishing experience. Dr. Hales will provide an overview of how book proposals and manuscripts are reviewed at APPI and provide specific guidelines to potential authors on the necessary steps to follow. Dr. Gabbard will discuss how authors may wish to develop overall themes or topics for their books and how to get feedback from more experienced authors. Dr. Phillips will provide suggestions on how to evaluate other books that have been published and how to develop a unique or novel focus. Dr. Oldham will outline strategies for editors managing the publication process of large texts. Dr. Stewart will summarize how authors may assist marketing in promoting their work, and what they may do individually to increase awareness among colleagues, trainees, and other potential readers about their work. Audience participation will be encouraged through question-and-answer sessions after each presentation and by asking attendees to provide personal anecdotes.

REFERENCES:

1. Kay J, Silberman EK, Pessar L: Handbook of Psychiatric Education. Washington, DC: American Psychiatric Publishing, 2005.
2. Roberts LW, Hilty DM: Handbook of Career Development in Academic Psychiatry and Behavioral Sciences. Washington, DC: American Psychiatric Publishing, 2006.

COMPONENT WORKSHOP 06

MENTORING 101: A SURVIVAL GUIDE FOR IMGS

APA Committee on International Medical Graduates

Chairperson: Antony Fernandez, M.D., McGuire VAMC (116A), 1201 Broad Rrock Blvd., Richmond, VA 23249; Antony Fernandez, M.D., Sanjay Dube, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participants will understand the significance of effective mentorship for a successful career. This interactive workshop will use a small-group discussion format. Several scenarios discussing the benefits and challenges of mentorship benefits will be highlighted. Participants will learn the value of networking and foster a culture of professional development and personal growth both for mentors and their charges.

SUMMARY:

It is an established fact that mentorship is essential for professional development. IMG psychiatrists are confronted by many challenges. These include being disconnected from countries of their medical education, not having connections within the U.S .medical community, and cultural barriers to being adopted by the "network." Additionally, they have little knowledge of different career tracks and opportunities, lack familiarity with the work setting, and struggle to maintain equilibrium between career and family. Absence of a support system during times of personal crisis such as triggered by socio-political events compound their struggles. Mentees will learn skills that will allow them to navigate areas of psychiatric practice such as, academic, service, administration, and research. Mentors will find fulfillment in serving as role models for their charges in providing leadership, guidance, and a safe haven. Qualities such as assertiveness, self-appraisal, autonomy, delivering and accepting feedback, effective communication, partnership, and networking, critical to success will be discussed. Discussants will include protégés,

and mentors at various levels of their professional careers and share their personal experiences. Audience participation will be encouraged. In summary, this workshop will emphasize the benefits inherent to the mentoring process and teach skills to mentors and protégés particularly to those who come from different cultural and educational backgrounds.

REFERENCES:

1. Rodenhauser P, Rudisill JR and Dvorak R: Skills for mentors and protégés applicable to psychiatry. Academic Psychiatry 2000; 24:14-27.
2. Davis LL, Little MS, Thornton WL: The art and angst of the mentoring relationship. Academic Psychiatry 1997; 21:61-71.

COMPONENT WORKSHOP 07

DISASTER PREPAREDNESS AND RESPONSE: STANDARDS FOR CARE BEFORE, DURING, AND AFTER A DISASTER

APA Committee on Psychiatric Dimensions of Disaster

Artin Terhakopian, M.D., Psychiatry Department, 4301 Jones Bridge Road, Bethesda, MD 20814; Artin Terhakopian, M.D., Albert V. Vogel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be able to: (1) List the most highly effective behavioral health interventions in times of disaster; (2) Identify mechanisms that translate knowledge of disaster response into effective practices and establish standards of care and credentialing mechanisms for organizations (e.g. schools, prisons, and workplaces); and (3) Name populations and places in need of special consideration during disaster planning and response.

SUMMARY:

Disaster psychiatric care is developing an evidence base that requires translation into standards of care for hospitals, communities, businesses, schools, and prisons, to name a few. Standards of care become a part of the certification of institutions and help maintain healthy workplaces, schools, and hospitals prepared to meet community needs. These standards ensure organizations are able to respond to disasters and mass trauma events. However, disaster psychiatric care standards are not well embedded and institutionalized in evaluation, certification, and care processes. We propose a panel of speakers to discuss the advantages, disadvantages, and costs of moving disaster behavioral health to JCAHO, School Health Boards, and business and incarceration facility requirements. This workshop is meant to generate discussion about the adequacy of translation of the current knowledgebase for disaster behavioral health interventions, for example, in areas such as treatment of acute traumatic stress and psychiatric disorders, psychotropic medications stockpiles, shelter in place, and evacuation behavior for specialized settings such as schools, workplaces, and prisons. More importantly, the workshop also seeks to generate discussion about ways that disaster psychiatric knowledge can be translated into operational requirements and care at various organizational settings. During this workshop, we will consider a number of ideas regarding current directions of behavioral health care during times of disaster. We encourage audience participation and comment regarding the current disaster response knowledge base, translation into standards, and institutionalization of procedures to maintain and enhance the gains achieved.

REFERENCES:

1. Townsend MH: (2007). Final Action Paper: Supporting the Activities of Psychiatrists Working in Disaster Areas.
2. Terhakopian A, Benedek DM: Hospital disaster preparedness: mental and behavioral health interventions for infectious disease outbreaks and bioterrorism incidents. American Journal of Disaster Medicine 2007; 2:43-50.

COMPONENT WORKSHOP 08

LOOKING FOR LOVE AND DODGING THE VIRUS

APA Committee on AIDS

Pamela Y. Collins, M.D., Unpublished Address, New York, NY 10024-5579; Pamela Y. Collins, M.D., Khakasa H. Wapenyi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to: Understand the impact of HIV/AIDS on women of color, describe three risk factors that contribute to their HIV infection, demonstrate comfort and proficiency in obtaining a sexual and substance use history, give examples of psychiatric illness that may occur in the context of HIV and pregnancy, and outline the steps for culturally competent HIV risk assessment.

SUMMARY:

HIV/AIDS disproportionably affects communities of color, especially women of color who constitute the group that has shown the most rapid increase in new HIV infections nationally. Psychiatrists specializing in HIV/AIDS demonstrate expertise and introduce skills to the general psychiatrist in taking a sexual history. We will review how relationship dynamics in communities of color may contribute to HIV infection risk. The presenters will review current data on HIV, pregnancy, vertical transmission, as well as the most common psychiatric disorders encountered in pregnancy. During an interactive case discussion with the audience, the presenters will demonstrate how to elicit essential and often taboo information regarding a female patient's sexual and substance-use history and the relationship to HIV prevention and treatment.

The presenters will demonstrate how to assess individual women of color in a culturally competent manner, paying attention to specific issues of culture, ethnicity/race, and spirituality and how this may affect relationships, sexuality, mental health, and well-being.

REFERENCES:

1. Dawson R: HIV & Women, NAM, 3rd Ed. 2007. http://www.aidsmap.com.
2. Turner AN, et al: Men's circumcision status and women's risk of HIV acquisition in Zimbabwe and Uganda. AIDS 2007; 21:1779-1789.

COMPONENT WORKSHOP 09

THE BEGINNING AND THE END OF TRANSINSTITUTIONALIZATION

APA Council on Social Issues and Public Psychiatry

Hunter L. McQuistion, M.D., Department of Psychiatry, The St. Luke's & Roosevelt Hospitals, 1090 Amsterdam Avenue, Suite 16C, New York, NY 10025; Hunter L. McQuistion, M.D., Tracee M. Burroughs, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand possible solutions to interrupt and prevent transinstitutionalization among people with serious mental illness.

SUMMARY:

There is a well-established view that the deinstitutionalization era produced at best a mixed bag for people with severe psychiatric disorders. As a result, the past generation has arguably witnessed a "transinstitutionalization" among people with serious mental illness that refers to the circuit between acute-care hospitals, homeless shelters-and, increasingly, jails and prisons. Not well understood, however, are solutions toward interrupting this circuit, enabling people to move forward in their personal recovery goals. Embarking primarily from a vantage point of prevention, this workshop explores innovative programs and discusses new ideas that seek to end transinstitutionalization. Presenters with diverse professional expertise -judicial, mental health, and housing - offer exemplary solutions that focus on interventions to prevent incarceration, on specialized treatment initiatives that focus on patients at risk of succumbing to a transinstitutionalization syndrome, and on novel housing approaches that promise to optimize domiciliary stability. These presentations also suggest how solutions might interweave, revealing both opportunities and continued service system gaps, consequently inviting creative discussion among all workshop participants.

REFERENCES:

1. Dunford JD, Castillo EM, Chan TC, et al: Impact of the San Diego Serial Inebriate Program on the use of emergency medical resources. Ann Emerg Medicine 2006:47,328-336, 2006.
2. Gilligan J: The Last Mental Hospital. Psychiatric Quarterly 2001:72,45-61.

COMPONENT WORKSHOP 10

PSYCHIATRY AND MANAGED CARE: PATIENT ACCESS, PHYSICIAN AUTONOMY, AND PROFESSIONAL ADVOCACY

APA Committee on Managed Care

Paul H. Wick, M.D., 3300 South Broadway Avenue, Suite 102, Tyler, TX 75701; David Nace, M.D., Jonathan Weker, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to understand how to advocate in the managed, care system, be aware of critical issues and recent changes within the managed-care system, and recognize concerns related to access, as well as autonomous and effective treatment.

SUMMARY:

The following workshop will consist of a brief overview of the health insurance industry. The presentation will focus on the three dimensions of managed care, including what is occurring with managed care, how patients access care, and ways that physicians can respond to advocate on behalf of their patients. The presentation will begin with Dr. David Nace providing an update on new trends in managed care. Dr. Nace will address topics regarding pay-for-performance programs, consumer directed health care and other innovative programs. Dr. Bransfield will then discuss how the managed-care system affects access to providers. He will also address how collaborative projects with primary care physicians are increasing access to care. Dr. Harris will discuss effective mechanisms that psychiatrists can use when advocating within managed-care systems. He will also discuss pragmatic solutions for addressing managed care problems with patients and managed-care organizations and creating a plan for advocating at the national and local level. Dr. Harris will also provide and update on what the managed-care committee is doing to advocate at the national level. Dr. Weker will address how psychiatrists can enhance their autonomy and still provide quality care while working within managed-care. Overall, this presentation will enable practicing psychiatrists to understand how the managed-care system works, anticipate new trends, and provide adequate and quality care for there patients.

REFERENCES:

1. Joshua E. Wilk, Ph.D., Joyce C. West, Ph.D., M.P.P., William E. Narrow, M.D., M.P.H., Donald S. Rae, M.A. and Darrel A. Regier, M.D., M.P.H. Economic Grand Rounds: Access to Psychiatrists in the Public Sector and in Managed Health Plans. Psychiatric Services 56:408-410, April 2005. http://psychservices.psychiatryonline.org/cgi/content/full/56/4/408.
2. Garner John C: Health Insurance Answer Book Seventh Additional 2007 Supplement. Aspen Publishers, 2007.

COMPONENT WORKSHOP 11

THE NEW ORLEANS SCHOOL RECOVERY DISTRICT: WHAT ARE THE RISK, PREDICTIVE, AND PROTECTIVE FACTORS?

APA Alliance

Kay Brada, 52 Mission Road, Eastborough, KS 67207
Presenters: Carl Bell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) List the adverse childhood experiences that have the potential to generate adverse physical health and mental health outcomes; (2) List four protective factors that prevent risk factors from being predicative of bad outcomes; and (3) List seven community field principles that promote healthy behavior changes.

SUMMARY:

Contrary to expectations of many psychiatric practitioners, exposure to a risk factor, e.g., a traumatic stressor, does not automatically put a person on a path to develop a psychiatric

disorder, e.g., PTSD. Scientific documentation will be provided that protective factors have the capacity to prevent risk factors from becoming predictive of "bad" mental health outcomes. Further, protective factors: (1) Rebuilding the village; (2) Access to modern technology; (3) Facilitating connectedness; (4) Improving social skills; (5) Increasing self-esteem, a sense of models, a sense uniqueness, a sense of power, a sense of being connected to something and/or someone of value; (6) Re-establishing the adult protective shield; and (7) Minimizing trauma can decrease the risk individuals who are exposed to adverse childhood experiences will have serious psychopathology in later life. A theoretically-sound, evidence-based, common-sense model is offered as a "directionally correct" way to ensure that at-risk populations obtain protective factors to prevent a potential risk factors from generating poor health and mental health outcomes.

REFERENCES:

1. Bell CC: Exposure to a Traumatic Event Does Not Automatically Put A Person On A Path to Develop PTSD: The Importance of Protective Factors to Promote Resiliency. http://www.giftfromwithin.org/html/promote.html.
2. Bell, CC, Bhana A, McKay MM, Petersen I. A Commentary on the Triadic Theory of Influence as a Guide for Adapting HIV Prevention Programs for New Contexts and Populatutions: The CHAMP-South Africa Story." In McKay MM, Paikoff RL (Eds). Community Collaborative Partnerships: The Foundation for HIV Prevention Research Efforts. Binghamton, NY, Haworth Press, 2007, p. 243-261.

COMPONENT WORKSHOP 12

ROLE OF INTERNATIONAL HEALTH ORGANIZATIONS IN PROMOTING GLOBAL CHILD AND ADOLESCENT MENTAL HEALTH

APA Council on Global Psychiatry and the APA Council on Children, Adolescents, and Their Families

Siham Muntasser, M.D., Dept of Behavioral Medicine and Psychiatry, 930 Chestnut Ridge Road, Morgantown, WV 26505; Siham Muntasser, M.D., Eliot Sorel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Appreciate the seriousness of the neglect of the mental health needs of children and adolescents worldwide; (2) Learn about the importance of health policy and planning to facilitate implementation and advocacy within government and consumer community; and (3) Recognize the importance of the multi-agency agreement on the essential first steps toward protecting mental health and psychosocial support for children and families in the midst of emergencies.

SUMMARY:

This presentation highlights the efforts of The United Nations Children's Fund (UNICEF), the World Psychiatric Association (WPA), the World Health Organization (WHO), and the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP), at providing mental health services to children/adolescents worldwide. It emphasizes the need for improved awareness and the need for more collaborative efforts to maximize access and service delivery. The WPA implemented a program aimed at: increasing the awareness of policy and health decision-makers, health professionals, and the general public on the impact of pediatric psychiatric disorders; promoting the application of measures of primary prevention; and supporting the development of pediatric mental health services. The WHO Department of Mental Health and Substance Abuse has recognized the global gap with regard to pediatric mental health services. The WHO Atlas on resources for children/adolescent mental health identified gaps in training, services, and financial support for care. The WHO has developed a manual on child/adolescent mental health policy and plans that facilitates implementation and advocacy within governments and the consumer community. Other initiatives related to emergency response and services outcomes provide needed guidance and information that will aid future program development. The IACAPAP has developed several projects aimed at increasing access to mental health services. These included programs to decrease school violence and school dropout; programs fostering the integration of mental health into primary care; and programs increasing public awareness.The UNICEF has spoken loud and clear about the impact of poverty, illiteracy, and armed conflicts on millions of children. The Paris Principles and Guidelines and most recently the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings are two of many activities bringing aid and relief to children and families. All these agencies recognize the need for more collaborative efforts. They highlight common goals/objectives, and discuss practical ways to foster collaboration and bridge differences.

REFERENCES:

1. The Mental Health of Children and Adolescents - An Area of global neglect. Edited by Remschmidt H, Nurcombe B, Belfer BL, Sartorius N, Okasha A. John Wiley and Sons, 2007.
2. Murthy SR: Mass Violence and mental health - Recent epidemilogical findings. Inter Rev of Psychiatry 2007: 19: pp 183-192.

COMPONENT WORKSHOP 13

ANXIETY, IMPULSIVITY, AND AGGRESSION: DIAGNOSTIC AND TREATMENT DILEMMAS IN INTELLECTUAL DISABILITY

APA Committee on Developmental Disabilities

Joel D. Bregman, M.D., Fay J. Lindner Center for Autism and Developmental Disorders, North Shore-LIJ Health System, 4300 Hempstead Turnpike, Bethpage, NY 11714; Stephanie Hamarman M.D., John de Figueiredo M.D., Ramakrishnan Shenoy M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Accurately assess the precipitants and likely causes of anxiety, impulsivity, and disruptive behavior in those with intellectual disability (ID); (2) Interpret affective and behavioral symptom profiles within the context of common neurogenetic syndromes; and (3) Develop an effective individualized treatment approach for addressing challenging neuropsychiatric symptoms

in complex cases in ID.

SUMMARY:

Increasingly, community psychiatrists are faced with complex clinical challenges presented by patients with intellectual disability (ID). Serious behavioral symptoms in intellectual disability (ID) (e.g., aggression, self-injury, destruction) typically result from a complex interplay of genetic, neurobiological, and environmental factors, which should be considered for accurate diagnosis and effective treatment. Although most clinicians choose to approach these behavioral symptoms directly, an indirect treatment approach may be more effective. For example, neurophysiological state variables (such as impulsivity, anxiety, and obsessive-compulsive symptoms) can act as setting events for problem behaviors, the recognition and treatment of which can result in an elimination of such target behaviors. An emerging field that directly impacts on clinical care is that of behavioral genetics. Identifiable genetic disorders are often associated with specific social-behavioral profiles (behavioral phenotypes) and represent ideal models for identifying potential genetic mechanisms, which underlie specific neuropsychiatric symptoms. This workshop will present clinical vignettes and videotapes that highlight challenging behavioral symptoms exhibited by individuals with genetic disorders (such as fragile X, Williams, Prader-Willi, Down, and Cornelia de Lange syndromes). These syndromes often present with characteristic patterns of psychopathology, including anxiety (generalized, obsessive-compulsive, social, phobic), depression, and impulsivity (e.g., ADHD, impulse control disorders), and will serve points of discussion regarding assessment, diagnosis, and treatment. Similar behavioral clusters can occur across these genetic syndromes; however, the pathophysiology and treatment may differ. Assessment instruments, data collection and interpretation, differential diagnosis, interdisciplinary communication, and treatment integration (psychopharmacologic, behavioral, cognitive-behavioral, and interpersonal) will be emphasized.

REFERENCES:

1. Whitaker S, Read S: The prevalence of psychiatric disorders among people with intellectual disabilities: An analysis of the literature. Journal of Applied Research in Intelluctual Disabili-
ties 2006; 19:330-345.
2. Gothelf D (ed): Neuropsychiatric genetic syndromes. In Child and Adolescent Psychiatric Clinics of North America, edited by Martin A, Philadelphia, W.B. Saunders Company, 2007, 16 (3):541-749.

COMPONENT WORKSHOP 14

ASSESSING SUICIDE RISK IN THE GENERAL HOSPITAL: IMPLEMENTING THE 2007 NATIONAL PATIENT SAFETY GOAL

APA Committee on Standards and Survey Procedures

Steven R. Daviss, M.D., Baltimore Washington Medical Center, Department of Psychiatry, 301 Hospital Drive, Glen Burnie, MD 21061; Steven R Daviss, M.D., Angelos Halaris, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to list three procedures for identifying hospital patients at risk for suicide; describe the role of the consultation-liaison psychiatrist in the identification and assessment of patients at risk of suicide; and identify the Joint Commission's expectations regarding suicide assessment in the general hospital and emergency department.

SUMMARY:

The Joint Commission in 2007 added National Patient Safety Goal 15a, that each patient treated in a hospital or behavioral health care facility be assessed for suicide risk. This has been implemented in a variety of ways, and is most challenging in the general hospital. This NPSG is applicable to "psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals." The challenge is defining and identifying appropriate general hospital patients. While inpatient suicide is the second most common sentinel event (12% of all sentinel events), it remains a relatively rare phenomenon (60 annually). There are currently no standard or clinically proven suicide assessment tools. For general hospitals, the following are true: (1) Completed suicide is rare; (2) Most completed suicides involve jumping or hanging; (3) Acute alcohol withdrawal is associated with an increased risk of suicide; (4) Suicide risk is higher when patients are transferred to a lower intensity of care; and (5) Patients with major psychiatric disorders are at higher risk of suicide. Successful implementation of this goal requires that: (1) The risk assessment includes identification of specific factors and features that may increase or decrease risk for suicide; (2) The client's immediate safety needs and most appropriate setting for treatment are addressed; and (3) The organization provides information such as a crisis hotline to individuals and their family members for crisis situations. This workshop will focus on steps taken to achieve the Joint Commission goal of improving suicide risk assessment, as well as barriers to implementation. Ample time will be provided for discussion and for attendees to compare notes about their facilities. Attendees are encouraged to submit forms, tools, policies, and procedures, which they would like to share with others in a web-based repository.

REFERENCES:

1. JCAHO: Sentinel Event ALERT- Inpatient Suicides: Recommendations for Prevention. Joint Commission on Accreditation of Healthcare Organizations 1998; Issue 7. http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_7.htm.
2. Mills P, Neily J, Luan D, Osborne A, Howard K: Actions and implementation strategies to reduce suicidal events in the Veterans Health Administration. Journal on Quality and Patient Safety 2006; 32(3):130-41.

COMPONENT WORKSHOP 15

PSYCHOTHERAPY UPDATE: PSYCHODYNAMIC THERAPY FOR PANIC DISORDER

APA Committee on Psychotherapy by Psychiatrists

Chairperson: Eric M Plakun, M.D., Austen Riggs Center, 25 Main Street, Stockbridge, MA 01262-0962
Presenters: Barbara Milrod M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be familiar with elements of panic, focused psychodynamic psychotherapy and begin to use them to enhance outcomes in patients with panic disorder.

SUMMARY:

In a randomized-controlled trial a form of psychodynamic psychotherapy called Panic, Focused Psychodynamic Psychotherapy (PFPP), a 12-week, twice weekly, manualized psychoanalytic psychotherapy, was shown to be an efficacious treatment for *DSM-IV* panic disorder. In this workshop the study's lead researcher offers a practical overview of the three phases of PFPP. These include: (1) an acute panic phase, in which the unconscious psychological meanings of panic symptoms are explored, especially as they relate to conflicts around separation, autonomy and unconscious anger, while panic symptoms begin to diminish, (2) a panic vulnerability phase, in which identified core conflicts are engaged and worked through in the transference, while recurrence of panic diminishes and relationships improve, and (3) a termination phase, in which there is sometimes a re-experiencing of identified separation and anger conflicts or recrudescence of symptoms in the context of termination as a new ability to manage separation is achieved. Differences between PFPP and CBT will be noted. There will be ample time for discussion with participants, including discussion of cases offered by the presenters and by participants.

REFERENCES:

1. Milrod B, Leon AC, Busch F, Rudden M, Schwalberg M, Clarkin J, Aronson A, Singer M, Turchin W, Klass ET, Graf E, Tres JJ, Shear MK: (2007). A randomized, controlled clinical trial of psychoanalytic psychotherapy for panic disorder. American Journal of Psychiatry, 164:265-272.
2. Milrod BL, Leon AC, Barber JP, Markowitz JC, Graf E: (2007). Do comorbid personality disorders moderate panic-focused psychotherapy? An exploratory examination of the APA practice guideline. Journal of Clinical Psychiatry. 68:885 -891.

COMPONENT WORKSHOP 17

ON THE BRINK: UNIVERSAL HEALTH INSURANCE AND MENTAL HEALTH SERVICES

APA Council on Healthcare Systems and Financing

Chairperson: Anita S Everett, M.D., 3563 Cattail Creek Drive, Glenwood, MD 21738
Co-Chairpersons: Frederick J. Stoddard, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Demonstrate an understanding of multiple state universal health care proposals, including Massachusetts, California; (2) Demonstrate an understanding of multiple federal universal health care proposals, including those put forth by Clinton, Obama, and Guiliani; and (3) Demonstrate an understanding of the impact that universal access to health insurance might have on mental health care delivery.

SUMMARY:

In the past decade, the national interest in health care reform has drastically increased, with some polls indicating that greater than 70% of the nation supports universal coverage. The factors that are most likely driving this change in opinion are self-interest: employers are becoming a less reliable source of coverage and insurance premiums and co-pays are rising at a much faster rate than household salaries. Lawmakers from across the political spectrum now see a window of opportunity. In this setting, innovative state plans, not the least of which was the Massachusetts plan signed into law by Mitt Romney, have opened the flood gates and the nation now seems poised to implement far-reaching health care reform. Of paramount importance during this critical juncture is the extent to which mental health care will be affected. Given that many states and several presidential candidates have submitted proposals for universal coverage, examining how these different plans might impact the mental health care system can help mental health practitioners make informed decisions about how to best advocate for our patients. This workshop seeks to present and discuss several of the proposals that have been proposed at the state and also at the Federal level. Anita Everett, will provide background with regards to national health and mental health expenditures from all sources over the last decade. Mary Giliberti, J.D., from NAMI, will discuss the NAMI tracking of state health reform as impacts mental health services within states that have engaged in health care reform. Patrick Runnells will review the current proposals as set forth by presidential campaigns of the '08 election. Discussants who have committed to participate include Steve Sharfstein, M.D., who has participated in a number of national and state mental health initiatives as well as Joe English, M.D. who has long-term leadership in mental healthcare financing.

REFERENCES:

1. Ellis RP, McGuireTG: Predictability and predictiveness in health care spending. J Health Econ 2007 Jan; 26(1):25-48.
2. Mark TL, Levit KR, Buck JA, Coffey RM, Vandivort-Warren R: Mental health treatment expenditure trends, 1986-2003. Psychiatr Serv 2007 Aug; 58(8):1041-8.

COMPONENT WORKSHOP 18

EVALUATING COMPETENCY IN PSYCHOSOMATIC MEDICINE

APA Council on Psychosomatic Medicine

Chairperson: Mary Jane Massie, M.D., 1275 York Avenue, Box 421, New York, NY 10021
Presenters: Samuel Sostre M.D., Thomas Wise M.D., Lawson Wulsin M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants will know the ACGME core competency requirements for residents in psychosomatic medicine; the knowledge, skill, and attitude requirements for the competent PM practitioner; how competency of trainees can be effectively and practically evaluated in psychosomatic medicine (PM) through case presentation; and how training program directors can utilize assessment information to modify their program objectives and strengthen teaching in PM.

SUMMARY:

As a first step in a long-term effort designed to emphasize educational outcome assessment in residency programs and in the accreditation process, the ACGME defined six areas (patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice) in which residents must achieve competency for a training program to achieve and retain ACGME accreditation. Currently, specialists in PM are defining the knowledge, skills, and attitudes required for training in PM; designing learning objectives and curricula to provide educational experiences as needed in order for trainees to demonstrate achievement in the competencies; developing tools to measure achievement of objectives; and are determining how to use the information gleaned to improve the educational experience. *Purpose:* Attendees will learn how TPDs can efficiently and effectively evaluate the success of their trainees in achieving learning in the competency areas in PM. *Methodology:* In this case-based, interactive workshop, a challenging psychosomatic medicine case will be described. The participants, leaders in the field of PM education and members of organizations committed to developing standards (APM) and assuring competency (ABPN), and a PGY3 resident, will show what a resident needs to know or to demonstrate to be considered competent in PM. During this lively demonstration, the audience will observe how resident performance is assessed. The presenters will invite debate with the workshop participants about the useful application of ACGME standards of competence to assess trainee performance and the use of assessment data to provide feedback to trainees and to modify program curricula. *Results and Importance:* This workshop will help TPDs receive continued program accreditation from the ACGME in the area of PM and will facilitate trainees' understanding of how they are evaluated.

REFERENCES:

1. Andrews LB, Burrus JW: Core Competencies for Psychiatric Education: Defining, Teaching, and Assessing Resident Competence. Washington, DC, American Psychiatric Publishing, Inc 2004.
2. Swick S, Hall S, Beresin E: Assessing the ACGME competencies in psychiatry training programs. Academic Psychiatry 2006; 30: 300 - 351.

COMPONENT WORKSHOP 19

REDUCING JUVENILE DELINQUENCY THROUGH PREVENTION

APA Corresponding Committee on Juvenile Justice Issues

Chairperson: Stephen B Billick, M.D., 11 East 68th Street, #1-B, New York, NY 10021
Presenter: Eraka Bath M.D.,

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand some of the ways to prevent juvenile delinquency through early detection of abuse, school-based programs promoting pro-social values, and treatment of psychiatric disorders to prevent recidivism.

SUMMARY:

Dr. Billick will introduce the panel and the scope of the problem. Dr. Ferrand will provide a brief history of the juvenile justice system and general approaches and understandings of delinquency. Dr. Bath will discuss the relationship of juvenile delinquency to child abuse and neglect with an emphasis on the need for early detection and correction. Dr. Loo will review the school-based programs designed to identify children and adolescents at risk. Programs designed to promote pro-social values will be discussed. Dr. Billick will discuss the need for identification of psychiatric disorders and treatment in adolescent offenders, and the reduction of recidivism through treatment. There will be active interaction between the presenters and the audience.

REFERENCES:

1. Lubit RH, Billick SB: Juvenile delinquency, in Rosner, R. ed of Principles and Practice of Forensic Psyciatry, 2nd Edition, Arnold, 2003, New York
2. Sugai, G, Sprague JR, Horner R: Walker HM: Preventive school violence: The use of office discipline referrals to assess and monitor school wide discipline interventions. J. Emotionals and Behav Dis, 8:94-101, 2000.

COMPONENT WORKSHOP 20

METHAMPHETAMINE ABUSE IN AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES: RESTORING HARMONY THROUGH AN INTEGRATED TREATMENT MODEL

APA Committee of American Indian, Alaska Native, and Native Hawaiian Psychiatrists

Chairperson: Daniel L Dickerson, D.O., 1015 Roswell Avenue, Long Beach, CA 90804

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Understand the pharmacological, psychological, and culturally-specific treatment options with regards to methamphetamine abuse in American Indian/Alaska Native populations; (2) Describe the specific methamphetamine use characteristics among rural and urban American Indians/Alaska Natives; and (3) Recognize the need for collaborative participation and a system-wide effort with regards to methamphetamine abuse in American Indian/Alaska Native communities.

SUMMARY:

Methamphetamine abuse among American Indians/Alaska Natives (A.I./A.N.) is a significant public health care issue. Methamphetamine use rates among A.I./A.N. over the age of 12 are approximately 1.9%, two times higher than rates among Caucasians (0.7%), and four times higher than among Hispanics and Latinos (0.5%). Addressing methamphetamine abuse in A.I./A.N. communities requires a multi-faceted approach including adequate treatment, prevention, public health, law enforcement, and environmental approaches. This presentation will provide clinicians, medical students, and residents, a comprehensive overview of effective treatment and management of methamphetamine abuse with a specific focus on issues unique to the A.I./A.N. population. Cognitive-behavior therapy, motivational enhancement therapy, contingency management,

and the Matrix Model will be discussed. In addition, a discussion with regards to research conducted to date and research currently being designed by the speakers will be presented. Open discussion will be encouraged with regards to optimization of treatments, addressing psychiatric and substance, use comorbidities, use of traditional medicine, and future directions in treatment and research of methamphetamine abuse in this population. Methamphetamine abuse has significantly impacted American Indian and Alaska Native communities. Further understanding with regards to current treatment options for methamphetamine abuse in A.I./A.N. communities, in addition to further open dialogues between clinicians and researchers, can assist toward decreasing the impact of this problem in A.I./A.N. communities.

REFERENCES:

1. Office of Applied Studies, Substance Abuse and Mental Health Services Administration. (09/16/05). Methamphetamine use, abuse, and dependence: 2002, 2003, and 2004.
2. The National Survey on Drug Use and Health Report (NSDUH). Spear S, Crevecoeur DA, Rawson RA, Clark R: The rise in methamphetamine use among American Indians in Los Angeles County. Am Indian Alsk Native Mental Health Res 2007; 14(2):1-15.

COMPONENT WORKSHOP 21

ETHICAL DILEMMAS IN CLINICAL PRACTICE: ASK THE EXPERTS

APA Ethics Committee

Chairperson: Wade Myers, M.D., Division of Child and Adolescent Psychiatry, 12901 Bruce B Downs Blvd, MDC102, Tampa, FL 33612
Presenters: Burton V. Reifler M.D., William Arroyo M.D., L. Alan Wright M.D., Lea DeFrancisci Lis M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize common situations, which may signal professional risk.

SUMMARY:

This will be an interactive workshop designed to engage psychiatrists in discussion of common situations, which may signal professional risk. Brief presentations will be given by APA Ethics Committee members on the following areas: ethical dilemmas during residency, pharmaceutical industry relationships, speaking to the media, collaborative treatment, and boundary violations.

REFERENCES:

1. American Psychiatric Association: The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry. United States of America, American Psychiatric Association, 2006.
2. American Medical Association: Code of Medical Ethics of the American Medical Association. United States of America, American Medical Association, 2006.

COMPONENT WORKSHOP 22

I'M COMING OUT: HELPING YOUR LGBT PATIENTS OUT THE CLOSET DOOR

APA Committee on Gay, Lesbian, and Bisexual Issues

Chairperson: Philip A Bialer, M.D., Beth Israel Medical Center, First Ave. and 16th St., Fierman 509, New York, NY 10003
Presenters: Eugene Lee M.D., Umee Davae D.O., Eric Williams M.D., Serena Volpp M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the different stages of LGBT coming out and as a clinician learn how to help or guide someone to self-acceptance. Participant should also be able to identify the therapeutic obstacles and pitfalls in the coming out process.

SUMMARY:

Coming out can be most simply defined as revealing one's sexual identity, or in the case of a transgendered person one's gender identity, to others. However, the process of coming out is complex and can involve several stages including, self-awareness, denial, dissociation, and acceptance. Coming out is also not a static phenomenon and for most LGBT people occurs repeatedly during their lifetime within different family, social, and work situations. As with any developmental process, some people proceed with few psychological sequelae, while others may have a more difficult time and develop psychiatric symptoms requiring treatment. This workshop will explore the different stages and models of the LGBT coming out process. We will also look at some of the issues that may be unique to the transgendered person. Treatment issues for people seeking mental health care and guidance as well as countertransference issues for treatment providers will be specifically addressed. Case vignettes will also be presented. We will ask the audience to comment on how they would approach different patients and to share treatment dilemmas they may have faced when seeing LGBT patients during the coming out process.

REFERENCES:

1. Floyd FJ, Bakeman R: Coming out across the life course: implications of age and historical context. Arch Sexual Behavior 2006; 35:287-296.
2. Drescher J, Stein TS, Byne W: Homosexuality, gay and lesbian identities, and homosexual behavior. In Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 8th edition, edited by Sadock B, Sadock V, Baltimore, MD, William and Wilkins, 2005, pp. 1936-1965.

COMPONENT WORKSHOP 23

UNNATURAL CAUSES: IS INEQUALITY MAKING US SICK?

APA Committee of Black Psychiatrists

Chairperson: Michele Reid, M.D., 640 Temple, 8th Floor, Detroit, MI 48201
Co-Chairperson: Melva Green, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to be identify the risk factors for low-birth weight babies in the African-American community and the role racism plays

in determining this adverse pregnancy outcome. Participants will recognize the socioecominic and race-based disparities in health and their root causes and the role they and organized psychiatry can play in addressing these inequities.

SUMMARY:

The group will watch a 26-minute film by California NewsReel, entitled, "When the Bough Breaks," on African-American pre-term births and infant mortality. Despite professional degrees, African-American women face as much risk of poor pregnancy outcomes (premature births and low-birth weight newborns) as white high-school dropouts. The panel will discuss the implications of the American Psychiatric Association's Position Statement on Racism and Racial Discrimination and Their Adverse Impact on Mental Health and the relationship to physical health. The role of better social policies to address conditions that affect health will be discussed including how education, housing, and jobs are just as important as personal health strategies such as diet, smoking, and exercise in reducing these health disparities and improving the overall health in America.

REFERENCES:

1. Williams DR, Neighbors HW Jackson JS : Racial/ethnic discrimination and health: Findings from community studies. American Journal of Public Health,2003 93:200-208.
2. Williams, DR, Rucker, TD: Understanding and addressing racial disparities in health care. Health Care Financing Review: (2000), 21:(4), 75-90.

TUESDAY, MAY 6, 2008

COMPONENT WORKSHOP 24

LETHAL BEAUTY: THE GOLDEN GATE BRIDGE

APA Northern California Psychiatric Society

Chairperson: Mel I. Blaustein, M.D., 1199 Bush Street, #600, San Francisco, CA 94109, Presenters: Mary Zablotny

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand current suicide demographics explain myths and misconceptions about suicide and discuss the most effective suicide deterrents.

SUMMARY:

The Golden Gate Bridge--the most photographed man-made structure in the world--is also the number one suicide site in the world. Over 1,200 bodies have been found (not counting those washed out to sea) since the bridge was built in 1937. The toll continues at two per month. Suicide is the number 10 cause of mortality nationally but number three among young people aged 10 to 24. As psychiatrists, we know that suicides are most often impulsive acts of desperate individuals. We know that suicides are preventable. The Psychiatric Foundation of Northern California organized a bridge barrier task force in 2004 to educate the public about suicide. We addressed the question of whether bridge jumpers would go elsewhere to suicide, as well as whether suicidal individuals are exercising free will. Working cooperatively with family members of victims, mental health advocates and concerned public citizens, we persuaded the Bridge Board to conduct an engineering and environmental impact study. This workshop will look at public attitudes, misconceptions, and myths about suicide as well as the allure and iconic mystique of the bridge. We will talk about suicide deterrents and the concern with the issue of whether barriers work in an interactive dialogue with the audience. My co-presenter, an artist and wife of a psychiatrist, whose 18-year old son suicide from the Golden Gate Bridge in 2005, will reflect on that experience.

REFERENCES:

1. Mann J: Suicide prevention strategies. JAMA 2005; 294(16): 2004-2074.
2. Seiden R: Where are they now? a follow-up study of suicide attempters from the golden gate bridge. Suicide and Life Threatening Behavior 1978; 8(4): 203-216.

COMPONENT WORKSHOP 25

DRUG ABUSE IN ATHLETES: THE CHALLENGES OF PREVENTION AND TREATMENT

APA Council on Addiction Psychiatry

Chairperson: Evaristo Akerele, M.D., Department of Psychiatry, Columbia University, Harlem Hospital, 506 Lenox Avenue, New York, NY 10037
Presenters: Herbert Kleber M.D., Edward Nunes M.D., Richard Rosenthal M.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop, participants should be able to identify: (1) Key phases in the history of substance use in athletes; (2) The factors that influence the use of drugs in athletes; (3) The most commonly used drugs and their perceived/real effects in athletes; and (4) How to prevent and treat substance use in athletes.

SUMMARY:

Drug abuse is a key issue in sports. Athletes who use drugs are believed to have an unfair advantage over rivals. The implications are significant. It is unethical and results in loss of public faith in fairness in sports. However, for both athletes and their entourage the advantages of victory, albeit disingenuously, are immense. These include immense financial gains in income both on and off the field. There is increasing public interest in this subject. This is fuelled by drug-related problems of celebrity athletes on and off the field. It behooves us as experts in the field to enhance the knowledge of our colleagues and the general public on this subject. In this workshop, we will address the following: (1) the history of substance use in athletes, (2) the factors that influence the decision to use, (3) the use of therapeutic, performance enhancing, and recreational drugs, (4) the challenges of prevention and treatment.

REFERENCES:

Brukner P, Khan K, Drugs and the Athlete in Clinical Sports Medicine. The McGraw-Hill Companies, 2001; 872-899.
Green GA, Uryasz FD, Petr TA, et al. NCAA study of substance use and abuse habits of college students-athletes. Clin J Sport Med 2001; 11:51-56.

COMPONENT WORKSHOP 26

WORKPLACE PSYCHIATRY 101

APA Corresponding Committee on Psychiatry in the Workplace

Chairperson: Jeffrey P. Kahn, M.D., Suite 1C, 300 Central Park West, New York, NY 10024
Presenters: Steven Pflanz M.D., Alan Langlieb M.D., Andrea Stolar M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the clinical range of workplace psychiatry; understand the importance of psychiatric skills to the workplace; and recognize the role of psychiatric factors in the workplace.

SUMMARY:

Although many psychiatrists are interested in organizational and occupational psychiatry, there have been few opportunities to learn about the field. Rather than attempting a comprehensive presentation, the five psychiatrists in this workshop will each highlight a topic of particular interest in their work. Suicide prevention, corporate consultation on presenteeism (productivity), fitness for duty evaluations, workplace policies, and mental health and violence/risk assessment will be included.

REFERENCES:

1. Kahn JP: Organizational and occupational psychiatry: Overview and Examples. Psychiatric Annals 36:11;747-753, 2006.
2. Langlieb AM, Kahn JP: How much does quality mental health care profit employers? Journal of occupational and environmental medicine 47:1099-109, 2005.

COMPONENT WORKSHOP 27

BETTER LUCK TOMORROW: GAMBLING IN ASIAN-AMERICANS

APA Committee of Asian-American Psychiatrists

Chairperson: Mona H. Gill, M.D., UC Davis Medical Center 2230 Stockton Boulevard, Sacramento, CA 95817
Presenters: Dan Tzuang M.D., Timothy W. Fong M.D., Shirley Liu B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: (1) Distinguish recreational gambling from pathological gambling; (2) Recognize the prevalence of pathological gambling in Asian Americans; (3) Understand the existing literature on gambling in Asian Americans; (4) Identify the cultural aspects that influence gambling behaviors; and (5) Apply clinical pearls in treatment of pathological gambling.

SUMMARY:

Gambling is a common pastime both nationally and internationally. It includes betting on specific games, such as cards, dice, slot machines, lotteries, bingo, roulette, races, and sporting events. It is legal in 48 states, and it has extended its reach even more broadly through the Internet. As many as one in 20 Americans will develop a problem with gambling at some point in their life, with up to one in 50 progressing to pathological gambling. Similar to substance abuse disorders, pathological gambling is defined in *DSM-IV* as gambling that causes significant suffering in the lives of gamblers and their loved ones, resulting in loss of home, job and relationships, and disruption of family life. It is also highly comorbid with substance dependence and depression. The prevalence of pathological gambling is thought to be significantly higher in Asian-Americans, ranging as high as 60% in certain subgroups. This workshop will explore the limited data on this phenomenon in Asian Americans. Participants will better understand: (1) the epidemiology of pathological gambling among various Asian American subpopulations, and (2) the cultural factors that perpetuate the behavior and complicate treatment. These aspects include stigma and shame, denial, and cultural beliefs about gambling. The speakers will review the existing literature on gambling in Asian Americans and provide clinical pearls for treatment and management of pathological gambling, including the use of psychotherapy and psychopharmacology for this disorder. The workshop is intended for all clinicians who may encounter a high-risk gambling population and for those who want to increase their knowledge about gambling in Asian Americans. In summary, pathological gambling is a significantly impairing yet underrecognized problem for a large number of Asian Americans. Increased awareness is the first step toward successfully identifying and treating affected individuals.

REFERENCES:

1. Raylu N, Oci TP: Role of culture in gambling and problem gambling. Clinical Psychology Review 2004; 23:1087-1114.

2. Petry NM: Pathological Gambling: Etiology, Comorbidity and Treatment. Washington, DC, American Psychological Association, 2005.

COMPONENT WORKSHOP 28

AMERICAN PSYCHIATRY: CARE QUALITY, ACCESS, ETHICS, AND ADVOCACY

APA Council on Quality Care

Chairperson: Eliot Sorel, M.D., 2301 E Street, N.W., Suite # 1011, The George Washington University School of Medicine & School of Public Health, Washington, D.C., DC 20037
Co-Chairpersons: Daniel K. Winstead, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Identify the challenges of culturally specific care quality, access, ethics, and advocacy in American Psychiatry; (2) Augment knowledge and skills to better advocate for patients and colleagues; and (3) Enhance collaboration on these issues at local and national levels.

SUMMARY:

Psychiatric disorders account for the leading burden of disease in low, middle, and high income economies, including the United States. In the United States, 50% of these disorders occur by age 14 and 75% by age 24, with some scientists referring to psychiatric disorders as the chronic diseases of the young. Additionally, there are significant comorbidities with other medical conditions such as cardiovascular diseases, diabetes, cancer, and many others. Paradoxically, access to care for psychiatric disorders is

markedly curtailed by discriminatory practices, negative financial incentives, pervasive stigma, and a markedly fragmented health care system. Minimal or no integration with primary, with regrettable consequences for care quality, access for both general medical conditions and, especially, psychiatric disorders with consequential augmented chronicity, comorbidities and increased costs of care. This workshop, address. These challenges facing our patients and our colleagues, in a diverse, multicultural, nation. It focuses on the importance of cultural specificity in diagnosis and treatment as a quintessential quality component. It explores professional roles in developing access advocacy strategies buttressed by medical ethics and scientific evidence with the intent of delivering what is best for the patient and not motivated by the business, profit motives as key determinant, comparing and contrasting business and medical/psychiatric ethical principles. Ample opportunities are provided for a robust and dynamic dialogue between the panelists and the workshop participants.

REFERENCES:

1. Insel T, Fenton W: Psychiatric epidemiology, Arch Gen Psychiatry. Vol 62, pp. 590-592 June 2005.
2. Kessler RC: et al., Lifetime prevalence and age of onset distributions of *DSM IV* Disorders in the National Comorbidity survey replication. Arch Gen Psychiatry vol 62, pp 593-602.

COMPONENT WORKSHOP 29

DOES CULTURE MATTER? A DEBATE ON THE UNDERUSE AND OVERUSE OF CULTURAL DIFFERENCES IN PSYCHIATRY

APA/SAMHSA and APA/AstraZeneca Minority Fellowships

Chairperson: Natalie Weder, M.D., 42 Mechanic Street, #2, New Haven, CT 06511
Co-Chairpersons: Liwei L Hua, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Identify cross-cultural issues in psychiatry; (2) Promote cultural sensitivity among mental health workers; (3) Discuss the underuse and overuse of cultural differences in the diagnosis and treatment of mental illnesses; and (4) Integrate the cultural dynamics into the diagnosis and treatment of psychiatric disorders.

SUMMARY:

In the face of increasing cultural diversity in the United States, it can be tempting to either overlook or exaggerate cultural characteristics in psychiatric care. According to the U.S. 2000 Census, about 30% of the American population is considered “minority”. While many agree that culture affects psychiatric practice, the specific applications of culture are much more contentious. How should psychiatrists apply culture to diagnosis and treatment, or should they? How valid is the concept of matching the culture of the psychiatrist to that of the patient/supervisors? Will matching their cultures enhance alliance or create a bias? While some agree that integration of cultural issues is of paramount importance, it is unclear if there is evidence to support that cultural formulation improves diagnosis and treatment outcome. Given that the *DSM-V* is currently being developed, it is a particularly crucial time to address these issues. The goal of this workshop is to explore the role of culture in clinical practice for the purposes of creating awareness, as well as fostering dialogue and understanding, within the mental health community. Senior discussant: Carl C. Bell, M.D.

REFERENCES:

1. Brain and Culture: Neurobiology, Ideology, and Social Change by Bruce E. Wexler
2. Clinical Manual of Cultural Psychiatry by Russell F. Lim.

COMPONENT WORKSHOP 30

NOVEL CAREERS IN PSYCHIATRY: WOMEN WHO HAVE MADE THEIR OWN WAY

APA Committee on Women

Chairperson: April H Morciglio, M.D., 204 Ridge Spring Dr., Columbia, SC 29229
Co-Chairpersons: Jamae C Campbell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify and appreciate creative solutions to professional challenges from the perspectives of pioneers who have built unique careers in psychiatry.

SUMMARY:

In training, psychiatrists are exposed to a limited number of career options. Mentors typically represent traditional choices such as academics, private practice, or public sector psychiatry. Yet, those who have established non-traditional paths may have knowledge that could help guide colleagues through diverse career challenges. In this interactive roundtable discussion, innovative psychiatrists who have had unusual careers will be interviewed regarding challenges they faced as well as successful strategies developed. The personal exploration of their experiences, including triumphs and mistakes, may offer insights to psychiatrists on all levels.

REFERENCES:

1. A Resident’s Guide to Surviving Psychiatric Training. Edited by Tonya Foreman-El Masri, MD and Leah Dickstein, MD. Published by APA April 2003.
2. Hardball for Women: Winning at the Game of Business. Pat Heim, PhD and Susan Golant.

COMPONENT WORKSHOP 31

ELECTRONIC HEALTH RECORDS IN PSYCHIATRY: EXPERIENCES OF EARLY ADOPTERS

APA Corresponding Committee on Electronic Health Records

Chairperson: Farrell H. Braziel, M.D., 11111 Houze Rd Ste. 225, Roswell, GA 30076
Presenters: Laura Fochtmann M.D., Suzanne Albrecht M.D., John Boronow M.D., Peter Fore M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Describe potential advantages of electronic health Records in various clinical settings; (2) Describe potential pitfalls of electronic health records in various clinical settings; (3) Describe considerations in electronic health records selection; and (4) Describe the current status and major initiatives of the national EHR movement.

SUMMARY:

In response to the growing political and consumer demand for electronic health records (EHR), the Secretary of the Department of Health and Human Services released in July 2004 the first outline of a 10-year plan to build a national health information infrastructure in the United States. In this workshop, several "early adopter" psychiatrists from various settings will share how they are utilizing electronic health records TODAY. Presenters will touch on themes such as privacy and security, impact on clinical workflow, considerations in software selection, perceived benefits on patient care, usability, and unintended or unexpected consequences. After brief presentations drawing from real electronic health record software, the session will provide an opportunity for attendees to engage in open dialog on the potential benefits and pitfalls of EHR use.

REFERENCES:

1. Litvin CB: In the dark – The case for electronic health records. N Engl J Med 2007; 356: 2454-2455.
2. Miller RH, et al: The value of electronic health records in solo or small group practices. Health Aff 2005; 24:1127-1137.

COMPONENT WORKSHOP 32

DEMYSTIFYING THE SYSTEM: ELIMINATING BARRIERS TO EFFECTIVE TREATMENT OF THE MENTALLY ILL IN JAILS AND PRISONS

APA Corresponding Committee on Jails and Prisons

Chairperson: Henry C. Weinstein, M.D., 1111 Park Avenue, New York, NY 10128
Presenters: Avram Mack M.D., Erik Roskes M.D., Tom Hamilton, Cassandra Newkirk M.D., William Arroyo M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Describe the complexity of the interrelating systems involved in the custody and care of individuals with mental illness and criminal justice involvement; (2) Explain how this complexity may act as a barrier to adequate service delivery; and (3) Demonstrate an understanding as to how such complex systems may be analyzed in order to improve the delivery of behavioral health services to such individuals.

SUMMARY:

A major barrier to providing adequate mental health services to persons with mental illness in the criminal justice system is the complexity of the system - made up of law enforcement agencies, social service agencies, mental health agencies, correctional agencies as well as a wide variety of facilities. Overlapping responsibilities and lack of communication and coordination are often the rule. Under these circumstances, it is unsurprising that many individuals with mental illnesses are lost or fall through the many gaps inherent in this complex system. This workshop will focus on the criminal justice system in the District of Columbia, to highlight this problem. The jurisdiction contracted with a local academic center to engage in a study of the system to highlight the many agencies involved in criminal justice within the city limits. In the system to be analyzed in detail in this workshop, there are 38 separate governmental agencies responsible for these patients. In addition to presenting this complexity, workshop presenters will discuss the implications of this complexity as it relates to the experience of the individual offender with mental illness and as it relates to people or organizations wishing to advocate for change within the system to better manage defendants who suffer with mental illness. Examples of jurisdictions, which have evolved, based on an improved understanding of its unique criminal justice system, or isolated parts of that system, will be included for discussion. This advocacy thrust of this workshop most strongly embodies the theme of this meeting: "Our Voice in Action."

REFERENCES:

1. The Interface of Mental Illness and the Criminal Justice System in the District of Columbia: Analysis and recommendations (available at: http://cjcc.dc.gov/cjcc/frames.asp?doc=/cjcc/lib/cjccsubstanceabuse/gap_analysis.pdf).
2. Criminal Justice/Mental Health Consensus Project (available at www.consensusproject.org).

COMPONENT WORKSHOP 33

DISASTER PREPARATION AND MENTAL HEALTH RESPONSE: ROLES FOR DISTRICT BRANCH EMERGENCY COMITTEES

APA Washington Psychiatric Society

Chairperson: Julia Z. Frank, M.D., 2150 Pennsylvania Ave. NW, Washington, DC 20037
Co-Chairpersons: Cheryl Person, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to formulate a plan for meaningful participation in disaster preparedness and response as a member of a district branch of the APA.

SUMMARY:

Among mental health professionals, psychiatrists have both shared and unique roles to play in organized responses to such events as natural disasters, fires, mass casualty accidents, and terrorism. The effects of such events go well beyond transient stress reactions and include exacerbating or bringing on major psychiatric disorders, disrupting existing psychiatric care networks, and overwhelming primary care practitioners with patients in need of mental health care. Psychiatrists in the Washington, D.C., area have had opportunities to respond professionally to several recent emergencies, including the attack on the Pentagon and the anthrax epidemic in 2001 and both local and Gulf region responses to the hurricanes of 2005. After each response, reflection has fostered new initiatives in preparing for future events. The Washington Psychiatric Society Emergency Preparedness Committee provides a forum for coordinating

various initiatives, including a unique program for providing psychiatric consultation to local embassies, efforts to incorporate psychiatric expertise into hospital emergency plans, and initiatives that have provided avenues for volunteering professionally in the care of hurricane survivors. These activities have raised members' awareness of the many administrative and legislative barriers to professional volunteering, inspiring efforts to address these at the local and national level. Educating other psychiatrists about the role of mental health in disaster response has been another important concern of the committee and the society. Each panelist in this workshop will present a brief description of his/her disaster-related expertise, to encourage attendees to share their experiences and to brainstorm ways in which psychiatrists in other areas of the country can find meaningful pathways to facilitate professional responses to future events.

REFERENCES:

1. Frank JB: Trinidad AC: Katrina relief: lessons for the academic medical center. [Journal Article] Academic Psychiatry 31(3):196-9, 2007.
2. Norwood AE: Ursano RJ: Fullerton CS. Disaster psychiatry: principles and practice. Psychiatry Quarterly 71(3):207-26, 2000.

COMPONENT WORKSHOP 34

CAREER ADVANCEMENT IN ACADEMIC PSYCHIATRY FOR EARLY CAREER PSYCHIATRISTS

APA Assembly Committee of Early Career Psychiatrists

Chairperson: Marina Goldman, M.D., Treatment Research Center, University of Pennsylvania, 3900 Chestnut Street, Philadelphia, PA 19104
Co-Chairpersons: Elisabeth J. Kunkel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand how to negotiate the complexities of academic psychiatry departments; to improve their ability to prioritize conflicting responsibilities; and to focus their own career path with a goal of effective career advancement.

SUMMARY:

Academic psychiatry has undergone significant changes over the past few decades. Departmental structures became more complex while clinical, research, and teaching responsibilities have expanded. These numerous responsibilities are often poorly integrated. Junior faculty often struggle to understand what is expected of them in order to advance within their departments. Junior faculty needs a clear road map to develop a successful academic career. Recent literature emphasizes the need for mentors who can help early career psychiatrists set priorities, align conflicting clinical, research and teaching responsibilities, and be effective at meeting departmental expectations. Faculty will discuss with participants practical issues of academic career development. The workshop will be highly interactive with emphasis on eliciting the needs of early career psychiatrists and providing guidance from senior academic faculty.

REFERENCES:

1. McGuire LK, Bergen MR, Polan ML: Career advancement for women faculty in a U.S. school of midicine: perceived needs. Academic Medicine 79(4): 319-25, 2004 Apr.
2. Elinicki DM, Hemmer PA, Udden MM, Wong R, Hefner J, Battistone M, ALbritton TA, Griffith CH: Does being a clerkship director benefit academic career advancement: results of a national survey. Teaching & Learning in Medicine 15(1): 21-4, 2003.

COMPONENT WORKSHOP 35

THE ROLE OF THE PSYCHIATRIST IN PALLIATIVE AND END-OF-LIFE CARE

APA Committee on Access and Effectiveness of Psychiatric Services for the Elderly

Chairperson: David A Casey, M.D., University of Louisville Department of Psychiatry and Behavioral Sciences, 500 S. Preston St. Suite 210A, Louisville, KY 40202
Co-Chairpersons: Lina Shihabuddin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the basic principles of palliative care as they apply to advanced or terminal medical conditions as well as dementia. The participant will recognize the value of psychotherapuetic, psychopharmacologic, and case management skills, which the psychiatrist can bring bring to the palliative care team.

SUMMARY:

Palliative care is an interdisciplinary approach to treatment focused on relief of suffering for patients with advanced or terminal illness. This approach emphasizes communication, symptom management, coordinated care, and psychosocial support. Grief and bereavement issues are a part of the plan of care for both patients and their families. Palliative care is an approach that emphasizes relief from pain and suffering rather than intensive medical intervention. It is a coping rather than curing approach. Palliative care, along with hospice, has gained significant acceptance in the medical community as well as the community at large. Since its inception, this approach has been utilized for cancer. In recent years, other conditions, including AIDS and advanced cardiovascular disease have also benefited from a palliative-care model. Some psychiatrists as well as palliative-care specialists have become interested in applying this approach to end stage dementia as well. Many palliative-care patients experience enormous emotional suffering including depression, anxiety, insomnia, and delirium as well as acute and chronic pain. Psychiatrists can bring enormous expertise to the care of such patients (and their families) who are suffering in the context of an advanced or terminal disease and require emotional support, psychotherapy, and judicious use of psychiatric medications to address depression, anxiety, or delirium. Many psychiatrists also possess knowledge of pain management techniques, both pharmacologic and non-pharmacologic. Psychiatrists also possess the team management, communication, and liaison skills necessary for a palliative care approach. Psychiatrists should be viewed as important members of the palliative care team.

REFERENCES:

1. Chochinov HM, Breitbart W, eds: Handbook of Psychiatry in Palliative Medicine. New York: Oxford University Press; 2000.
2. Baumrucker SJ, Davis MP, Paganini E, et al: Case study: dementia, quality of life, and appropriate treatment. Am J. Hosp Palliat Care 2005; 22:385-391.

COMPONENT WORKSHOP 36

REACHING OUT: APPROACHES TO SUICIDE AMONGST THE PHYSICIAN POPULATION

APA Corresponding Committee on Physician Health, Illness, and Impairment

Chairperson: Malkah T Notman, M.D., 54 Clark Road, Brookline, MA 02445
Presenters: Derek Puddester M.D., Penelope Ziegler M.D., Michael Myers M.D.

EDUCATIONAL OBJECTIVES:

At the end of the workshop, participants will be able to identify the determinants of physician suicide, the current controversies in the physician-suicide literature, and the current efforts in physician-suicide research; develop an individual and institutional plan for reaching out and supporting a suicidal colleague; and demonstrate a reasonable understanding of the components of response to a completed physician suicide.

SUMMARY:

Physician suicide is an ongoing concern. Data have varied and there have been methodological problems in the past studies. This workshop summarizes the literature on physician suicide with particular emphasis on the literature of the past ten years, including methodological challenges and reasonable interpretations of the data. Dr. Puddester will present a recent review of international literature by the Canadian Medical Association's Centre for Physician Health and Well Being and the University of Ottawa's Faculty Wellness Program. It suggests that suicide and suicidal ideation amongst physicians and medical students is not uncommon. There is limited experience and skills with dealing with this. This has a significant impact on the physician's family and colleagues. He will also describe a number of methodological issues that limit our quantitative understanding of the problem. Dr. Ziegler will briefly discuss these findings. Dr. Notman will describe the effects on physicians' families, particularly in the context of the changing demographics of medicine. Losing a patient has been called one of the most stressful events in a psychiatrist's career. Dr. Myers will discuss how this loss of a patient affects the psychiatrist. He will describe common symptoms and outline ways in which psychiatrists can protect their personal health. Participants will then spend the balance of the workshop engaged in individual and interactive discussion. Case vignettes, video clips, and narratives from the qualitative literature will be structured to help participants develop their skills at identifying risk factors amongst colleagues and trainees, the boundaries inherent in working with physician-patients, how to work with institutions on behalf of a suicidal colleague, and strategies to assist in the response to a completed physician suicide.

REFERENCES:

1. Givens JL, Tjia J: Depressed medical students' use of mental health services and barriers to use. Acad. Med 2002; 77(9):918-921.
2. Frank E, Dingle AD: Self-reported depression and suicide attempts among U.S. women physicians. Am J Psychiatry 1999;156(12):1887-1894.

COMPONENT WORKSHOP 37

SHOULD WE HAVE A V-CODE FOR RESPONSE TO MILITARY OPERATIONAL STRESS?

APA Lifers

Chairperson: Sheila Hafter Gray, M.D., Box 40612 Palisades Station, Washington, DC 20016-0612
Co-Chairpersons: Edward Hanin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Differentiate normative vs. psychopathological responses to the stress of military operations; (2) Implement therapeutic interventions informed by these differences; and (3) Conduct informed debates on a proposal to introduce a V-Code for Response to Military Operational Stress.

SUMMARY:

It is common knowledge, confirmed and amplified by epidemiological and clinical research, that war changes those who participate in it. Are the psychological after-effects of war normative, adaptive responses to specific, severely stressful situations, or do they reflect significant underlying psychopathology associated with considerable functional impairment? In recent years some in the Army originated BATTLEMIND, a strengths-based educational program to inform service members about how the skills they use in combat may relate to emotions and behaviors they may encounter during and after deployment. It uses risk-communication strategy that soldiers understand to encourage use of mental health resources for identified problems. Clinicians who view combat-related symptoms as a non-pathological response to a life event, similar to bereavement, argue that a V-Code for deployment-related psychological changes can help avert mistakenly assigning warriors and veterans the role of psychiatric patient, reduce stigma, and promote access to mental health interventions that support rapid recovery. Others hold that these symptoms and the impairments associated with them are true PTSD; and the availability of a V-Code in the *DSM* will tend to conceal psychopathology and impede appropriate clinical research. Will the introduction of a specific V-Code for Response to Military Operational Stress, into the *DSM* promote keener diagnostic classification or will it obscure the prevalence of combat-related PTSD? Organized psychiatry, which developed and is the steward of the *DSM*, should assure that these concerns are addressed so that *DSM-V* will reflect the best available evidence. DISCLAIMER: The opinions or assertions contained in these presentations are the private views of the authors and are not to be construed as official or as reflecting the views or policies of the Department of Veterans Affairs or the Department of Defense or any of their affiliated institutions.

REFERENCES:

1. Hoge CW, Auchterlonie JL, Milliken CS: Mental Health

Problems, Use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. JAMA 2006; 295:1023-1032.
2. Kudler H: The need for psychodynamic principles in outreach to new combat veterans and their families. Journal of the american academy of psychoanalysis and dynamic psychiatry 2007; 35:39-50.

COMPONENT WORKSHOP 38

LANGUAGE ACCESS IN HEALTH CARE: CHALLENGES AND INITIATIVES FOR PSYCHIATRY

APA Council on Minority Mental Health and Health Disparities

Chairperson: Francis G. Lu, M.D., Department of Psychiatry, 7M8, San Francisco General Hospital, 1001 Potrero Ave., San Francsico, CA 94110
Co-Chairpersons: Andres J. Pumariega, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the importance of language access in health and mental care with a focus on Hispanic Americans and to understand how language access can be increased at individual clinician and policy levels.

SUMMARY:

Nearly 47 million people – 18% of the U.S. population – speak a language other than English at home. The 2000 census documented that over 28% of all Spanish speakers, 22.5% of Asian and Pacific Island language speakers, and 13% of Indo-European language speakers speak English "not well" or "not at all." Limited English proficiency (LEP) affects the person's ability to access and receive health and mental health care. This workshop will first describe the National Health Law Program Language Access in Health Care Statement of Principles, which has been co-signed by over 75 health care organizations including the APA, AMA, American Psychological Association, National Association of Social Workers, and the Joint Commission on the Accreditation of Health Care. These 11 principles state the importance of effective communication between clinician, and patients for quality care as well as that all stakeholders – including government agencies that fund, administer or oversee health care programs – must be accountable for providing or facilitating the provision of those services. The importance of language access for LEP Hispanic-Americans as well as cultural competence standards that include interpreters and current national interpreter standards will be reviewed. The challenges and opportunities of clinicians working with LEP patients in private practice will be outlined. The APA activities on language access in 2007 will be reviewed including signing onto the statement of principles and joining the coalition supporting the statement of principles. Discussion will focus on how language access to mental health care can be improved at both the individual clinician and policy levels.

REFERENCES:

1. Derose K, Baker D: Limited English proficiency and latinos' use of physician services. Med Care Res Rev, Mar 2000; 57: 76 – 91.
2. National Health Law Program: Language Access in Health Care Statement of Principles, June 2007 update.
3. http://www.healthlaw.org/library.cfm?fa=detail&id=56882&appView=folder.

COMPONENT WORKSHOP 39

BREAKING BARRIERS: EMPOWERING PROVIDERS AND PATIENTS

APA/SAMHSA Minority Fellows

Chairperson: Eugene Lee, M.D., 8730 Alden Drive, #W-101, Los Angeles, CA 90048
Co-Chairpersons: Otis Anderson III, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) recognize potential barriers to accessing mental health care; (2) provide outreach to identified, vulnerable, and underserved communities in need; and (3) openly discuss barriers with patients in order to overcome them.

SUMMARY:

This workshop was born in an effort to discuss the relevance of barriers from our perspectives as psychiatrists in training. At times, we have noted that training programs may lack time and other resources to thoroughly explore cultural barriers to accessing mental health care. In this workshop psychiatry trainees will present cases and personal experiences of barriers to mental health care access. We will conduct this discussion in a case-vignette format to present issues and dilemmas that we have faced; including but not limited to cultural stigma in general, immigration and economic factors, geographic location, criminalization of the mentally ill, and religious/spiritual issues. Each vignette will be examined in the context of the more sociodynamic forces of stigma and shame, followed by audience reactions and group discussion of ways to overcome these barriers.

REFERENCES:

1. Kleinman A: Rethinking Psychiatry: From Cultural Category to Personal Experience, New York: Free Press, 1991
2. Lim R F. (Ed.): Clinical Manual of Cultural Psychiatry Washington, DC : American Psychiatric Pub., 2006.

WEDNESDAY, MAY 7, 2008

COMPONENT WORKSHOP 40

ADVOCACY: WHAT MEDICAL STUDENTS, RESIDENTS, AND EARLY CAREER PSYCHIATRISTS NEED TO KNOW TO AFFECT CHANGE IN THE POLITICAL PROCESS

APA Assembly Committee of Area Member-in-Training Representatives

Chairperson: Jose Vito, M.D., 145 East 48th Street, #16A, New York, NY 10017
Co-Chairpersons: Bob Kearley,

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be

able to understand that getting actively involved in the political process at all levels of government as advocate is essential to protecting the safety of patients and the future of the psychiatric profession. The participants will learn more about the added value of the government relations services that the APA provides to its members-in-training and other opportunities like the Jeanne Spurlock Congressional Fellowship.

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 government. Effective grassroots advocacy efforts passed mental health parity law, 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 governmental 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.

REFERENCES:

1. Ruiz P: Psychiatry, advocacy, and the federal budget, Psychiatric News, Aug 2006; 41:3.
2. Yates DF, Wiggins JG, Lazarus JA, Scully Jr. JH, Riba M: Patient safety forum: Should psychologists have prescribing authority? Psychiatric Services 2004; 55:1420-1426.

COMPONENT WORKSHOP 41

ONE PSYCHIATRIST'S BOUNDARY VIOLATION MAY ANOTHER'S AREA OF WORK

APA Assembly Allied Organization Liaisons

Chairperson: Lee Combrinck-Graham, M.D., 1515 Summer Street, Stamford, CT 06905
Presenters: Rachel Glick M.D., David Brook M.D., Anita Everett M.D., Robert Pyles M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that some "rules" change depending on the context of the work being done.

SUMMARY:

The APA ethical guidelines are currently undergoing significant revisions. In the summer of 2007, a draft document from this process was put out for comment. This draft document stirred a round of passionate discussion within several of the allied organizations. In particular, the American Association of Community Psychiatrists and the Association of Family Psychiatrists were challenged to address the traditional office-based and boundary-oriented ethical guidelines within the framework of many contemporary approaches to treatment that include family members and social and treatment networks and often provide treatment in non-office-based settings. This stimulated thought among other allied organizations, concluding with the observation that from some psychiatrist's practice perspectives others' work may appear to involve boundary violations. Increasingly psychiatrists can be effective practicing in a variety of settings from the emergency room to people's homes to a variety of locations in communities, and increasingly, psychiatrists find that work is enhanced by information from and participation of others in a patient's relational network. Ethical guidelines for the profession need to be adjusted for these practices with particular attention to how privacy and confidentiality are respected and maintained. The workshop will explore the implication of boundaries in several practice settings: individual psychodynamic psychotherapy, group psychotherapy, and the emergency room, community settings. Each presenter will address issues of confidentiality and privacy as well as how boundaries are defined and managed.

REFERENCES:

1. Opinions of the Ethics Committee on the priniciples of medical Ethics 2001.
2. American Psychiatric Association: The principles of medical ethics with annotations especially applicable to psychiatry.

COMPONENT WORKSHOP 42

GRASS ROOTS IN ACTION: DISTRICT BRANCH INITIATIVES AND APA GRANT FUNDING UNITE IN MAKING A DIFFERENCE

APA Council on Member and District Branch Relations

Chairperson: Nioaka N. Campbell, M.D., 15 Medical Park, Ste. 141, Columbia, SC 29203
Co-Chairpersons: Jeffrey S. Akman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to: identify successful strategies for public affairs outreach and education that may be replicated in the provider's local community, evaluate the successes and challenges in district branch initiatives that have been APA funded, assess the impact of these grassroot projects on district branch members and communities, and discuss future plans for enhancing the face of psychiatry on the local level in a limited funding environment.

SUMMARY:

In December 2004, the American Psychiatric Association (APA) Board of Trustees voted to approve a competitive grant process for awarding funding to the district branches/state associations (DB/SA). In 2005, 47 grant requests from DB/SAs, representing all geographic areas of the APA, were submitted and 23 DB/SA grants were approved. The approved projects addressed recruitment and membership, member-in-training/early career psychiatrists development, public affairs/outreach, access to care, minority affairs, technology, and scholarship. In this workshop, we will discuss and compare three successful DB/SA projects from different geographical regions that were funded through this process. We will evaluate the successes and the pitfalls of each grassroots project, brainstorming on how these ventures may be duplicated in other areas of the country. We will identify the significance of each activity to their DB/SA, respectively, and how the projects are relevant to the strategic plan of the APA. The Massachusetts Psychiatric Society will address their project

on increasing awareness and training members on the use of technology in psychiatric practice. The South Carolina Psychiatric Association will review their project involving public awareness, the media and anti-stigma campaigns using members in training and journalism students. The Ohio Psychiatric Association will present their project on addressing the developmental needs of members in training as well as solidifying outreach efforts with patient advocacy groups. The impact of these projects to their individual DB/SA will motivate, enhance, and assist other local grass roots initiatives. Future collaboration and endeavors of our DB/SAs will provide the innovative approaches needed in today's limited funding environment to make a difference at the local level for APA membership, education, and public outreach.

REFERENCES:

1. Shuchman,M: Journalists as Change Agents in medicine and health care. JAMA. 2002;287:776.
2. Kutner L and Bersin E: Reaching Out: mass media techniques for child and adolescent psychiatrists. Journal of the American
Academy of child psychiatry. 200; 39(11): 1452-1454.

COMPONENT WORKSHOP 43

FOSTER CARE: ARE WE DOING OUR BEST FOR THE CHILDREN?

APA Committee on Family Violence and Abuse

Chairperson: Gail Robinson, M.D., Toronto General Hospital, 8-231 EN, 200 Elizabeth St., Ontario, Toronto, Canada M4W 3M4, Presenters: Sandra Kaplan M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the risk factors for children in the foster care system and identify approaches that will reduce them and increase the well-being of these children.

SUMMARY:

Almost one million children are currently in foster care in the U.S. Although most children enter foster care with medical, mental health, or developmental problems, many do not receive adequate or appropriate care while in placement. Psychological and emotional problems, in particular, may worsen rather than improve. Although some children in foster care are looked after by loving and caring individuals, other children are at risk of violence, abuse, and neglect. Policies that promote frequent moves to prevent too much attachment between the children and the caregivers, serve only to impair the child's ability to form relationships. Every effort most be made to make foster care a positive experience and a healing process for the child. Psychiatrists have an important role in assessing needs, providing comprehensive care, and working with the legal and child welfare services to advocate for the children. This workshop will provide an overview of the issues from psychiatric, legal, and social service perspectives with a discussion about how these groups can work together.

REFERENCES:

1. Rosenfeld AA, Pilowsky DJ, Fine P et al: Foster Care: An Up-
date. J Am Acad. Child Adolesc. Psychiatry. 1997; 36: 448-457.
2. Simms MD, Dubowitz H, Szilagyi MA: Health care needs of children in the foster care system. 2000; 106 (4suppl): 909-18.

COMPONENT WORKSHOP 44

PREVENTING INCARCERATION OF THE MENTALLY ILL: THE ROLE OF PSYCHIATRY

APA Assembly Allied Organization Liaisons

Chairperson: Steven K. Hoge, M.D., Bellevue Hospital Center,462 First Avenue Room #19N45, New York, NY 10016
Presenters: Erik Roskes M.D., Alec Buchanan Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the clinical, programmatic, and administrative obstacles to providing care for patients currently enmeshed in the criminal justice system. In addition, the participant will understand current models for providing care at various points in the criminal justice process.

SUMMARY:

Jails and prisons are now the leading providers of institutional care for the mentally ill. The majority of mentally ill inmates leaving incarceration receive no mental health treatment or social services. The rate of re-incarceration in this group is high. In the wake of deinstitutionalization, outpatient services have not been developed to adequately address the needs of this segment of the seriously mentally ill population. This workshop will present emerging models of providing clinical services at various points in the continuum of involvement with the criminal justice system, beginning with first contact with police, through court diversion opportunities, to discharge from incarceration. The workshop will also explore barriers to providing care in outpatient settings and propose ways in which training and programs can be improved so the mentally ill in the criminal justice system can be better served.

REFERENCES:

1. Hoge SK: Providing transition and outpatient services to the mentally ill released from correctional institutions, in Public Health Behind Bars: From Prisons to Communities. Edited by Greifinger R. New York, Springer, in press.
2. Munetz MR, Griffin PA: Use of the sequential intercept model as an approach to the decriminalization of people with serious mental illness. Psychiatric Services 2006; 57:544-549.

COMPONENT WORKSHOP 45

CPT CODING AND DOCUMENTATION UPDATE

APA Committee on RBRVS, Codes, and Reimbursements

Chairperson: Ronald M. Burd, M.D., P.O. Box MC, Fargo, ND 58122-0390
Co-Chairpersons: David K. Nace, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be knowledgeable about current Medicare and CPT coding changes; up to date on Medicare reimbursement concerns; and have their individual questions about coding, documentation, and reimbursement addressed.

SUMMARY:

The goals of the workshop are to inform practitioners about changes in the RBRVS Medicare physician reimbursement system, modifications in CPT coding, and current issues associated with documentation guidelines. This year's workshop will focus on: (1) updating participants as to current issues related to CPT coding (including coding for quality measures), (2) a review of current Medicare reimbursement issues and concerns, and (3) discussion of documentation guidelines for psychiatric services as well as the evaluation and management service codes. Time will be reserved for questions and comments by the participants about the above topics as well as issues and problems faced by the participants in their own practices.

REFERENCES:

1. American Medication Association: Current Procedural Terminology, Fourth Edition (CPT), 2007, Chicago, IL, AMA Press, 2006.
2. American Medical Association: Medicare RBRVS: The Physicians Guide, 2007, Chicago, IL, AMA Press 2007.

COMPONENT WORKSHOP 46

PSYCHIATRIC SERVICES IN JAILS AND PRISONS: IT'S TIME TO REVISE THE APA GUIDELINES!

APA Caucus of Psychiatrists Working in Correctional Settings

Chairperson: Henry C Weinstein, M.D., 1111 Park Avenue, New York, NY 10128
Presenters: Kathryn Burns M.D., Cassandra Newkirk M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; describe and discuss the critical issues and changes in the criminal justice/mental health environment that call for a revision of the APA Guidelines on Psychiatric Services in Jails and Prisons, and describe and discuss the developing process of revising the APA Guidelines on Psychiatric Services in Jails and Prisons.

SUMMARY:

The publication in 1989 of the APA Guidelines on Psychiatric Services in Jails and Prisons was a landmark in correctional psychiatry: the first detailed guidelines specifically directed to the provision of adequate mental health services for mentally ill inmates. It was hailed as the finest as well as the first. The APA guidelines uniquely set out the broad general principles of such care, such as the requirement for the provision and assessment of quality care, issues of the education and training of all mental health professionals, requirements of informed consent, confidentiality, treatment modalities to be available, issues relating to research in jails and prison, administration and administrative issues and interprofessional relationships. The second part of the APA guidelines then set out, in detail, the specific, required, mental health services to be provided in local lock-ups, jails and prisons. The second edition, published a decade later, added sections to the "Principles" on cultural awareness, suicide prevention, the provision of psychiatric services in courts and other settings and as well as jail diversion and other alternatives to incarceration. Importantly, the second edition added a new section applying the principles and the guidelines to specific populations: women inmates, youth in adult correctional facilities, inmates, and patients with HIV/AIDS, patients with substance-use disorders and/or co-occurring disorders, geriatric patients and patients with mental retardation/developmental disability. Since the publication of the second edition, further dramatic changes have been taking place including requirements for evidence-based practice, the publication of the APA practice guidelines, new models for the administration and management of correctional facilities, the rapid development of diversion programs and mental health courts, a major focus on reentry issues and, concomitantly, the need for close coordination with community mental health agencies. This interactive workshop will describe and discuss these issues and changes and the development of plans to revise the APA Guidelines on Psychiatric Services in Jails and Prisons.

REFERENCES:

1. American Psychiatric Association, Psychiatric Services in Jails and Prisons, Second Edition, Washington DC, American Psychiatric Press, 2000. Council of State Governments. Criminal Justice / Mental Health Consensus Project. New York: Council of State Governments. June 2002.

COMPONENT WORKSHOP 47

WHY BUSINESS NEEDS PSYCHIATRY AND WHY PSYCHIATRY NEEDS BUSINESS: LESSONS LEARNED FROM THE CABR MODEL

APA Committee on APA/Business Relationships

Chairperson: Alan M Langlieb, M.D., 600 N. Wolfe Street, Meyer 4-181, Baltimore, MD 21287
Presenters: Dauda Griffin M.D., Gabriela Cora M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: (1) identify the diverse practice opportunities that may be available for entrepreneurial psychiatrists at different stages of their careers, (2) implement specific strategies to pursue novel opportunities, (3) identify ways of networking with larger groups to align potential services, (4) learn about opportunities for cross collaboration with other colleagues, (5) identify the opportunities of offering consulting services in a wide range of settings, and (6) learn the importance of marketing psychiatry services.

SUMMARY:

Employers are a fundamental component in our health care system. With health care costs rising, many employers are focusing more attention on the cost of illness and related expenditures of disability and lost productive time. Mental health costs consistently rank among the leading concerns of employers, and in many instances, stress and depression have

now exceeded musculoskeletal symptoms as the leading cause of employee problems. For the past several years, the APA Committee on Business Relations (CABR) has helped bring psychiatrists to the boardroom where decisions about quality care, mental health benefits, disability management, and the role of psychiatric services have been presented. CABR has also had the opportunity to learn first-hand what employers are looking for in terms of traditional physician roles of diagnosis and treatment but they have also expressed interest in a host of other areas such as executive assessment, disease management, telepsychiatry, resilience, stress and trauma, and the like. This workshop will present both views -- what business needs from psychiatry and what roles psychiatry can play for patients, employees, employers and the business community at large in the new millennium – as evidence by the work of APA's CABR.

REFERENCES:

1. Kahn JP, Langlieb AM (eds.): Mental Health and Productivity in the Workplace: A Handbook for Organizations and Clinicians. San Francisco: Jossey-Bass/Wiley, 2003.
2. An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services, National Business Group on Health, Washington, DC, 2005.
3. www.businessgrouphealth.org.

COMPONENT WORKSHOP 48

NEW APA PRACTICE GUIDELINES: MDD AND BIPOLAR DISORDER

APA Steering Committee on Practice Guidelines

Chairperson: John S McIntyre, M.D., 2000 Winton Rd. S., Rochester, NY 14618
Presenters: Alan Gelenberg M.D., Robert Hirschfeld M.D., Laura Fochtmann M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify: (1) the uses and limitations of clinical practice guidelines; (2)the APA practice guideline development process; and (3) new treatment recommendations that are expected for the next editions of APA's practice guidelines on major depressive disorder and bipolar disorder.

SUMMARY:

APA practice guidelines provide evidence-based recommendations for the treatment of patients with psychiatric disorders. The guidelines' purpose is to inform clinical decision-making and improve patient care. New editions of the guidelines on major depressive disorder and bipolar disorder are currently being developed. Publication is expected in 2009. Presenters in this workshop will review APA's practice development process and summarize changes and new recommendations expected in the MDD and bipolar Disorder guidelines based on the evidence review conducted by the work groups. Audience participation will be encouraged to discuss both general issues concerning guidelines and specific recommendations concerning major depressive disorder and bipolar disorder.

REFERENCES:

1. American Psychiatric Association 2000. Practice guideline for the treatment of patients with major depressive disorder (Revision) Am J Psychiatry 157, 1-45.
2. American Psychiatric Association 2002. Practice guideline for the treatment of patients with bipolar disorder (Revision). Am J Psychiatry 159, 1-50.

COMPONENT WORKSHOP 49

MENTAL HEALTH OF LATINAS: CHANGING ROLES AND NEEDS

APA Committee of Hispanic Psychiatrists

Chairperson: Andres J. Pumariega, M.D., The Reading Hospital and Medical Center, 6th Avenue and Spruce Street, Reading, PA 19611
Presenters: Natalie Weder M.D., Daniel Castellanos M.D., Sarah Huertas-Goldman M.D., Tatiana Falcone M.D., Carlos Rodriguez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) understand special stressors that adversely impact on the mental health of Latinas; (2) better recognize the presentation of anxiety and depressive disorders in Latina women; (3) understand the special adaptations and evidence-based practices that are most effective in treating Latinas; and (4) better recognize and address the family stressors and reactions that interact with the mental health of Latinas.

SUMMARY:

While Latinos/Hispanics are now the largest minority group in the United States, the mental health of Latinas has received limited attention from clinicians and researchers. Latinas are perhaps most affected by the stresses resulting from acculturation, including the demands of mastering new cultural values, changes in family structure and organization, and different role demands. These changes are affecting Latinas largely through rising rates of depressive and anxiety disorders (including post traumatic stress disorders). This is seen most clearly in Latina adolescents, who have the highest suicide ideation, planning, and attempt rates of any ethnic/gender group in the United States. At the same time, Latinas face many barriers that prevent them from receiving effective treatment and support services, particularly culturally competent services that can address their specialized needs. This component workshop focuses on the mental health needs of Latina women both from the lifespan perspective (examining the needs and challenges faced by Latina youth and adults) and from the psychopathological perspective (focusing on depression and anxiety disorders, which are most frequently seen in Latinas). Iven This combined perspective will address special diagnostic and treatment considerations in working with Latinas, including special adaptations to treatment to address both cultural and gender specific needs. The epidemiological literature on depression and anxiety in Latina youth and women and necessary the literature on evidence-based approaches to treating Latinas will be reviewed. Given the centrality of Latina women to Latino families, an added perspective that will be examined is the interaction between the mental health of Latinas and the stresses by and functioning of the Latino family.

REFERENCES:
1. Centers for Disease Control and Prevention (2004). Suicide among Hispanics--United States, 1997-2001. Morbidity & Mortality Weekly Report. 53, 478-481
2. U.S. Office of the Surgeon General (2001) Mental health: Culture, race, and ethnicity. A supplement to: Mental health: A report of the surgeon general. Rockville, Md.: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

COMPONENT WORKSHOP 50

RELIGION AND PSYCHIATRY IN THE POST-FREUDIAN AGE

APA Corresponding Committee on Religion, Spirituality, and Psychiatry

Chairperson: John Peteet, M.D., 75 Francis St, Boston, MA 02115

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to recognize the movement of antidepressants and beyond therapy to appreciate the challenge to the sense of spiritual self/identity given the widespread use of mood enhancers and to develop a therapeutic appreciation of antidepressant use among patients with strong ties to faith communities.

SUMMARY:

In this discussion to follow his Oskar Pfister Award Lecture, Dr. Dan Blazer will consider how the growing use of antidepressants influences personality, including our spiritual selves. Are we looking in our society to Prozac to treat modern disorders of the self? What do we expect from antidepressants that only narratives, communities and spiritual resources can provide? What clinical issues need to be addressed in prescribing antidepressants to individuals who are active in faith communities?

REFERENCES:
1. Kramer P: Listening to Prozac. New York, Penguin Books, 1994.
2. Blazer DG: The Age of Melancholy (especially chapter 8). New York, Routledge, 2005.

COMPONENT WORKSHOP 51

PSYCHIATRIC ASPECTS OF BARIATRIC SURGERY

APA Caucus on Eating Disorders

Chairperson: Daniel I Bober, D.O., 173 Russell Senate Bldg., Washington D.C., DC 20510
Co-Chairperson: Jodi E Star, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to: (1) understand the basic types of bariatric surgery procedures being utilized, as well as the current patient criteria and indications; (2) define the current pre-surgical psychological assessment recommended for bariatric surgery candidates, as well as the prognostic significance of mental illness as a predictor of post-operative success; (3) discuss bariatric surgery in children and adolescents; and (4) describe the psychiatrists unique role in the assessment, evaluation and treatment process of patients who are receiveing bariatic surgery.

SUMMARY:

The obesity epidemic continues to remain one of the most significant public health threats worldwide. As obesity causes a variety of medical disorders, including cardiovascular disease, hypertension, and diabetes, public health agencies have recommended maintenance of a healthy weight and aggressive treatment of obesity. Unfortunately, many patients are refractory to standard therapies and are unable to sustain weight loss or maintain control over co morbid medical conditions. Extreme obesity, characterized by a body mass index (BMI) of 40 kg/m2 or greater, is associated with significantly increased mortality. It also is associated with an increased risk of psychosocial complications, including depression, eating disorders, and impaired quality of life. One option for patients who are recalcitrant to standard weight management therapies is bariatric surgery. It routinely induces weight losses of 25% to 30% of initial weight; such weight loss is associated with marked improvements in obesity-related co morbidities, including type 2 diabetes, hypertension, and sleep apnea. With the varying and often temporary success of lifestyle and behavioral weight loss interventions, the number of bariatric procedures performed in the United States has been increasing exponentially. Although bariatric surgery is now relatively safe, it is not a benign procedure. It is elective, and as with all surgery, has risks associated with it. It should not be undertaken unless the chance for success has been optimized and is likely. It is well known that the psychiatric status varies greatly among persons who seek bariatric surgery. Therefore, a multidisciplinary assessment that includes psychiatrists is essential to insuring the best chances of success of patients who elect to undergo this procedure. The purpose of this workshop is to provide clinicians with information regarding the patient selection and indications for bariatric surgery. More detailed presentations will discuss the current recommendations for pre-assessment and evaluation procedures, as well as the role that co-morbid psychiatric disorders play as a predictor on post-surgical success. A final session will focus on the unique role of the psychiatrist in the assessment and treatment process in these patients. Additionally, information will be shared on bariaric surgery in children. Interactive techniques and clinical cases will be utilized to encourage audience participation.

REFERENCES:
1. Wadden, T.A., Sarwer, D.B., Fabricatore, A.N. et al: Psycho-social and Behavioral Status of Patients Undergoing Bariatric Surgery: What to Expect Before and After Surgery. Medical Clinics of North America. Vol. 91. Issue 3. May (2007).
2. Puzziferri, N., Psychologic Issues in Bariatric Surgery--the Surgeon's Perspective. Vol. 85. Issue 4. August (2005).

COMPONENT WORKSHOP 52

ONE IN A MILLION? SAFETY OF TRAINEES IN THE PSYCHIATRIC SETTING

APA/GlaxoSmithKline Fellows

Chairperson: Umee A Davae, D.O., 3333 N. Green Bay Rd., N. Chicago, IL 60064
Co-Chairperson: Han-chun Liang, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to understand the prevalence of assaults on trainees in psychiatric settings, understand and assess the risk of violence by people with mental illness, and develop and discuss guidelines for personal and training program prevention of and response to violence.

SUMMARY:

Violence toward psychiatry residents is an issue of considerable importance, yet the literature on this topic is scant. The risk of violence by individuals with mental illness is debated among researchers. Numbers describing assaults on psychiatric residents during their training vary. Physical and verbal assaults are identified as among the most stressful adversities during psychiatric training. Residents are at the front line of patient assessment and care, and are relatively inexperienced in managing escalating, violent situations. Residents also face risks due to the greater number of hours spent in the hospital, some of which occur during the least secure times. Another contributing factor includes denial of the possibility of patient assaults, which increases the risk of being assaulted. This workshop, led by the APA/GlaxoSmithKline Fellows, will focus on this important topic. Through an interactive case presentation format, the impact of violence toward psychiatry residents will be explored and critically appraised. There will be a review of the existing literature discussing psychiatry resident safety and risk, psychological and fiscal costs, and management of counter transference. Links between mental illness and violence will be reviewed. Audience participation will allow attendees to share personal experiences as well as discuss the need for and development of clear policies addressing violence toward residents in training programs.

REFERENCES:

1. Chaimowitz GA, Moscovitch A: Patient assaults on psychiatric residents: The canadian experience. Can J Psychiatry 36(2):107-110, 1991.
2. Coverdale J, Gale C, Weeks S, Turbott S: A Survey of threats and violent acts by patients against training physicians. Medical Education 35: 154-159, 2001.

COMPONENT WORKSHOP 53

MENTAL HEALTH EFFECTS OF DISASTERS AMONG ETHNIC MINORITY ELDERLY

APA Committee on Ethnic Minority Elderly

Chairperson: Maria Llorente, M.D., 1201 NW 16th Street, #116A, Miami, FL 33125
Co-Chairperson: Iqbal Ahmed, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) recognize the varying belief systems that exist among ethnic minority elderly to explain the causes of disasters; (2) understand how these belief systems impact on coping strategies before, during, and following a disaster; (3) identify the mental health consequences associated with certain natural disasters among ethnic minority elderly, particularly hurricanes; and (4) identify the mental health consequences associated with mass violence disasters among ethnic minority elderly, with particular attention to the September 11 events in New York.

SUMMARY:

Disasters are frequent occurrences, with one disaster occurring daily worldwide. Disasters can be categorized as natural (hurricanes, earthquakes, floods, tornadoes, etc), technological (airplane crashes, nuclear accidents, fires, etc) and mass violence (terrorist attacks, shooting sprees, etc). Older adults are disproportionately at risk for mortality and psychiatric morbidity following most disasters. Ethnic minority elderly, in part, due to health disparities, language barriers, and an increased risk for dementing illnesses, are at even greater risk for these consequences. This workshop will introduce this topic to participants, and encourage the sharing of clinician experiences in working with minority elderly following disasters. The workshop will first describe the belief systems regarding causes of disasters, locus of control, and trust of governmental authority. In some cases, for example, immigrants may be resistant to evacuating to public shelters for fear of arrest and deportation. The workshop will then explore the mental health consequences associated with exposure to two types of disasters, natural and mass violence. Elderly are more likely to suffer adverse mental health consequences for several reasons, including impaired physical mobility, diminished sensory awareness, existing medical conditions, social isolation, and financial constraints. Certain medical conditions, such as diabetes and dementia, are more prevalent among minority elderly, who are also more likely to be isolated due to language barriers and poorer socioeconomic status. Workshop participants will have the opportunity to share strategies regarding disaster preparedness and coping techniques to use with ethnic minority elderly who have been exposed to a disaster.

REFERENCES:

1. Norris FH: Range, Magnitude and duration of the effects of disasters on mental health: review update 2005. www.redmh.org.
2. Fernandez LS, Byard D, Lin CC, Benson S, Barbera JA: Frail elderly as disaster victims: emergency management stratedies. Prehosp Disast Med 2002;17(2):67-74.

COMPONENT WORKSHOP 54

HOT ISSUES IN PSYCHIATRY AND LAW

APA Council on Psychiatry and Law

Chairperson: Paul S. Appelbaum, M.D., New York State Psychiatric Institute 1051 Riverside Drive, Unit 122, New York, NY 10032
Co-Chairperson: Steven K. Hoge, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) identify the advantages and problems with registries restricting firearms purchases by people with mental illness; (2) understand the legal issues faced by psychiatrists working on college campuses; and (3) recognize the varying approaches to providing outpatient services to forensic patients.

SUMMARY:

The Council on Psychiatry and Law monitors developments in law that affect psychiatric practice, and makes recommendations regarding the profession's responses. This workshop provides an opportunity for attendees to learn about several of the most important issues currently being addressed by the Council, and for Council members to obtain feedback about proposed directions. Three "hot issues" will be presented: (1) Registries restricting firearms purchases by certain persons with mental disorders are in place in many parts of the U.S., and their expansion has been proposed in response to recent tragic acts of violence. The Council is working on a resource document that discusses the pros and cons of this approach, and the work to date will be discussed. (2) Recent court cases highlighting the potential for colleges' and their clinicians' liability in the event of suicide, and the murders at Virginia Tech have combined to raise a large number of questions about mental health on college campuses. These include the scope of students' confidentiality (including the role played by the federal HIPAA and FERPA statutes), colleges' responsibility for students' safety, and the rights of disabled students. The council is working jointly with the Committee on College Mental Health to address many of these issues, and the complex issues involved will be described. (3) A growing number of persons with major psychiatric disorders are being drawn into the criminal justice system. Once diverted or released from confinement, however, their outpatient treatment is often problematic. Clinicians and agencies are often afraid of and unwilling to deal with offenders, leaving them liable to decompensation and a return to incarceration. The APA Task Force on Outpatient Forensic Services, a component of the council, will describe the promising models that exist for treatment of this difficult population. Time will be reserved after each presentation for audience participation.

REFERENCES:

1. Appelbaum PS: "Depressed? Get out!": dealing with suicidal students on college campuses. Psychiatric Services 2006;57: 914-916.
2. Fisher WH, Packer IK, Simon LJ, Smith D: Community mental health services and the prevalence of service mental illnesses in local jails: are they related? Admin Policy Ment Health 2000;27:371-382.

MONDAY, MAY 5, 2008

ISSUE WORKSHOP 01

PARAPHILIAS, PERSONALITY DISORDERS, AND PHARMACEUTICALS: UNUSUAL SUSPECTS IN PSYCHIATRIC DEFENSE

Chairperson: Renee M. Sorrentino, M.D., 2 Shaker Road, Office D221, Shirley, MA 01464
Presenters: Susan Hatters Friedman M.D., Joy Stankowski M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will better understand the relationship between mental illnesses and the insanity defense. Participants will learn the criteria for criminal responsibility and its application to paraphilias, personality disorders, and pathological intoxication.

SUMMARY:

What constitutes a crime of insanity? What level of mental illness constitutes "insanity?" Are mental illnesses with a scientific basis successful insanity defenses? Courts considering the insanity defense have not agreed upon what constitutes a disease of the mind. Some courts have defined "mental illness" narrowly as "any abnormal condition of the mind, which substantially affects mental or emotional processes and substantially impairs behavior controls." Other courts define mental illness with exclusionary criteria, such as the exclusion of antisocial personality disorder, while other jurisdictions adopt the definition of mental disorder used in the *DSM-IV*. Although the presence of a mental illness is obviously central in cases involving an insanity defense, the insanity defense is built on legal and moral conceptions about guilt and responsibility. The insanity defense is based on the principle that an individual who suffers from a mental illness may not be able to form willful intent, an essential part of most offenses. The definition of insanity varies by state, but is generally defined as the presence of a mental illness at the time of the crime, which impairs the individual's ability to appreciate the criminality of their behavior. Do paraphilias render a person's reasoning irrational? Do personality-disordered individuals reason irrationally? Is an individual who becomes homicidal after ingestion of an SSRI responsible for his or her behavior? In this workshop the panel will discuss the use of paraphilias, personality disorders, and pathological intoxication with SSRIs as psychiatric defenses. The panel will review actual cases which involved these psychiatric disorders as insanity defenses. In conclusion, the panel will review the legal, ethical, and scientific challenges in the determination of criminal responsibility in these psychiatric syndromes.

REFERENCES:

1. Falk A: Sex offenders, mental illness and criminal responsibility: The constitutional boundaries of civil commitment after Kansas v. Hendricks. American J Law and Medicine 1999; 25(1):117-47.
2. Slovenko R: The mental disability requirement in the insanity defense. Behav Sci Law 1999; 17(2):165-80.

ISSUE WORKSHOP 02

MAINTENANCE OF CERTIFICATION FOR DIPLOMATES OF THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

Chairperson: Patricia W. Tivnan, M.A., 500 Lake Cook Road, Suite

335, Deerfield, IL 60015
Co-Chairperson: Larry R. Faulkner, M.D.
Presenters: Victor Reus M.D., Naleen Andrade M.D., Christopher Colenda M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the four components of the maintenance of certification (MOC) program of the American Board of Psychiatry and Neurology as it applies to general psychiatry and to the subspecialties.

SUMMARY:

The purpose of this workshop is to review the components and requirements of the ABPN's maintenance of certification (MOC) program. The four components are professional standing (licensure), self-assessment and lifelong learning, cognitive expertise,(recertification examination), and assessment of performance in practice. The participants will learn what options are available to complete the MOC requirements as well as what new requirements to expect in the future. A substantial amount of time will be available for the panelists to respond to queries from the audience.

REFERENCES:

1. Shore JH, Scheiber SC (eds): Certification, Recertification, and Lifetime Learning in Psychiatry, Washington, DC, American Psychiatric Press, 1994.
2. Scheiber SC, Kramer TAM, Adamowski S (eds): Core Competencies for Psychiatric Practice: What Clinicians Need to Know. Washington, DC, American Psychiatric Press, 2003.

ISSUE WORKSHOP 03

MALPRACTICE: A DEFENDANT'S PRIMER

Chairperson: Abe M. Rychik, J.D., Melito & Adolfsen, P.C., 233 Broadway, 28th Floor, New York, NY 10279
Co-Chairperson: Eugene L. Lowenkopf, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) understand the process of a medical malpractice lawsuit; (2) participate more effectively within the legal system; (3) know the relevant legal issues and standards, and (4) competently respond to accusations in a court of law.

SUMMARY:

In every malpractice lawsuit there are a number of critical junctures at which time the physician and the attorney can positively or negatively affect the outcome of the suit, regardless of the merits of the case. This workshop presents one case from the viewpoint of the defendant psychiatrist and the defendant's attorney, with emphasis on the decisions and actions to be taken, which in this case contributed to a verdict in favor of the defendant.

The workshop presents the general legal framework and discusses the issues that arise. It offers concrete recommendations for a successful litigation outcome. Included in this workshop are an examination of the following issues: (1) What constitutes malpractice?-standards of care. (2) Venue (state or federal) considerations. (3) Reporting requirements and insurance policy concerns. (4) Role of the insurer vis-à-vis the lawyer and the defendant. (5) Pre-litigation discovery. (6) The pleadings and necessary motions. (7) The discovery process (depositions, interrogatories, fact and expert documents). (8) Plaintiff and cefendant strategies. (9) Trial proceedings. (10) Post-trial activity. (11) Issues of licensure and the National Practitioner's Databank. (12) In summary, this workshop will provide the audience with basic knowledge and recommendations on how to most effectively proceed in a malpractice litigation.

REFERENCES:

1. Lowenkopf EL: Memoirs of a malpractice suit. Jnl of Am Acad. Psychoanalysis 23(4): 731-748, 1995.
2. Rychik AM, Lowenkopf EL: Reviewing medical malpractice and Risk management issues. Psychiatric Times 2000 17(8): 52-54.
3. Engelhart v. County of Orange, 16 A.D.3rd 369, 790 N.Y.S.2d 704 (2nd Dept. 2005).

ISSUE WORKSHOP 04

CROSS-CULTURAL VALIDATION OF SELF-REPORT QUESTIONNAIRES IN NON-WESTERN POST CONFLICT SETTINGS

Chairperson: Peter Ventevogel, M.D., HealthNet TPO Burundi, Avenue Muyinga 28, Bujumbura, Burundi BP 1110
Co-Chairperson: Pim Scholte, M.D.

EDUCATIONAL OBJECTIVES:

At the end of the workshop the participant should be able to: (1)Recognize the advantages and disadvantages of working with brief, self-report screening questionnaires in post-conflict settings in low-resource settings; (2) Use a five step-wise procedure to translate and adapt self-report screening questionnaires; and (3) Describe the steps needed to validate such instruments in low-income countries.

SUMMARY:

Brief, self-report questionnaires are often used to screen for *DSM* disorders for people exposed to collective trauma. These instruments are usually developed and validated in western populations. We cannot therefore assume a-priori that in other cultural and social contexts such instruments will measure what they are intended to measure. A process of translation & adaptation and subsequent cross-cultural validation is needed to tailor the instruments to local circumstances and to assess their practical usefulness. In non-western post-conflict settings the use of self-report questionnaires risks to provide severely distorted results due to factors such as: (1) measuring general expressions of non-wellbeing rather than specific disorders, (2) not assessing the extent to which symptoms are experienced as distressing and (3) ignoring socio cultural influences into the way symptoms cluster. These risks will be discussed and illustrated with experiences from the literature and the authors' own field experience with validation of questionnaires in Afghanistan, Burundi and Rwanda. A five step method for cross cultural adaptation is presented and illustrated with field examples: (1) Translation and lexical back translation; (2) Review by bilingual professionals; (3) Evaluation

in focus group discussions; (4) Blind back translation; and (5) Pilot testing. Translation only is not sufficient. A validation process is needed. Often a DSM derived diagnosis is used as gold standard. In cross-cultural contexts this entails additional pitfalls, necessitating prior assessment of the gold standard itself. Practical issues such as designing a validation research in a community setting, cross-cultural adaptation of a gold standard, and basic procedures for statistical analysis, in particular ROC analysis will be discussed. The workshop will provide the participant with a practical overview of relevant issues in cross-cultural use of self-report questionnaires in post conflict settings.

REFERENCES:

1. Van Ommeren M, Sharma B, Thapa SB, Makuju R, Prasain D, Bhattarai R, De Jong JTVM: Preparing instruments for transcultural research: use of the translation monitoring form with Nepali-speaking Bhutanese refugees. Transcult.Psychiatry 1999; 36:285-301.
2. Ventevogel P, De Vries G, Scholte WF, Shinwari NR, Faiz H, Nassery R, van den BW, Olff M: Properties of the Hopkins Symptom Checklist-25 (HSCL-25) and the Self-Reporting Questionnaire (SRQ-20) as screening instruments used in primary care in Afghanistan. Soc.Psychiatry Psychiatr.Epidemiol. 2007; 42:328-335

ISSUE WORKSHOP 05

MAKING YOUR TALKS MORE INTERACTIVE: THE BETTER WAY!

Chairperson: Jon Davine, M.D., 2757 King Street East, Hamilton, Canada L8K 2G4

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Understand the superiority of interactive group teaching verses traditional didactic models in changing physicians behaviour; (2) Use and participate in different group activities that enhance interactive group teaching; and (3) Maximize the use of commercial film clips and audiovisual patient encountered to enhance group teaching.

SUMMARY:

Educational literature has shown that the traditional didactic 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 review the literature behind these conclusions. We discuss factors that can enhance interactive learning techniques, including room arrangements, proper needs assessment, and methods to facilitate interactive discussion. The workshop will then have an interactive component, which involves 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 film to enhance educational presentations has been coined “cinemeducation.” We discuss techniques to help use film as a teaching tool, and then have an experiential component which will involve the direct viewing and discussion of a film clip to demonstrate principles of using films as a teaching tool. Audio-visual tapes of patient encounters have been used as interactive teaching tools. In this workshop, we will discuss the literature describing how to maximize the use of audiovisual patient encounters as a teaching tool. We will then have another experiential component which will involve direct viewing of an audiovisual tape encounter of a patient where the group will directly participate in an interactive session using the audiovisual tape as a teaching tool.

REFERENCES:

1. Davis D, Thomson Mary Ann et al: Impact of formal continuing medical education: do conferences, workshops, rounds and other traditional continuing education activities change physician behaviour or health care outcomes? JAMA, vol 232, no 9, 1999.
2. Jacques D: Teaching small groups: ABCs of learning and teaching in medicine. BMG, vol 326, 2003.

ISSUE WORKSHOP 06

TREATING THE CHRONICALLY DEPRESSED PATIENT USING THE COGNITIVE-BEHAVIORAL ANALYSIS SYSTEM OF PSYCHOTHERAPY

Chairperson: Eric Levander, M.D., 9171 Wilshire Blvd., Suite 680, Beverly Hills, CA 90210
Co-Chairperson: James P McCullough, Ph.D.

EDUCATIONAL OBJECTIVES:

(1) Learn the scientific rationale for CBASP (Cognitive behav-ioral analysis system of psychotherapy); (2) Learn to diagnose forms of chronic depression; (3) Learn behavioral patterns ex-hexhibited by patients with chronic depression; (4) Learn the rationale for situation analysis; and (5) Demonstrate how to perform situation analysis.

SUMMARY:

As recent evidence from STAR-D demonstrates, medically treating both acute and chronic depression to remission remains a difficult task for the physician. Chronic depressive illness such as dysthymic disorder or major depression with a current episode lasting longer than two years often is more treatment refractory to both medication and standard psychotherapy. The Cognitive Behavioral Analysis System of Psychotherapy (CBASP) was developed specifically to treat the chronically depressed adult. Results from the largest psychotherapy and medication trial ever conducted of 681 participants demonstrated CBASP was as effective as medication alone, and in combination with medication management produced significant improvements in symptom relief. Results from a second large trial of CBASP for 850 patients with chronic major depression will soon be published. Yet few clinicians are familiar with this novel psychotherapy. The principal techniques of CBASP include situation analysis in addition to two types of disciplined personal involvement by the therapist. Situation analysis teaches chronically depressed patients, with global and defeatist perspectives, adaptive and effective interpersonal problem solving skills. Disciplined therapist personal involvement, a taboo from the infancy of

psychotherapy, targets problematic interpersonal behaviors through the use of the Interpersonal Discrimination Exercise (IDE) and Contingent Personal Responsivity (CPR). The IDE is a personal involvement methodology used by the CBASP therapist to heal earlier developmental trauma while CPR employs disciplined personal involvement in a contingent manner to modify pathological interpersonal behavior. With few effective evidence-based psychotherapies used to treat chronic depressive illness, this two-part workshop is designed to give an overview of CBASP as well as an introduction to its major techniques.

REFERENCES:

1. Keller MB, McCullough JP, Klein DN, Arnow BA, Rush AJ, Nemeroff CB, Ninan PT, Kocsis JH, Schatzberg A, Thase ME, Miller V, Keitner G, Markowitz JC: A comparison of nefazadone, the Cognitive Behavioral Analysis System of Psychotherapy and their combination for the treatment of chronic depression. N Engl J Med 2000; 322: 1462-1470.
2. McCullough JP: Treatment for Chronic Depression: Cognitive Behavioral Analysis System of Psychotherapy (CBASP). New York, Guilford Press, 2000.

ISSUE WORKSHOP 07

IMPACT OF PATIENT SUICIDE ON PSYCHIATRY RESIDENTS: A WORKSHOP DISCUSSION

Chairperson: Elizabeth S. Harre, M.D., New York State Psychiatric Institue, 1051 Riverside Drive, New York, NY 10032
Co-Chairperson: Christina V. Mangurian, M.D.
Presenters: Aaron Reliford M.D., Andrew Booty M.D., Francine Cournos M.D., Carolyn Douglas M.D.

EDUCATIONAL OBJECTIVES:

Participants should be able to identify the myriad of feelings residents may have after a patient commits suicide. Participants should be able to better understand their feelings about the experience of patient suicide. Participants should be able to recognize the common colleague and residency training program responses after a patient commits suicide. Participants should also be able to make recommendations for their home institutions to better support residents through this difficult time.

SUMMARY:

According to the Centers for Disease (CDC), almost 31,000 people committed suicide in the U.S. in 2001. Studies estimate that anywhere from 20 to 68% of psychiatrists will lose a patient to suicide at some point in their career. A significant number of residents will experience the suicide of a patient during residency training. Unfortunately, open discussions about the feelings and issues raised in response to suicide are rare in training programs and in the literature. This silence may be due to the shame, guilt, fear, confusion, sadness, and other emotions that exist in residents and their colleagues and supervisors after a patient commits suicide. It is the belief of this panel that this lack of discussion interferes with the use of positive coping strategies by residents during this very difficult experience. The workshop will begin with the resident panelists sharing their experiences after their own patients committed suicide. The attending panelists will then reflect on their early experiences with patient suicide. Audience members will be invited to share their own experiences. The final portion of the session will be devoted to developing helpful strategies that could be proposed to residency training programs to provide better support to residents whose patient commits suicide, including maximizing mentorship/supervision, encouraging senior staff members to share their experiences, education, peer discussions, and case conferences. In general, this workshop will be dedicated to providing a safe place for residents to share the experience of having a patient who commits suicide and to developing better ways to support residents through this experience. This workshop was held at the 2007 APA meeting. Feedback was uniformly positive and it was felt that a much-needed dialogue on this often neglected topic had been initiated.

REFERENCES:

1. Cournos F: Staff reaction to inpatient homicide. Hosp community psychiatry 1985; 36(6):664-6.
2. Gitlin MJ: A psychiatrist's reaction to a patient's suicide. Am J Psychiatry 1999; 156(10):1630-1634.
3. Pilkinton P, Etkin M: Encountering suicide: The experience of psychiatric residents. Acad Psychiatry 2003; 27(2):93-99.
4. Plankun EM, Tillman JT: Responding to the impact of suicide on clinicians. Dir In Psychiatry 2005; 25:301-309.
5. Reeves G: Terminal mental illness: Resident experience of patient suicide. J Am Acad Psychoanal Dyn Psychiatry 2003; 31(3):429-441.
6. Ruskin R, Sakinofsky I, Bagby RM, Dickens S, Sousa G: Impact of patient suicide on psychiatrists and psychiatric trainees. Acad Psychiatry 2004; 28(2):104-110.

ISSUE WORKSHOP 08

PSYCHODYNAMIC PSYCHOTHERAPY WITH SELF-DESTRUCTIVE BORDERLINES

Chairperson: Eric M. Plakun, M.D., Austen Riggs Center, 25 Main Street, Stockbridge, MA 01262-0962
Presenter: Edward Shapiro M.A

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to enumerate principles in the dynamic psychotherapy of self-destructive borderline patients, implement newly acquired skills in establishing and maintaining a therapeutic alliance with such patients, and be familiar with the countertransference problems inherent in work with these patients.

SUMMARY:

Psychotherapy with self-destructive borderline patients is recognized as a formidable clinical challenge. Although much has been written about metapsychological issues in psychodynamic psychotherapy, relatively little practical clinical guidance is available to help clinicians establish a viable therapeutic relationship with these patients. This workshop includes review of eight 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) differentiation of lethal from non-lethal self-destructive behavior,

(2) inclusion of lethal self-destructive behavior in the initial therapeutic contract, (3) metabolism of the countertransference, (4) engagement of affect, (5) non-punitive interpretation of the patient's aggression; (6) assignment of responsibility for the preservation of the treatment to the patient, (7) a search for the perceived injury from the therapist that may have precipitated the self-destructive behavior, and (8) provision of an opportunity for reparation. These principles are compared Linehan's DBT and Kernberg's Transference Focused Psychotherapy (TFP). DBT and TFP arrive at a similar clinical approach to work with suicidal patients despite markedly different theoretical starting points. After the presentation, the remaining time will be used for an interactive discussion of case material. Although the workshop organizers will offer cases to initiate discussion, workshop participants will be encouraged to offer case examples from their own practices. The result should be a highly interactive opportunity to discuss this challenging and important clinical problem.

REFERENCES:

1. Plakun EM: Principles in the Psychotherapy of self-destructive Borderline Patients. Journal of Psychotherapy Practice and Research 1994; 3:138-148.
2. Plakun EM: Making the alliance and taking the Transference in work with suicidal borderline patients, Journal of Psychotherapy Practice and Research 2001; 10: 269-276.

ISSUE WORKSHOP 09

JUMPING OFF A CLIFF, OR THE ROAD NOT TAKEN: ALTERNATIVE CAREER CHOICES AND WHERE THEY LEAD

Chairperson: Deborah Spitz, M.D., University of Chicago, Department of Psychiatry, 5841 S. Maryland--MC 3077, Chicago, IL 60637
Presenter: Edward Silberman M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) identify and prioritize vocational goals, (2) identify and prioritize academic and personal values, and (3) examine areas of conflict in identified goals and values, and consider alternative career options to maximize fulfillment.

SUMMARY:

What happens when you make an unplanned, unorthodox move in an otherwise predictable career trajectory? Can you throw caution to the winds and still land on your feet? Traditionally, an academic career is presented as a sequential developmental process, unfolding logically over time as the protagonist moves from assistant to associate to full professor, from one institution to another for better career opportunities or for promotion, from being mentored to mentoring others in research, education, and clinical projects. Often, however, real-life issues wreak havoc with career planning. As real people juggle two career relationships, unexpected family demands, new opportunities when relationships change or children leave home, and desires to pursue deep interests outside one's career, sometimes the predictable career path seems too limiting for a full life. This workshop, sponsored by the Association for Academic Psychiatry, will explore what happens when academic psychiatrists make career choices off the beaten path. The leaders, two senior psychiatrists who left satisfying academic leadership positions for the unknown (no jobs, new cities, new systems) will share what they found and what they ultimately built, focusing on the challenges and the discoveries that marked their "next acts." In exercises with workshop participants, we will examine how to prioritize vocational needs, how to assess one's values so as to be clear about what is important to carry along and what is possible to leave behind, how to transfer experience from one context to another very different context, and we will explore both the gains and losses that one may encounter in the transition. Unfasten your seat belts!

REFERENCES:

1. Roberts LW, Hilty DM, Hales DJ: Networking. In Handbook of Career Development in Academic Psychiatry and Behavioral Sciences, edited by Roberts LW and Hilty DM, Washington DC, American Psychiatric Press, 2006, pp 299-306.
2. Corbett BA: Taking Care of Yourself. In Handbook of Career Development in Academic Psychiatry and Behavioral Sciences, edited by Roberts LW and Hilty DM, Washington DC, American Psychiatric Press, 2006, pp 307-318.

ISSUE WORKSHOP 10

CHRONIC PAIN, PRESCRIPTION OPIOIDS, AND PSYCHIATRY: CONCEPTS, TOOLS, AND RISK MANAGEMENT TO HELP PATIENTS AND IMPROVE OUTCOME

Chairperson: Alex N. Sabo, M.D., Chairman, Department of Psychiatry, Berkshire Medical Center, 725 North Street, Pittsfield, MA 01201
Co-Chairperson: John F. Rogers, Esq.
Presenter: Jennifer Michaels M.D., John Harrington Ph.D., Donald Burt M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant will understand a comprehensive strategy for assisting PCPs to insure appropriate pain treatment while reducing substance abuse and diversion; an evidence-based pain manual as a blueprint for community care; regulations related to privacy and sharing information; how CBT, depression screening, expert consultation, and buprenorphine wrap-around services are essential elements of a comprehensive strategy to assist PCPs.

SUMMARY:

Practitioners, government, and the pharmaceutical industry have all responded to the call for more effective treatment of pain, and many more patients have been successfully treated. On the negative side, greater availability of opioid pain medication (9.5 billion doses annually by 2003) has led to a troubling rise in misuse and diversion. Prescription opioid abuse now surpasses all drug abuse but, cannabis abuse, is a major gateway to substance abuse; and fuels increased opioid deaths, opioid detoxification admissions and opioid poisoning emergency room visits. Psychiatrists have

a vital role in addressing acute cases of addiction and suicidality complicating the treatment of pain but must also intervene much earlier as a treatment resource, including the up-front assessment of individuals at risk. Psychiatrists are also essential in helping their local health care and community systems defuse this complex problem before it reaches the acute treatment setting. This workshop describes the design, implementation and early feedback on a two-year-old community pain project in Berkshire County, Massachusetts. Baseline data on opioid prescriptions, doctor shopping, and emergency-room opioid overdoses will be compared with follow-up data after a multidisciplinary and community-wide pain management strategy was introduced. Key elements of the strategy will be discussed including: an evidence-based pain manual, legal issues around sharing of information among stakeholders, using technology to integrate information, developing and refining treatment resources such as CBT and buprenorphine wrap-around treatment, and the provision of tamper proof prescription pads. Brief case vignettes will illustrate concepts and promote discussion. Participants in the workshop will be asked to share their views about what may be needed in their own communities, and, if they have participated in similar efforts, what has been most useful in their own experience.

REFERENCES:

1. Fiellin D, Pantalon M, Chawarski M, et al: Counseling plus buprenorphine-naloxone maintenance therapy for opioid dependence, New England Journal of Medicine 2006; 355: 365-374.
2. Ives TJ, et al: Predictors of opioid misuse in patients with chronic pain: A prospective cohort study. BMC Health Research 2006; 6:1-10.

ISSUE WORKSHOP 11

THE WRATH OF GOD: A FAITH-BASED SURVIVAL PARADIGM (VIDEO INTERVIEWS OF SURVIVORS IN THE EARTHQUAKE REGION OF PAKISTAN)

Chairperson: Samoon Ahmad, M.D., 800 Fifth Avenue, New York, NY 10065

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to will understand how faith, religion, society, and family can play a large role in coping mechanisms and apply to their clinical practices. At the conclusion of this session, the participant will recognize that lack of basic necessities and resources cultivates passivity, dependency, hopelessness, resentment and ultimately the potential exploitation by extremist viewpoints.

SUMMARY:

Purpose: An individual's ability to cope with disaster is a function of culture, religion, faith, and many other factors. Common patterns of trauma have emerged among those affected by disaster, irrespective of language, race, or culture, and have been the subject of numerous studies. On October 8, 2005, at 8:52 am, an earthquake measuring 7.5 on the Richter Scale struck Pakistan. More than 250,000 people perished, though the official toll remains around 80,000. The majority of the dead were children. Millions (3.5) are homeless, with no relief in sight. Individuals in this population may cope with disaster differently since they exist as nuclear extended families with strong religious and spiritual belief systems. *Method:* I visited the region twice, interviewed victims and utilized Traumatic Stress Symptom Checklist to assess the prevalence and severity of PTSD, anxiety and depressive Disorder, as well as resiliency factors. Rather than simply screen the survivors, I conducted video interviews with survivors and caregivers so that the resulting video could create awareness and exposure to the plight of children and adults in the region. The 18-minute documentary (The Wrath of God – A Faith-Based Survival Paradigm) has been shown numerous times since its completion and was presented at the ISTSS conference in Los Angeles November 2006. Interviews were conducted in Urdu and survivors ranging in age from 13-70 were screened. Findings: The role of God was quite prevalent, as was a shift from a collective society to an individualistic one and disintegration of familial bonds. Despite high scores on the TSSC, suggesting high prevalence of PTSD and depressive disorder, there was less incidence of suicide and more optimism due to faith and religious belief systems. It received The Internationa Society for traumatic strees studies 2007. Frank Ochberg Award for Media and Trauma Study."

REFERENCES:

1. Matt Gillard, Douglas Paton,The Australasian Journal of Disaster and Trauma Studies ISSN: 1174-4707 Volume : 1999-2.
2. A.J.W.Taylor, Ph.D, TRAUMATOLOGYe, 4:1, Article 3, 1998.

ISSUE WORKSHOP 12

PSYCHOPATHY AND ADDICTION AMONG CRIMINAL JUSTICE POPULATIONS: NEW DIRECTIONS

National Institute on Drug Abuse

Chairperson: Wilson M. Compton III, M.D., 6001 Executive Blvd MSC5153, Bethesda, MD 20892-9589
Co-Chairperson: Joseph Frascella, Ph.D.
Presenters: Linda Teplin Ph.D., Scott Henggeler Ph.D., Kent Kiehl M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will understand the relationship of conduct disorder and psychopathy to drug addiction, will understand key abnormalities of paralimbic structures among incarcerated youth with pschopathic traits, and will understand key treatment principles for juvenile delinquents with conduct disorder.

SUMMARY:

Mental health problems in prison and other criminal justice settings include high rates of drug addiction and psychiatric illness. This workshop will present recent findings that address the inter-related problem of antisocial syndromes (including conduct disorder in juveniles as well as antisocial personality and psychopathy in adults) and addiction. Trajectory analysis

of juvenile justice subjects shows complex overlap among antisocial syndromes, addiction, and HIV-risk behaviors as juveniles transition to adulthood. Morbidity and mortality are markedly increased and is a major public health concern. Clinical neuroscience studies of youth and young adults document that the brain regions implicated in psychopathy include the orbital frontal cortex, insula, anterior and posterior cingulate, amygdala, parahippocampal gyrus, and anterior superior temporal gyrus--collectively termed the paralimbic system. Abnormalities in these brain regions may relate to the key symptoms of impulsivity, irresponsibility, poor behavioral control, promiscuity and lack of empathy, guilt, or remorse. Finally, treatments can interrupt the negative developmental and social trajectories among youth with antisocial traits. Among the most effective are family-based interventions like multisystemic therapy. Applying these interventions in juvenile justice settings is quite promising.

REFERENCES:

1. Washburn JJ, Romero EG, Welty LJ, Abram KM, Teplin LA, McClelland GM, Paskar LD: Development of antisocial personality disorder in detained youths: the predictive value of mental disorders. J Consult Clin Psychol. 2007;75 (2:221-31.
2. Kiehl KA: A cognitive neuroscience perspective on psychopathy: evidence for paralimbic system dyfunction. Psychiatry Res 2006;142(2-3):107-28.

ISSUE WORKSHOP 13

PSYCHIATRIC SERVICES FOR GIRLS AND WOMEN IN CORRECTIONAL FACILITIES

Chairperson: Cassandra F. Newkirk, M.D., 621 NW 53rd St., Boca Raton, FL 33428
Presenters: Otis Anderson III M.D., Saundra Maass-Robinson M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify predisposing factors that increase the chances of some girls and women being incarcerated. Participants will also be able to recognize the challenges of providing adequate psychiatric treatment to girls and women in correctional settings whose primary focus is control and not treatment.

SUMMARY:

During the last decade the number of girls and women entering the criminal justice system has increased twice as fast as male offenders. There are now more than one million women involved in some sort of criminal justice oversight. Women and girls now comprise 7% of the incarcerated population. The biopsychosocial factors that have impacted the lives of these girls and women lead to extensive and complex psychological and physical issues that must be addressed during their incarceration. More women than men report using drugs prior to their incarceration. More than half of the girls and women report having experienced physical and/or sexual abuse at some point in their lives with subsequent mental distress and disorders. It is imperative that psychiatrists understand the complexities of the lives of these girls and women as the majority will be released back into the communities. There are now innovative programs in communities as well as correctional facilities that are positively impacting the lives of these girls and women involving mental health and recovery. The special issues that these women have experienced and the treatment during incarceration are important to understand as they make their transitions back into their communities so as to increase the likelihood of their not returning to the criminal justice system.

REFERENCES:

1. Braithwaite R, Arriola K, Newkirk C: Health Issues Among Incarcerated Women. New Brunswick, NJ, Rutgers University Press, 2006.
2. Van der Kolk B: Assessment and Treatment of Complex PTSD. In Treating Trauma Survivors With PTSD, edited by Yehuda R, Washington, DC, American Psychiatric Press, 2002.

ISSUE WORKSHOP 14

POETS, PSYCHIATRIC TREATMENT, AND THE CREATIVE PROCESS

Chairperson: Richard M. Berlin, M.D., 856 Lenox Road, Richmond, MA 01254,
Co-Chairperson: Vanessa Haley, L.C.S.W.
Presenters: J.D. Smith M.A., Vanessa Haley L.C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the crucial role of effective psychiatric treatment in enhancing the creative process. Participants will also develop a more comprehensive understanding of the current theories and myths about creativity in patients who suffer from a psychiatric disorder.

SUMMARY:

Many people still believe the myth that if suffering is relieved by effective psychiatric treatment, then the creative process may be impaired. In part, this myth is based on the romanticized stories of anguished poets and artists who are now deceased. This workshop will include presentations by three living poets who will provide a contemporary view of the impact of psychiatric treatment on creativity. Richard M. Berlin, M.D.,a poet and psychiatrist, will provide a brief review of the many theories about psychiatric treatment and creativity. Two of our finest contemporary poets, Barbara Lefcowitz and John Smith, will subsequently describe their personal experiences with psychiatric treatment and reveal the ways treatment influenced their creativity. The presentations will address many of the key questions about psychiatric treatment and creativity: Do poets need to be mentally ill to produce great work? Does mental illness enhance or diminish creativity? What is the impact of substance use/abuse? What are the benefits and risks of prescribed psychoactive medications? Is creativity heightened by treatment or does treatment reduce emotional pain to the extent that the poet no longer has anything to say? Does a

person have to be "crazy" to write good poetry? What do poets themselves define as crucial elements in their creative process?

REFERENCES:

1. Berlin RM: Poets on Prozac: Mental Illness, Treatment, and the Creative Process. Baltimore, Johns Hopkins University Press, 2008.
2. Rothenberg A: Creativity and Madness: New Findings and Old Stereotypes. Baltimore, Johns Hopkins University Press, 1990.

ISSUE WORKSHOP 15

COMPLEXITIES OF POST-TERMINATION RELATIONSHIPS

Chairperson: Malkah T. Notman, M.D., 54 Clark Road, Brookline, MA 02445
Presenters: Elissa Benedek M.D., Carl Malmquist M.D., Linda Jorgenson J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better evaluate and implement boundary limits to a variety of psychiatric relationships including psychopharmacology, consultations and intensive psychotherapy.

SUMMARY:

Although the APA ethics guidelines state that "once a patient always a patient" and this is understood to mean that ethical restrictions always apply to relationships with former patients, this does not address the range and variability of post-termination encounters. During psychotherapy the boundary limits concerning certain kinds of relationships are not always clear. However, sexual relationships during psychotherapy are always considered unethical. The limits to business relationships are less clear, although exploitative relationships such as having a patient barter demeaning service for payment are certainly unethical. Post termination boundaries and the ethical and clinical implications of post termination relationships are even less clear and are less addressed. Post-termination sexual relationships are usually still considered unethical by the APA. Different professional groups such as psychology and social work have somewhat different guidelines. However, friendships and social and collegial relationships remain an ambiguous area. In some situations they are inevitable. Sometimes they verge on intimacy; sometimes they become the basis of political alliances in departments or programs. The differences between relationships developed in long and intensive psychotherapy and those in more limited encounters, such as consultations or medications visits also need to be considered. This workshop will address the nature, implications, and consequences of a variety of post-termination relationships. Strategies for management will be considered. A videotape will present several vignettes of post-termination relationships. They will be discussed by the workshop members in terms of a range of positions--a strict interpretation of ethical rules and a broader view. Audience participation and discussion will be encouraged. Previous presentations by this group have considered other boundary issues and have generated lively discussions.

REFERENCES:

1. Applebaum PS, Jorgenson LM: Psychotherapist-patient sexual contact after termination of treatment: An analysis and a proposal. Am J Psychiatry 1991; 148: 1466-1473.
2. Malmquist CP, Notman M: Psychiatrist-patient boundary issues following treatment termination. Am J Psychiatry 2001;
1010-1018.

ISSUE WORKSHOP 16

TEACHING AND LEARNING AT THE MEDICAL-PSYCHIATRIC INTERFACE: A RESIDENCY TRAINING PERSPECTIVE

Chairperson: Henry W. Weisman, M.D., Consultation-Liaison Psychiatry, Temple University Hospital, 3401 North Broad St., Philadelphia, PA 19140
Co-Chairperson: Kaplan Lawrence, M.D.
Presenters: Natalia Ortiz M.D., Neil Sanuck M.D., Sheri Hollander M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to define the educational goals of the consultation-liaison training experience, discuss ways to teach around the psychiatric consultation process, describe the role of residents as teachers, and describe the benefits and difficulties of an integrated learning experience for psychiatric and medical residents.

SUMMARY:

Consultation psychiatry services have traditionally addressed educational as well as cliical interests. However, in recent years, the formal liaison component of our work has decreased, although patient and trainee needs have not. This workshop addresses the question: How do we learn and how do we teach at the medical-psychiatric interface in a post-liaison era? The workshop leaders are two consultation-liaison psychiatry/psychosomatic medicine attendings, an academic internist, two psychiatry residents and one resident from internal medicine who has rotated on consultation-liaison. The reorganization of our C-L service over the past two years has provided us the opportunity to build our program around the academic needs of our residents (among others) in the process of answering consultations. This workshop focuses on the interface between psychiatry and internal medicine at the resident training level. We ask ourselves and participants the following questions: (1) What are the target competencies required of our trainees? (2) How do these differ between internists and psychiatrists? (3) What is the value of an integrated learning experience? and (4) How do our residents function as teachers of other resident colleagues while they are learning psychosomatic medicine, and answering consults? The C-L rotation provides a full spectrum of psychopathology, ranging from common major psychiatric disorders and substance-use disorders, to disorders specific to the interface, including delirium, dementia, somatoform disorders, and the psychological issures of patient and family coping with medical illness and hospitalization. It requires that residents work and learn in close contact with interdisciplinary colleagues, learning aspects of the practice of their specialties, including

clinical language and culture, and invites innovations in learning and teaching. We present this workshop as a work in progress toward novel ways of teaching and learning at the interface.

REFERENCES:

1. Strain JJ, George LK, Pincus HA, et al: Models of mental health training for primary care. Psychosomatic medicine 49:88-98, 1987.
2. Andrews LB, Burruss JW: Core Competencies for Psychiatric Education: Defining, Teaching and Assessing Resident Competence. Washington, American Psychiatric Publishing, 2004.

ISSUE WORKSHOP 17

INTERNET-ASSOCIATED MENTAL HEALTH PROBLEMS: DESIGNING TREATMENT PLANS BASED ON PSYCHIATRIC NOSOLOGY

Chairperson: Daniel J. Pimstone, B.S., Cedars-Sinai Medical Center, Thalians Building, 8730 Alden Drive, Room 101,, Los Angeles, CA 90048
Co-Chairperson: Jeffery Wilkins, M.D.
Presenters: Jack Kuo M.D., William Huang M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, within the context of psychiatric nosology, the participant should be able to: (1) Provide a definition of internet addiction and its subtypes; (2) Describe the difference between internet addiction and addictions that use the internet as their vehicle; (3) Understand different types of online programs and why they have addictive potential; and (4) Potentially use various treatment modalities for patients with internet addiction.

SUMMARY:

Internet-associated mental health problems are a hot topic in today's computer and technology savvy world; however, many professionals in psychiatry do not have a solid foundation in understanding how the internet works, what types of mental health problems may be exacerbated by or potentially created through internet use, and what treatment modalities are appropriate. For example, different subtypes of internet addiction require conceptually different understanding and treatment approaches. One highly susceptible group to internet addiction are participants of massive multi-player online role-playing games (MMORPGs) such as World of Warcraft and Everquest. These users are drawn into an alternate real-time world where assimilation requires complete devotion of time and focus, often consuming 40+ hours per week. Two types of users are found in this realm: those that use their online persona as a playful expansion of the self, and those that use this persona to meet or substitute for an apparent inner need. It is important to further delineate these gamers from addicts who use the internet as a vehicle to satisfy their addiction needs, such as those addicted to pornography, gambling and shopping. We will present a theoretical basis for MMORPG-associated behavioral problems as unique to the world of internet addiction and one for which current psychiatric nosology may not apply. In this workshop, we will review current definitions and literature for internet addiction, describe the role that technology plays in shaping and streamlining compulsions, and propose multi-faceted treatment plans that will best address the complexities of such addiction. This presentation will also include interactive real-time projected internet activities as well as role-playing online and case presentations by specialists in the field of addiction. In summary, we will bring to light new and promising solutions to the growing and largely undefined epidemic of internet addiction.

REFERENCES:

1. Allison SE, Von Wahlde L, Shockley T, Gabbard GO: The development of the self in the era of the internet and role-playing fantasy games. American Journal of Psychiatry, March 2006; 163:3:381-385.
2. Ng BD, Wiemer-Hastings P: Addiction to the internet and online gaming. Cyberpsychology and Behavior, November 2005; 8:110-113.

ISSUE WORKSHOP 18

DO-NOT-RESUSCITATE ORDERS IN SUICIDAL PATIENTS: CLINICAL, ETHICAL, AND LEGAL DILEMMAS

Chairperson: Stephen M. Soltys, M.D., SIU School of Medicine, Department of Psychiatry, 3605 Brandonshire Drive, Springfield, IL 62704
Presenters: Renee Cook D.O., Philip Pan M.D., Ross Silverman J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to quickly decide how to handle do-not-resuscitate orders secondary to a suicide attempt with an awareness of the ethical and legal complexities involved.

SUMMARY:

The introduction of advance directives can be seen as a major positive contribution to patient rights in medicine starting in the 1960s. Patients who have these important documents are able to make known their wishes about end-of-life care should there come a time when they are unable to voice these decisions because of certain medical conditions. Physicians are strongly encouraged, and in some states are required by law, to comply with these legal documents provided they have been completed in the appropriate manner. Seriously suicidal patients often include updating wills and making specific financial arrangements in their preparations for an attempt. Increasingly, these preparations may include developing an advance directive with do-not-resuscitate (DNR) provisions with intent that if the patient is found, nothing will be done to resuscitate them. Using a case presentation as a focus to illustrate those dilemmas such situations present, this highly interactive workshop will feature a senior psychiatry resident, two psychiatrists (one with forensic background) and an attorney to discuss the clinical, ethical, and legal issues raised by such situations. Participants will be asked to share situations they have faced in their own practices. Among the topics dealt with will be understanding the leeway that various state laws give physicians in not following a DNR advance directive, evaluating patient requests for DNR orders and directives, use of ethics

consultations when the psychiatrist believes a DNR directive should not be enforced, and how to handle the clinical issues that underlie a DNR request in a suicidal patient.

REFERENCES:

1. Ganzini L, Lee MA, Heintz RT, Bloom JD: Do-not-resuscitate orders for depressed psychiatric patients. Hospital and Community Psychiatry 1992; 43:915-919.
2. Hall SP: An analysis of dilemmas posed by prehospital DNR oOrders. The Journal of Emergency Medicine 1997; 15:109-111.

ISSUE WORKSHOP 19

CHILDREN AND TRAUMA: RESPONDING TO SPECIAL POPULATIONS RANGING FROM MILITARY CHILDREN TO THOSE EXPOSED TO NATURAL DISASTERS AND MUCH MORE

Chairperson: Heather L.. Shibley, M.D., Medical University of South Carolina, 67 President Street, Institute of Psychiatry, Charleston, SC 29425
Co-Chairperson: Niru Nahar, M.D.
Presenters: Stephen Cozza M.D., Steven Berkowitz M.D., Arshad Husain M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be able to: Identify the special needs of children during times of disaster and trauma learn about the current knowledgebase for the preparation and response and treatment of children with trauma-related disorders and recognize the importance of the need for further research and widespread implementation of these practices.

SUMMARY:

Many children experience traumatic events such as abuse, illness, domestic or school violence, and natural and human-made disasters. In addition, as Operation Iraqi Freedom continues, many children are struggling with the stressors of repeated service member parent deployment, parental stress-related illness, and parental injury or death. As with adults children's responses are likely to be related to the level of trauma. Most children are likely to remain healthy; others can become distressed and experience symptoms that interfere with daily functioning. Due to their greater dependence, magical thinking, or less mature cognitive processes, children are at a higher risk for poorer outcomes. We propose a panel of speakers to address the special needs of children during periods of disaster and trauma. In addition, these speakers will discuss methods of implementing the proposed interventions in schools, clinics, and in community disaster scenes. This workshop is meant to distinguish the concepts of disaster and trauma and to discuss current practices related to disaster preparation, response, and treatment of exposed children. This workshop seeks to generate ideas that inform our future research agenda, trauma response strategies, and treatment approaches appropriate for pediatric subjects. As a multi-component education effort, the session will also promote effective collaboration between respective APA and AACAP disaster and trauma committees. Workshop co-chairs will encourage audience participation around these topics, with special emphasis on the needs of children of special populations: children of combat exposed service members, those with developmental disorders, with pre-existing psychiatric illness or other identified at-risk groups.

REFERENCES:

1. Cohen JA, Mannarino AP, Gibson LE, et al: Interventions for children and adolescents, in Mental Health Interventions Following Mass Violence and Disasters, Guilford New York, 2006.
2. Cozza, SJ, Chun RS, Polo JA: Military families and children during Operation Iraqi Freedom. Psychiatric Quarterly Winter
2005; 76(4): 371-378.

TUESDAY, MAY 6, 2008

ISSUE WORKSHOP 20

OFF-LABEL USE OF PSYCHOTROPIC MEDICATIONS IN CONSULTATION-LIAISON PSYCHIATRY: MEDICO-LEGAL ISSUES

Chairperson: Ramaswamy Viswanathan, M.D., State University of New York Downstate Medical Center, 450 Clarkson Av # 127, Brooklyn, NY 11203-2098
Presenters: Rebecca Brendel M.D., John McIntyre M.D., Paul Appelbaum M.D., James Levenson M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) understand the legal and regulatory principles underlying the labeling of medications, (2) appreciate that in consultation-liaison psychiatry one often has to use psychotropic medications off label, and (3) learn how to minimize medico-legal risks while optimizing patient care in using psychotropic medications off label in the consultation-liaison psychiatry setting.

SUMMARY:

Off-label use of psychotropic medications is common in the medical/surgical setting. Pharmaceutical manufacturers typically apply for FDA labeling approval of psychotropic medications for the treatment of major psychiatric disorders, primarily using studies on patients in psychiatric settings. Due to cost, resources required, difficulties in doing studies and marketing considerations, they do not apply for FDA labeling approval for other kinds of psychiatric disorders such as those due to a general medical condition, even though these agents might be effective in those conditions also. Hence consultation-liaison psychiatrists in the medical/surgical setting are often forced to recommend medications off-label, based on factors such as their knowledge of the kinds of symptoms a particular medication can be good for, and evidence of varying levels in the literature. This workshop will discuss (1) the general legal, regulatory, and professional practice standards aspects of on-label and off label medication use; and (2) how to minimize medico-legal risks while optimizing patient care in using psychotropic medications off label in the consultation-liaison psychiatry setting. Members of the audience will be encouraged to discuss their own experiences, their concerns, and suggested solutions including proper documentation of reasoning and consent, literature support, protocol development, and peer

consultation.

REFERENCES:

1. Nightingale SL: Off-label use of prescription drugs. American Family Physician 2003; 68:425-427.
2. American Academy of Pediatrics, Committee on Drugs: Uses of drugs not described in the package insert (Off-label uses). Pediatrics 2002; 110:181-183.

ISSUE WORKSHOP 21

PEARLS AND PITFALLS IN NEGOTIATING YOUR FIRST JOB

Chairperson: Molly K. McVoy, M.D., 11100 Euclid Ave., Cleveland, OH 44106
Presenter: William Campbell M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to understand key concepts necessary for sound decision-making in negotiating professional employment.

SUMMARY:

Experience has shown that residency programs in psychiatry do not adequately prepare residents for the job market. Psychiatry residents must acquire a working knowledge of both the common and competing interests of employers and employees to adequately protect their interests. This workshop provides a systematic review of key concepts that will empower the participants to make sound decisions when negotiating their first job. The faculty, the director of a large mental health care system and former health maintenance organization senior executive, will cover the key concepts in a PowerPoint presentation. Following the presentation, ample time will be devoted to a Q&A session to promote faculty-participant interaction.

REFERENCES:

1. American Psychiatric Association: Member's Corner. Practice Management for Early Career Psychiatrists: A Reference Guide. Available at http://www.psych.org/members/ecp/index.cfm (APA membership is required to access this document).
2. Fisher R, Ury W, Patton B: Getting to Yes: Negotiating Agreement Without Giving In. 2nd Edition. New York, NY, Penguin Books, 1991

ISSUE WORKSHOP 22

VIETNAM VETERANS AND THE IRAQ WAR: IS THE PAST EVER THE PAST?

Chairperson: Laura C. Kordon, M.D., 541 N Fairbanks Ste 2719, Chicago, IL 60611
Co-Chairperson: Eric T. Glessner, L.C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize how current events and issues affect patients with PTSD, how past traumatic events impact interpretation of the present, and how the clinician can effectively respond to these complaints.

SUMMARY:

Vietnam Veterans with post traumatic stress disorder (PTSD) have unique emptional reactions and responses to the U.S. war in Iraq. This workshop will address the experiences of these patients specifically the presentation and manifestation of PTSD, how current issues trigger the past, and how the past impacts interpretation of the present. These veterans' interpretations of current events are implicitly connected to and colored by past events. Predominate complaints of combat veterans with PTSD include sensitivity to reminders of the war, re-experiencing of past military events, and persistent avoidance of these reminders resulting in social isolation. Discussion of this topic will enhance the clinician's ability to recognize the impact and ramifications of trauma in trauma survivors.

REFERENCES:

1. Solomon, A: Trajectories of PTSD: A 20-year longitudinal study. Am J Psychiatry 2006; 4 659-666.
2. Shay J: Odysseus in America: Combat Trauma and the Trails of Home Coming. Schribner, 2002.

ISSUE WORKSHOP 23

MENTAL HEALTH ISSUES IN RESPONSE TO HURRICANES KATRINA AND RITA

National Institute of Mental Health

Chairperson: Agnes E. Rupp, Ph.D., 6001 Executive Blvd., Bethesda, MD 20892-9631
Presenters: Sheryl Kataoka M.D., Lisa Jaycox Ph.D., Audra Langley Ph.D., Michael Schoenbaum Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be informed about trauma-related health service needs as a result of Hurricanes Katrina and Rita, and recognize the long-term public health and public mental health impacts of natural disasters.

SUMMARY:

This set of papers, presented by researchers from three different institutions, highlights unique perspectives about mental health service delivery for adults and children in response to a large-scale disaster. In-depth description of service delivery from New Orleans school and community-based clinicians and factors at the child, provider, system, and policy levels affecting mental health services in schools is addressed by Dr. Kataoka. Dr. Jaycox will then discuss barriers and facilitating factors in providing mental health care in schools across several states affected by Hurricanes Katrina and Rita. Successes and challenges across these states in providing services post-disaster will be presented. Next, Dr. Langley will focus on the implementation of evidence-based practice in response to trauma-related mental health symptoms in youth. Results of a randomized trial comparing two evidence-based treatments, CBITS, which is a group intervention delivered in the school setting and TF-CBT, which is delivered individually to youth in a clinic setting, will be discussed. Finally, Dr. Schoenbaum will present a model for estimating mental health need as a result of Hurricanes Katrina and Rita and the costs associated with providing evidence-based treatment models to meet the needs of all adults and children who developed mental

health symptoms following the hurricanes. He will discuss the policy implications for such a wide-scale response, and innovative ways to overcome system capacity issues in post-disaster situations.

REFERENCES:

1. Jacox LH, Morse LK, Tanielian T, Stein BD: How Schools Can Help Children Recover from Traumatic Experience. RAND Research Brief 2006; RB9229.
2. Wang PS, RE Powers, M Schoenbaum, AH Speier, KB Wells, RC Kessler: Disruption of existing mental health treatments and failure to initiate new treatments after Hurricane Katrina. Forthcoming in the Am J Psychiatry.

ISSUE WORKSHOP 24

TEACHING ON THE FLY: PRACTICAL TIPS FOR TEACHING MEDICAL STUDENTS ONE-TO-ONE

Chairperson: Andrea E. Waddell, M.D., 1-ES-565 - 200 Elizabeth Street Toronto General Hospital, Toronto, Canada M5G 2C4
Presenters: Lana Benedek B.A., Kien Dang M.D., Jodi Lofchy M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Discuss the basic theories of one-to-one teaching of psychiatry to medical students, (2) Demonstrate techniques used to engage a medical student in one-to-one teaching, and (3) Apply advanced techniques in challenging one-to one teaching situations.

SUMMARY:

Residents are actively involved in the teaching of medical students during their clinical rotations providing more than 50% of inpatient teaching to medical students and approximately 30% of teaching to other housestaff. Despite their role as teacher, many residents do not receive any training on how to teach effectively. This is one of two workshops to help residents and early career psychiatrists develop effective teaching skills. This workshop will review the theory behind effective one-to-one teaching and demonstrate the skills needed to teach effectively in this way. Participants will have opportunities to develop their teaching skills throughout this workshop. In the latter portion of the workshop, participants will work in a small group to develop techniques to effectively engage challenging students in a one-to-one teaching session. This workshop is an updated version of one previously offered at the APA and includes new vignettes and roleplays.

REFERENCES:

1. Gordon J: ABC of learning and teaching in medicine: one to one teaching and feedback. BMJ: 2003; 326:543-5.
2. Hicks PJ, et al: To the point: medical education reviews--dealing with student difficulties in the clinical setting. Am J Obstet Gynecol 2005 Dec;193(6):1915-22.

ISSUE WORKSHOP 25

COMPUTER-MEDIATED RELATIONSHIPS: BLOGS, ONLINE COMMUNITIES, AND VIRTUAL WORLDS

American Association for Technology in Psychiatry

Chairperson: Robert C. Hsiung, M.D., 5737 South University Avenue, Chicago, IL 60637
Presenters: Steven Daviss M.D., Jerald Block M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able (1) to describe the differences between blogs, onlines communities, and virtual worlds; and (2) to list potential benefits and risks of participating in each.

SUMMARY:

There's more to the internet than Google. What should you know if you or your patients do more than just surf the web? Three psychiatrists and three patients introduce basic ideas and vocabulary and discuss their firsthand experiences with blogs, online communities, and virtual worlds. Some of the questions posed by a blog are how to define and reach one's audience, what to write about, how often to post, how to handle responses, and how to limit without unnecessarily precluding links to other blogs and useful information. Legal and ethical issues include blogging anonymously, including clinical scenarios, establishing physician-patient relationships, liability, and censorship. Patients in online communities post to educate each other about medication, alternative treatments, and transference; to relieve stress, loneliness, and boredom; to share their ups and downs; or just to procrastinate. If they reveal too much, especially if it is archived, friends, family, or therapists may be angry or jealous, but without some openness, group members will not get to know each other. Conflicts with fellow posters or a moderator may inhibit posting, as may fear of addiction. Online relationships can interfere with "real" relationships -- or be practice for them. "Virtual worlds" are even more elaborate computer interfaces where people connect in visually rich and "alive" settings. In the past decade, there has been an exponential increase in their use, and millions of people now visit them each day. More telling, commerce has invaded them; participants now buy and sell virtual property and services for real cash. Yet patients rarely speak of the virtual worlds they inhabit. Perhaps this is understandable. Do psychiatrists really need to know about these virtual worlds? Can we adequately imagine them? What do we think when patients go there for several hours, every night for weeks on end, with 40 "friends" they never actually meet?

REFERENCES:

1. Hsiung RC: The best of both worlds: an online self-help group
hosted by a mental health professional. CyberPsychology & Behavior 2000; 3 (6): 935-950.
2. Block JJ: A (virtual) world of their own: computer gaming and
your patients. Oncology Net Guide 2005. 6 (5). http://www.oncologynetguide.com/v6n5/pc_block.php.

ISSUE WORKSHOP 26

FIBROMYALGIA: CURRENT UNDERSTANDING AND FUTURE DIRECTIONS

Chairperson: Alan Z. Manevitz, M.D., 60 Sutton Place South, Suite #1CN, New York, NY 10022
Co-Chairperson: James Halper, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to learn to diagnose fibromyalgia, to learn approaches to current and future clinical treatment of fibromyalgia, and to understand the pathophysiology and new research of fibromyalgia.

SUMMARY:

Fibromyalgia syndrome (FMS) is a common, chronically painful, frequently disabling disorder of unknown origin. Epidemiologic data indicate that FMS affects at least 2 to 6% of the general population in the U.S. (approximately 5-12 million persons). Six to ten percent of all individuals in a medical physician's waiting room may have FMS. In addition to the pain classification criteria, FMS patients report a variety of other clinical symptoms, including psychiatrically relevant anxiety, depression, headaches, and dysfunctional sleep. Fibromyalgia is associated with high rates of disability, increased health care utilization, more frequent psychiatric consultations, and a greater number of lifetime psychiatric diagnoses than controls. More and more patients with this frustrating disorder present themselves or are referred to psychiatrists, and/or even diagnosed for the first time by psychiatrists, and are treated with psychotropic medications. In the past there was a common perception that FMS was just a manifestation of depression. We now understand the prevalence of depression in FMS is about 40%. The pain associated with FMS appears to involve many physiologic components of nociception, so the earlier perception that patients were psychosomatic malingerers has been replaced by the recognition of neurophysiologial abnormalities such as abnormal brain imaging and abnormal levels of CSF substance P. During the presentation, presenters and audiences will share cases of psychiatric disorder and abnormal pain so the psychiatrist will (1) better be able to recognize and diagnose FMS; (2) learn up-to-date clinical approaches to treatment of this complex disorder including the latest information about the use of milnacipran, prgablin, duloxtine and other medications; (3) learn about new research findings that indicate FMS is a primary CNS disorder and thus may be better treated by psychiatrists rather than rheumatol.

REFERENCES:

1. Fibromyalgia Update on Mechanisms and Management: Clauw, DJ: Journal of Clinical Rheumatology:2007,13:102.
2. Journal Article Duloxetine and other antidepressants in the treatment of patients with Fibromyalgia: Arnold LM; Pain Medicine 2007; 8:Supp2:563.

ISSUE WORKSHOP 27

MID TO LATE LIFE ONSET OF SUBSTANCE USE DISORDERS: RISK, DIAGNOSIS, AND EVIDENCED-BASED TREATMENT IN AN ETHNO-CULTURALLY DIVERSE POPULATION

Chairperson: Neeraj Gandotra, M.D., VA Hospital (West Haven),950 Campbell Ave., Building 36, West Haven, CT 06516
Co-Chairperson: Louis A Trevisan, M.D.
Presenters: Neeraj Gandotra M.D., Lily Arora M.D., Zinaida Boutaeva M.D., Denis Drubetskiy M.D., Raquel Lugo M.D., Sergio Yero M.D., Bachaar Arnaout M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to define the nature and prevalence of substance use disorders in an ethnically evolving elderly primary care and geriatric clinic; describe and discuss the initial evaluation of substance use and dependence in ethno-culturally defined populations of elderly patient; and review evidence-based approaches to pharmacologic, psychosocial, brief treatment and formal substance abuse treatment options available.

SUMMARY:

The onset of substance abuse is primarily considered to occur in teenagers and young adults. Few studies have described substance abuse in older populations and fewer have examined later life onset substance abuse in many ethnic groups. The number of adults over age 50 requiring treatment is expected to double by 2020 and minority populations have already experienced this phenomenon. Compounding the scarcity of research with this population is lack of a consensus definition for late-onset substance abuse. The purpose of this workshop is to present the current information about mid to late-onset substance use and through the discussion provide the participants with the latest information about risk factors, age-related changes, prevalence, and treatment options for culturally diverse populations. Given the relatively high prevalence and poor identification of substance use in the elderly, this workshop fulfills a critical ongoing educational need for geriatric psychiatrists, internists, family practitioners, and allied professionals who work directly with "at risk" and substance abusing elderly patients from varying cultural and ethnic backgrounds. While screening techniques, psychosocial and pharmacologic interventions have been developed and are supported in the literature, a comprehensive review and demonstration of available treatment options with respect to the culturally sensitive issues of various ethnic groups will enhance the clinical competence of clinicians treating this population. While a great deal of research is yet needed, several studies in the past few years have clarified the use of assessment tools, brief interventions and pharmacologic treatments of substance abuse in the elderly. This workshop aims to increase the psychiatrists' competence by reviewing the initial assessment and work up of substance abuse, reviewing brief versus focused treatment, and finally, reviewing the available literature on the latest pharmacologic treatments of substance abuse.

REFERENCES:

1. Thomas L. Patterson, Ph.D. and Dilip V. Jeste, M.D. The Potential Impact of the Baby-Boom Generation on Substance Abuse Among Elderly Persons Psychiatr Serv 50:1184-1188, September 1999.
2. Change in the pattern of illegal drug use in an inner city population over 50: an observational study J Addict Dis. 2004; 23(2):95-107.

ISSUE WORKSHOP 28

SEXUAL HISTORY: THE ART AND THE SCIENCE

Chairperson: Waguih W. Ishak, M.D., 8730 Alden Drive, W101, Los Angeles, CA 90048
Presenters: Norana Caivano M.D., Eugene Lee M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate knowledge on how to take a sexual history, recognize the patient and clinician factors that interfere with the process, and utilize the information to address patient's sexual difficulties.

SUMMARY:

Taking a detailed history of past and present sexual behavior is an extremely valuable clinical practice that leads to learning about an important aspect of personal history, identifying sexual disorders, improving the quality of life of patients, addressing high-risk behavior, and treating sexual side effects of medications. Avoidance of discussing sexual issues is seen in clinical settings, and is often related to both clinician's and patient's anxiety about the topic. Taking a detailed sexual history sometimes is avoided by clinicians on basis of fear of increasing the distress of patients and/or feeling unqualified to deal with content in addition to personal barriers. Age of the patient, gender difference, sexual orientation, and cultural factors, could also contribute to the reluctance of taking an adequate sexual history. The participants will be able to share their own experience in taking sexual histories from patients, explore patient factors as well as clinician factors, and how to address them.

REFERENCES:

1. Sadock VA: Normal human sexuality and sexual dsyfunctions.
In Sadock VA and Sadock BJ (Eds.) Comprehensive Textbook of Psychiatry. Baltimore, MD, Lippincott Williams & Wilkins Publishers, 8th edition 2005.
2. Marwick C: Survey says patients expect little physician help on sex. JAMA 1999;281(23):2173-4.

ISSUE WORKSHOP 29

THE MAN WHO CAN'T STOP SWALLOWING SHARP OBJECTS: MEDICAL ETHICS AND MANAGEMENT LIMITATIONS IN PATIENTS WITH CHRONIC FACTITOUS DISORDER

Chairperson: Kahlil A. Johnson, M.D., George Washington University Medical Center, Department of Psychiatry and Behavioral Sciences, 2150 Pennsylvania Avenue, NW, 8th Floor, Washington, DC 20037
Co-Chairperson: Anton C. Trinidad, M.D.
Presenter: Robert J. Boland M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) appreciate the complexity of diagnosing and managing a patient who presents with multiple episodes of swallowing foreign bodies; (2) Understand limitations accessing community-based psychiatric resources for the long-term management of similar patients; and (3) Explore alternative resources for management that have not been addressed in the current mental health law or community-based psychiatric resources.

SUMMARY:

This workshop will review the case of a patient with chronic swallowing of sharp objects as a symptom of vhronic factitious disorder that resulted in multiple surgeries over the course of a year. The patient currently has been deemed inoperable in the future due to the past surgeries, almost ensuring his death should he again swallow an object. Despite the urgency, organizing necessary community-based psychiatric care has posed such insurmountable obstacles that a sense of nihilism has become pervasive among his caregivers. The lack of appropriate fit between mental health law in the District of Columbia and the character of the patient's psychiatric disorder has hindered both the organization of appropriate outpatient psychiatric treatment and location of a needed residential treatment facility. There is an absence of psychiatric professionals and outpatient treatment programs that specifically target chronic self-injurious behaviors. The patient's Medicaid and Medicare funding are not accepted for payment by the major clinical program needing to be involved in his care. Although the patient's health care costs for medical and psychiatric hospitalizations during the past two years have been astronomical, there has been no open avenue for designing a less expensive, but more effective program of care. These barriers in legal, political, and economic policy are likely to have lethal consequences for this patient's life. In this discussion, we will review each tier of these barriers to his treatment. We will brainstorm with audience participants from clinical, ethical, and political perspectives in an effort to determine whether more effective strategies for his care can be created.

REFERENCES:

1. DC Department of Mental Health Policies, Procedures and Rules. http://dmh.dc.gov/dmh/ cwp/view,a,3,q,621393,dmhNav,|31262|.asp.
2. Gitlin DF, et al: Foreign-body ingestion in patients with personality disorders. Psychosomatics 2007; 48:162-166.

ISSUE WORKSHOP 30

LEADERSHIP DEVELOPMENT FOR EARLY CAREER WOMEN: FULFILLING YOUR DREAMS AND ASPIRATIONS

Chairperson: Roslyn Seligman, M.D., 231 Albert Sabin Way, Cincinnati, OH 45267-0559
Co-Chairpersons: June A. Powell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to be a leader in psychiatry in diverse settings such as academic medicine, organized psychiatry and medicine, and private practice at the appropriate career level, be comfortable in bragging, taking risks, and speaking in public, network, negotiate positions, benefits and salary, know and understand the governance structure of APA, and know the resources for continuing to learn leadership skills.

SUMMARY:

The chair and co-chair of this workshop have organized and

convened workshops for women at the APA members in training (MIT) and early career psychiatrists (ECP) level. These workshops have been well received and highly rated. Dr. Seligman convened and participated in one in Area IV (2006) and Dr. Powell in Area V (2007). Participants and attendees recommended that these be given nationally in order to reach a broader audience. The 90 minutes provided for this interactive workshop means that the material presented will be compact and brief. Enough material will be presented to direct and enhance the ensuing discussion. Handouts will provide needed resources so that each attendee/participant can continue to learn on her own at her own pace. At the conclusion, attendees/participants will have the personal and printed resources outlined in the objectives to embark on a tract of leadership.

REFERENCES:

1. Cohen: You Can Negotiate Anything. Toronto; New York: Bantam Books, 1982, c1980.
2. Bickel J, Wara D, Atkinson BF, et al: Increasing women's leadership in academic medicine: Report of the AAMC Project Implementation Committee. Acad Med 2002; 1043-61.

ISSUE WORKSHOP 31

THE DESIGN AND RENOVATION OF THERAPEUTIC SPACE IN AN OVERREGULATED AND UNDERFUNDED WORLD

Chairperson: Virginia L. Susman, M.D., New York Presbyterian Hospital, Westchester Division, 21 Bloomingdale Road, White Plains, NY 10605
Presenters: Jaques Black, Philip Wilner M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the challenges of meeting increased regulatory standards for safety while upgrading or recreating aesthetically pleasing and restorative treatment environments and gain deeper understanding of the therapeutic value of design.

SUMMARY:

To avoid restraint, to ensure individual dignity and safety, to provide comfortable and pleasant surroundings for the pursuit of well-being and health--these remain the essential features of psychiatric inpatient design today, just as they were the goals of inpatient design in the late eighteenth century, as articulated by William Tuke, the founder of the York Retreat and John Bevans, its architect. Moral treatment, the humane treatment of the mentally ill, inspired the physical design of the retreat, and gave rise to the creation of asylums where great attention was focused on aesthetics, exposure to nature, and individualized expression. As asylums grew in size, number, and patient volumes, the need for oversight and regulation grew. Reformers such as Dorothea Dix campaigned passionately to ensure clean and safe conditions. It has been said that such reform spawned intense regulatory oversight that interfered with development and was so costly that the grand aims of the asylums were subverted. Anyone involved in design or renovation of inpatient facilities no doubt deals with the same tensions among cost, regulation, and therapeutic needs. Reconciling the advantages of individual comfort and of non-institutional public areas, with mandates to install prison-grade hardware and unbreakable laminates over safety-tempered glass, pose considerable challenges. CMS, JCAHO, state departments of health, and the American Institute of Architects (AIA) establish guidelines that emphasize minimizing risk for violence and self-harm. The same guidelines address needs for patient privacy and dignity. Facilities planning redesign are hard pressed to strike a balance between codified standards and individual expression; and arguably are harder pressed to afford both. This workshop will highlight the history of psychiatric architecture, current regulatory standards, contemporary design features, and the difficult choice between building anew and renovation.

REFERENCES:

1. Edginton B. The Design of Moral Architecture at the York Re-
treat. J. of Design History. 2003 16:102-117.
2. Moran J, Topp L., Andrews J, (eds.): Madness Architecture and the Built Environment: Psychiatric Spaces in Historical Context. London: Routledge, 2007.

ISSUE WORKSHOP 32

BUILDING THE BRIDGES: REACHING THE SOUTH ASIAN COMMUNITY THROUGH RESEARCH AND EDUCATION

Indo-American Psychiatric Association

Chairperson: Vani Rao, M.D., Division of Geriatric Psychiatry & Neuropsychiatry, Suite 308,550 North Broadway, Johns Hopkins Hospital, Baltimore, MD 21205
Co-Chairperson: Geetha Jayaram, M.D.
Presenter: Sunil Khushalani M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: recognize the problems South Asian Americans with mental illness face, the influence of culture on the clinical presentations and treatment, the barriers therapists/psychiatrists have to overcome to provide mental health care; and learn culturally congruent and competent approaches to diagnose and treat mental illness among South Asian Americans.

SUMMARY:

There is increasing ethnic diversity in the U.S. population. Asian Americans have the highest growth rate and make up 4% of the total U.S. population. Of this South Asians (Indians, Pakistanis, Sri Lankans, Bangladeshi, Nepalese) account for about 18% of the total Asian population (U.S. Census Bureau, 2000). Compared with other Asian Americans, South Asians have unique social, cultural and religious traditions that often provide a challenge to diagnosis and treatment of mental illness. The goals of the workshop are threefold: (1) to explore biases, concerns, and treatment challenges associated with treating South Asians with mental illness, (2) to discuss the results of pilot national survey done to determine attitudes and needs of South Asians living in the United States (3) to provide psychiatrists and therapists culturally competent treatment approaches to improve mental health among South Asians. The workshop will begin with the chair, Dr. Vani Rao questioning the audience on their experiences in working with South Asians. This will be followed

by two presentations: (1) Dr. Rao will discuss the results of a pilot national study on the rates of mental illness and treatment preferences among S. Asians living in the United States. The study was conducted by the members of the Maryland/DC chapter of the IndoAmerican Psychiatric Association (IAPA). (2) Dr. Sunil Khushalani will discuss the challenges associated with treating mental illness among South Asians. This will include services currently available and resources necessary to build the bridges between the patient, family, providers and organization. Dr. Geetha Jayaram, the discussant, will provide a comprehensive summary integrating the pertinent findings of the presentations and the addressing the concerns and issues raised by the audience both prior and after the presentations.

REFERENCES:

1. U. S. Census Bureau Population Estimates Program, Profiles of General Demographic Characteristics: National summary: 2000 census of population and housing, 2001. Available from http://www2.census.gov/census_2000/datasets/demographic_profile/0_National_Summary/2khus.pdf.
2. Conrad MM, Pacquiao DF: Manifestation, attribution, and and coping with depression among Asian Indians from the perspectives of health care practitioners. J Transcult Nurs 2005; 16(1):32-40.

ISSUE WORKSHOP 33

THE SPECIAL UTILITY OF STANDARDIZED PATIENTS IN THE PSYCHIATRIC TRAINING OF INTERNATIONAL MEDICAL GRADUATES

Chairperson: Jacob E. Sperber, M.D., Department of Psychiatry, Nassau University Medical Center, Box 51, 2201 Hempstead Turnpike, East Meadow, NY 11554
Co-Chairperson: Nyapati R. Rao, M.D.
Presenter: Anthony Errichetti Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; (1) Describe three cultural obstacles to learning psychiatry characteristic of IMG residents; (2) Explain three advantages of using standardized patients (SPs) for psychiatry clinical training, compared to actual acute patients; and (3) Assess the current evidence of effectiveness SP educational technology for summative and formative competency feedback.

SUMMARY:

Cultural awareness is essential to learning and teaching psychiatry. The impact of culture on psychiatry training assumes greater significance because 40% of psychiatry residents are foreign-born, with a preponderance from Asian cultures. These trainees face additional educational challenges in learning psychiatry, which can be traced to cultural issues such as the psychological impact of migration on IMGs, IMGs' cultural conflicts in using English as a second language, and the differing attitudes toward mental illness in Eastern and Western cultures. The use of standardized patients (SPs) in psychiatry training grows at a steady pace. Because IMG residents train in a country other than their land of origin, they practice on and learn from almost entirely cross-cultural patients. Having a novice resident practice interviewing with real, acute patients whose demographics combine different cultural background AND social disadvantage, is, in itself, a culturally insensitive act. SPs are an effective antidote to this training dilemma, with its added relevance to IMG trainees. SP teaching format benefits include: Residents can receive feedback from SPs, who are well-positioned to comment about doctor-patient communication and interpersonal skills, including cultural sensitivity, -Video recording which enables effective precepting/supervision, Standardization of the training process by exposing residents to the types of psychiatric disorders (simulated) relevant to training goals,-Novice residents can be exposed to more serious simulated disorders without putting actual patients at risk. We present experience from psychiatry training at a large, safety-net public hospital, where almost all residents are IMGs. In collaboration with the Institute for Clinical Competency at the New York College of Osteopathic Medicine, we have integrated specific SP-based methods to improve IMG cultural competency training. Workshop will include illustrative excerpts from training videos, followed by audience reaction and discussion.

REFERENCES:

1. Rao NR: The influence of culture on learning of psychiatry: the case of Asian-Indian international medical graduates, International Journal of Applied Psychoanalytic Studies 4: 2: 128-143, 2007.
2. Klamen DL, Yudowsky R: Using standardized patients for formative feedback in an introduction to psychotherapy course Academic Psychiatry 2002; 26:168-172.

ISSUE WORKSHOP 34

PATHOLOGICAL GAMBLING IN SPECIAL POPULATIONS: MILITARY, PSYCHIATRIC CO-MORBIDITIES, AND INDIVIDUALS WITH INTELLECTUAL DISABILITY

Chairperson: Lesley R. Dickson, M.D., Department of Psychiatry, UN SOM, 2810 W Charleston Blvd, #78, Las Vegas, NV 89131
Presenter: Coni Kalinowski M.D., Zeba Hafeez M.D., Rena Nora M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify risk factors for pathological gambling in special populations (military, patients with psychiatric comorbidities, and individuals with intellectual disability); Demonstrate knowledge regarding incidence and demographic profiles of pathological gamblers among special populations; and List barriers to care and implications for assessment, treatment, and service delivery to these special populations.

SUMMARY:

Pathological gambling (PG)is described in *DSM IV* as "a persistent and recurrent maladaptive behavior that disrupts personal, family, or vocational pursuits." Expansion of legalized gambling in almost all of the states increased access and availability of gambling opportunities. Eighty-percent of adult Americans engage in some form of recreational gambling. However, an estimated three million people meet the criteria for PG disorder with negative consequences (financial devastation, family turmoil, psychiatric disorders, performance problems,

demotions, court martial, and forensic issues). This workshop will focus on three special populations: (1) PG in the Military, -(briefly reviews the historical background of establishment of slot machines in military bases since 1930. Today, 8,000 video poker slot machines exist in 94 bases overseas, generating roughly $2 billion dollars. $127 million is used by the military to support "morale, welfare, and recreation activities." Incidence of PG, risk factors, and correlation of gambling with alcohol, depression, PTSD will be discussed. Brief description of an intensive outpatient program for Pathological Gambling will be presented. (2) Comorbidity of pathological gambling With other psychiatric disorders: Results from two hospitals in Las Vegas, an observational Study to examine the comorbidity of PG wiht Axis I and II in the outpatient and inpatient departments of the Veterans AFfairs and the Southern Nevada Mental Health system (460 patients seen) indicated PG significantly associated with substance abuse/dependence, PTSD and personality disorders. (3) Gambling habits of individuals having intellectual disability (ID)-seventy-nine patients were surveyed regarding their gambling behavior . Reasons for under- estimation of prevalence of PG in this population, alterations in neurotransmitter metabolism, neuropsychological and cognitive distortions and comorbidity in ID will be discussed as unique characteristics to ID population.

REFERENCES:

1. Petry NM, Stinson FS, Grant BF: Comorbidity of DSM IV pathological gambling and other psychiatric disorders: results from the National Epidemiologic survey on alcohol and related Conditions. J ClinPsychiatry 2005;66(5):564-574.
2. Pathological Gambling: A Critical Review,Natiional Research
Coluncil, Washington, DC, National Academy Press, 1999.

ISSUE WORKSHOP 35

HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE: PART 1

Chairperson: William E. Callahan, M.D., 120 Vantis, #540, Aliso Viejo, CA 92656
Presenters: Martin Tracy J.D., Marynell Hinton, Keith Young M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: list the 10 key tips to avoiding lawsuits and malpractice; discuss the three most frequent reasons why psychiatrists are successfully sued; and discuss different types of malpractice insurance and which one is best for you.

SUMMARY:

This is part 1 in a three-part comprehensive course that provides you all the information you need to launch a successful private practice. It is composed of two workshops and one symposium all on one day. It has been offered for the last 10 years and directed by faculty who have succeeded using this information. Even if you are not in private practice, this course will offer lots of useful information that will assist you in launching your career. Our material is constantly update with up-to-the-minute solutions from our faculty with thriving practices. In part 1, we focus on risk management, avoidance of malpractice suits, ways to maximize quality and high-risk issues that you must address in your practice. Other sessions cover coding for maximum billing, marketing, office location and design, streamlining your practice, and business/financial principles.

REFERENCES:

1. Molloy Patrick: Entering the Practice of Psychiatry: A New Physician's Planning Guide, Roering and Residents, 1996.
2. Practice Management for Early Career Psychiatrists, APA Office of Healthcare Systems and Financing, 1998.

ISSUE WORKSHOP 36

TO WORK OR NOT TO WORK: WHAT IS THE QUESTION?

APA Corresponding Committee on Psychiatry in the Workplace

Chairperson: Andrea Stolar, M.D., Department of Psychiatry, University Hospitals of Cleveland, 11100 Euclid Avenue, Cleveland, OH 44106
Presenters: Marie-Claude Rigaud M.D., Marcia Scott M.D., Marilyn Price M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the importance of assessing patient function, tailoring treatment to symptoms of impairment, the value of rating scales to measure response to treatment, and the importance of work and workplace function in their patients' health maintenance and recovery.

SUMMARY:

Psychiatrists are frequently called upon to complete the forms or provide the supporting information to assist their patients in obtaining or maintaining disability income or taking a medical leave of absence. Learning to help patients stay at work, return to work, and how to manage documentation and privacy issues in communicating with employers and insurers is something not often addressed in residency training, yet is an important component of psychiatric practice. Addressing workplace issues begins with the patient assessment. Obtaining an occupational history, similar to the inquiry into educational and relationship history, provides a framework to understand our patients and how they view the world and interact with others. And in the ongoing treatment of patients, symptoms predicting risk of relapse can be identified when psychiatrists ask about work performance and stress. Assisting with adaptation to illness and recognizing the therapeutic risks and benefits of supporting work withdrawal are other components of treatment. This interactive workshop will overview workplace psychiatry using a case-based approach. Case 1 will address the acutely ill patient: the dangerousness assessment and how and when to intervene. Case 2 will address the identification of prodromal symptoms, the normalization of distress in the workplace, and active coping strategies. Case 3 will address the management of the acute exacerbation of chronic illness, the benefits of rating scales to monitor symptoms, and the pros and cons of continued employment. Case 4 will address the chronic out-of-work patient and the barriers complicating a return to work.

REFERENCES:
1. Wang PS, Beck AL, Berglund P, McKenas DK, Pronk NP, Simon GE, Kessler RC: Effects of major depression on moment-in-time work performance. Am J Psychiatry 2004; 161:1885-1891.
2. Adler DA, McLaughlin TJ, Rogers WH, Chang H, Lapitsky L,
Lerner D: Job performance deficits due to depression. Am J Psychiatry. 2006 Sep;163(9):1569-76.

ISSUE WORKSHOP 37

QUALITY OF LIFE OF PATIENTS WITH MAJOR DEPRESSION IN A NATURAL CLINICAL SETTING

Chairperson: Waguih W. IsHak, M.D., 8730 Alden Drive, W101, Los Angeles, CA 90048
Co-Chairperson: Mark H. Rapaport, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to:(1) Recognize the importance of quality of life as an important dimension in the treatment of depressive disorders; and (2.) Demonstrate skills of utilizing quality of life measures in addition to other assessment methods to guide treatment strategies.

SUMMARY:

The World Health Organization defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease." Successful treatment must go beyond ameliorating signs and symptoms to address the broader issue of restoration of health. Patients' subjective views of social relationships, physical health, functioning in daily activities, work and economic status, and overall sense of well-being need to be factored in the assessment of the impact of psychiatric illness or interventions. The above perceptions are quantified in quality-of-life measures. Patients with major depressive disorder are assumed to have a decline in quality-of-life. Most studies had small samples of individuals and did not focus on a natural clinical setting but rather on a highly selective population of recruited subjects. Studies had shown that symptom severity measures explained only a small proportion of the variance in quality of life. Clinical trials also showed that quality of life changes with treatment tend to occur during robust and sustained response to interventions and are least likely to respond to placebo interventions, when compared with symptom severity measures. The individual's perception of his or her quality of life is an essential factor that should be part of a complete patient assessment. The presenters will show clinical data supporting the importance of incorporating quality of life as a dimension in detecting clinical improvement or deterioration. This workshop will engage participants in a lively debate about the importance and the implementation of quality of life measurement in addition to other methods of assessment in natural clinical settings.

REFERENCES:

1. Rapaport MH, Clary C, Fayyad R, Endicott J: Quality-of-life impairment in depressive and anxiety disorders. Am J Psychiatry 162(6):1171-8, 2005.
2. Trivedi MH, Rush AJ, Wisniewski SR, et al: Factors associated with health-related quality of life among outpatients with major depressive disorder: A STARD Report. Journal of Clinical Psychiatry 67:185-195, 2006.

ISSUE WORKSHOP 38

REDUCING SUICIDE RISK IN A SMALL COMMUNITY: A PROJECT UPDATE

Chairperson: Alex N. Sabo, M.D., Chairman, Department of Psychiatry, Berkshire Medical Center, 725 North Street, Pittsfield, MA 01201
Presenters: Sharon Mozian M.D., Brenda Bahnson M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant will be able to explain: (1) a community-based strategy for reducing suicide risk that educates gatekeepers and derives feedback from them on barriers to access and how to improve access; (2) the rationale and early data analysis for a simple, systematic screening for depression and suicide risk in a community medical hospital; and (3) a patient's experience of a near-miss acute suicidal moment.

SUMMARY:

Suicide is the 10th leading cause of death in the United States. Over 90% of people who kill themselves have a treatable mental illness or substance abuse disorder, and 50% of those who suicide have never seen a mental health professional. Reducing suicide risk in a community is an important public health goal, yet it is not clear what really works. This workshop describes the design, implementation, and early feedback on a MA DPH-funded pilot project to reduce suicide risk in Berkshire County, a community of 135,000 people nestled in the western hills of Massachusetts.

The project strategy is to educate "gatekeepers," improve screening for depression and suicide risk in mental health, primary care and community hospital settings. Gatekeepers include: emergency first responders, police, firemen, corrections and probation officers, clergy, visiting nurses, wellness counselors, primary care physicians, crisis workers and psychiatrists. The program includes lecture/discussions, video-taped interviews with suicidal patients, and PHQ-9 screenings. Data-based measures include: pre-and post-training test scores; feedback from gatekeepers on barriers/improvement to access; numbers of people screened, PHQ-9 scores and sub-scores; and monitoring of violent death data provided by the DPH. The presenters focus on three aspects of the project: (1) education of gatekeepers and the feedback loop to the clinical system; (2) screening strategy in the community hospital and early data analysis; (3) a brief vignette from one of the educational videos of a patient describing an acutely suicidal state. Participants in the workshop will be asked to discuss their own thoughts about what is useful in the strategy of this project, share their views about what may be needed in their own communities, and, if they have participated in similar efforts, what has been most useful in their own experience.This project is supported, in part, by a grant (RFR #607914) from the Massachusetts DPH.

REFERENCES:
1. National strategy for suicide prevention: Goals and objectives for action. U.S. Department of Health and Human Services, 2001.
2. Massachusetts Strategic Plan for Suicide Prevention 2003 @ http://www.masspreventsuicide.org.

ISSUE WORKSHOP 39

FAMILY-INCLUSIVE TREATMENT FOR BIPOLAR DISORDER: HAS THE TIME ARRIVED FOR A FAMILY PSYCHIATRIST?

Chairperson: Igor Galynker, M.D., Beth Israel Medical Center, 9th Floor 313 E 17th Street,, New York, NY 10003
Co-Chairperson: Susan Tross, Ph.D.
Presenters: Allison Lee M.D., Philip Yanowitch M.D., Helen Kraljic

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: understand the family-inclusive treatment method as it applies to treatment of bipolar illness, and understand both the benefits and challenges of setting up FIT or similar treatments in a hospital setting.

SUMMARY:

Bipolar mood disorder (BD) is a chronic life-long mental illness, affecting at least 4.4% of the population. Untreated, it can cause significant impairment in family life and work function for both bipolar sufferers and their family members. There is persuasive evidence that: (1) making willing families an integral part of treatment improves outcome; and (2) family characteristics influence outcome of treatment. In spite of these findings, and in contrast to the treatment of chronic physical illnesses such as diabetes, family members of bipolar patients are often left out of the treatment process due to a complex of reasons including tradition, mental illness stigma, and medical-legal issues. To address this inconsistency, we have developed a new treatment model: family-inclusive treatment (FIT). FIT uses a "family psychiatrist" to: (1) guide open communication within the patient's family about bipolar symptoms and medications; and (2) provide ongoing follow up of both the patient and the family or primary caregiver. FIT is a manualized, community clinic-friendly, reimbursable, sustainable treatment, readily integrated into clinic infrastructure and delivered by both permanent staff and house staff. This workshop will discuss successes and pitfalls of creating and implementing FIT from the points of view of providers, consumers, and caregivers. Presenters will engage the audience with questions encouraging discussion about audience members' own clinical experiences and their views of how they might apply the techniques being discussed in their clinical approach. By the end of the workshop, participants should: (1) be able to understand the family-inclusive treatment method as it applies to treatment of bipolar illness, and (2) understand both the benefits and challenges of setting up FIT or similar treatments in a hospital setting.

REFERENCES:
1. Merikangas K R, Akiskal H S, Angst J, Greenberg P E etal: Lifetime and 12-month prevalence of bipolar spectrum disorder in the National Comorbidity Survey Repulican. Arch Gen Psychiatry. 2007;64:543-552.
2. Miklowitz D J, George E L, Richards J A, et al: A randomized study of family-focused pyschoeducation and pharmcotherapy in the outpatient management of bipolar disorder. Arch Gen Psychiatry 2003;60:904-912.

ISSUE WORKSHOP 40

COGNITIVE AND BEHAVIORAL TECHNIQUES TO IMPROVE BRIEF PHARMACOTHERAPY SESSIONS

Chairperson: Donna M. Sudak, M.D., Drexel University College of Medicine, c/o Friends Hospital, P.O. Box 45358, Philadelphia, PA 19124
Presenters: Judith Beck Ph.D., Jesse Wright M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Use key techniques for depressed patients; (2) Use key techniques for patients with anxiety: and (3) Use key techniques to promote medication adherence.

SUMMARY:

Cognitive behavioral therapy has been demonstrated to be effective, both with and without medication, for a wide range of psychiatric disorders. Although many practitioners do not have the time or expertise to conduct CBT sessions, they nevertheless can learn key techniques to use when doing medication consults, to help reduce depressive and anxiety symptoms, enhance medication adherence, and improve outcomes. This workshop will focus on demonstrating the use of activity scheduling, responding to distressing cognitions, and other "high yield" interventions that can be implemented in briefer sessions. Participants will see role-play and videotape demonstrations of the intervention and learn the rationale for each strategy. We anticipate considerable discussion about the practical application of these techniques in clinical practice. The audience will receive information about other resources available to learn about this approach to patients.

REFERENCES:
1. Beck J S: (2001). A cognitive therapy approach to medication compliance. In Annual Review of Psychiatry. Washington, D.C.: American Psychiatric Press.
2. Wright J H: (2003). Integrating cognitive therapy and pharmacotherapy. In Leahy, R. (Ed.) New advances in cognitive therapy. New York: Guilford.

ISSUE WORKSHOP 41

METABOLIC SCREENING OF PATIENTS ON ANTIPSYCHOTIC MEDICATIONS: PROGRESS OF A QUALITY IMPROVEMENT PROGRAM IN AN URBAN TRAINING CLINIC

Chairperson: Diane Gottlieb, M.D., Temple University, Department of Psychiatry Outpatient Department, 100 E. Lehigh Ave. , Suite 105 MAB, Philadelphia, PA 19125

Co-Chairperson: April S. Ladavac, M.D.
Presenters: Elizabeth Tien M.D., Kathleen Diller M.D., Shaneek Johnson M.D., Chioma Iheagwara D.O., Neil Sanuck M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the risks of obesity, glucose intolerance, and lipid abnormalities in patients on antipsychotics and be able to monitor these clinical parameters in order to make appropriate interventions and referrals. Participants will be able to develop a Performance improvement process to address metabolic issues.

SUMMARY:

Increased awareness of the metabolic syndrome, characterized by obesity, the lipodystrophies, and glucose intolerance, has raised concern about the risks of treatment with antipsychotics. These changes may increase mortality in this population. Despite the need for interventions, programs to identify, prevent, and treat these disorders have been limited or minimally effective. In 2005 we instituted a quality initiative (QI) in our inner-city university training clinic to identify patients on antipsychotic medication. Our goals are to teach residents to identify these health concerns, and train them to monitor these clinical parameters, and institute appropriate interventions. We will demonstrate how this will maximize the quality of health care by providing appropriate diagnoses and referrals for our patients. Our program monitors clinical outcomes for these patients, communication with primary care physicians, and adherence to psychiatric treatment. We will present a literature review, demonstrate our flow sheet, and our monitor of compliance with the use of the flow sheet. Ongoing chart reviews determine whether patients are being adequately monitored for potential health problems, and detail the clinical decision making which occurs as a result of abnormal findings. We will discuss changes in our QI process instituted as a result of this monitoring, the initiation of a focus group, and feedback mechanisms for residents.

REFERENCES:

1. Marder SR, Essock SM, Miller AL, Buchanan RW, Casey DE,
Davis JM, Kane JM, Lieberman JA, Schooler NR, Covell N, Stroup, S, Weissman, EM, Wirshing, DA, Hall CS, Pogach L, Pi-Sunyer X, (2004). Physical health monitoring of patients with schizophrenia. Amer J of Psychiatry, 161: 1334-1349.
2. Boonyasai RT, Windish DM, Chakraborti C, Feldman LS, Rubin HR, Bass EB,(2007). Effectiveness of Teaching Quality
Improvement to Clinicians. JAMA 298(9):1023-1037.

ISSUE WORKSHOP 42

HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE: PART 2

Chairperson: William E. Callahan, M.D., 120 Vantis, #540, Aliso Viejo, CA 92656
Co-Chairperson: Keith W. Young, M.D.
Presenter: Tracy Gordy M.D., Chester Schmidt M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: discuss the use of codes for insurance to accurately reflect your work with patients; understand documentation requirements consistent with the codes you use; and list resources to get updated information on coding throughout your career.

SUMMARY:

This is part 2 in a three-part comprehensive course that provides you all the information you need to launch a successful private practice. It is composed of two workshops and one symposium, all on one day. It has been offered for the last 10 years and directed by faculty who have succeeded using this information. Even if you are not in private practice, this course will offer lots of useful information that will assist you in launching your career. Our material is constantly updated with up-to-the-minute solutions from our faculty with thriving practices. In part 2, we focus on the complexities of using the insurance industry's procedure codes to accurately reflect your work with patients. Even if you intend to have a fee-for-service, cash-based practice many patients will require "superbills" for insurance so they can get reimbursed. There are documentation requirements for each code, and not understanding them and following them can leave you prosecuted for fraud.

REFERENCES:

1. Practice Management for Early Career Psychiatrists, APA Office of Healthcare Systems and Financing, 1998.
2. Logsdon, L: Establishing a Psychiatric Private Practice, Washington, D.C., American Psychiatric Press, Inc., 1985.

ISSUE WORKSHOP 43

THE THEORY AND UTILIZATION OF YOGA AND MEDITATION AS IT RELATES TO WELL BEING, HUMAN RELATIONSHIPS, AND GLOBAL SOCIETY

Chairperson: Norana I. Caivano, M.D., Cedars-Sinai Medical Center, 8730 Alden Dr., W101, Los Angeles, CA 90048
Co-Chairperson: Karl Goodkin, M.D.
Presenter: Tara Klein M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: recognize the treatment of the individual with a psychiatric disorder as an entity of a culturally diverse, but geographically small world; explore the basis for yoga and meditation as psychiatric treatment modalities with long traditions but only relatively recent scientific validation; and make informed patient care management decisions about utilizing the clinical research findings on these techniques.

SUMMARY:

The opening of geographical and cultural boundaries around the world provides both an opportunity and a need for psychiatrists to understand non-Western treatments. The objective for this workshop is to introduce the psychiatrist to yoga and meditation as long-term traditions of mental healing and self-growth that can be utilized to improve the individual's sense of identity, mental health symptoms, interpersonal relationships, and ultimately, the

intricacies of global mental health and societal health. Yoga and meditation are two therapeutic modalities that have long and highly esteemed traditions in Eastern cultures. Yet, only recently have they been increasingly practiced by more than 10 million Americans as an acceptable form of exercise and mental self-improvement. After discussing the theory behind the practice of yoga and meditation, we will review the specific evidence-based data examining their application in the treatment and prevention of mental illness. We will present data demonstrating how these techniques have also been proven to be psychotherapeutic at the local community and societal levels by creating a sense of connection. An interactive yoga demonstration and meditation exercise will provide first hand experience of the techniques to be discussed. At the conclusion of the workshop, psychiatrists will have the tools to integrate these complimentary techniques into their treatment regimen to improve the mental health of the individual by experiencing their connectedness to others.

REFERENCES:

1. Janakiramaiah N, Gangadhar BN, Naga Venkatesha Murthy PJ, Harish, MG, Subbakrishna DK,Vedamurthachar A: (2000). Antidepressant efficacy of Sudarshan Kirya Yoga (SKY) in melancholia: a randomized comparison with Electro convulsive therapy (ECT) and Imipramine. Journal of Affective Disorders. 57(1-3):255-9.
2. Astin, J.A. et al: A review of the incorporation of complementary and alternative medicine by mainstream physicians. Arch Intern Med 1998; 158:2303-2310.

ISSUE WORKSHOP 44

IMPLEMENTING A COGINITIVE THERAPY FOR PSYCHOSIS PROGRAM IN THE USA: CHALLENGES AND REWARDS

Chairperson: Page Burkholder, M.D., 56 Midwood Street, Brooklyn, NY 11225
Presenters: Peter Weiden M.D., David Kingdon M.D., Yulia Landa Psy.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify benefits and roadblocks, which may be encountered in trying to introduce a CBT for schizophrenia program in a USA setting. Included are possible models for educating service users and staff, adapting U.K. practices and language for North American clients, and an analysis of how the health care systems of the two sites may impact on the implementation of CBT.

SUMMARY:

CBT for the treatment of schizophrenia is an accepted approach in the U.K., but as yet is far from common in psychiatry settings in the U.S. Given that psychiatric treatment takes place within the larger context of mental health treatment services, if CBT is to be integrated in the U.S. it must be done in a way that is compatible with the mental health system. Several groups have piloted programs for introducing CBT in North America. Representatives of some of those programs will present their services in the context of their local health care system, including a description of projects at Kings County Hospital and at Kingsboro State Hospital in Brooklyn, NY. Dr. David Kingdon will compare and contrast the U.K. systems and settings with those described for the U.S. Discussion and input from workshop attendees will be crucial to the format.

REFERENCES:

1. Kingdon,D. and Turkington, D. (2005) Cognitive Therapy of Schizophrenia, Guilford Press, New York Turkington,D., Kingdon D, and Weiden P. (2006), Cognitive behavior therapy for schizophrenia, American Journal of Psychiatry 163: 365-373.

WEDNESDAY, MAY 7, 2008

ISSUE WORKSHOP 45

TRAINING FOR ALL PSYCHIATRIC RESIDENTS IN RESEARCH AND SCHOLARLY ACTIVITY

Chairperson: Milton Kramer, M.D., 1110 N Lake Shore Dr.23S, Chicago, IL 60611
Co-Chairperson: Michele Pato, M.D.
Presenters: Jerald Kay M.D., Mantosh Dewan M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be familiar with the problems in teaching research and scholarly activity to all residents and have several techniques to teach them to do scholarly work and research undertakings.

SUMMARY:

The goal is admirable that all psychiatric residents become knowledgeable about research and scholarly work and develop critical skills to evaluate the literature. Programs with resources to teach such skills have faculty who are unable to take the time to teach in these areas. Programs without such resources have additional issues with lack of teachers and fewew more clinically oriented residents who need to be motivated in these areas. We will review the efforts in three programs, which have used different approaches: working up and publishing a case report (Dewan), doing retrospective chart reviews and poster presentations at national meetings (Kramer) and teahing supervisors how to teach supervisors of residents doing research or scholarly activity (Pato). Specific techniques and approaches focused on completion “pay-offs” are essential motivators for success. The value of such experiences needs to be demonstrated.

REFERENCES:

1. Pato MT, Pato CN: Teaching research basics to all residents: Ten years of experience. Academic Psychiat 2001,25:77-81.
2. Pincus HA:Research and clinical training in psychiatry. Psychiatr Q 1991,62:121-133.

ISSUE WORKSHOP 46

INFERTILITY: WHAT TO EXPECT WHEN YOU ARE NOT EXPECTING

Chairperson: Joyce A Spurgeon, M.D., 501 East Broadway Suite 340, Louisville, KY 40202
Co-Chairperson: Julianne Flynn, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) identify some of the common emotional experiences of both men and women struggling with infertility; (2) understand the effects of infertility on their professional colleagues and their patients; and (3) discuss the challenges and strategies for dealing with infertility in the professional workplace.

SUMMARY:

The number of couples struggling with infertility (currently in the United States 1 in 5 couples) continues to rise as people are waiting longer to get married and have children, and this phenomena seems to be affecting professional men and women at surprising rates. Despite the number of couples currently struggling with infertility, it is a topic that is not generally discussed due to its very personal nature. The psychiatrist's distinctive role in treating others for emotional issues while at the same time struggling with such a uniquely personal problem such as infertility can be overwhelming and isolating. In a profession where isolation professionally occurs for numerous reasons, further isolation due to an experience with infertility can be detrimental to one's well-being as well as potentially impact the care of patients. The biopsychosocial model of treating one's patients is equally important in treating oneself. Following a brief summary of the depth and impact of infertility on society as a whole, each panelist will discuss a particular aspect of infertility and how if affected them bother personally and professionally including both the male and female perspective of the experience. The panel will then participate in a discussion and question and answer session with the goal of furthering the understanding of a complex, emotional, and often not talked about experience like infertility.

REFERENCES:

1. Porter R, Kaplan J: Merck Manuals Online Medical Library: Home Edition for Patients & Caregivers, 2004-2007. http://www.merck.com/mmhe/index.html.
2. Souter VL, Penney G, Hopton JL, Templeton AA: Patient satisfaction with the management of infertility. Human Reproduction 1998; 13 (7): 1831-1836.

ISSUE WORKSHOP 47

CREATING A BUPRENORPHINE WRAP-AROUND PROGRAM IN YOUR COMMUNITY: LESSONS LEARNED AND WHAT WORKS

Chairperson: Jennifer L. Michaels, M.D., Brien Center, 333 East Street, Pittsfield, MA 01201
Presenter: Alex Sabo M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants will be able to recognize: (1) the rationale and potential benefits of providing buprenorphine with enhanced services in a community setting, (2) how to design and implement an integrated buprenorphine program that addresses the complex biological, psychological, and social needs of the opioid-dependent population, 3) assessment and treatment planning for the more challenging (co-occurring chronic pain, pregnant, mentally ill, medically ill, etc.) opioid-dependent patient.

SUMMARY:

Berkshire County is a community of 135,000 people nestled in the western hills of Massachusetts. Prior to 2003, opioid replacement therapy for the treatment of opioid dependence did not exist in Berkshire County, with this treatment option requiring two or more hours of daily travel time. To address this treatment deficit, Berkshire County community treaters designed an integrated buprenorphine program. The treatment team created a wrap-around model of services to address the biological, psychological, and social needs of opioid-dependent patients. The program currently provides mental health assessment and treatment, medical screening and referral, family services, vocational rehabilitation, residential placement, and coordination of treatment with the criminal justice system. In this workshop, the presenters will describe the design, demographic baseline data, and patient outcomes over a two-year period for their wrap-around buprenorphine program. Dramatic improvement has been shown in the first 60 patients to participate for a year or more, with less than 40% employment or school attendance at baseline to 90% at one to two-year follow up. Presenters will discuss screening, treatment contracts, urine drug testing, family support, buprenorphine treatment group structure and content, comorbidities, fiscal viability, and integration of care among the community mental health staff and primary care physicians. Case presentations will illustrate core concepts and foster audience participation. Participants will be asked to discuss the treatment needs of opioid-dependent patients and how best to provide services to them. Participants will be encouraged to identify the effective components of a comprehensive buprenorphine treatment program and share their views about what may be needed in their own communities and how best to apply these treatment principles. Audience members who have participated in similar efforts will be encouraged to share their experiences.

REFERENCES:

1. Dermatis H, Galanter M, Clinical Advances in Pharmacological and Integrated Treatment Approaches for Alcohol and Drug Use Disorders, Focus 2007; 5:141-150.
2. Fiellin D, Pantalon M, Chawarski M, et al: Counseling plus Buprenorphine-Naloxone Maintenance Therapy for Opioid Dependence, New England Journal of Medicine 2006; 355:365-374.

ISSUE WORKSHOP 48

LEADERSHIP IN PSYCHIATRY

Chairperson: Julian Beezhold, M.D., Milestones Hospital, Vicarage Road, Salhouse, United Kingdom NR13 6HA
Co-Chairperson: Victor J. Buwalda, M.D.
Presenter: Abigail Donovan M.D., Victor Buwalda M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify key issues and use new ideas regarding leadership for psychiatrists at a personal and an organizational level.

SUMMARY:

How does psychiatry as a medical specialty, and how do psychiatrists as professionals, influence and lead the significant and rapidly changing developments in mental health care? This is an issue of everyday importance to all psychiatrists, whether in the multidisciplinary workplace or in professional organizations. It is widely reported that young psychiatrists feel inadequately trained and equipped for a leadership role. Yet more experienced psychiatrists display high levels of cynicism and burn-out. The potential danger for us as individuals and as a specialty is that we enter a state of learned helplessness. This symposium presents three very different perspectives. All presenters have experience at different levels of leadership in both national and international psychiatry. All three passionately believe that as psychiatrists we can take control of our own destiny. The workshop will use their presentations to provoke discussion and debate about leadership in a context of increasingly integrated multidisciplinary mental health services. The aim is that participants will leave with new awareness and new ideas for future leadership.

REFERENCES:

1. Kotter JP, Cohen DS: (2002). Getting to the heart of how to make change happen. Harvard Business School Press.
2. Licinio, J: (2004) A leadership crisis in American psychiatry. Molecular Psychiatry 9, 1.

ISSUE WORKSHOP 49

USING INTERPERSONAL PSYCHOTHERAPY WITH GERIATRIC PATIENTS

Chairperson: Mark D. Miller, M.D., Western Psychiatric Institute and Clinic 3811 Ohara Street, Pittsburgh, PA 15213
Co-Chairperson: Gregory A. Hinrichsen, Ph.D.

EUCATIONAL OBJECTIVES

At the conclusion of this session, the participant should be able to understand the basic elements of interpersonal psychotherapy, to appreciate how IPT has been applied in geriatric care settings, and to become familiar with the published studies using IPT in elders. The participant will witness examples of the use of IPT by watching video vignettes.

SUMMARY:

Interpersonal pPsychotherapy (IPT) is a short-term, manual-based psychotherapy originally developed for treating depression. Its' use has expanded to various subgroups including geriatric patients. The presenters have both worked in separate settings utilizing IPT in outpatient, inpatient, and research settings and intend to summarize and highlight their experience for the participant interested in using IPT with this population. For those with no prior experience using IPT, a brief overview of its principles will be provided along with information on how to obtain formal training. The extant published research will be summarized about the use of IPT in research to date including the Maintenance Therapies in Late Life Depression studies I and II and the PROSPECT study. The focus of the workshop will be interactive and tailored to the interests of the participants to learn about pragmatic strategies for applying IPT in clinical and research settings with a focus on the the user-friendly attributes of IPT that are particularly adaptable for the common problems seen in geriatric populations such as grief, role transitions (eg. retirement or increasing disability), and role disputes that can stem from caregiver burden. Recent adaptations of IPT for depressed elders with cognitive impairment (IPT-Ci) will also be outlined. Video vignettes will be used for illustration. Interactive audience participation is encouraged.

REFERENCES:

1. Reynolds CF, Frank E, Perel JM, Imber SD, Cornes C, Miller MD, et al: Nortriptyline and interpersonal psychotherapy as maintenance therapies for recurrent major depression: a randomized controlled trial in patients older than 59 years. JAMA. 1999 Jan 6;281(1):39-45, 1999.
2. Miller MD, Richards V, Zuckoff A, Martire, LM, Morse J, Frank E, Reynolds CFA: model for modifying interpersonal psychotherapy (IPT) for depressed elders with cognitive impairment. Clinical Gerontologist Vol 30(2): 79-101, 2006.

ISSUE WORKSHOP 50

COGNITIVE THERAPY FOR PSYCHOSIS IN PRACTICE BY PSYCHIATRISTS: BASIC TECHNIQUES

Chairperson: Shanaya Rathod, M.D., Hampshire Partnership NHS Trust, Melbury Lodge,, Winchester, United Kingdom SO22 5DG
Presenters: Douglas Turkington M.D., David Kingdon M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Understand which of their patients with schizophrenia may benefit from cognitive therapy; and (2) Be able to incorporate evidence-based elements of cognitive Therapy into their work with patients with schizophrenia.

SUMMARY:

Cognitive-Behavior therapy (CBT) as an adjunctive therapy for persistent symptoms of schizophrenia is now supported by meta-analyses and 22 published randomized, controlled trials. Unfortunately, few training schemes exist and consequently trained therapists are rarely available. Psychiatrists may need to consider if they can adapt their practice to incorporate elements of CBT successfully. They can build on general psychiatric engagement, assessment and formulation skills with a particular focus on the first episode of psychosis and its antecedents. General understanding of cognitive therapy processes and ways of working can be adapted. Specific work on voices, visions, delusions, thought disorder and negative symptoms can then be incorporated within the framework of identified clinical groups in clinic, community, and inpatient settings. CBT compliments medication management by assisting with understanding and improving compliance with treatment and also the delusional elaboration sometimes associated, or simply faulty assumptions about the function and purpose of medication. It is also valuable in eliciting risk issues through its ways of drawing out connections between thoughts, feelings, and actions, for example, in relation to passivity or command hallucinations. The workshop will use key strategies, case examples, video-interviews, and allow plenty of opportunity for discussion.

REFERENCES:
1. Kingdon DG, Turkington D: (2002). A Casebook Guide to Cognitive Behaviour Therapy: Practice, Training and Implementation. Chichester: Wiley Kingdon, D.G., Turkington, D (2004).
2. Treatment Manual for Cognitive Behaviour Therapy of Schizophrenia and Psychotic Symptoms. Series Editor: J. Persons. NY: Guilford.

ISSUE WORKSHOP 51

COGNITIVE THERAPY FOR PERSONALITY DISORDERS

Chairperson: Judith S. Beck, Ph.D., Beck Institute for Cognitive Therapy and Research, Suite 700,One Belmont Avenue Bala Cynwyd, Philadelphia, PA 19004-1610

EDUCATIONAL OBJECTIVES

At the conclusion of this session, the participant should be able to conceptualize personality disorder patients according to the cognitive model, improve and use the therapeutic alliance in treatment, set goals and plan treatment for patients with characterological disturbance, enhance medication adherence, and describe and implement advanced cognitive and behavioral techniques.

SUMMARY:

Cognitive therapy, a time-limited, structured, problem-solving oriented psychotherapy, has been shown in over 400 trials to be effective in treating Axis I disorders. In the past 15 years cognitive therapy methods have been developed for Axis II disorders and research has verified the utility of this treatment approach. Cognitive therapy for personality disorders requires substantial variation from Axis I treatment. A far greater emphasis is placed on developing and maintaining a therapeutic alliance, modifying dysfunctional beliefs and behavioral strategies, and restructuring the meaning of developmental events. In this workshop, a variety of case examples of patients with personality disorders will illustrate the principles of cognitive therapy, conceptualization of individual patients, developing the therapeutic relationship, planning treatment, and medication adherence. Roleplays will provide clinicians with demonstrations of how cognitive and behavioral techniques are employed. Questions and clinical material from participants will be encouraged throughout and a final segment will instruct interested participants in the steps they can take to learn about this empirically validated approach for a difficult patient population.

REFERENCES:
1. Beck JS: (2005) Cognitive therapy for challenging problems: What to Do When the Basics Don't Work. New York: Guilford. Beck AT, Freeman A et al: (2004). Cognitive therapy of personality disorders, second edition. Second Edition. New York: Guilford.

ISSUE WORKSHOP 52

PHANTOMS OF THE MIND: THE ROLE OF NARCISSISM IN THERAPIST BOUNDARY CROSSING

Chairperson: Howard E. Book, M.D., 2900 Yonge Street, Suite 101, Toronto, Canada M4N 3N8
Presenters: Gary Schoener M.A., Carolyn Quadrio M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the role of narcissism and narcissistic injury in boundary crossings and boundary violations by therapists and ways of healing the transferential relationship.

SUMMARY:

This workshop will examine the role of narcissism and narcissistic injury in boundary crossings and boundary violations by therapists. The overall focus will be on narcissistic injury and the healing of a transferential relationship. Theoretical viewpoints will including self-trauma theory, Jungian perspectives, and the issue of projective identification. The interlocking dynamics of the professional and the patient will be examined. The topic will be examined through a creative power point presentation built around the play and film Phantom of the Opera in which many of these themes are played out and can be easily examined. Using this dramatic theatrical vehicle some of these topics can be examined in a non-threatening manner. The goal of this issue workshop will be to foster a discussion of the role of narcissism and narcissistic injury in the creation of therapist blind spots which can in turn lead even experienced practitioners to lose their way and cross boundaries with patients. The main presenter has utilized this approach in Australia to foster an examination of these issues. The chair and discussant will both comment from the perspective of Canadian and American experiences in examining the causes of boundary violations by therapists.

REFERENCES:
1. Twemlow SW, Gabbard GO: (1989). The lovesick therapist. In G.O. Gabbard (Ed.) Sexual Exploitation in Professional Relationships (pp. 71-87). Washington, DC: American Psychiatric Press.
2. Celenza, A: (2007). Sexual Boundary Violations NY, NY: Jason Aronson.

ISSUE WORKSHOP 53

THE AIR FORCE SUICIDE PREVENTION PROGRAM: A COMMUNITY AND ORGANIZATIONAL APPROACH TO PREVENTION

Chairperson: Steven E. Pflanz, M.D., 5201 Leesburg Pike, Suite 1501, Falls Church, VA 22041

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and apply both community and organizational concepts to suicide prevention, and be able to utilize community and organizational infrastructures to build effective suicide prevention programs.

SUMMARY:

Suicide is the eleventh leading cause of death in America,

claiming roughly 30,000 lives each year. On average, someone takes his or her own life every 17 minutes in the United States. The greatest tragedy of suicide is that it is often preventable. Both communities and organizations can take action to prevent suicide. The Air Force Suicide Prevention Program (AFSPP) has received international recognition as one of the few community suicide prevention programs to achieve proven results. Air Force suicides are down by 30% since the inception of the program in 1996. The 11 initiatives of the AFSPP represent a state-of-the art integrated system of policy and programs that incorporates both community and organizational elements. The cornerstone of the AFSPP is the recognition that suicide prevention is a community responsibility. The Air Force cultivates a culture that encourages and supports early help-seeking behavior for personnel suffering from distress. The AFSPP trains Air Force personnel to better recognize individuals suffering from suicidal ideation and to immediately refer these individuals for necessary psychiatric care. The majority of this workshop will be devoted to an audience discussion of community and organizational approaches to suicide prevention.

REFERENCES:

1. Mann JJ, et al: Suicide prevention strategies: A systematic review. JAMA 2005; 294:2064-2074.
2. Knox KL, et al: Risk of suicide and related adverse outcomes after exposure to a suicide prevention programs in the U.S. Air Force: A cohort study. British Medical Journal 2003; 327: 1376-1378.

ISSUE WORKSHOP 54

TEACHING RESIDENTS IN CONSULTATION-LIAISON SERVICE TO RECOGNIZE AND MANAGE COUNTERTRANSFERENCE

Chairperson: Damir Huremovic, M.D., Nassau University Medical Center, 2201 Hempstead Turnpike, East Meadow, NY 11554
Co-Chairperson: Nyapati R. Rao, M.D.
Presenters: Jacob Sperber M.D., Aleksandar Micevski M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the significance of teaching residents in consultation-liaison service to identify and manage countertransference towards psychiatric and nonpsychiatric patients, to identify situations and opportunities for teaching activities, and to appreciate how managing countertransference can enhance overall patient care, strengthen communication between C-L team and treatment team, and improve residents' teaching skills.

SUMMARY:

Countertransference, transfer of the therapist's own unconscious feelings to the patient, is a phenomenon valued in psychotherapy training, as it allows growing therapists to gain insight into their own intrapsychic processes and to understand kinds of emotions and reactions their patients tend to induce in others. Consultation-liaison (C-L) service is often perceived as not conducive to teaching countertransference, because of the limited time residents spend with individual patients and because C-L operates in the realm of somatic medicine, which emphasizes physiological concept of disease and steers clear from interpretations and psychological mindedness. In reality, the role of hospital patient is associated with dependence, anxiety, and, ultimately, regression, all serving as powerful generators of patient's transference toward medical team, and resulting in countertransference on the part of the team. Consulting psychiatrists and residents have the firsthand opportunity to observe transference and countertransference between patients and their treatment teams, and to experience their own intense counte transferential reactions, directed both towards the patient and the treatment team. Patients seen on consultation service provide ample opportunity for residents to experience positive and negative countertransference and learn about the concept. Spending time with residents encouraging them to identify their own emotional reactions toward psychiatric and nonpsychiatric patients alike, helps them master the concept and appreciate its universality and applicability. Managing countertransference results in improved understanding of patients, their illnesses, and their emotional needs, helps resolve conflicts, and leads to overall better quality of care. In liaison work, teaching residents to help their colleagues recognize and manage countertransference, strengthens the relationship between C-L and medical team and helps residents advance their teaching skills.

REFERENCES:

1. Rao NR, Meinzer AE, Berman SS: Countertransference. Its continued importance in psychiatric education. Journal of Psychotherapy Practice and Research 1997; 6:1-11.
2. Blumenfield M: The place of psychodynamic psychiatry in consultation-liaison psychiatry with special emphasis on counter transference. J Am Acad Psychoanal Dyn Psychiatry 2006 Spring;34(1):83-92.

ISSUE WORKSHOP 55

QUALITY IMPROVEMENT INTERVENTION FOR DEPRESSION IN PRIMARY CARE

National Institute of Mental Health

Chairperson: Agnes E. Rupp, Ph.D., 6001 Executive Blvd., Bethesda, MD 20892-9631
Presenters: Jeanne Miranda Ph.D., Kenneth Wells M.D., Cathy Sherbourne Ph.D., David Kennedy Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be familiar with the long-term clinical effects of a quality improvement intervention for depression in primary care in comparison with usual care. Findings from a unique nine-year longitudinal study (Partners in Care) will assist the participants to identify the long-term effects of an intervention from individual and group perspectives concerning health disparities and other topics.

SUMMARY:

Quality improvement programs for depression in primary care are known to improve mental health outcomes and affect use of services and treatments for depression over months to one to two years after their implementation; but very long-term effects are not known. In particular, patients could learn new patterns of coping

that are applied in subsequent illness episodes, that have long-term outcome consequences. Discontinuation of support for systems to implement quality improvement programs could lead to adverse outcomes over time, as patients continue to have symptoms but no longer have facilitated access to evidence-based treatments. Thus, long-term impacts could reflect a mixture of direct and indirect effects of both implementation and discontinuation of system support. This set of studies uses unique data on nine-year outcomes in the Partners in Care study, in which 1,300 depressed patients enrolled in clinics randomized to usual care or one of two quality improvement interventions that provided six to 12 months of support. Then patients were followed for nine-years, both through a traditional quantitative survey, and for minorities and a subset of whites, a series of three qualitative interviews to help explain long-term effects. The presentations review: (1) the main effects on outcomes and access/barriers to care; (2) cumulative effects over nine years; (3) effects on stressful life events; and (4) the design of the qualitative component and early findings on framing of symptoms in diverse groups, differential effects for ethnic groups, and rich cultural context for observing such effects.

REFERENCES:

1. Jeanne Miranda, Kenneth B. Wells, Naihua Duan, Maga Jackson-Triche, Isabel Lagomasino, Cathy D. Sherbourne: Improving Care for Minorities. Can Quality Improvement Intervention Improve Care and Outcomes for Depressed Minorities? Results from a Randomized Controlled Trail. Health Services Reseach, 38 (2):613-630, 2003.
2. Cathy Sherbourne, Michael Schoenbaum, Kenneth Wells, Thomas Croghan: Characteristics, Treatment Patterns and Outcomes of Treatment-resistant Depression in Primary Care. Gen Hosp Psychiatrym 26(2):106-114, March-April 2004.

ISSUE WORKSHOP 56

FORGIVENESS AND INDIVIDUAL PSYCHOTHERAPY: TO ERR IS HUMAN, TO FORGIVE DIVINE, OR IS IT?

Chairperson: Janet L. Lewis, M.D., 108 Kimball Ave, Suite One, Penn Yan, NY 14527

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: recognize multiple possible meanings of "forgiveness," when a patient is working with the concept of forgiveness; appreciate countertransference issues in working with the concept of forgiveness; recognize particular issues for trauma victims, for women, and for men in dealing with the concept of forgiveness; and use the psychospiritual developmental model of Ken Wilber as a theoretical framework.

SUMMARY:

There is controversy in the burgeoning forgiveness literature over whether patients who are dealing with interpersonal injuries should be encouraged to work on forgiveness. We often see patients who are considering whether they can or should forgive or who have been told by others that they should forgive. The concept of forgiveness has many explicit and implied meanings, psychologically, socially, culturally, religiously, and spiritually. There is not a consensus definition of forgiveness in the literature. However, there is research correlating forgiveness with psychological and physical health benefits, and there are now various "forgiveness therapies" aimed at teaching people to forgive. At the same time, many have voiced concern over the possible dangers of encouraging forgiveness, particularly in trauma victims, in women, and in other potentially oppressed or disadvantaged groups. In this workshop, we will explore healthy and unhealthy aspects of various forms of "forgiveness." The psychospiritual developmental model of Ken Wilber will be presented as a way of understanding the health or unhealth of any particular forgiveness and of understanding the tasks which, if appropriate, may eventually result in a healthy forgiveness. Issues for particular populations such as trauma victims, men, and women, will be highlighted, as will potential countertransference issues. This workshop will include experiential exercises, and small and large group discussion of case vignettes, as well as lecture format. There will also be opportunity for participants to reflect on and discuss their own clinical and/or personal experiences with forgiveness and nonforgiveness. We will explore this important topic, which is at the crossroads of individual psychotherapy, religion and spirituality, and trauma studies.

REFERENCES:

1. Worthington EL Jr, (editor): Handbook of Forgiveness. New York, Brunner-Routledge, 2005.
2. Lewis JL: Forgiveness and psychotherapy: The prepersonal, the personal, and the transpersonal. Journal of Transpersonal Psychology 2005; 37:124-132.

ISSUE WORKSHOP 57

KATRINA'S LONG-TERM IMPACT ON MENTAL HEALTH AND EDUCATION

Chairperson: Phebe M. Tucker, M.D., Department of Psychiatry, University of Oklahoma Health Sciences Center, WP 3440 P.O. Box 26901, Oklahoma City, OK 73190
Co-Chairperson: Harold M. Ginzburg, M.D.
Presenters: Richard Dalton M.D., Janet Johnson M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand Katrina's impact on mental health of directly exposed adults and children, both those remaining in affected areas and those relocated to other states. Attendees will be able to discuss challenges in assessing and meeting treatment needs for PTSD and other disaster-related mental disorders over time. Participants will recognize Katrina's effects on medical student education programs and ways to address problems.

SUMMARY:

Purpose: Hurricane Katrina's broad path of destruction continues to strain mental health services and medical student education. Mental health sequelae and recovery needs for adult and child survivors are explored in hurricane-affected areas and areas where survivors migrated. *Content*: We will describe Hurricane Katrina's devastating effects on local infrastructures involved with health and mental health care and medical education. We discuss

long-term mental health needs of Katrina's survivors, as well as the process of developing a mental health needs assessment tool to identify vulnerable groups. Survivors relocated far from familiar community supports have unique adjustment problems. Medical student education used flexible approaches to survive. *Methodology*: Mental health utilization patterns related to Katrina are described. Tulane's curriculum is examined pre- and post-hurricane to assess deficits and growth opportunities. Adult and adolescent survivors relocated to Oklahoma are assessed for psychiatric diagnoses (SCID), PTSD (CAPS), depression (BDI and CDI), and psychosocial functioning. *Results*: Symptoms associated with PTSD among those affected by Katrina have been adversely affected by the inability of various bureaucracies to meet promised needs. Uncertainty complicates an individual's need for predictability in their lives. Needs assessments predicted PTSD and other problems to assist recovery. Katrina has had negative and positive effects on psychiatric education. A shortage of psychiatric hospitals and clinics normally used for training have required development of creative training opportunities in the wake of Katrina. Forty percent of survivors relocated to Oklahoma experienced PTSD, with PTSD and depressive symptoms at levels of moderate illness, challenging mental health systems far from Katrina. *Importance*: Understanding Katrina's diverse effects on mental health in survivors is crucial to assist survivors of this and future disasters.

REFERENCES:

1. Mills MA, Edmondson D, Park CL: Trauma and stress response among Hurricane Katrina evacuees. Am J Public Health 2007; 97 Suppl 1:S116-23.
2. Ursano RJ, Fullerton CS, Hamaoka DM, Derrick A: Hurricane Katrina: disasters teach us and we must learn. Academic Psychiatry 2007; 31(3):180-182.

ISSUE WORKSHOP 58

MAKING THE MOST OF YOUR CHIEF YEAR: CHIEF RESIDENTS' FORUM, PART I

Chairperson: Amy W. Poon, M.D., P O Box 660475 Arcadia, CA 91066
Co-Chairperson: Carolyn I. Rodriguez, M.D.
Presenters: Christina Mangurian M.D., Shirley Liu B.A., Violeta Tan M.D.,Anjali D. Souza, M.D., S.Shane Knorad. M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Define the chief resident role more clearly, (2) Identify effective strategies used in other programs to deal with the common difficult issues and logistical tasks faced by chief residents, (3) Share his/her own learning experiences with other participants at the workshop; and (4) Network with chief residents from other programs, who can potentially provide ongoing support and consultation in the upcoming year.

SUMMARY:

This is Part I in a two-part workshop for incoming chief residents. Outgoing and former chief residents, residency directors, and others interested in administrative psychiatry are encouraged to attend and share their experiences. In a recent study, most chief residents report having satisfying, positive experiences, with the majority (90.6%) saying they would choose to perform the chief resident's duties again. However, they also reported that they were less likely to have a clear statement of their responsibilities. Prior literature dating back to 1980 discussed the several problems inherent in the role, including poor definition of the role, lack of training for the job, divided loyalties, and unrealistic expectations. The purpose of this workshop is to provide a forum to discuss these chief residency issues, and to improve the lack of information that often accompany this role, (most programs typically have only one or two chief residents who are doing the job for the first time). This will include presentations from panelists who are finishing their chief year at programs across the country. Since chief residents often face similar tasks, there will also be small group time to exchange ideas and strategies with chief residents and administrators from other programs. Issues to be addressed include: (1) logistical issues (making schedules, providing call coverage when residents are sick or away, organizing retreats, improving resident morale), and (2) dealing with difficult resident issues (how to support a resident after a patient suicide, how to support a resident after violence, how to support a resident struggling academically). Since 88.7% of chief residents in a recent study said that their chief experience has inspired them to seek future leadership opportunities, this workshop provides administrative training and networking for future potential leaders in psychiatry.

REFERENCES:

1. Ivany CG, Hurt PH: Enhancing the effectiveness of the psychiatric chief resident. Academic Psychiatry 2007; 31:277-280.
2. Warner CH et al: Current perspectives on chief residents in psychiatry. Academic Psychiatry 2007; 31: 270-276.
3. Sherman RW: The psychiatric chief resident. Journal of Medical Education 1972; 47: 277-280.

ISSUE WORKSHOP 059

DELIVERING PSYCHIATRIC AID TO IRAQ: HOW CAN AMERICAN PSYCHIATRISTS HELP IN A CONFLICT ZONE?

Chairperson: Amir Afkhami, M.D., Department of Psychiatry and Behavioral Sciences, 2150 Pennsylvania Avenue, NW, Washington DC, 20037
Presenters: James Griffith M.D., Saman Anwar M.D., Saman Halabjayi M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Understand the current state of psychiatry in Iraq, including prevaining psychopathologies and social stressors, (2) Identify the medical and educational needs of the Iraqi people and its psychiatric community, and (3) Explore ways in which American psychiatrists can provide help to their Iraqi counterparts.

SUMMARY:

The population of Iraq has endured terrible ordeals in the past two decades. An eight-year war with Iran, chemical attacks on its

own civilian population, Desert Storm and the total destruction of its infrastructure, years of sanctions, followed by Operation Iraqi Freedom in 2003. Iraqi society today is characterized by massive sectarian violence, internal strife, and one of the largest internally displaced populations in the world. Health Ministry-run hospitals in Iraq are characterized by pervasive insecurity, and lack of equipment and supplies. Since the election of Nuri al-Maliki in 2005 sectarian violence has entered the health care realm with the Sadrist Party's takeover of the Ministry of Health. Physicians are frequent targets of kidnappings, leading to a massive brain drain. Prior to the war in 2003 there were 30,000 physicians registered in Iraq's Medical Union. In April 2007 this number had dwindled to 8,000 with many of these physicians concentrated in the more stable northern segment of the country. The psychiatric sector has been most heavily hit by this situation. Today, less than thirty attending psychiatrists remain in Iraq and most reside in the north. Electroconvulsive therapy has become the mainstay of treatment due to lack of effective medicines for pharmacotherapy. The largest psychiatric hospital in Baghdad, the Al-Rashad Hospital with its 1,300 patients, has access to merely one attending psychiatrist one day a week. Research on the impact of conflict and war on psychiatry in Iraq remains sparse, however case reports indicate a growing number of suicides and cases of depression and post-traumatic stress disorder. The aim of this workshop is to bring together experts on Iraq and conflict zone psychiatry together with Iraqi psychiatrists to explore the current psychiatric challenges in Iraq and the ways in which American psychiatrists can become involved in helping the improve psychiatric education and health care delivery in Iraq.

REFERENCES:

1. Lehmann C: U.S. experts may help build new MH system in Iraq. Psychiatric News April 2, 2004; 39: 24.
2. Nazar M Mohammad Amin, Mohammad Qadir Khoshnaw: Medical Education and Training in Iraq. The Lancet 2003; 362: 1326-1326.

ISSUE WORKSHOP 60

THE PHYSICIAN AS PATIENT: HOW CAN WE HELP?

Chairperson: Michael F. Myers, M.D., St Paul's Hospital, Dept of Psychiatry, 1081 Burrard Street, Vancouver, Canada V6Z1Y6
Co-Chairperson: Glen O. Gabbard, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) Appreciate the range of problems that physicians bring to psychiatrists; and (2) Know how to assess and treat physicians with psychiatric illness.

SUMMARY:

Most psychiatrists, irrespective of their focus or subspecialty, treat physicians or their family members. This work can be challenging. Drs. Myers and Gabbard have been assessing and treating physicians for more than 30 years. In this workshop, they will briefly highlight the following dimensions of physician health: the psychology of the physician and the culture of medicine; unique issues for minority physicians and IMGs; psychiatric evaluation of physicians; psychiatric and medical illnesses in physicians, including addictive disorders; physicians with personality disorders; therapeutic modalities with physicians – psychodynamic psychotherapy, cognitive-behavior therapy, couples' therapy and more; the suicidal physician and the aftermath of suicide; and prevention. One third of the workshop time will be preserved for audience participation and interaction. Psychiatrists are encouraged to bring disguised clinical examples from their practices for discussion with the presenters and other attendees.

REFERENCES:

1. Myers MF, Gabbard GO: The Physician as Patient: A Clinical Handbook for Mental Health Professionals. Washington, DC, American Psychiatric Publishing, Inc. 2008.
2. Gabbard GO, Martinez M: Professional boundary violations by physicians. Journal of Medical Licensure and Discipline 91:10-15, 2005.

ISSUE WORKSHOP 61

PSYCHIATRY IN ASIA: PROBLEMS, PRIORITIES, AND SOLUTIONS

Chairperson: Pedro Ruiz, M.D., University of Texas Health Science Center at Houston, 1300 Moursund Street,, Houston, Texas, TX 77030
Co-Chairperson: Bruce S. Singh, Ph.D
Presenters: Pichet Udomratn M.D., Tsuyoshi Akiyama M.D., Haroon Chaudhry M.B.B.S, Chiao-Chicy Chen M.D..

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: understand the current mental health problems facing the Asian continent; develop priorities to address and resolve them; and learn the best methods of mental health interventions in Asia.

SUMMARY:

The Asian continent is one of the most populated regions of the world. Some of the areas have shown a strong economic growth in recent years, for instance, China, Australia, India, and Japan. Despite this strong financial perspective, many problems and challenges besieged this continent from a mental health point of view. For instance, psychiatrists tend to migrate from this region toward the West, especially from India, Pakistan, and Philippines. Additionally, recent natural disasters like the tsunami in Sri Lanka and the earthquakes in Pakistan and Bangladesh have cause instability and an increase in morbidity and mortality in the countries affected. Problems related to mental illness are on the rise and the resources available to address them are scarce and limited. As a result of these challenges, many Asians migrate to the United States. Presently, there are about 11 million Asian Americans residing in this country. It is, thus, very important that we address these mental health problems and that we find the most appropriate solutions for them. In this workshop, top mental health experts from this region will examine and discuss the current state of affairs from a mental health point of view affecting Asia.

REFERENCES:

1. Chrisholm D, Sekar K, Kumar K, et al.: Integration of mental health care into primary care: Demonstration costs. outcome study in India and Pakistan. British Journal of Psychiatry 176: 581-588, 2000.
2. Patel V: The epidemiology of common mental disorders in South Asia. NIMHANS Journal 17: 307-327, 1999.

ISSUE WORKSHOP 62

(HU)MANUALIZED CBT WITH CHILDREN: INNOVATION AND IMPROVISATION IN TREATMENT

Chairperson: Robert D. Friedberg, Ph.D., 22 Northeast Dr., Hershey, PA 17033
Presenters: Fauzia Mahr M.D., Ellen Flannery-Schroeder Ph.D., Angela Gorman Ph.D., Jolene Garcia M.D., Elizabeth Gosch Ph.D

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the developmental vicissitudes inherent in CBT with children, identify potential alliance ruptures and ways to repair these ruptures; appreciate the experiential tradition in CBT with children, and understand various ways to improvise and innovate in CBT with children without suffering theoretical drift.

SUMMARY:

The empirical success of cognitive, behavioral therapy protocols for children has lead to many welcome developments in child psychotherapy. Treatment manuals have operationalized child psychotherapy, systematized procedures, and specified treatment sequences. The favorable outcomes realized from randomized clinical trials make CBT a compelling standard for responsible mental health care. However, treatment manuals are not easy to implement! Good clinical skills are required for successful and flexible implementation. Good clinical skills and therapeutic innovation "breathe life" into treatment manuals and protocols. Indeed, recent attention is being directed toward this clinical resuscitation. Accordingly, this panel deals with the clinical issues inherent in (hu)manualizing cbt. The panelists represent child psychiatrists and clinical child psychologists who are both experts in empirically- supported approaches and adept at adapting these techniques to fit patients' challenging needs and circumstances. They will share their ideas regarding several pivotal issues. Developmental vicissitudes, school/peer issues, working with parents, and using clinical creativity without suffering theoretical or clinical drift will all be addressed. Further, the way the therapeutic alliance impacts CBT will be considered. In particular, research examining the relationship between therapeutic alliance, child involvement, and treatment outcome with anxious children will be reviewed. Finally, suggestions for remaining faithful to the experiential traditions in CBT while conducting empirically informed practice will be discussed. Case examples will be used to emphasize salient points. The panel will be interactive and each panelist will comment on each others' points. The attendees will also be given ample time to comment and ask questions.

REFERENCES:

1. Friedberg RD, Gorman AA: (2007). Integrating procedures and processes in cognitive behavioral therapy with children. Journal of Contemporary Psychotherapy, 37, 185-193.
2. Gosch EA, Flannery-Schroeder E, Mauro CF, Compton SN: Principles of cognitive-behavioral therapy for anxiety disorders in children. Journal of Cognitive Psychotherapy 2006; 20, 247-262.

ISSUE WORKSHOP 63

INTEGRATING PSYCHIATRY AND PRIMARY CARE: A RATIONAL RESPONSE TO CONTINUING MENTAL HEALTH NEEDS FOLLOWING HURRICANE KATRINA

Chairperson: Julia Z. Frank, M.D., 2150 Pennsylvania Ave NW, Washington, DC 20037
Co-Chairperson: Catherine S. May, M.D.
Presenters: Robert Titzler M.D., Lorna Mayo M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the rationale for integrating psychiatric and primary medical care services in responding to mass disasters. Participants will also know how to use appropriate screening tools for post-disaster mental health concerns, including PTSD, depression, anxiety, and substance-related disorders. Participants will also understand the administrative issues that affect professional volunteering in disaster.

SUMMARY:

Psychiatric disorders after natural disasters may persist long after the emergency has passed. The gulf hurricanes of 2005 destroyed whole communities and their infrastructure for mental health care. Two years later, people were still dispersed or living in substandard housing, often unemployed and uninsured. The ongoing crisis has created a need for outside professionals to provide services on a volunteer basis, so that local care providers can rebuild their own lives and practices. Participants in this workshop will share insights gained from repeated trips to different post-hurricane primary care clinics in the gulf region. They will present data from surveys conducted during four trips over two years that found large numbers of psychiatric problems in primary care clinics serving survivors. From this experience, it is clear that people with mental health problems are most easily identified while seeking medical or social services. Screening, focussed intervention and appropriate referral is both feasible and necessary in these non-psychiatric settings. Timing and qualities of the settings influence how effective mental health providers can be. Administrative support in the form of liability protection, credentialing and resource mobilization are also essential to getting services to people in need. Attendees will have the opportunity to share their own prior experiences as professional volunteers and to discuss ways of promoting continuing and future involvement in providing post disaster psychiatric services.

REFERENCES:

1. Ursano RJ, Fullerton CS, Benedek DM, Hamaoka DA: Hurricane Katrina: disasters teach us and we must learn. Academic Psychiatry 31(3):180-2, 2007.
2. Lopez-Ibor JJ: Disasters and mental health: new challenges for the psychiatric profession. World Journal of Biological Psychiatry. 7(3):171-82, 2006.

ISSUE WORKSHOP 64

WHAT TIME DOES NOT HEAL: ACHIEVING FUNCTIONAL RECOVERY IN PSYCHIATRIC ILLNESS

Chairperson: Marcia Scott, M.D., 19 Sibley Court, Cambridge, MA 02138
Co-Chairperson: Paul Pendler, Psy.D.
Presenters: Marilyn Price M.D., Andrea Stolar M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to use specific techniques to assess, support, and restore function during limited encounters with previously high functioning patients. They should also be able to assist them with maintaining compensation and employment using direct and written encounters with nonclinical entities maintaining the therapeutic alliance, ethical guidelines, and privacy boundaries.

SUMMARY:

Treating diagnosis and treating symptoms is never adequate treatment in psychiatric illness.

Often, even high functioning psychiatric patients don't resume their usual life roles or don't return to work despite standard treatment. Often, financial problems, bad marriage, bad boss, personality problems are blamed and efforts to assist the patient in obtaining compensation unnecessarily divert efforts to restore function. These diversions can result in unnecessary recurrences, prolonged disability, loss of employment, and diminished quality of individual and family life. Studies show that function is lost early and, once lost, often does not return when symptoms remit. Patients, even previously high functioning patients, need specific assistance in preserving and recovering function. This is not surprising since studies show that after a heart attack, patients with excellent cardiac function are less likely to resume full function without a cardiac rehab program and that patients avoid physical activity after the fracture heals if they do not participate in physical therapy. The "physical therapy" regimens of psychiatric treatment include Early aggressive evaluation and treatment before function is lost specific assessment of mental and role dysfunction in every psychiatric evaluation routine treatment of relevant coping patterns, specific interventions to maintain identity, life patterns and structures. The panel will use two role, play interviews with a high functioning patient with multiple mental and physical symptoms to illustrate and explore specific interventions and tools that even high functioning patients need if they are to maintain and recover function as well as retain compensation and employment during treatment of an episode of mental illness.

REFERENCES:

1. Goldman H.H R.E.Drake: Mood disorders and workplace performance: Half a Loaf. Am J Psychiatry, 2006; 163: 1490-1491.
2. Frueh C, Elhai JD et al, Disability compensation seeking among veterans evaluated for posttraumatic stress disorder. Psychiatr Serv 2003; 54: 84 - 91.

ISSUE WORKSHOP 65

ELVIN SEMRAD'S INTERVIEWING FUNDAMENTALS FOR HIGH-PRESSURE CLINICAL, FORENSIC, AND EDUCATIONAL CONTEXTS

Chairperson: Robindra K. Paul, M.D., 27020 Cedar Road, Apartment 111-1, Beachwood, OH 44122
Presenters: Max Day M.D., Jason Rafferty B.S., Beata Zolovska M.D., Harold J. Bursztajn M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants will be able to: deepen their understanding of the fundamentals of interviewing via observation of the style of the master clinician Elvin Semrad, apply these insights to their own clinical and forensic interviewing styles, and develop approaches to teaching interviewing in time pressured and anxiety-filled contexts.

SUMMARY:

Elvin Semrad for decades was a master clinician and respected educator at the Massachusetts Mental Health Center. His teachings influenced a generation of practitioners and teachers. The current workshop builds upon the enthusiastic response to the two prior APA workshops, which have used a recorded Semrad patient interview as a starting point for exploration of the fundamentals of interviewing. The current workshop will explore further what interviewing fundamentals can be applied in today's time-pressured clinical and educational contexts. Applications will be extended to such perennially anxiety-filled settings as forensic evaluations of dangerousness and intensive care unit ethical consultations.

REFERENCES:

1. Semrad EV: Teaching Psychotherapy of Psychotic Patients; Supervision of Beginning Residents in the "Clinical Approach." Workshop collaborators: Dan H. Buie (and others)
   Editor: David Van Buskirk. New York, Grune & Stratton, 1969.
2. Gopal A, Bursztajn HJ: On skepticism and tolerance in psychiatry and forensic psychiatry. Psychiatric Times Bonus Issue: Clinical Psychiatry and the Law April 15, 2007 Vol. 24 No. 5.

ISSUE WORKSHOP 66

TRANSITION-AGE YOUTH: AN OVERVIEW ON PSYCHOLOGICAL DEVELOPMENT, SERVICE DELIVERY, AND TREATMENT MODELS

Chairperson: Brooke A. Goldner, M.D., Harbor-UCLA Medical Center 1000 West Carson Street, Box 498, Torrance, CA 90509
Presenters: Joel Sherrill Ph.D., Maryann Davis Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants will be able to define the population known as Transition-aged

Youth (TAY). They will understand their unique developmental challenges, often subsequent to complex interactions between genetic vulnerability and environmental trauma, and will understand the desired characteristics of programs specifically oriented toward their care.

SUMMARY:

TAY describes an emerging field in mental health care that targets patients in their late teens to early 20s who are struggling with the transition to adulthood as a result of behavioral problems, substance abuse and dependence, and other psychiatric disorders. Many of these patients fall through the cracks of the mental health system, as they no longer qualify for adolescent services yet often are not considered "sick enough" to receive high-intensity adult mental health services. The TAY programs that have emerged in recent years recruit patients who are homeless, are ageing out of foster care, and are leaving jails and long- term inpatient psychiatric settings. These patients often present Axis II traits or pathology, which may impede and/or delay the type and quality of care they are provided. Furthermore, care for individuals in this age range is complicated by limitations of available evidence-based interventions. This workshop provides an overview of the unique developmental and clinical features of the individual during the transition to adulthood and their implications in the design of clinical interventions. We will review potentially promising research directions for informing our understanding about how to intervene and improve clinical course and functional outcomes. Five basic features of a transition support system promoting good care have been identified: continuity and coordination of services, sufficient availability of appealing and age appropriate services, continued support of family's role, and sufficient expertise. We will look into the progress of two aspects of programs at a national level: continuity of services and availability of services. We also will highlight the system impediments to providing good care for this specific age group and consider the limitations in current interventions and service delivery models.

REFERENCES:

1. Wang P, Sherrill J ,Vitiello B: Unmet need for services and Interventions Among adolescents with mental disorders. Am J Psychiatry 164:1-3, January 2007.
2. Davis M, Vander Stoep A: The transition to adulthood for youth who have serious emotional disturbance: developmental transition and young adult outcomes. J Ment Health Adm. 1997 Fall;24(4):400-27.

ISSUE WORKSHOP 67

PORTRAYAL OF PSYCHIATRY IN RECENT AMERICAN FILM

Chairperson: Steven E. Pflanz, M.D., 5201 Leesburg Pike, Suite 1501, Falls Church, VA 22041

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the impact of the portrayal of psychiatry in film on the public perception of psychopathology and the profession of psychiatry, as well as be able to critically analyze films containing psychiatric content.

SUMMARY:

The American film industry has long had a fascination with psychiatry. The history of film is replete with vivid images of psychiatrists and their patients. Perhaps unlike any other force in America, major motion pictures have the power to enduringly influence the public perception of mental illness, its treatments and the profession of psychiatry. In particular, the far-reaching appeal of films with success at the box office gives them a unique opportunity to shape the attitudes of everyday Americans. In order to understand the forces shaping the public perception of our profession, it is necessary to examine the images of mental illness and the mentally ill in commercially successful films. In this workshop, the audience will discuss the portrayal of psychiatry in contemporary films from the past decade, including such films as A Beautiful Mind, K-Pax, The Hours, Unfaithful, Antwone Fisher, Analyze That, About Schmidt, and In Her Shoes. Each of these films achieved a certain degree of both critical acclaim and box-office success and was seen by millions of Americans. The audience will view short film clips from each of these movies, discussing each in turn. The majority of the session will be devoted to audience discussion of how we understand contemporary film to influence the image of psychiatry in America.

REFERENCES:

1. Gabbard GO, Gabbard K: Psychiatry and the Cinema, 2nd Edition. Washington, DC, American Psychiatric Press, 1999.
2. Hesley JW, Hesley JG: Rent Two Films and Let's Talk in the Morning: Using Popular Movies in Psychotherapy. New York, John Wiley & Sons, Inc., 1998.

ISSUE WORKSHOP 68

PARTNERSHIPS IN THE AMERICAS: UPDATE FROM THE WORLD PSYCHIATRIC ASSOCIATION

American Psychiatric Association and the World Psychiatric Association

Chairperson: Michelle B. Riba, M.D., University of Michigan, Department of Psychiatry, 1500 E. Medical Center Drive, Room F6325 MCHC,, Ann Arbor, MI 48109-0295
Co-Chairperson: Lawrence Hartmann, M.D.
Presenters: Rodolfo Fahrer M.D., Roger Montenegro, Julio Arboleda-Florez M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Review several of the clinical projects being undertaken by psychiatry colleagues in the Americas; (2) Examine various cross-cultural clinical factors in caring for patients in the Americas; and (3) Determine some of the opportunities for psychiatric collaborations between the Americas, and with WPA-APA.

SUMMARY:

Within the World Psychiatric Association, there have been increased linkages between member countries in the Americas. This workshop will highlight topics in the Americas related to a number of clinically important topics such as work force;

primary care psychiatry, adolescent psychiatry, role of WPA member societies in the Americas, and diagnostic issues as they relate to culture and ethnicity. Panel members will each highlight an important clinical topic in their WPA zone. This presentation will allow for audience participation and discussion between WPA and APA members.

REFERENCES:

1. Remschmidt H, Belfer M: Mental health care for children and adolescents worldwide: a review. World Psychiatry 4:3, October 2005, 147-153.
2. Mezzich JE: Institutional consolidation and global impact: towards a psychiatry for the person. World Psychiatry 5:2, June 2006, 65-66.

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SSUE WORKSHOP 69

MAKING THE MOST OF YOUR CHIEF YEAR: CHIEF RESIDENTS' FORUM, PART II

Chairperson: Amy W. Poon, M.D., P O Box 660475 Arcadia, CA 91066
Co-Chairperson: Carolyn I. Rodriguez, M.D.
Presenters: Christina Mangurian M.D., Violeta Tan M.D., Shirley Liu B.A.,Anjali D. Souza, M.D., S. Shane Konrad, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to define the chief resident role more clearly; identify strategies for maximizing administrative and professional growth, and for handling the dual role of resident and administrator; share his/her own learning experiences with other participants at the workshop; and network with chief residents from other programs, who can potentially provide ongoing support and consultation in the upcoming year.

SUMMARY:

This is Part II in a two-part workshop for incoming chief residents. Outgoing and former chief residents, residency directors, and others interested in administrative psychiatry are encouraged to attend and share their experiences. In a recent study, most chief residents report having satisfying, positive experiences, with the majority (90.6%) saying they would choose to perform the chief resident's duties again. However, they also reported that they were less likely to have a clear statement of their responsibilities. Prior literature dating back to 1980 discussed the several problems inherent in the role, including poor definition of the role, lack of training for the job, divided loyalties, and unrealistic expectations. The purpose of this workshop is to provide a forum to discuss these chief residency issues, and to improve the lack of information that often accompany this role, (most programs typically have only one or two chief residents who are doing the job for the first time). This will include presentations from panelists who are finishing their chief year at programs across the country. Since chief residents often face similar tasks, there will also be small group time to exchange ideas and strategies with chief residents and administrators from other programs. Issues to be addressed include: (1) the "dual role" of interfacing between residents and administrators, and (2) ways to maximize administrative, professional, and personal growth in a year that is rich in opportunities for all the above. Since 88.7% of chief residents in a recent study said that their chief experience has inspired them to seek future leadership opportunities, this workshop provides administrative training and networking for future potential leaders in psychiatry.

REFERENCES:

1. Ivany CG, Hurt PH: Enhancing the effectiveness of the psychiatric chief resident. Academic Psychiatry 2007; 31:277-280.
2. Warner CH, et al: Current perspectives on chief residents in psychiatry. Academic Psychiatry 2007; 31: 270-276.
3. Sherman RW: The psychiatric chief resident. Journal of Medical Education 1972; 47: 277-280.

ISSUE WORKSHOP 70

NAVIGATING TERRORISM AND ITS RELATION TO MENTAL HEALTH: MIDDLE EAST PERSPECTIVE

Chairperson: Mostafa K. Ismail, M.D., Institute of Psychiatry, Faculty of medicine Ain Shams University, Cairo, Egypt Deir Elmalak
Co-Chairpersons: Zeinab Bishry, M.D.
Presenters: Yasser Elsayed M.D., Mohamed Ghanem M.D., Afaf Khalil M.D., Abdel Naser Omar M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to define the concept of terrorism and its relation to mental health, discuss the controversial relationship of terrorism to Islam and other ethnic and culture groups, and define the role of mental health professionals in combating terrorism.

SUMMARY:

Mental health is a psychological state of well-being, characterized by continuing personal growth, a sense of purpose in life, self-acceptance, and positive relations with others. Terrorism may be defined as "the deliberate creation and exploitation of fear to innocent people for bringing about political change." Mental health and terrorism are hot topics nowadays and many of issues are in need of discussion. Why persons kill themselves and kill unknown others, the normacy of this thinking, and the mental health of such persons, are Islam is one of the three major world religions, along with Judaism and Christianity, that profess monotheism, or the belief in a single God. A controversial issue came to the surface at the last few years after the September 11 attack about the relation of terrorism to Islam. These issues and more will be discussed in this workshop

REFERENCES:

1. Palmer I: Terrorism, suicide bombing, fear, and mental health. Int Rev Psychiatry 2007 Jun;19(3):289-96.
2. Hawley SR, Ablah E, Hawley GC, Cook DJ, Orr SA, Molgaard CA: Terrorism and mental health in the rural Midwest. Prehosp Disaster Med 2006 Nov-Dec;21(6):383-9.

WORKSHOPS

ISSUE WORKSHOP 71

PSYCHIATRISTS WHO HAVE BEEN IN TREATMENT: PART II

Chairperson: Michael F. Myers, M.D., St Paul's Hospital, Dept of Psychiatry, 1081 Burrard Street, Vancouver, Canada V6Z1Y6
Co-Chairpersons: Leah J. Dickstein, M.D.
Presenters: Brenda Czaban M.D., Raymond Reyes M.D., Heather Goff M.D., Desmond Kaplan M.D., Melanie Spritz D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1)appreciate issues around disclosure of living with or having been treated for a psychiatric illness, and (2) understand the circuitous route to care for many psychiatrists.

SUMMARY:

This workshop builds on the energy that was generated at a workshop called "Psychiatrists Who Have Been in Treatment: An Interactive Discussion," presented at the 2007 annual meeting of the American Psychiatric Association. Our goal is to educate and to diminish the internalized stigma that many psychiatrists feel when they develop a mental illness. Research shows that symptomatic psychiatrists often suffer silently and for a long time before seeking professional help. This enhances morbidity and treatment refractoriness. Each presenter, including a resident, will give a brief summary of their respective journeys, followed by dialogue and interaction with the audience. Psychiatrists who have experienced a psychiatric illness or who treat psychiatrists in their practices, or both, are encouraged to come with questions to pose to the panel. At the conclusion of this session, those attending will not only feel better informed about the subject but also experience a sense of camaraderie and support with colleagues who have faced similar challenges.

REFERENCES:

1. Baxter EA. The turn of the tide. Psychiatric Services 1998;49: 1297-1298.
2. Cournos F. City of One: A Memoir. New York, NY. WW Norton & Co, 1999.

ISSUE WORKSHOP 72

EMERGING TRENDS IN DRUG ABUSE: MONITORING TO STAY AHEAD OF THE CURVE

National Institute on Drug Abuse

Chairperson: Timothy P.Condon, Ph.D., National Institute on Drug Abuse, 6001 Executive Blvd., Suite 5274 MSC 9581, Bethesda, MD 20892
Presenters: Timothy Condon Ph.D., Edward Boyer M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will gain an enhanced understanding of the early drug abuse warning systems that are currently in place, their strengths and weaknesses, and identify the latest emerging trends. The information presented should enable psychiatrists to become more familiar with epidemiological trends and phenomena that could have a profound impact on their practice.

SUMMARY:

The drug abuse and addiction landscape is constantly being reshaped, leaving little room for celebration or complacency. As a result, we must maintain our focus on basic and translational drug abuse and addiction research while keeping a watchful eye for signs of trouble ahead. For instance, the latest "Monitoring the Future" survey registered a stunning 23% decline over a five- year period in the percent of students reporting past month use of illicit drugs, but any good news was quickly tempered by the revelation that one in ten 12th graders reported having used Vicodin for non-medical purposes in the past month. Among the many factors that contribute to the evolving, unpredictable nature of abuse are the constantly changing methods to use mind-altering substances, the instantaneous online access to information about new (and old) abusable drugs, and the unfettered access to mostly unregulated sites for their acquisition. Particularly worrisome has been the blurring of the lines between licit and illicit psychoactive substances, as we document growing evidence of abuse of over-the-counter medications (e.g., DXM), previously exotic or ethnically limited plant extracts (e.g., khat, salvia), new energy concoctions (e.g., high-caffeine content drinks), and prescription drugs (e.g., opiate analgesics). The presentations will focus on the implementation, interpretation, and exploitation of various "monitoring strategies." These will include (1) the early detection devices used by NIDA to track emerging drug abuse trends; (2) the use of Internet search methods to identify new trends and detect new substances of abuse; and (3) the creation of surveillance systems for drug overdose epidemics, the components of which can be designed to detect geographically-diverse overdose outbreaks among marginalized populations.

REFERENCES:

1. Johnston LD, O'Malley PM, Bachman JG, Schulenberg JE: Monitoring the Future national results on adolescent drug use: Overview of key findings, 2006 (NIH Publication No. 07-62 02), 2007; Bethesda, MD: National Institute on Drug Abuse.
2. Boyer EW, Lapen PT, Macalino G, Hibberd, PL: Dissemination of psychoactive substance information by innovative drug users. Cyberpsychology and Behavior 2007; 10(1): 1-6.

THURSDAY, MAY 8, 2008

ISSUE WORKSHOP 73

THE HISTORY OF WORLD PSYCHIATRY: CONTENT AND CONSEQUENCES

Chairperson: Milton Kramer, M.D., 1110 N Lake Shore Dr.23S, Chicago, IL 60611
Presenters: Prakash Desai M.D., Douglas Lehrer M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to have an understanding of the possibility that a well-intentioned event may have unfortunate consequences, and be alerted to consider the possible negative consequences of either individual or profession-wide changes.

SUMMARY:

The history of psychiatry as a series of important events is of interest in its own right. However, attention to the consequences of such events is of even greater interest as it invites us to scrutinize our activities for what unintended consequences may result from our choices and behaviors. Dr. Douglas Lehrer will provide an overview of the history of Western psychiatry focusing particularly on the consequences of events such as the result of academic German psychiatry in the early 19th century searching with the newly available microscope for abnormal brain structure in psychosis resulting in a disinterest in therapy, both organic and psychological. Dr. Prakash Desai will look at Eastern Psychiatry, particularly Indian and Chinese, examining the consequence of health being defined philosophically in one case as the search for wisdom and in, other as a search for harmony. Did the goal of transcendence lead to a neglect of the psychiatric patient? Dr. Milton Kramer will offer examples from the history of American psychiatry in which unfortunate unintended consequences resulted from well intended actions such as the closure of state hospitals resulting in patients ending up in nursing homes, jails, and the street. A discussion with the audience will be invited to explore these and other unintended consequences and how they are to be understood and perhaps ameliorated or avoided.

REFERENCES:

1. Porter R: The Greatest Benefit to Mankind: A Medical History of Hunanity. New York: W.W. Norton & Company, 1997.

2. Shorter E A: History of Psychiatry. New York: Free Press, 1997.

ISSUE WORKSHOP 74

THE FUTURE OF PSYCHIATRY: UTILIZING A NEURODEVELOPMENTAL MODEL FOR CASE FORMULATION

Chairperson: Jennifer L. McLaren, M.D., Dartmouth Hitchcock Medical Center, Department of Psychiatry, 1 Medical Center Drive, Lebanon, NH 03766
Co-Chairperson: Robert L. Hendren, D.O.
Presenters: Daniel Weinberger M.D., Charles Nemeroff M.D., Jean Frazier M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: (1) Describe the neurodevelopmental model; (2) Understand the utility of the neurodevelopmental model; (3) Utilize the framework proposed to develop a neurodevelopmental case formulation; and (4) Develop a treatment plan based on neurodevelopmental case formulation.

SUMMARY:

The last decade has seen an explosion in knowledge in the field of psychiatry, with advances in molecular genetics and neuroimaging. These new technologies have altered the field of psychiatry and some of the basic tenets upon which traditional psychiatric case formulation is based. Application of translational neuroscience in the fields of neurobiology and developmental psychopathology has yielded great insights into our understanding of the neurodevelopmental basis for psychopathology. The many technologic advances have outpaced the current methods of psychiatric case formulation. Despite these developments, a basic framework upon which to apply the neurodevelopmental model in case formulation has been lagging behind the pace of scientific study in the field. The goal of this workshop is to formulate a complex psychiatric case utilizing the neurodevelopmental model and develop a treatment plan based on that formulation. Workshop participants will be encouraged to discuss how their neurodevelopmental perspective might add to the understanding of the case, lead to further work up, and how this information might guide treatment decisions. Participants will also be asked to discuss their opinions regarding the neurodevelopmental model and how they feel it impacts practice and treatment now and in the future. Understanding psychopathology using a neurodevelopmental framework allows clinicians to gain a more fundamental/basic understanding of their patients. This workshop will explain the neurodevelopmental model of case formulation, display its utility, and demonstrate the future of clinical psychiatry should this type of case formulation become common practice.

REFERENCES:

1. Prathikanti S, Weinberger DR: Psychiatric genetics- the new era: genetic research and some clinical implications. British Medical Bulletin 2005; 73 and 74: 107-122.
2. Insel TR, Quirion R. : Psychiatry as a clinical neuroscience discipline JAMA.2005; 294: 2221-2224.

ISSUE WORKSHOP 75

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY UPDATE: CERTIFICATION AND MAINTENANCE OF CERTIFICATION IN PSYCHIATRY AND ITS SUBSPECIALTIES

Chairperson: Larry R. Faulkner, M.D., American Board of Psychiatry and Neurology, 500 Lake Cook Road, Suite 335, Deerfield, IL 60015
Presenters: Barbara Schneidman M.D., Burton V. Reifler M.D., Naleen Andrade M.D., David Mrazek M.D., Victor Reus M.D., Beth Ann Brooks M.D., Christopher Colenda M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the American Board of Psychiatry and Neurology's policies and procedures for certification and maintenance of certification in psychiatry and its subspecialties.

SUMMARY:

The purpose of this workshop is to present information on the requirements for certification by the ABPN in psychiatry and the subspecialties of addiction psychiatry, child and adolescent psychiatry, forensic psychiatry, geriatric psychiatry, and psychosomatic medicine, as well as clinical neurophysiology and pain medicine. Information on the new subspecialty certificates in sleep medicine and hospice and palliative medicine will also be presented. Application procedures, including training and licensure requirements, will be outlined. The new requirements for the assessment of clinical skills during residency training will be delineated, and the content of the Part I (multiple choice), Part II (oral), and subspecialty examinations will be reviewed. The

evolving maintenance of certification (recertification) program has four components (professional standing, self-assessment and lifelong learning, assessment of performance-in-practice, and cognitive expertise), and the requirements for each will be described. A substantial amount of time will be available for the panelists to respond to queries from the audience.

REFERENCES:

1. Shore JH, Scheiber SC (eds): Certification, Recertification, and Lifetime Learning in Psychiatry. Washington, DC, American Psychiatric Press, 1994.
2. Scheiber SC, Kramer TAM, Adamowski S (eds): Core Competencies for Psychiatric Practice: What Clinicians Need to Know. Washington, DC, American Psychiatric Press, 2003.

ISSUE WORKSHOP 76

DEVELOPMENTS IN THE ASSESSMENT OF CAPACITY, STATUTORY CHANGES, AND ADMINISTRATIVE AIDS: THE ROAD TO LESS LITIGATION

Chairperson: Michael J. Wise, M.D., 15 Brondesbury Rd., London, United Kingdom NW6 6BX
Co-Chairperson: Julian Beezhold, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to list the essential elements of capacity in a range of jurisdictions, understand how to elicit and record their presence or absence and be aware of a variety of available tools to reduce litigation risk.

SUMMARY:

Aim: The aim of the workshop is to help participants improve their ability to assess capacity and be aware of relevant tools for aiding decisions regarding capacity and consent. *Audience*: The workshop is aimed at psychiatrists of all levels. Research has shown that there is room for improving the knowledge of the principles of capacity at all levels of experience from trainee to board registered practitioner. *Method*: Teaching will be a mix of interactive exercises, demonstrations, presentation, and discussions. Initially participants will view a clinical dilemma and discuss whether capacity is present. A presentation will then inform participants of legal principles. A second dilemma will allow participants to determine their understanding of the principles. The second case will be used to demonstrate an algorithm, which has been used in multiple jurisdictions for the assessment of capacity. A third dilemma will illustrate the boundaries of tools and involve a group decision. Prior versions of this workshop have improved assessment accuracy from 40% to 80%. *Objectives*: To be aware of the issues involved in assessing capacity, including relevant legal tests. To improve the assessment skills of participants. To learn about resources for assessing capacity and consent.

REFERENCES:

1. Restoration of Competency to Stand Trial. Journal of the American Academy of Psychiatry & Law. 31(2): 189-201, 2003.
2. Informed Consent: Information or Knowledge? Medicine & Law. 22(4): 743-50, 2003.

ISSUE WORKSHOP 77

CONTROVERSIES IN BIPOLAR DISORDER: A CLINICAL PERSPECTIVE

Chairperson: Gary E. Miller, M.D., 530 Wells Fargo Drive, Suite #110, Houston, TX 77090
Presenter: Richard Noel M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will have acquired an understanding of controversies in bipolar disorder and their effect on clinical decision making in routine practice, and they will have become familiar with diverse clinical presentations of bipolar disorder and with the pros and cons of various treatment strategies, for example, the role (if any) of antidepressants in management of bipolar disorder.

SUMMARY:

This workshop will focus on controversies in bipolar disorder including the scope of the bipolar spectrum, subthreshold presentations, rapid cycling and manic switches, the role of antidepressants (including antidepressant monotherapy) in management of bipolar patients, presentations of bipolar disorder in children and adolescents, the relationship of bipolar disorder to attention- deficit/hyperactivity disorder, psychotic presentations of bipolar disorder, the association of bipolar disorder with atypical depression, and the role of thyroid hormones in management of bipolar disorder. The moderators are clinical psychopharmacologists who have treated over 10,000 patients of all ages over the last 15 years. They will present vignettes of actual patients, each illustrating a controversial issue in bipolar disorder. Participants will be encouraged to discuss the cases presented and to convey their own clinical experience and views.

REFERENCES:

1. Akiskal HS, Benazzi F: The DSM-IV and ICD-10 categories of recurrent [major] depressive and bipolar II disorders: Evidence that they lie on a dimensional spectrum. J Affect Disord 2006; 92:45-54.
2. El-Mallakh RS, Karippott A: Use of antidepressants to treat depression in bipolar disorder. Psychiatric Services 2002;53: 580-584.

ISSUE WORKSHOP 78

ATHEROGENIC DYSLIPIDEMIA IN PATIENTS TREATED WITH ATYPICAL ANTIPSYCHOTICS

Chairperson: Peter Manu, M.D., Medical Services, Zucker Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004
Co-Chairperson: Mariana Roida, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) understand the contribution of antypsychotic-related weight gain and metabolic syndrome to new, onset or worsening of atherogenic dyslipidemia (elevated LDL-cholesterol, elevated triglycerides and decreased HDL-cholesterol), (2) calculate the LDL-cholesterol target for primary prevention of cornary artery

disease; and (3) use non-HDL-cholesterol to manage abnormal triglyceride levels.

SUMMARY:

Epidemiological and clinical research has indicated a sharp increase in cardiovascular deaths among schizophrenia patients since the mid-1980s. This unfortunate development has been attributed to treatment with atypical antipsychotics, such as clozapine and olanzapine, which produce weight gain and metabolic syndrome, and increase the risk of coronary events. The National Cholesterol Education Panel has identified elevated levels of low-density lipoprotein cholesterol as the primary aim of therapeutic intervention. Elevated triglycerides and lowered high-density lipoprotein cholesterol, expressed as abnormally high non-HDL cholestrol are the secondary target for reducing the risk of coronaryy events and death. Emerging data indicate suboptimal treatment of atherogenic dyslipidemia in at-risk psychiatric patients. The workshop will attempt to correct this reality by familiarizing practicing psychiatrists with the national standard for th recognition and treatment of atherogenic dyslipidemia.

REFERENCES:

1. Correll CU, Frederickson AM, Kane JM, Manu P: Metabolic syndrome and risk of coronary heart disease in 367 pastients treated with second-generation antipsychotic drugs. J Clin Psychiatry 2006;67:575-583.
2. Correll CU, Harris JL, Pabntaleon Moya RA, Frederickson AM, Kane JM, Manu P: Low-density lipoprotein cholesterol in patients treated with atypical antipsychotics: Missed targets and lost opportunities. Schizophrenia Res 2007;92:103-107.

ISSUE WORKSHOP 79

PATIENT SIMULATION: BRITISH AND AMERICAN ADAPTATIONS FOR PSYCHIATRIC EDUCATION OF MEDICAL STUDENTS

Chairperson: Julia Z. Frank, M.D., 2150 Pennsylvania Ave NW, Washington, DC 20037
Co-Chairperson: Subodh Dave, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to implement standardized patient methods to enhance students' skills in psychiatric diagnostic interviewing, cross, cultural communication about behavioral problems, and explaining psychiatric treatment to patients prior to referral.

SUMMARY:

Increasing demands for standardization and accountability in medical student education and new limits on what medical students may do in patient care have fostered rapid growth of standardized patient training methods in the undergraduate curriculum here and in Britain. These methods may enhance the teaching of psychiatric skills, especially diagnostic interviewing and basic behavioral counseling. A teacher using simulated patients under standardized conditions can assign specific objectives for particular encounters, rather than hoping that an important diagnostic or relational issue will come up in a real clinical setting, with an educator present to help the student learn from it. Observing student interviews under standardized conditions, in turn, helps educators identify gaps in training. This workshop will offer participants the opportunity to participate in and reflect on two well-tested standardized patient exercises that address such gaps. One deals with the problem of presenting a psychiatric diagnosis and explaining treatment to a patient who has come to a general medical clinic for a related medical problem. The second provides safe practice in raising and discussing a behavioral problem during a cross-cultural encounter. Attendees will first participate in these exercises. They will then have the opportunity to suggest improvements in the exercises and to discuss ways to adapt standardized patient methods for use in their own training settings.

REFERENCES:

1. Beach MC, Rosner M, et al: Can Patient-centered attitudes reduce racial and ethnic disparities in care? Academic Medicine 82(2):193-8, 2007.
2. Epstein RM, Shields CG, Franks P, Meldrum SC, Feldman M, Kravitz RL, Exploring and validating patient concerns: relation to prescribing for depression. Annals of Family Medicine.
5(1):21-8, 2007.

ISSUE WORKSHOP 80

MEDICAL LEGAL ASPECTS OF PSYCHIC TRAUMA: A FAMILY APPROACH

Chairperson: Michael Hughes, M.D., 2701 S. Bayshore Drive, #310, Miami, FL 33133
Co-Chairperson: Jon A. Shaw, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Understand legal concepts of personal injury and wrongful death as they relate to psychic trauma; (2) Relate to aspects of psychic trauma to bereavement, posttraumatic stress disorder, and other psychiatric comorbidites; and (3) Discuss the effects of psychic trauma and its comorbidities within the traumatized family.

SUMMARY:

This presentation will examine the interface of psychiatry and the law for children, adults, and their families who seek economic damages through the courts for alleged psychological trauma. Such personal injury lawsuits involve issues of trauma and loss. Recent studies are explicating distinctions and interrelationships for bereavement, complicated traumatic grief, depression, and PTSD. These issues are considered within the context of the injured family, which offers both support and adversity to its members. Dr. Hughes will present an overview of forensic psychiatric assessment, consultation with attorneys, and testimony. Relevant legal issues are addressed: emotional damages (pain and suffering, losses, and functional impairment); proximate cause; use and reliability of various data; and prognosis. Dr. Shaw will present the case of a 14-year-old girl of divorced parents, who was living with her father when he died suddenly and unexpectedly, in an auto accident. Issues of bereavement, depression, and PTSD are emphasized as they

reverberate within the primary and extended family. A dialogue between the presenters will juxtapose medical-legal requisites with relevant clinical and family data, leading to an interactive colloquy with the audience.

REFERENCES:

1. Simon RI (ed): Posttraumatic Stress Disorder in Litigation (2nd Edition). Washington, American Psychiatric Publishing, Inc. 2003.
2. Horowitz MJ, Siegel B, Holen A et al (1997). Diagnostic criteria for complicated grief disorder. Am J Psychiatry 154: 904-910.

ISSUE WORKSHOP 81

IRAQ ON THE GROUND: THE REAL STORY THROUGH A PSYCHIATRIST'S LENS

Chairperson: Anita S. Everett, M.D., 3563 Cattail Creek Drive, Glenwood, MD 21738
Presenters: Mohammed Al-Zuri M.D., Allen Dyer M.D

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1)List several barriers involved with teaching psychiatry in contemporary Iraqi culture; (2) Identify cultural resilience factors that are found in Iraq and war torn cultures: (3) Recognize the value of cultural exchange as informative in shaping our own practice assumptions; and (4) Recognize the value of contemporary technology such as e-mail, teleconferencing and blogs to throw a safety net to our peers in other countries.

SUMMARY:

The people in IRAQ live in a war zone. We hear reports of death, disaster and devastation, yet millions of people in Iraq are living their lives. They work in their professions, send their children to school, visit family and speculate about the future. Forty years ago, Medical City in Baghdad was a regional center of excellence for healthcare of all kinds including psychiatry. A generation of neglect and war has damaged this structure, however medical schools, resilient faculty and dedicated physicians are practicing, teaching and planning for a brighter future. This workshop provides a unique opportunity to learn from two psychiatrists who have recently been on a civilian teaching adventure to Irbil, IRAQ to provide basic CME to Psychiatrists in Iraq. Through their experience, participants will learn the realities of living and practicing psychiatry in Iraq. The work of a small planning workgroup sponsored by the US, HHS, Substance Abuse Mental Health Services Administration will be reviewed.

REFERENCES:

1. Sadik S, Al-Jadiry M: (2006) Mental Health services in Iraq: past, present and future. International Psychiatry, 3(4), 11-13.
2. Abed, R (2003) An update on mental health services in Iraq. Psychiatric Bulletin, 27: 461-462.

ISSUE WORKSHOP 82

ENHANCING THE MILIEU: DEVELOPMENT OF A COMPREHENSIVE INPATIENT CBT PROGRAM

Chairperson: Katherine L.. Lynch, Ph.D., Weill Cornell Medical College, 21 Bloomingdale Road, White Plains, NY 10605
Co-Chairpersons: Jean Kim, M.D.
Presenters: Virginia Susman M.D., Courtney Berry M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the challenges associated with the development of a comprehensive cognitive behavioral inpatient program and understand the basic elements required for successful implementation; understand how to adapt cognitive-behavioral treatment for a group-oriented, milieu based inpatient environment; appreciate how use of structured CBT programming can foster patient engagement, fostering their active role in treatment.

SUMMARY:

In recent years, inpatient treatment has been faced with many challenges, including briefer admissions and increased fiscal limitations that have significantly impacted service delivery. An ongoing struggle for inpatient units remains how to maximize treatment for a heterogeneous inpatient population with the minimal resources available. In this workshop, psychiatrists and clinicians will learn how to enhance the inpatient treatment experience through the development of a comprehensive cognitive behavioral therapy (CBT) program. Discussion will center on our hospital administration's interest in fostering the development of such programming, the history of efforts required to make the program a reality, and the impact on the overall unit milieu. The presentation will also address the challenges of program implementation and culture change on an inpatient unit. Further topics to be discussed include cultivating interest and investment of all unit staff in order to create a truly comprehensive, multidisciplinary approach to CBT, providing effective and efficient training and support to staff, and maintenance and ongoing evolution of programming to meet patient and staff needs. We will also highlight the potential of this environment as an invivo training ground for psychiatry and psychology trainees, allowing them the opportunity to begin developing CBT psychotherapy competency during the inpatient years of training. Additionally, discussion will focus on how to adapt CBT for group and milieu based treatment, capitalizing on patients' time in the hospital and promoting their active involvement in treatment, as well as how the therapy works for patients with varying psychiatric diagnoses. Finally, we will share our own experiences regarding the benefits of commitment to a unified treatment model, sharing the positive impact observed in the milieu, as well as Press Ganey patient satisfaction scores and anticipated patient outcome data.

REFERENCES:

1. Durrant, C., Clarke, I., Tolland, A., Wilson, H: Designing a CBT Service for an acute inpatient setting: A pilot evaluation study. Clinical Psychology and Psychotherapy 2007 14:117--125.
2. Wright, J.H., Thase, M.E., Beck, A.T., Ludgate, J.W. (eds.): Cognitive Therapy with Inpatients: Developing a Cognitive Milieu. New York, Guilford Press, 1993.

ISSUE WORKSHOP 83

SECOND CHANCE PROGRAM: TEN YEARS OF SUCCESSFULLY TREATING THE TREATMENT-REFRACTORY PATIENT WITH SCHIZOPHRENIA

Chairperson: Adam J. Savitz, M.D., NYPH-Weill Cornell Medical Center, Paynew Whitney Westchester, 21 Bloomingdale Road, White Plains, NY 10605
Presenters: Andrew Bloch M.S.W., Barbara-Ann Bybel B.S.N., Steven Silverstein Ph.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop, participants will be able to demonstrate: (1)evidence for the effectiveness of social learning programs (token economies) in treating institutionalized patients with schizophrenia; (2) the components of the Second Chance Program that make it successful and that differentiate if from typical programs for institutionalized patients; (3) the role of different disciplines in the success of the program and the need for close coordination among the different care givers.

SUMMARY:

Despite recent advances, a number of patients with schizophrenia remain hospitalized for much of their lives. In 1997, N.Y. Presbyterian Hospital, the N.Y.S. Office of Mental Health, and four residential providers in N.Y.C. collaboratively founded the Second Chance Program with the idea that a private, academic center could help patients that could not be discharged from state hospitals. The program is almost entirely funded by Medicaid. Patients come from N.Y. state hospitals (80%) or are waiting transfer to a state hospital from acute units. The admission criteria are few: willingness to come, primary psychotic disorder, and no recent sustained community tenure. Though pharmacology (particularly clozapine) is important, the Program uses evidence-based psychosocial interventions such as a social learning program (SLP, token economy) and manualized skills training groups. In 2000, a SLP was instituted to help patients learn community skills since multiple studies have shown the benefit of SLPs for this population. The SLP focuses on skill training in areas such as ADLs and room care, as well as systematically assessing and rewarding community appropriate behaviors and discouraging inappropriate or institutionalized behaviors. The SLP has thrived because all staff are required to complete training and show competency in SLP practices. Most patients have been institutionalized the majority of their adult lives, 2/3 are male, 2/3 have substance abuse histories, and approximately 1/2 have criminal histories. The program is successful in placing patients in the community. For its entire 10 years, approximately 80% have been discharged at least once to the community with about 65% having significantly community tenure. In the last three years, 86% have been discharged to the community, and 55% had at least a year of continuous community tenure. In summary, the program uses evidence-based practices to help a majority of treatment refractory patients transition to the community.

REFERENCES:

1. Silverstein SM, Hatashita-Wong M, Wilkniss S, Bloch A, Smith T, Savitz A, McCarthy R, Friedman M, Terkelsen: Behavioral rehabilitation of the treatment-refractory schizophrenia patient: conceptual foundations, interventions, and outcome data. Psychological Services 2006; 3:145-169.
2. Corrigan PW: Use of a token economy with seriously mentally ill patients: criticisms and misconceptions. Psychiatr Serv. 1995; 46:1258-63.
3. Paul GL, Lentz RJ: Psychosocial treatment of chronic mental patients: Milieu vs. social learning programs. Cambridge, MA, Harvard University Press, 1977.

ISSUE WORKSHOP 84

IS THERE A ROLE FOR COMPLEMENTERY AND ALTERNATIVE MEDICINE IN THE TREATMENT OF DEPRESSION?

Chairperson: Meera Narasimhan, M.D., Department of Neuropsychiatry and Behavioral Science, 3555 Harden Street Extension, Columbia, SC 29203
Presenters: Shilpa Srinivasan M.D., Travis Bruce M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: Evaluate the role of alternative and complementary medicine in treating major depressive disorder; review the best available clinical evidence with alternative and complementary medicine as an add-on to antidepressants in depression; and understand the neurobiology and mechanism of action of exercise and nutritional supplements in depression.

SUMMARY:

Depression afflicts an estimated 340 million people worldwide, and over 18 million in the United States. The World Health Organization projects depression will rank second to heart disease in disease burden worldwide by 2020. Up to 2 million individuals in the United States with depression experience an inadequate treatment response during their lives. Social stigma associated with pharmacotherapy is a frequent barrier. Given these and other disadvantages of orthodox antidepressant treatments, individuals often choose to self-medicate with alternative treatments. Complementary and alternative medicine therapies such as exercise, herbal supplements including omega-3 fatty acid, and SAMI, folic acid have been studied as options without a negative social stigma as monotherapy for depression or to augment traditional medicine. Exercise has a role in the treatment armamentarium against depressive disorders, particularly among partial responders to established treatments, and in the elderly. Controlled trials have examined exercise as monotherapy and as an adjunct to established pharmacologic treatments for depression. The TREAD study, a randomized, controlled trial, is examining the efficacy of aerobic exercise added-on to SSRI treatment of major depressive disorders. The shift over the past century in the Western diet resulting in a higher physiologic ratio of omega-6 to omega-3 fatty acids has been hypothesized to create a proinflammatory state that is contributing to the prevalence of mood disorders. Efficacy of use of omega-3 fatty acid has been shown to be promising in the majority of related trials. A number of proposed mechanisms for this effect have been reported, including regulation of neurotransmitter signaling, corticotrophin-releasing factor through inhibition of inflammatory cytokines, increased

dendritic arborization, increased synapse formation, increase in neurogenesis in the adult brain, and prevention of neuronal apoptosis with both exercise and nutraceuticals. Further studies in this area are warranted given the potential gains in patient care and understanding of depression. This workshop will focus on evidence-based trials and the potential role of complementary and alternative medicine as monotherapy and add on to antidepressant in major depressive disorder.

REFERENCES:

1. Lee J, Seroogy KB, Mattson MP: Dietary restriction enhances neurotrophin expression and neurogenesis in the hippocampus of adult mice. J Neurochem 2002;80:539-47.
2. Trivedi MH, Greer TL. Grannemann BD, Church TS, Glaper DI, Dunderajan P, Wisniewski SR, Chambliss HO, Jordan AN,
Finley C, Carmody TI. TREAD.

ISSUE WORKSHOP 85

INSECURITY, VIOLENCE, AND TRAUMA IN HAITI: CLINICAL IMPLICATIONS

Haitian-American Psychiatric Association

Chairperson: Jacques Vital-Herne, M.D., P.O. Box 692, Hicksville, NY 11801-0692
Co-Chairperson: Pierre Jean-Noel, M.D.
Presenters: Joseph Clerisme M.D., Georges Casimir M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the psychiatric consequences of political and societal violence for Haitian patients and consider the implications for clinical work.

SUMMARY:

For the past five decades, there has been a significant Haitian migration to the United States and Canada. Currently, over 1 million Haitians live in New York, Miami, Boston, Chicago, Washington, D.C., and Montreal. The migration waves began in the 1960s under the 28-year rule of the Duvalier dictatorship (1957-1986). From 1986 to the present, a new type of violence has been terrorizing the population: kidnappings for finanacial gains, armed robberies, systematic rapes of members of an entire family, and murders. As a result of this climate of insecurity and violence, there has been a significant increase in cases of depression, PTSD, psychosis, suicide attempts among adults. Children and adolescents often present with aggressive/disruptive behaviors, enuresis, avoidance, poor academic performance, hypervigilance, and recurrent nightmares. This workshop will address clinical issues highly relevant to the care of a growing number of Haitian patients (largely victims), residing and/or seeking treatment in North America. Clinical vignettes will illustrate several aspects of the problem. Dr. Clerisme will discuss clinically relevant aspects of violence in Haiti and its impact on the society. Dr. Jean-Noel will discuss the emotional consequences of insecurity/violence on children and adolescents, both in Haiti and the diaspora. Dr. Casimir will present issues related to the elderly; he will conclude with a summation on the impact of violence on the family unit and the extended family. This session will provide an opportunity for psychiatrists to share information and experiences in working with the Haitian community.

REFERENCES:

1. van der Kolk BA: Psychological Trauma, Washington, Washington, DC, American Psychiatric Press, 1986.
2. Eth S: PTSD in Children and Adolescents, Washington, DC, American Psychiatric Press, 2001.

ISSUE WORKSHOP 86

THE CLINICIAN'S ROLE IN CHANGING THE LIGHT BULB

Chairperson: Marcia Scott, M.D., 19 Sibley Court, Cambridge, MA 02138
Co-Chairperson: Paul Pendler, Psy.D.
Presenters: Marilyn Price M.D., Dennis Egnatz A.B.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to assess, document, and modify barriers to mental and role function resulting from identity shifts, conflicting agendas, and dysfunctional coping in previously high functioning psychiatric patients.

SUMMARY:

The old joke asks, "How many psychiatrists does it take to change a light bulb?" The answer is "None." It has to want to change." In the language of mental health, the corollary has been that when symptoms remit in a previously functioning patient, the patient will move on and function in their usual roles. But it is now clear that functional recovery often does not follow symptom remission and that failure to recover function is not simply a consequence of life problems and the detritus of prolonged sub threshold illness. The human condition favors adaptation. When treatment of an episode of illness is delayed, desultory or non-specific, function is very quickly lost. Illness becomes the stable adaptation, unlikely to be given up. Unless treatment addresses specific functional impairments and the dysfunctional coping patterns that maintain them and the patient is given the tools to carry that forward, lives and families fall apart. Three cases will be presented. The panel will focus their discussion on specific tools useful even in brief medication visits, for maintaining and restoring function during treatment of an episode of mental illness. The cases will present opportunities to deal, during limited treatment contacts. (1) Dr. Egnatz's case will illustrate the effects of loss of structure/pattern and identity change on function; (2) Dr. Pendler's case will illustrate the effect of conflicting agendas on function; and (3) Dr. Price's case will illustrate the role of specific coping deficits on mental and role function and will outline specific intervention strategies.

REFERENCES:

1. Goldman HH, Drake RE: Mood disorders and workplace and workplace performance: Half a loaf. Am J Psychiatry 2006; 163: 1490 - 1491.
2. Frueh C, Elhai JD, et al: Disability compensation seeking among veterans evaluated for posttraumatic stress disorder. Psychiatr Serv 2003; 54: 84 - 91.

WORKSHOPS

ISSUE WORKSHOP 87

REDUCING INPATIENT SUICIDE FOR KIDS: PRACTICAL STRATEGIES FOR THE INPATIENT TEAM

Chairperson: Meena Ramani, M.D., Nassau University Medical Center, 2201 Hempstead Turnpike, East Meadow, NY 11554
Co-Chairpersons: Nyapati R. Rao, M.D.
Presenters: Sadaf Javaid M.D., Nicholas Forlenza Ph.D., Noumana Hameed M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) recognize the predictors/variables contributing to inpatient suicide, and (2) be able to implement prevention strategies and improve safety.

SUMMARY:

Obtaining appropriate services and treatment are crucial components in preventing suicide. Individuals often require hospitalization when they are most vulnerable to self-harm. However, even during inpatient treatment the potential for suicidal acts remains a very real danger. This danger is of great concern in the pediatric population because of cognitive limitations associated with developmental level, and the impulsive quality of many pediatric disorders. Many of these children and adolescents do not have the resources to cope with the events precipitating their hospitalization or the reality of being separated from the family environment. Therefore, treatment teams must both provide the support needed by the children and adolescents and create an environment that nullifies the risk of self-harm. Creating an optimally safe environment requires a great deal of planning, preparation, and maintenance. The Reducing Inpatient Suicide for Kids (RISK) program has been created to offer a model for how these measures can be implemented. This program highlights the combination of personal, family, and social factors that place a child or adolescent most in danger of suicidal behavior. Methods of identifying and addressing these factors are discussed. Particular attention is paid to policies and environmental issues that can assist staff in protecting this vulnerable population.

REFERENCES:

1. D'Eramo KS, Prinstein MJ, Freeman J, Grapentine WL, Spirito A: Psychiatric diagnoses among comorbidity in relation to suicidal behavior among psychiatrically hospitalized adolescents. Child Psychiatry and Human Development 35:21-35.
2. Horesh N, Apter A: Self-disclosure, depression, anxiety, and suicidal behavior in adolescent psychiatric inpatients. Crisis 2006; 27:66-71.

ISSUE WORKSHOP 88

RISK MANAGEMENT ISSUES IN PSYCHIATRIC PRACTICE

Chairperson: Jacqueline M. Melonas, J.D., PRMS, Inc., 1515 Wilson Blvd., Suite 800,, Arlington, VA 22209
Co-Chairperson: Martin G.Tracy, J.D.
Presenters: Charles Cash J.D., Donna Vanderpool J.D

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) identify the major psychiatric professional liability risks that lead to malpractice lawsuits; (2) discuss at least three risk- management strategies that can be incorporated into their practices to decrease or prevent exposures to high-risk psychiatric professional liability risks; and (3) understand that effective risk management strategies support patient safety initiatives.

SUMMARY:

This workshop will be the annual opportunity for Professional Risk Management Services, Inc. (managers of the APA-endorsed Psychiatrists' Professional Liability Insurance Program) to present its psychiatric malpractice claims data. Based on PRMS' years of experience managing claims and lawsuits against psychiatrists, we are able to identify common sources of malpractice actions against psychiatrists and the outcomes of such lawsuits.

Malpractice lawsuits pose a significant problem for psychiatrists in all practice settings. At least 8% of practicing psychiatrists are sued each year. It is important for psychiatrists to understand the sources of malpractice lawsuits and the malpractice risks they face as clinicians, teachers and administrators. Participants will review and discuss malpractice case studies with the panel of risk managers (specialists with clinical, legal, insurance, and risk-management experience/expertise) and will use polling devices to predict trends in psychiatric liability. Special emphasis will be placed on what can be learned from analyzing high-risk exposure liability cases. In particular, the case studies will focus on (1) patient suicide and (2) adverse events related to prescribing psychotropic medication, two frequent sources of malpractice lawsuits against psychiatrists. Other issues that have the potential to influence malpractice risk will be illustrated in the case studies (e.g., collaborative and/or supervisory relationships with non-medical therapists, off-label use of psychotropic medication, termination of the patient-psychiatrist relationship, etc.). Additionally, the cases will illustrate how including risk-management strategies and actions, such as effective communication and documentation, into a psychiatrist's practice can reduce malpractice risk as well as support patient safety and quality patient care. The workshop will conclude with the panel providing a review of risk-management strategies that have the most potential to protect against high-risk psychiatric malpractice actions and with a question and answer period with the audience.

REFERENCES:

1. Studdert DM, Mello MM, Gawande AA, Gandhi TK, Kachalia A, Yoon C, Puopolo L, Brennan TA Claims, errors, and compensation payments in medical malpractice litigation. New Eng Journal of Medicine. 2006 354:2024-2033.
2. Melonas JM: Professional liability risk related to psychopharmacology. Psych Times 2005. Vol. XXIII, Issue 14.

ISSUE WORKSHOP 89

ADOPTION PSYCHIATRIST ON THE MOVE

Chairperson: Victor J. Buwalda, M.D., Parnassusweg 28-III, Amsterdam, Netherlands 1076 AR
Co-Chairperson: Michelle Riba, M.D.

Presenter: Christine Van Boeijen M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: recognize the difference between the Dutch and the Hellerstedt study; and understand the difficulties international adoptive parents go through.

SUMMARY:

Objectives: To study the difficulties adoptive parents have to deal with during the process of adoption, as well as to compare the international adoptive parents with a professional medical background vs. non-medical background. *Content:* International adoptions are becoming more and more popular. In this study we compare the results of the Hellerstedt study with the results of a small Dutch study of adoptive parents of international colored newborn babies. We also compare the parents with a professional medical background. The results will be completed with the story of two international oriented psychiatrists. *Method*: In the Netherlands 75 couples adopted international coloured newborn babies. We used the Hellerstedt 556-item survey and sent it to the Dutch parents who adopted newborns from 2000 to 2007. Secondly, we compared the Dutch results with the results of Hellerstedt. *Importance*: International adoption is becoming more and more popular. Results are needed to overcome the difficulties the international adoptive parents face and help them to solve their problems for the benefit of the international adoptive child.

REFERENCES:

1. Johnson DE: International adoption: what is fact, what is fiction, and what is the future. Pediatric Clin North Am 2005:52: 1221-46.
2. Hellerstedt WL, Madsen NJ, Gunnar MR, et al: The international Adoption Project: Population-based Surveillance of Minnesota Parents Who Adopted Children Internationally. Matern Child Health J. 2007.

ISSUE WORKSHOP 90

THE CHILD PSYCHIATRIST AS GRANDPARENT: GRAND JOYS AND GRAND CHALLENGES

Chairperson: Ellen H. Sholevar, M.D., Temple Episcopal Campus, Suite 105 Medical Arts Building, 100 E. Lehigh Avenue, Philadelphia, PA 19125
Co-Chairperson: G. Pirooz Sholevar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify intrapsychic aspects of grandparenting by psychiatrists, recognize demographic trends that impact grandparents and their adult children and grandchildren, list skills needed in parenting adult children who are parents, and describe dynamic family issues in grandparenting.

SUMMARY:

The literature on successful aging is limited, but a high level of education and of interpersonal skills has been noted as positive predictive factors. The literature on grandparents and grandchildren is also limited and there is almost no literature on the topic of psychiatrists who are also grandparents. As mature adults with both high levels of education and superior interpersonal skills, psychiatrists and child/adolescent psychiatrists should demonstrate successful aging as well as successful grandparenting. Child/adolescent psychiatrists who are grandparents are in a unique position to observe the intrapsychic, demographic, intergenerational, and family issues related to grand parenting and to comment on the joys and challenges of this phase of adult life. The workshop will draw on the personal, clinical and scientific experience of the presenters, both of whom are child/adolescent psychiatrists, family therapists and grandparents, as well as those of the psychiatrists and other mental health professionals in attendance. Cultural influences on the role of the grandparent, parent and grandchild will be emphasized Grand parenting is a rich experience for grandparents, grandchildren and parents and can enhance personality development for all involved.

REFERENCES:

1. Brown LH, Roodin PA: Grandparent-grandchild relationships and the life course pPerspective. In Handbook of Adult Development, edited by Demick J, Andreoletti C, New York, Kluwer Academic/Plenum Publishers, 2002, pp 459-474.
2. Dickson FC, Christian A, Remmo CJ: An exploration of the marital and family issues of the later-life adult. In Handbook of Family Communication, edited by Vangelisti AL, New Jersey, Lawrence Erlbaum Associates, Publishers, 2004, pp 153-174.

ISSUE WORKSHOP 91

THE SCIENCE OF LIFE: THE APPLICATION OF AYURVEDA IN MENTAL HEALTH

Chairperson: Aravinda Kolan, M.D., Cedars-Sinai Medical Center, 8730 Alden Dr., W101,, Los Angeles, CA 90048
Co-Chairpersons: Karl Goodkin, M.D.
Tara Klein M.D., Norana Caivano M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the theory and language of the Vedic sciences; gain knowledge and understanding of when and how to use these techniques; and become familiar with recent research showing the psychiatric utility of these techniques.

SUMMARY:

Ayurveda, or "the science of life," is an Indian medical tradition of healing and promoting health that dates to ancient times. In the last century, there has been a growing interest from the Western world in Ayurvedic medicine although, thus far, it has not been formally incorporated into Western treatments. Three components of Ayurvedic medicine -- massage, yoga, and meditation -- have each been shown to benefit mental health. In this workshop, we will introduce the psychiatrist to the theory and language of Vedic science. This will allow them to intelligently engage their patients in these theories. We will subsequently present evidence-based data in support of each individual component ,- including preliminary data from our own institution - in support of these treatments. These techniques have each been shown to increase oxytocin, decrease basal cortisol levels, increase parasympathetic tone, enhance immune function, and decrease measures of anxiety and depression. Lastly, we will demonstrate the actual

techniques that practitioners can use in their own practice. This workshop will demonstrate how current-day psychiatry can integrate Eastern and Western theories and techniques into a comprehensive treatment plan.

REFERENCES:

1. Goodkin K: The potential psychoneuroimmunological application of Sudarshan Kriya Yoga to HIV-1 infection. In: V. Kochupillai (ed), "Science of Breath", International Symposium on Sudarshan Kriya, Prananyam and Consciousness, March 2-3, 2002, All India Institute of Medical Sciences, New Delhi, India, pp.71-72.
2. Frawley D, et al: Ayurveda: Nature's Medicine. Lotus Press, Twin Lakes, Wisconsin ISBN 0-914955-97-7.

ISSUE WORKSHOP 92

COGNITIVE DYSFUNCTION IN SUBSTANCE DEPENDENCE: TYPES OF DEFICITS AND THEIR POSSIBLE MODULATION

National Institute on Drug Abuse

Chairperson: Frank J. Vocci, Ph.D., 6001 Executive Boulevard, Room 4133, MSC 9551, Bethesda, MD 20892,
Presenters: W Bickel, Frederick Moeller M.D., W Stewart, Ann Rose Childress Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the state of the science in the area of cognitive dysfunction and substance-dependence. Participants will become familiar with the myriad cognitive dysfunctions that may present in substance dependent patients and the clinical challenges that these dysfunctions present to the treating clinician. The participants will also learn that some of these dysfunctions are remediable, either through behavioral or pharmacological modulation.

SUMMARY:

Treatment of substance dependence is characterized by high dropout rates and relapses. Length of treatment is a positive predictor of treatment response, including lasting changes in abstinence and increased functionality. Patients with cognitive deficits and impulsivity drop out at high rates, suggesting that improvement in cognition and strengthening of inhibitory responses would be of value in improving treatment. This workshop will explore the types of cognitive deficits, assessed by neuropsychological testing batteries and other rating scales, in substance abusing patients. Data will be presented that suggests a strong association between treatment retention and cognitive status. Thus, executive function deficits will be introduced as both a challenge and an opportunity for therapeutic intervention. Conditioned cues represent a different cognitive process that is thought to be responsible for increasing the desire to seek drugs. Taken together, executive dysfunction and an increased appetitive drive may underlie the compulsive nature of addiction. Cues represent another opportunity for therapeutic intervention, as they can be modulated through behavioral or pharmacological approaches. Pharmacological strategies to improve attention, cognition, decision making, and extinction of conditioned cueing are being tested in human subjects. Medications will be discussed that can enhance learning, improve attention, increase inhibitory responses, and improve decision making. The state of the science in the assessment of cognitive deficits in substance dependence and their possible modulation through behavioral and pharmacological means will be overviewed in the workshop.

REFERENCES:

1. Verdejo-Garcia A, Bechara A, Recknor EC, Perez-Garcia M: Executive dysfunction in substance-dependent individuals during drug use and abstinence: an examination of the behavioral, cognitive and emotional correlates of addiction. J Int Neuropsychol Soc 2006; 12(3):405-415.
2. Chamberlain SR, Muller U, Robbins TW, Sahakian B.J. Neuropharmacological modulation of cognition. Curr Opin Neurol
2006; 19(6):607-612.

ISSUE WORKSHOP 93

BRAIN SUBSTRATES OF IMPAIRED ERROR DETECTION, MORAL JUDGMENT, AND AGENCY AS CORE DEFICITS IN SUBSTANCE ABUSE

National Institute on Drug Abuse

Chairperson: Steven Grant, Ph.D., Clinical Neuroscience Branch, Div. Clinical Neuroscience & Behavioral Research, National Institute on Drug Abuse, NIH/HHS, 6001 Executive Blvd., Bethesda, MD 20892
Presenters: Kent Kiehl M.A., Janet Metcalfe Ph.D., Jordan Grafman Ph.D., H Garavan Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify areas of the brain involved in (1) detection and awareness of performance errors and their subsequent correction; (2) recognition that an action is or is not under one's control (agency); and (3) processing of moral issues and resolution of moral conflicts. The participant also will be able to recognize the degree of overlap between the brain systems that process information in each of these seemingly disparate domains, and the relevance to diagnosis and treatment of substance abusers.

SUMMARY:

A puzzling aspect of substance abuse is why chronic drug users keep using drugs despite mounting adverse consequences. New research has suggested that drug abusers have impairments in brain circuits that mediate the detection of errors during performance of simple tasks requiring inhibition of prepotent responses. These brain areas include the anterior cingulate, medial prefrontal cortex, and ventrolateral prefrontal cortex. These brain circuits also appear to overlap with brain regions involved in highly complex cognitive processes including perception of agency (whether a person considers themselves to be in control of their own behavior) and assessment of moral value (i.e., good vs. bad). Dysregulation in these brain circuits may provide an explanation of why drug abusers keep making the same mistakes over and over in violation of social norms and express powerlessness to change their behavior. This research provides insight into seemingly contradictory aspects of the behavior of substance abusers such

as continued drug use despite mounting adverse health and social consequences. The workshop will provide a forum to introduce recent findings and discuss the implications for the development of improved diagnosis and treatment.

REFERENCES:

1. Garavan H, Hester R: The role of cognitive control in cocaine dependence. Neuropsychol Rev. 2007 (Epub ahead of print).
2. Moll J, Zahn R, de Oliveira-Souza R, Krueger F, Grafman J: The neural basis of human moral cognition. Nat Rev Neurosci 2005 6:799-809.

ISSUE WORKSHOP 94

PRACTITIONER FEEDBACK ON NIMH'S CLINICAL TREATMENT TRIALS

National Institute of Mental Health

Chairperson: John K.. Hsiao, M.D., ATPIRB/DSIR/NIMH/ NIH,6001 Executive Blvd., Bethesda, MD 20892
Co-Chairperson: Barry D. Lebowitz, Ph.D.
Presenters: A. John Rush M.D., Thomas Stroup M.D., Andrew A. Nierenberg M.D.

EDUCATIONAL OBJECTIVES:

Workshop participants will discuss whether and how clinical practice has been affected by NIMH's large clinical trials (CATIE, STAR*D, and STEP-BD). Participants will discuss current trials in development or in process on the clinical trial networks that grew out of these three projects, and will provide input on what should be studied in the future by NIMH.

SUMMARY:

In 1998, NIMH undertook a major initiative to expand the evidence base available to clinicians in the community to guide treatment of the most severe mental illnesses. NIMH issued contracts for CATIE (comparing antipsychotics in schizophrenia and in Alzheimers disease), STAR*D (treatment algorithms for depression), and STEP-BD (management of bipolar disorder). The three projects addressed critical public health questions that could only be answered by large-scale, government-sponsored, randomized clinical trials. They studied effectiveness in real-world clinical situations, used sicker patients who often had comorbid medical disorders or substance abuse, and went beyond symptom ratings to look at long-term functional outcomes. The trials are widely considered to be landmark studies, and are expected to change both clinical practice and health care policy. In 2005, NIMH extended the contracts supporting the clinical sites and coordinating centers (the infrastructure) that carried out CATIE, STAR*D, and STEP-BD, to create three independent clinical trial networks studying bipolar disorder (BTN), depression (DTN), and schizophrenia (STN). A number of projects, supported through contracts, NIMH grants, and foundation grants – are in process or in development on the three networks, but none of the networks are operating at full capacity. NIMH expects to initiate additional clinical trials, and is interested in gathering ideas for research projects that will increase the ability of clinicians to personalize and individualize care, improve long-term functional outcome, and improve day-to-day care of people suffering with bipolar disorder, depression, and schizophrenia. This workshop will provide a unique opportunity for NIMH to obtain feedback from practitioners on the impact CATIE, STAR*D, and STEP-BD have had on clinical mental health care, and provide a forum for clinicians in the community to help guide NIMH's treatment research priorities.

REFERENCES:

1. Lieberman JA, Stroup TS, McEvoy JP, Swartz MS, Rosenheck RA, Perkins DO, Keefe RSE, Davis SM, Davis CE, Lebowitz BD, Severe J, Hsiao JK: Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. N Engl J Med 2005. 353:1209-1223.
2. Rush AJ, Trivedi MH, Wisniewski SR, Stewart JW, Nierenberg AA, Thase MA, Ritz L, Biggs MM, Warden D, Luther JF Shores-Wilson K, 3. Niederehe G, Fava M: Bupropion-SR, sertraline, or venlafaxine-XR after failure of SSRIs for depression. N Engl J Med 2006. 354:1231-1242.

ISSUE WORKSHOP 95

PRIMARY CARE DEPRESSION MANAGEMENT: THE DESIGN AND IMPLEMENTATION OF A FOCUSED, ACUTE-PHASE MEDICATION MANAGEMENT QUALITY IMPROVEMENT PROGRAM

Chairperson: Robert C. Joseph, M.D., Cambridge Health Alliance, Department of Psychiatry, 1493 Cambridge Street, Cambridge, MA 02139
Presenters: Amy Bauer M.D., Carleen Riselli R.N.C.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Identify the three public HEDIS measures for depression and understand the implications of these measures for mental health providers, (2) Understand key steps in developing collaborative partnerships between primary care and psychiatry, and (3) Understand the critical role of collaboration with information systems in the development of a depression management program in the primary care setting.

SUMMARY:

Depression is common, often chronic, and causes significant morbidity, mortality, and disability. Treatment of depression most often occurs in the primary care sector, rather than specialty mental health. In primary care settings, detection rates are low and treatment is often inadequate, yielding poor overall outcomes. Research indicates that patients who receive high-quality depression care during the acute phase may be more likely to stay in treatment, receive adequate doses of antidepressant medication, and have better outcomes. In an attempt to improve depression management in primary care, the National Committee for Quality Assurance has adopted evidence-based, publicly-reported, quality measurements (HEDIS Measures). However, adherence to these guidelines is difficult for most primary care practitioners. In an effort to improve acute-phase medication management for individuals with a new episode of depression, Cambridge Health Alliance (CHA) has developed an innovative quality improvement program that we have implemented in over 10 primary care clinics. Features of the program include

an EMR, depression registry, quality reports, interactive PHQ-9 depression screening tool, nurse care managers, and co-located psychiatric clinicians to support the primary care team. All of these have contributed to a "culture change" among our primary care clinicians. Planning and implementation strategies will be shared as well as representative clinical vignettes. Outcome data from a series of chart reviews will be reviewed. Preliminary analysis demonstrates gradual improvement over time in meeting the HEDIS process measures. Summary Statement: Enhancing depression treatment in primary care is crucial to reducing its disease burden, yet there are many challenges to the large-scale implementation of quality improvement programs. We will describe how CHA has developed a program to overcome such obstacles, thus facilitating quality depression care.

REFERENCES:

1. Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ: Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. Arch Intern Med 2006; 166: 2314-2321.
2. Katon WJ, Unutzer J, Simon G: Treatment of depression in primary care: where we are, where we can go. Med Care 2004; 42: 1153-1157.

ISSUE WORKSHOP 96

INSIGHT AND AWAKENING: MINDFULNESS AND PSYCHOTHERAPY

Chairperson: Anjali C. Dsouza, M.D., 2150 Pennsylvania Ave, NW, 8th floor Psychiatry, Washington, DC 20001
Co-Chairperson: James L. Griffith, M.D.
Presenter: Anjali Dsouza M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe and understand the basic theories of mindfulness, be able to utilize some basic practices with their own patients, and know where and how to get more information and/or training in mindfulness.

SUMMARY:

Mindfulness refers to a discipline of cultivating purposeful focus on present moment awareness, as opposed to resting in our more natural state where one hundred and one things constantly flood the mind at once. The need for a mindful approach to life has become more attractive in recent years, as the instant gratification culture in which we are surrounded by is one predicated on goal striving, recognition achieving, and material attaching in various forms. This way of life supports a scattered existence, and a risk for disappointment and sadness. Although traditional psychotherapy is effective in generating greater understanding, alteration of behaviors, and mitigation of symptoms, it does so through punctuated sessions in time. Mindfulness, on the other hand, is a practice that attempts to foster an alternate way of living where individuals work to become aware of themselves every day in a moment to moment fashion. Research studies thus far have demonstrated the usefulness of mindfulness practices for improving one's capacity to regulate emotions, to live more fluidly within all emotional states, and to reduce negative cognitions. Mindfulness has influenced a wide range of psychotherapies, including psychotherapies for posttraumatic stress disorder; depression, eating disorders, and obsessive-compulsive disorder; dialectical behavioral therapy for borderline personality disorder; and relapse prevention programs for substance dependence. The practice can therefore be used alone, or as an adjunct to traditional psychotherapy. In this workshop, we will demonstrate and teach mindfulness practices drawn from the 2,500-year-old tradition of Buddhism that can be implemented within an everyday practice of psychotherapy. We will present (1) a theoretical overview of mindfulness, (2) a brief exercise of mindfulness for participants, and (3) clinical illustrations and suggestions for how to incorporate mindfulness into clinical practice.

REFERENCES:

1. Kabat-Zinn, Jon, Segal Zindel, Williams Mark, Teasdale John:
The Mindful Way through Depression. New York, NY, The Guilford Press, 2007.
2. Germer CK, Siegel RD, Fulton PR: Mindfulness and Psychotherapy. New York, New York. Guilford Press, 2005.

ISSUE WORKSHOP 97

TRANSFORMING THE LOCAL MENTAL HEALTH SYSTEM: A PERSON-CENTERED PROGRAM

Chairperson: John S. McIntyre, M.D., 2000 Winton Rd. S., Rochester, NY 14618
Presenters: Adele Gorges B.A., Lloyd Sederer M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: identify the key issues in person-centered treatment; recognize the core strategies in effectively involving all relevant stakeholders; identify approaches to the integration of physical health care with the psychiatric treatment of serious mental illness; and identify potential outcome measures for the evaluation of such an initiative.

SUMMARY:

Since 2000, providers, consumers, and county mental health officials from six counties in upstate New York collaborated with one another and the Office of Mental Health in a "ground-up" effort to transform local mental health systems. This effort, known as the Western New York Care Coordination Program currently serves 3,000 individuals with serious and persistent mental illness, many of whom have significant comorbid physical and substance-abuse disorders. All the involved staff receive training in person-centered treatment and adherence to a person-centered approach is measured. Significant positive changes have been achieved. There has been a reduction in emergency room visits, inpatient days, self-harm, suicide attempts, physical harm to others, and arrests. Medicaid costs for participants have decreased 6% compared with an increase of 8% for the general population.

In this workshop, Dr. McIntyre, a member of the project's steering committee since its inception, will provide an overview of the project and discuss the incorporation of person-centered planning into the treatment protocols. Ms Gorges, the project's dDirector, will review some of the struggles in the early development of

the program and how the program achieved involving all the major stakeholders and maintained this involvement. Dr. Sederer, the medical director of New York State Office of Mental Health, will discuss other state-wide and national initiatives and review some of the key financial issues that must be addressed by such programs. Audience questions and participation will be encouraged throughout the presentations and there will be at least 30 minutes of audience discussion.

REFERENCES:

1. Adams N, Grieder D: Treatment Planning for Person-Centered
Care. New York, Elsevier, 2004.
2. Cook JA, Toprac M, Shore SE: Combining evidence-based practice with stakeholder consensus to enhance psychosocial services. Psychiatric Rehabilitation. Journal 2004; 27(4)307-318.

ISSUE WORKSHOP 98

SO YOU WANT TO BE A CLINICAL INVESTIGATOR!

Chairperson: Arthur L. Lazarus, M.D., 9 Carriage Path, Chadds Ford, PA 19317
Presenters: Andrew Cutler M.D., Katherine Wisner M.D., S. Charles Schulz M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be knowledgeable about factors considered important by research organizations (e.g., pharmaceutical companies and NIMH) in their selection of psychiatrists to conduct clinical drug trials.

SUMMARY:

Research organizations (pharmaceutical companies, NIMH, etc.) that fund clinical trials are mainly concerned with the viability of the idea proposed by the investigator and the potential benefits it poses to patients. Organizations make considerable efforts to qualify investigators prior to the investment. The performance and capabilities of an investigator is equally as important to choosing the right idea to support. Investigators have a tendency to over promise subject recruitment, and such potential pitfalls must be minimized, if not eliminated. Other potential problems include inadequate time, personnel support, or research experience; inappropriate delegation of authority; and mismanagement of personal conflicts of interest. Thus, it is important that during the selection process, investigators are qualified and selected based on certain standards. During this workshop, attendees will become knowledgeable about important factors involved in investigator selection. Although the thrust of the workshop is investigator-initiated studies, attendees will also become aware of how investigators are selected when organizations design and initiate the research themselves. More than 50% of practicing physicians have never conducted a clinical trial. This workshop will encourage a dialog between attendees and the workshop panelists, who are seasoned investigators representing the academic, pharmaceutical, and private practice sectors.

REFERENCES:

1. Lanter J: Complexities of starting an industry-sponsored clinical study. The Monitor 2006; 20(1):25-28.
2. Lazarus A: How to select investigators for independent research studies. Product Management Today 2005; 16(3):38-39, 48.

ISSUE WORKSHOP 99

BIOPSYCHOSOCIAL AND SPIRITUAL ASPECTS OF TREATING OUR PHYSICIAN COLLEAGUES

Chairperson: Monisha R. Vasa, M.D., 8730 Alden Drive, Suite W 101, Los Angeles, CA 90048
Presenters: Syed Naqvi M.D., Amy Dewar M.D., Alicia Ruelaz M.D., Michael Myers M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand important components of physician mental health, including burnout, depression, suicide, relationships, and substance abuse. Participants should be able to describe ways that psychiatrists can use their training to identify and treat such syndromes in our colleagues.

SUMMARY:

Maslach eloquently described burnout as “erosion of the soul.” Burnout is a syndrome characterized by emotional exhaustion, decreased personal satisfaction, and a sense of depersonalization in physicians exposed to chronic stress. Personal consequences of burnout include marital difficulties, substance abuse, and the development of depression and anxiety. Physician burnout has also been associated with poor prescribing habits, and increased likelihood of physician error. Depression is just as prevalent in physicians as in the general population; however, physicians have an increased suicide rate compared with the general population, as well as compared with other professionals. As psychiatrists, we are poised in the unique position of understanding the biological, psychological, social, and spiritual factors that affect a physician throughout training and practice. We need to assume a leading role in decreasing stigma associated with mental health care in physicians, and encouraging physicians to receive treatment for burnout and its debilitating consequences. This workshop is intended for all mental health professionals who are involved in the care of physicians.

REFERENCES:

1. Center C, et al: Confronting Depression and Suicide in Physicians: A Consensus Statement. JAMA 2003; 289: 3161-3171.
2. Goldman LS, Myers M, Dickstein LJ: The Handbook of Physician Health: The Essential Guide to Understanding the Healthcare Needs of Physicians. Chicgo, American Medical Association, 2000.

ISSUE WORKSHOP 100

FACTS ABOUT FACT (A DUTCH VERSION OF ASSERTIVE COMMUNITY TREATMENT): THEORY, IMPLEMENTATION, PRACTICE, AND EVALUATION

Chairperson: J. Remmers J. van Veldhuizen, M.D., Praediniussingel

20/9, Groningen, Netherlands 9711 AG
Presenters: Marijke van Putten, Cathrien Hoff M.S.C., Annet Nugter Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to reflect on theory and practice and evaluation of FACT: the Dutch version of Assertive Community Treatment. The participant should have basic information on the model, the daily practice, and the possibilities for implementation and evaluation. Participants discuss actively the possible (dis)advantages of FACT: continuity of care, "transmural care," recovery-oriented treatment and care. Is the American "evidence" valid in Europe?

SUMMARY:

Four presenters, working closely together in different positions in one mental health care system in the Netherlands present the FACT model (Function ACT or Flexible ACT). FACT is a rehabilitation-oriented clinical case management team with partly an individual approach and partly a shared caseload approach. It is based on the ACT model, but is more flexible and able to serve a broader range of SMI with continuity of care. Where ACT focuses on the 20% most unstable SMI, FACT focuses on all the SMI in an area or neighborhood. This gives opportunities for continuity of care and social inclusion. FACT teams routinely perform outcome measurement as a part of the individual treatment planning. Symptoms, functioning and QUOL are assessed with the HoNOS and MANSA. We will discuss the model, some challenging problems in implementation, the daily practice, and the outcome evaluation and first steps to model fidelity. We hope to challenge the U.S collaegues with some questions and to reflect on our model. Some topics of discussion will be: * Theory of ACT and FACT, model description;

* How to support individual caseworkers to start as workers in a shared case-load team;
* How to implement recovery, treatment, and EBM (like IPS and CBT) in one team;
* The importance of Integrated Dual Diagnosis Treatment in FACT;
* FACTteams being a part of a "transmural circuit" with inpatient facilities;
* Which factors have stimulated succesfull implementation; what were difficulties;
* Working as a psychiatrist in a multidisciplinary FACT team
* Working with former patients as coworkers (workers of experience);
* Routine Outcome Monitoring: feedback on individual and system level with MANSA and HoNOS;
* FACTS, a new version of the DACTS, preliminary results with a new fidelity scale;
* Centre for Certification of ACT and FACT: www.ccaf.nl;
* Comments from the United States (Bond & Drake)

REFERENCES:

1. Veldhuizen, J. R. van, (2007) FACT: A Dutch Version of ACT, Community Mental Health Journal, (43), 4, 421-433.
2. Bond, G.R.& R.E. Drake (2007). Should We Adopt the Dutch Version of ACT? Commentary on "FACT: A Dutch Version of ACT". Community Mental Health Journal, Vol 43, No.4, 435-437.

ISSUE WORKSHOP 101

INNOVATIONS IN THE EVALUATION OF PROFESSIONALS WHO ENGAGE IN BOUNDARY VIOLATIONS

Chairperson: Werner Tschan, M.D., PO Box 52, Basel, Switzerland 4012
Co-Chairperson: Gary R. Schoener, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the evaluation process of professionals who engage in boundary violations. Based on this evaluation, participants learn how to conceptualize a treatment plan and how to monitor professionals after practice re-entry.

SUMMARY:

Despite the fact that the professional community considers Professional Sexual Misconduct (PSM) to be the most egregious kind of ethical violation, little is known about assessment and treatment of professionals who have failed. In many cases these perpetrators are not addressed as sexual offenders, instead what they have done is often labeled as transference love, falling in love, erotic transference, and similar expressions. The author strongly supports any attempt to create a new diagnosis PSM similar to other paraphilias. In PSM cases, in the assessment the professional competence and the personality structure, with special attention to attachment style, are evaluated, including a detailed reconstruction of the boundary violation(s). Sexual fantasies and behavior play a crucial role in the evaluation. The treatment is based on a semi- structured offense-focused intervention program. Practice re-entry under a monitoring is supported after successfully finishing the program. Patient security is clearly ensured by this approach. The second presenter will focus on methods of boundaries training and re-training, using exercises and methods that can be utilized as part of training, or as part of remedial boundaries re-training or coaching. The overall plan for their use is based on a comprehensive assessment. The presentation will demonstrate the use of exercises and also discuss videotaped training materials and popular movies, which provide useful stimuli for such training. Issues regarding clinical supervision insofar as it impacts on boundaries will be discussed.

The program derives from more than 25 years of evaluation of physicians and other health care professionals who have been disciplined by an employer, district branch, or licensure board for boundary violations. The focus is on practical methods, which are easily utilized.

REFERENCES:

1. Richard S, Epstein RS: Keeping Boundaries. Maintaining Safety and Integrity in the Psychotherapeutic Process. Washington, American Psychiatric Press, 1994.
2. Tschan W: Missbrauchtes Vertrauen. Sexuelle Grenzverletzungen in professionellen beziehungen. Basel, Karger, 2005, 2nd ed.

ISSUE WORKSHOP 102
ORAL BOARDS BOOT CAMP: 2008

Chairperson: Elyse D. Weiner, M.D., 113 University Place, Suite #1010, New York, NY 10003
Co-Chairperson: Eric D. Peselow, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to create a preliminary comprehensive strategy to study for and pass the oral board exam in psychiatry.

SUMMARY:
Since the inception of Oral Boards Boot Camp in 2003, the oral boards have undergone radical changes. The video portion of the exam has been replaced by vignettes and the scoring system has been revamped, posing major new challenges for candidates preparing for the oral boards and being graded on their performance. Oral Boards Boot Camp is a comprehensive, interactive approach that helps candidates to develop an individual, long-term training framework and, ultimately, to succeed on the oral boards. Now in its fifth edition, Oral Boards Boot Camp is updated each year with the chairpersons continually gathering and incorporating novel information about the exam. The workshop format consists of a didactic portion in which a practical long-term study method is presented, highlighted with actual advice from past candidates, followed by an open discussion with ample time for audience questions. An overview is given of the entire oral boards preparation process, from the day a candidate passes the written section until the day of the oral exam. Among the topics covered are a detailed study timeline, methods of practicing, study aids, a description of the interview, tips on fielding examiners' questions, tips on relating to patients and examiners, travel arrangements, boards courses, tips on how to dress and what to bring, description of the exam day, and reasons for failure. Consistent with the Oral Boards Boot Camp long-term approach, we invite all future candidates, no matter how early in their training, to begin working on improving their diagnostic interview and familiarizing themselves with the requirements for passing the oral boards. We also invite APBN diplomates to share their experiences with us, adding to our knowledge of what makes a candidate successful on the oral boards. The goal of Oral Boards Boot Camp is to help candidates begin developing an individual long-term training framework that they will further expand prior to taking the boards. Through lively discussion, future examinees will be on the road to increased confidence and decreased anxiety as they begin to define their own oral boards study experience and refine their diagnostic interview technique.

REFERENCES:
1. Morrison J, Munoz RA: Boarding Time: A Psychiatry Candidate's New Guide to Part II of the APBN Examination, Third Edition. Washington DC, American Psychiatric Press, 2003
2. Strahl NR: Clinical Study Guide for the Oral Boards in Psychiatry, Second Edition. Washington DC, American Psychiatry Press, 2005.

ISSUE WORKSHOP 103
RESPONDING TO THE IMPACT OF SUICIDE ON CLINICIANS

Chairperson: Eric M. Plakun, M.D., Austen Riggs Center, 25 Main Street, Stockbridge, MA 01262-0962
Presenters: Edward Shapiro M.A., Jane Tillman Ph.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to (1) enumerate clinician responses to patient suicide, and (2) list practical recommendations for responding to patient suicide from the personal, collegial, clinical, educational, administrative, and medico-legal perspectives.

SUMMARY:
It has been said that there are two kinds of psychiatrists--those who have had a patient commit suicide and those who will. Mental health clinicians often have less contact with death than clinicians from other environments. Nevertheless, each death by suicide of a psychiatric patient may have a more profound effect on psychiatric personnel than other deaths do on non-psychiatric colleagues because of powerful emotional responses to the act of suicide, and the empathic attunement and emotional availability that is part of mental health clinical work. This workshop offers results from a study revealing eight thematic clinician responses to suicide: Initial shock; grief and sadness; changed relationships with colleagues; dissociation; grandiosity, shame and humiliation; crises of faith in treatment; fear of litigation, and an effect on work with other patients. Recommendations derived from this and other studies are offered to guide individually impacted clinicians, colleagues, trainees, training directors, and administrators in responding to patient suicide in a way that anticipates and avoids professional isolation and disillusionment, maximizes learning, addresses the needs of bereaved family, and may reduce the risk of litigation. The workshop will include ample time for interactive discussion with participants about their own experiences with patient suicides.

REFERENCES:
1. Plakun EM, Tillman JT: Responding to the impact of suicide on clinicians. Directions In Psychiatry 2005; 25:301-309.
2. Tillman JG: When a patient commits suicide: An empirical study of psychoanalytic clinicians. International Journal of Psychoanalysis 2006; 87:159-177.

ISSUE WORKSHOP 104
SIZE MATTERS: TEACHING MEDICAL STUDENTS IN SMALL GROUPS

Chairperson: Kien T. Dang, M.D., St. Michael's Hospital - Department of Psychiatry 30 Bond Street, 17th Floor CC, Toronto, Canada M5B1W8
Presenters: Lana Benedek B.A., Andrea Waddell M.D.

EDUCATIONAL OBJECTIVES:
(1) Discuss basic theories of small-group teaching to medical students; (2) Demonstrate techniques used in the planning of a small group teaching session; and (3) Facilitate a small group teaching session for medical students.

SUMMARY:

As medical curricula move toward greater amounts of case-based, small-group learning, residents have increasing opportunities to teach in this setting. Small-group teaching presents a challenge to new teachers because in addition to knowledge of the material being taught, teachers are required to work within group dynamics to optimize the experience for individuals with different learning styles. This is the second in a series of two workshops designed to facilitate development of effective teaching skills. It aims to provide an opportunity for residents and early career psychiatrists to improve their teaching skills in small-group situations. During this second workshop, the majority of time will be spent on interactive learning and practicing new skills. There will be a short segment of didactic teaching on small-group learning theory. Learner interests, generated from the interactive and small-group practical components of the session, will drive the remaining content. Once residents have gained a better understanding of how to plan initiate and evaluate a small-group teaching experience, the remaining time will be devoted to practicing these skills. This is an updated version of a workshop presented previously.

REFERENCES:

1. Jaques D: ABC of learning and teaching in medicine: Teaching small groups. BMJ 2003; 326: 492-4.
2. Tiberius R: Small Group Teaching: A Trouble Shooting Guide.
London, Kogan Page, 1999.

ISSUE WORKSHOP 105

WHERE IS THE LINE DRAWN? IS THERE A CLINICAL INTERFACE BETWEEN AUTISM SPECTRUM DISORDERS AND BIPOLAR DISORDER IN CHILDREN AND ADOLESCENTS?

Chairperson: Michelle S. Guchereau, M.D., Children's National Medical Center, Department of Psychiatry, 111 Michigan Ave, N.W., Suite 1200, Washington, DC 20010
Presenters: Gabrielle Carlson M.D., Fred Volkmar M.D., Jay Salpekar M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will have enhanced discernment of the possible interface between autism spectrum disorders and bipolar disorder and will be able to better navigate diagnostic and treatment challenges related to the overlap and distinction between these disorders in children and adolescents.

SUMMARY:

Objective: To examine the possibility of clinical interface between autism spectrum disorders (ASD) and bipolar disorder (BD) in children and adolescents. *Summary*: Many symptoms common to ASD are primary symptoms of BD, including irritability, aggression, and labile mood. The junction between ASD and BD in children and adolescents, then, is complex and not well defined. The overlap of presenting symptoms poses a diagnostic dilemma in ascertaining whether symptoms are related to a distinct comorbid disorder (BD) or are better ascribed as important symptoms of ASD. Understanding the interface between these disorders will facilitate more accurate diagnosis and treatment, evolve research efforts, and enhance access to support resources. This workshop will delve into the diagnostic challenges and possible ramifications posed by the interface and relate recent research and clinical experience in treatment of comorbid ASD and BD in children and adolescents. The workshop will involve presentations by experts in child and adolescent BD and ASD, followed by a panel discussion of the relevant overlap and differentiation of symptoms and course. A presentation will highlight the issues involved in accurate diagnosis of comorbid mood disorders in children with autism and relate recent clinical research of medication treatment trials in an outpatient pediatric population diagnosed with both ASD and BD. This workshop will illuminate unique diagnostic and treatment challenges and launch interactive discussion of the controversial aspects related to the interface between these disorders. *Conclusion*: Awareness and comprehension of the junction between ASD and BD in children and adolescents is necessary for clinical practice involving these complex patient populations.

REFERENCES:

1. Carlson GA, Meyer SE: Phenomenology and diagnosis of bipolar disorder in children, adolescents, and adults: Complexities and developmental issues. Development and Psychopathology 2006; 18:939-969.
2. Leyfer OT, Folstein SE, Bacalman S, Davis NO, Dinh E, Morgan J, Tager-Flusberg H, Lainhart JE: Comorbid Psychiatic Disorders in Children with Autism: Interview Development and Rates of Disorders. J Autism Dev Disord 2006; 36:849-861.

ISSUE WORKSHOP 106

TRANSFORMING MENTAL HEALTH CARE IN SOUTH CAROLINA: A PERSPECTIVE ON STRENGTHENING PARTNERSHIPS BETWEEN ACADEMIA AND THE DEPARTMENT OF MENTAL HEALTH

Chairperson: Richard K. Harding, M.D., 3555 Harden Street Extension, Suite 301, Columbia, SC 29203
Presenters: Ronald Prier M.D., Meera Narasimhan M.D., Brenda Ratliff M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify disparities in the access and treatment of mental illness in contrast to other medical conditions. Encourage societal resolve to overcome these disparities, remove roadblocks that continue to hinder close collaboration between public, private and academic sectors in our states, plan effective implementation of the President's New Freedom Commission on Mental Health for States.

SUMMARY:

The President's New Freedom Commission offers a welcome change for the mental health system, moving the nation closer to the day when individuals with serious mental illnesses will live, learn, work, and participate fully in their communities. This living document has served as a catalyst for an unprecedented

number of collaborations between the government-federal-state ,and private agencies that are on the threshold of achieving the promise of transforming mental health care in America. It has opened the doors to model collaborative activities to focus on issues like stigma, parity, access, and affordability of care for the mentally ill with recovery now seeming like a realistic goal. Early recognition, accurate diagnosis, and prompt intervention are some of the key ingredients of improving mental health service in our communities. This needs to be reinforced by education, public awareness, evidence, based, recovery, focused, consumer and family driven programs. Each step requires the full commitment of agencies and individuals involved and warrants the need for the public/private partnerships that will make the commission's vision a reality. The Presidents New Freedom Commission has been an impetus to strengthen collaborations between public, private, and academic setting in the state of South Carolina. This workshop will focus on partnerships across agencies in the state of South Carolina, efforts and initiatives to better service delivery by bridging the gap between research, policy and clinical practice to improve disease burden for the citizens of South Carolina.

REFERENCES:

1. Jürgen Unützer, M.D., M.P.H., Michael Schoenbaum, Ph. D., Benjamin G. Druss, M.D., M.P.H. and Wayne J. Katon, M.D. Transforming Mental Health Care at the Interface With General Medicine: Report for the Presidents Commission. Psychiatr Serv 57:37-47, January 2006.
2. Sowers W Transforming systems of care: the American Association of Community Psychiatrists Guidelines for Recovery Oriented Services.Community Ment Health J. 2005 Dec;41 (6):757-74. Quality Management Committee of the American Association of Community Psychiatrists.

ISSUE WORKSHOP 107

CHILDREN OF PSYCHIATRISTS

Chairperson: Michelle B. Riba, M.D., University of Michigan, Department of Psychiatry, 1500 E. Medical Center Drive, Room F6325 MCHC, Ann Arbor, MI 48109-0295
Co-Chairperson: Leah J. Dickstein, M.D.
Presenters: Kevin McIntyre M.D., William Raskin, Hanna Stotland A.B.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and understand how as psychiatrist-parents, their children think and feel about their psychiatrist-parents.

SUMMARY:

This 11th annual workshop, which enables children of psychiatrists to share personal anecdotes and advice with the audience of psychiatrist-parents and parents-to-be, has been offered to standing-room audiences annually. While stigma toward psychiatry in general has diminished, psychiatrists, because of training and professional work, in addition to their professional life, bear emotional fears and concerns of how they will and do function as parents. The four presenters will speak for 15 minutes each about their personal experiences and also offer advice to attendees. There will be a brief introduction by Dr. Dickstein to set the tone for the audience, and she and Dr. Riba will lead the 20-minute panel discussion, following the individual presentations.

REFERENCES:

1. Dickstein LJ: an interview with Stella Chess, M.D., in Women
Physicians in Leadership Roles, edited by Leah J. Dickstein, M.D. and Carol C. Nadelson, M.D., American Psychiatric Press, Inc., pp. 149-158.
2. Mueller-Kueppers, Manfred: The Child Psychiatrist as Father,
The Father as Child Psychiatrist (German), Praxis der KInderpsychologie und Kinderpsychiatrie, Vol. 34j(8), Nov.-Dec., 1985, pp. 309-315.

ISSUE WORKSHOP 108

INFLAMMATION, PSYCHOSIS, AND THE BRAIN: WHAT DO WE REALLY KNOW?

Chairperson: Tatiana Falcone, M.D., Cleveland Clinic, 9500 Euclid Avenue P57, Cleveland, OH 44195
Presenters: Damir Janigro Ph.D., Kathleen Franco M.D., Omar Fattal M.D., Matthias Rothermundt, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the attendees will be able to identify different mechanisms of how inflammation can affect patient with psychosis, and recognize how different alterations in the blood brain barrier can affect the pathophysiology, and how can this could impact the treatment of patients with psychosis.

SUMMARY:

Objectives: This presentation, will review current state of the knowledge of the inflammation model in psychosis. Several lines of evidence have pointed to a link between CNS disorders, and specifically psychiatric illness, and inflammation, occurring both in response to pathogens, or of genetic/polymorphic origin. *Methods*: Presenters will describe different scientific findings that correlate inflammation, immunological responses, and mental illness. Dr Falcone will review current research data in a group of children and adolescents with psychosis. Dr Franco will discuss different immunological theories that link inflammation to psychosis. Dr Fattal will outline the state of the knowledge about inflammation and psychosis across the life span, especially schizophrenia. Dr Janigro will discuss how the impairment of the blood-brain barrier can affect patients with psychosis and play an important role in understanding a possible inmunopathogenic mechanism in psychosis, and how specific markers as s-100 Beta could be an important marker of blood-brain barrier dysfunction in psychotic patients across the lifespan. Results; the attendees will improve their knowledge about imnunopathogenic factors in psychotic patients. *Conclusions*: This presentation will provide the physiologic and clinical background necessary for understanding the complexity of different theories about inflammation and the brain of psychotic patients.

REFERENCES:

1. Rothermundt M, Ponath G, and Arolt V, S100B in schizophrenic psychosis, Int. Rev. Neurobiol., 59 (2004) 445-470.
2. Rothermundt,M., Arolt,V., and Bayer,T.A., Review of immu-

nological and immunopathological findings in schizophrenia, Brain Behav. Immun., 15 (2001) 319-339.

ISSUE WORKSHOP 109

STRESS RESPONSE AND WOMEN'S HEALTH: A LITERATURE REVIEW AND BIOPSYCHOSOCIAL PERSPECTIVE

Chairperson: Lucila Sloninsky, M.D., 8730 Alden Dr. W101, Los Angeles, CA 90048

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) List the components of the biochemical model of the stress response, (2) Identify specific women's health issues and the impact that stress may have on recovery and treatment, and (3) Recognize the stress response in relation to women's health issues as an interface between biological, psychological, and social factors.

SUMMARY:

The neurochemical pathways associated with responses to stress have been extensively studied in both human and animal models. More recently, examination and research have been applied to these stress response syndromes and how they impact multiple medical illnesses including cancers such as melanoma, Hodgkin's disease, and breast cancer. These stress responses and their effects on health, illness, and treatment have a multitude of implications when viewed in light of medical issues as they relate to women. In particular, recent studies have focused on responses to illness using the trauma model. In this workshop, we will review current literature that examines the effects of stress on women's health. We will review recent articles that include the effects of PTSD on women's health such as perinatal health and breast cancer. Specifically, we will examine the biological aspects of neurochemicals in the stress response and how they may affect treatment and recovery. We will also examine the psychological aspect of the stress response and the ways in which the perception of risk of disease may contribute to these illnesses. Furthermore, we will examine the notion of adaptation to situations of stress and women's vulnerability vs. resilience to handle illness and health concerns specific to women.

REFERENCES:

1. Charney D: Psychological mechanisms of resilience and vulnerability: implications for successful adaptation to extreme stress. AmJPsychiatry 2004;161:195-216.
2. Guervich M: Stress response syndromes and cancer: conceptual and assessment issues. Psychosomatics 2002;43:259-281.
3. Jackson J:Gender and symptoms in primary care practices. Psychosomatics 2003;44:359-366.
4. Morland L: Posttraumatic stress disorder and pregnancy health: preliminary update and implications. Psychosomatics 2007;48:304-308.
5. Sapolsky R: Why Zebras Don't Get Ulcers. New York, Henry and Company, 1998.
6. Wellisch D: A psychological profile of depressed and nondepressed women at high risk for breast cancer. Psychosomatics 2001;42:330-336.

ISSUE WORKSHOP 110

IMPROVING, INTERFERING, OR INANE: CURRENT LESSONS FROM FORMAL PATIENT FEEDBACK TO PSYCHIATRISTS

Chairperson: Jacob E. Sperber, M.D., Department of Psychiatry, Nassau University Medical Center, Box 51, 2201 Hempstead Turnpike, East Meadow, NY 11554
Presenters: Aleksandar Micevski M.D., Nyapati Rao M.D., Amandeep Nagra M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: identify key variables, supported by the literature, in patient satisfaction with psychotherapists and psychopharmacologists; describe specific, practical, effective techniques used to obtain patient feedback about their psychiatric treatments; and discuss lessons that have been learned from the patient satisfaction literature about the role of patient criticism in the working alliance and in relational concepts of therapy.

SUMMARY:

The idea of patient as consumer continues to force increasing transparency in the provision of medical care, including psychiatric care, and consumers of psychiatric care exercise expanding constituent rights. This trend has become institutionalized in requirements by regulatory agencies such as JCAHO and ACGME that patient feedback on treatment received be incorporated into care and quality improvement. In what forms are patient feedback on caretakers and care collected? What are the lessons from the psychiatry, psychology, and counseling literatures about the impact on patients and practitioners of different forms of feedback, and on the quality and outcome of care? For psychiatry, with its specific concerns about confidentiality and stigma, as well as unique problems related to mental capacity for consent, what techniques for collecting and measuring patient feedback have been problematic or successful? What has been learned about the patient's role in optimizing care?

Presenters will briefly (10 minutes) summarize literature and experience related to specific concerns for psychiatry about:

(1) Key variables in patient satisfaction with psychotherapists and psychopharmacologists, and the impact of anonymous and identified patient feedback on treatment course and treatment outcome;

(2) Specific techniques for feedback that have proven most practical, as well as effective; and

(3) Modifying concepts of working alliance in light of the lessons from patient satisfaction, and the consequences from patient feedback studies for theoretical issues raised by relational modifications of psychodynamic theory.

Each presentation will be followed by discussions structured and led by each presenter (10 minutes).

Audience members will then be invited to participate in brief role playing of case examples provided by the panel. Therapist and patient will discuss written feedback previously submitted by the patient, followed by discussion guided by panelists.

REFERENCES:

1. Lambert MJ, Harmon C, Slade K, Whipple JL, Hawkins EJ: Providing feedback to psychotherapists on their patients' progress: clinical results and practice suggestions. J Clin Psychol.
2005 Feb;61(2):165-74.
2. Sapyta J, Riemer M, Bickman L. Feedback to clinicians: theory, research, and practice. J Clin Psychol. 2005 Feb;61(2): 145-53.

ISSUE WORKSHOP 111

MY PATIENT IS STALKING ME: MANAGEMENT OF EROTOMANIA IN RESIDENCY AND BEYOND

Chairperson: Kenneth M. Certa, M.D., 833 Chestnut St., Suite 210, Philadelphia, PA 19107
Presenters: Amy McAndrew M.D., Kathleen Dougherty M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize characteristics of patients likely to become stalkers, identify reasons for the development of stalking behavior, and list strategies for dealing with this development at various stages of the progression.

SUMMARY:

One of the occupational hazards of the practice of psychiatry is the potential for a patient to develop such a strong emotional attachment that it becomes delusional and potentially dangerous. Managing such erotomania is particularly problematic when it occurs during residency, as trainees are just gaining experience. The duty of the training program and hospital to provide a safe environment for training can be compromised in such cases. There are unfortunate limits to what the legal system can do to assist programs in providing for the safety of residents. This workshop will examine the transformation of a patient into a stalker, using the experience of one of the presenters as a template. How the residency program responded, how others might have handled it, what the local law enforcement agencies did (and did not) do, and what changes in patient screening might have helped, will be presented. Participants will be encouraged to present their own experience with patients, in training or beyond, who reached over the boundary lines and made the psychiatrist feel threatened. Areas of particular interest are: What constitutes an appropriate patient for a resident to treat? Should patients with a history of stalking be excluded from care by residents or others? At what point should residency directors, or hospital administrators, become involved in treatment decisions about such patients? What types of accommodations can or should be made to safeguard residents who feel threatened? When stalking patients are referred out, what history can or should be provided to the receiving practitioner, with or without the patient's permission? How can the legal system be effectively engaged to protect our trainees?

REFERENCES:

1. Mullen PE, et al.: Assessing and managing the risks in the stalking situation. J Am Acad Psychiatry Law 2006; 34:4: 439-450.
2. Kamphuis JH, Emmelkamp PM: Stalking--a comtemporary challenge for forensic and clinical psychiatry. Br J Psychiatry 2000; ; 179:206-209.

ISSUE WORKSHOP 112

APPLICATION OF CULTURAL VARIABLES FOR EFFECTIVE PSYCHOTHERAPY OF THE MIGRANT ASIAN POPULATION IN THE UNITED STATES

Chairperson: Vijoy K. Varma, M.D., 1124 Lake Pointe Cove, Fort Wayne, IN 46845
Co-Chairperson: Nitin Gupta, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) recognize the relevance of cultural issues in the use of psychotherapy, (2) develop an understanding of approach to assessment for psychotherapy, and (3)use the cultural issues effectively in psychotherapy for Migrants from traditional societies, particularly from Asia, and especially, India and Southeast Asia who have settled in the U.S.

SUMMARY:

The Western model of psychotherapy is implicitly understood to be practiced across the world in different cultures. However, this conventional model has come under increasing scrutiny and criticism lately. This applies to the different types of psychotherapy; particularly to the dynamically oriented individual psychotherapy, and is also due to advances in psychotherapy in non-Western cultures. Ever-increasing experience in transcultural psychiatry is also demanding an adjustment in the definition of psychotherapy. Numerous key factors unique to traditional societies have been identified that influence the nature and course of psychotherapy, e.g., close and confiding relationship between doctor and patient (Guru-Chela paradigm), more permeable ego boundaries, dependency of patient, psychological sophistication, involvement of the family, etc. To be effective, psychotherapy should be consistent with the social and philosophical background and belief systems of the people. Industrialization and adaptation of western concepts does not necessarily translate into the "traditional mind" becoming a "western mind."

One needs to be mindful that psychotherapies that are unique to specific societies make use of the cultural fabric of that society, with its associated beliefs and aspirations and ways of seeing the world. Cultural variables can be of importance and relevance even in situations where the therapist and patient are from different ethnic groups. People from non-Western cultures may not place the same degree of emphasis on talking as a form of treatment, introspection, exploration, etc. but look for more directive instructions expected from the therapist. In fact, Indian psychotherapists suggest departures from the Western model; pleading for greater flexibility, greater activity on the part of the psychotherapist, and greater use of suggestion and reassurances. The co-chairpersons shall aim to present three cases whose presentation, evaluation and management shall be discussed with the audience. The format to be interactive with ample opportunity for a dialogue between the audience and the presenters regarding issues related to transcultural aspects of psychotherapy. The case presentations-cum-discussion will be 30 minutes each. It becomes important and pertinent to take into account numerous considerations and concepts that require a reassessment and management from a transcultural perspective.

REFERENCES:
1. Varma VK: Culture, personality, and psychotherapy. Int J Soc Psychiatry 1988; 34: 142- 149.
2. Varma VK, Gupta N: Psychotherapy in a Traditional Society (India): Context, Concept, and Practice (In Press).

ISSUE WORKSHOP 113

WOMEN SERVING LIFE SENTENCES: CRIME, PUNISHMENT, AND TREATMENT

Chairperson: Sharon S. Snow, Psy.D., Valley State Prison for Women, PO Box 99, Chowchilla, CA 93610
Co-Chairperson: Daun H. Martin, Ph.D.
Presenter: Lori Williams Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; (1)Identify gender differences in prisoners incarcerated for life; (2)differentiate groups of female who committed violent crime; (3) describe group specific treatment; and 4) recognize clinical and legal dilemma of women with life sentence.

SUMMARY:

Valley State Prison for Women in California houses over 400 women with life sentences ranging from 21 to76 year of age. About 50 of these women have spent more then 20 years in prison. Unlike male "lifers," most of the women who committed violent crime and serve life sentences had no criminal past and after obtaining their history, it is often hard to answer the question "Are they offenders or victims?" Analysis of the group of female lifers revealed three different subgroups: (1) Women who were protecting themselves and had no previous history of violence or criminal offence. (2) Women who had been frequently violent toward others as a response to abusive or criminal milieu, but with fair insight and remorse. (3) Women with antisocial personality traits or disorder, with history of violence and who believe that they have the right to kill a "bad" person. Evidently, each group requires different treatment. However, even the best clinical solution is not sufficient to slow down the growth of of females incarcerated for life. The legal dilemma that our society faces calls for solution as well. The goal of this presentation is to introduce a new approach to assessment and treatment of women who are serving life sentence for violent crime utilizing biopsychosocial and cultural model. We also hope to open the discussion of how these women could be out of prison, at home, contributing to society by caring for their children and paying taxes.

REFERENCES:

1. Spohn C, Beichner D. Is Preferential Treatment of Female Offenders a Thing of the Past? A Multisite Study of Gender, Race, and Imprisonment. Criminal Justice Policy Review, 2000, 11, 149-184
2. Stout K, Brown P. Legal and Social Differences Between Men and Women Who Kill Intimate Partners. Affilia, 1995, 10, 194-205.

ISSUE WORKSHOP 114

WITHDRAWN

ISSUE WORKSHOP 115

INNOVATIVE MODELS FOR EXTENDING PSYCHIATRIC CARE TO CHILDREN

Chairperson: Radmila Bogdanich, M.A., Southern Illinois University, School of Medicine, PO Box 19642, Springfield, IL 62794-9642
Presenters: Mary Dobbins M.D., John Record M.A., Deborah Seale B.A., Nicole Roberts Ph.D., Sandra Vicari Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop participants will be able toapply new consultation models to improve access to care,assist primary care providers in developing evidence-based practices,measure effectiveness of models, identify methods to build internal/external relationships, develop familiarity and comfort with using video-conferencing.

SUMMARY:

Access to child psychiatry services continues to be a profound problem. Although barriers are multifactorial, the lack of trained professionals is paramount. By developing interdisciplinary professional "partnerships," however, it is possible to modify current systems of care, creating the opportunity for innovative strategies for consultation and collaboration. By utilizing case discussion and time-limited direct patient care, child psychiatry can be integrated into the primary care model resulting in earlier intervention and more timely, evidence-based care. This interactive workshop will consist of interdisciplinary team presentations outlining the development of indirect and time-limited direct consultation services. Topics will include: the use of triage consultations; the use of case consultation conferences, the role of the consultant; the development of professional relationships, the identification of local resources; the incorporation of telemedicine, the determination of educational needs, the measuring of outcomes, and the development of best practices. Video vignettes will be used to demonstrate consultation methods, active learning of best practices and video conferencing etiquette. Topics will be pertinent to community and academic providers (including child psychiatrists, general psychiatrists, primary care physicians, physician assistants, nurse practioners, and therapists) in both urban and rural settings. Participants in this workshop will be able to apply this information to their own practice environments, strengthening their local service networks. As a result, patient populations will have improved access to quality mental health care, improving overall functioning at earlier stages.

REFERENCES:

1. Bower P, Garralda E, Kramer T, Harrington R, Sibbald B: The treatment of child and adolescent mental health problems in primary care: a systematic review. Family Practice 2001; 18: 373-382.
2. Stein REK, Zitner LE, Jensen PS: Interventions for adolescent depression in primary care. Pediatrics, 2006; 118:669-682.

ISSUE WORKSHOP 116

WORKSHOPS

A FEDERAL PERSPECTIVE ON REDUCING MENTAL HEALTH DISPARITIES: HOW CAN PSYCHIATRY PARTICIPATE

SubstanceAbuse and Mental Health Services Administration

Chairperson: Francis G. Lu, M.D., Department of Psychiatry, 7M8, San Francisco General Hospital, 1001 Potrero Ave., San Francsico, CA 94110
Co-Chairperson: Larke Huang, Ph.D.
Presenters: Kenneth Thompson M.D., Kana Enomoto M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the SAMHSA initiatives in reducing mental health disparities and to recognize ways in which psychiatry can participate in these federal initiatives.

SUMMARY:

In 2001, the Surgeon General's office released the landmark report: Mental Health – Culture, Race and Ethnicity. This report called attention to the disparities in care for the diverse racial and ethnic populations in the U.S. and put forward recommendations to reduce these inequities. In 2003, the President's New Freedom Commission on Mental Health stated as one of its six goals, the elimination of disparities. Recent national survey studies funded by the Centers for Disease Control and Prevention the National Institute of Mental Health, and the Substance Abuse and Mental Health Services Administration (SAMHSA) have empirically documented these continuing disparities in access to and quality of care. From a federal perspective, what are effective strategies to reduce these persistent disparities in care? This workshop will present and discuss with the audience efforts by SAMHSA to address and ultimately reduce these disparities. SAMHSA's agency-wide efforts are guided by a Cultural Competence and Eliminating Disparities blueprint of policy, program, and infrastructure activities to address disparities. One of these initiatives is the recently launched National Network to Eliminate Disparities in Behavioral Health Care (NNED). Specific details of this effort and opportunities for partnerships will be described. Within SAMHSA, the Center for Mental Health Service is addressing health equity through its transformation initiative. These initiatives and possible paths forward will be presented. At all levels of leadership within SAMHSA, mental health disparities are of priority. Efforts being led by the Office of the SAMHSA Administrator will be discussed highlighting specific efforts to provide resources to historically underserved populations. Discussion will focus on how psychiatry can participate in these efforts to reduce mental health disparities.

REFERENCES:

1. Department of Health and Human Services, U.S. Public Health Services: Mental Health: Culture, Race, and Ethnicity A Supplement to Mental Health: A Report of the Surgeon General, 2001, http://www.surgeongeneral.gov/library/mental health/cre.
2. President's New Freedom Commission on Mental Health: Final Report to the President, 2003.
3. http://www.mentalhealthcommission.gov/reports/reports.htm.

ISSUE WORKSHOP 117

PSYCHIATRY TRAINING FOR PRIMARY CARE PHYSICIANS: AN ONGOING CHALLENGE

Chairperson: Hoyle Leigh, M.D., Department of Psychiatry, Univ. of California, San Francisco-Fresno, 155 N. Fresno St., Fresno, CA 9370
Presenters: Don Lipsitt M.D., Seth Powsner M.D., Jon Streltzer M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the specific needs of primary care physicians for psychiatric training in diagnosis, evaluation, and treatment, and formulate the means and venues of providing such training.

SUMMARY:

This workshop will explore, with active audience participation, the role of the consultation-liaison psychiatrist in the education of the primary care physician, as a continuation of the successful workshops on this topic. The moderator of this workshop (HL) will briefly discuss issues concerning psychiatric diagnosis in teaching primary care physicians based on a survey of directors of training of primary care residencies. Dr. Lipsitt will discuss the perceived needs and practice of primary care physicians in caring for patients who might be diagnosed with hypochondriasis or somatization disorder. Dr. Powsner will discuss and demonstrate innovative teaching techniques in the emergency room setting for the teaching of psychiatry in a multimedia presentation. Dr. Streltzer will present his experiences and ideas in teaching primary care physicians about chronic pain. Presentations will be limited to 60 minutes with 30 minutes for discussion with the audience. The discussion is expected to stimulate consultation-liaison psychiatrists and psychiatric educators to develop a set of minimal competencies for primary care physicians and to generate ideas that will lead to the development of more effective and efficient curricular models.

REFERENCES:

1. Leigh H, Stewart D, Mallios R: Mental health and psychiatry training in primary care residency programs. Part I. Who teaches, where, when and how satisfied? Gen Hosp Psychiatry 2006; 28(3):189-94.
2. Leigh H, Stewart D, Mallios R: Mental health and psychiatry training in primary care residency programs. Part II. What skills and diagnoses are taught, how adequate, and what affets training directors' satisfaction? Gen Hosp Psychiatry 2006; 28(3):195-204.

ISSUE WORKSHOP 118

HUMOR AND HUMANS: A NEW TREATMENT MODALITY FOR PATIENTS WITH DEPRESSION

Chairperson: Anna Bokarius, B.A., 8730 Alden Dr Rm E123, Los Angeles, CA 90048
Co-Chairperson: Waguih W. IsHak, M.D.
Presenter: Ed Dunkelblau Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to:

(1) Recognize the limitation of modern treatments of depression; (2) Be familiar with the research on humor and depression that has been conducted in the past several years; (3) Identify the relationship between humor and depression; and (4) Understand the novel application of humor in treating depression.

SUMMARY:

Humor has stimulated the curiosity of many researchers and has been proposed as a potential adjunct treatment for various medical issues. In the field of psychiatry, it has been shown to help reduce stress and anxiety. However, the possibility of using humor to treat depression remains largely unconfirmed, and early publications involved little research data. More recent studies have shown modest results in humor alleviating depression; but, were based on healthy volunteers, lacking evidence-based validity. Given the limited amount of research on this topic, it is important to consider the feelings of patients themselves before testing the effects of humor in treating depression. A study in the outpatient clinic of Thalians Mental Health Center assessed patients' disposition toward humor and correlated it with their level of depression. Results showed no correlation between disposition toward humor and depression, indicating that depression does not seem to affect disposition toward humor. Consequently, regardless of their level of depression, patients generally appreciated humorous messages and situations, expressed humor themselves, and even welcomed humor as a possible adjunct to their treatment. With this newly confirmed possibility of integrating humor as an adjunct treatment of patients with depression, we can investigate the means of implementing this new strategy. Some pioneering mental health professionals have already begun to apply humor in building rapport with their patients or even in treating depressive symptoms. This workshop sheds light on not only the possibility of using humor, but also the novel methods of the field's most forward-thinking and innovative specialists.

REFERENCES:

1. Moran CC: Short-term mood change, perceived funniness, and effect of humor stimuli. Behavioral Medicine. 22(1):32-38. 1996.
2. Deaner, S.L., McContha, J.T. The Relation of humor to depression and Personality. Psychological Reports 72: 755-763.1993.

ADVANCES IN EATING DISORDERS

ADVANCES IN EATING DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe and discuss current issues in the diagnosis and assessment of patients with eating disorders, inpatient and outpatient management of anorexia nervosa, psychotherapeutic and psychopharmacological management of patients with bulimia nervosa and binge eating disorder, obesity related to the use of psychotropic medications, and the management of patients with chronic, intractable eating disorders.

DIAGNOSIS AND ASSESSMENT OF EATING DISORDERS

David B. Herzog, M.D., 2 Longfellow Place, Suite 200, Boston, MA 02114, David B. Herzog, M.D., Kamryn T. Eddy, Ph.D., Debra L. Franko, Ph.D., Andrea E. Kass, B.A.

SUMMARY:

The *DSM-IV* includes three eating disorder diagnoses: anorexia nervosa (AN), bulimia nervosa (BN), and eating disorder not otherwise specified (EDNOS). In this presentation, we will first review the clinical features, differential diagnoses, epidemiology, and clinical course of these three eating disorders. Looking ahead at *DSM-V,* we will also discuss recent research concerning the diagnosis of binge eating disorder, and evidence showing that diagnostic subgroups of AN and BN show considerable cross over across time.

MANAGING PATIENTS WITH CHRONIC, INTRACTABLE EATING DISORDERS

Joel Yager, M.D., 1 University of New Mexico, MSC09 5030, Albuquerque, NM 87131-0001

SUMMARY:

Follow-up studies of patients with anorexia nervosa reveal that fewer than 50% of patients fully recover and that about 20% have courses marked by chronic and substantial impairment. A variety of impairments can contribute to chronicity, and chronicity occurs in both stable and unstable forms. Chronicity can occur in patients who fully engaged in treatment but who nevertheless fail to respond to adequate regimens, as well as in patients who never fully engage, are treatment reluctant, and fail to adhere to recommendations. This presentation will discuss goal setting, working with families, determining the site and nature of treatment, and the use of a variety of psychopharmacological and other somatic interventions. For patients with established chronicity, modest goals may be required, where treatment may focus on attempts to decrease self-harm and assure safety, increase patients' motivation, and provide patients with their optimum quality of life through psychosocial rehabilitation. Finally, a host of legal, ethical, and humanistic considerations must be addressed in patients who refuse treatment and are in danger of imminent collapse, and who are chronically suicidal and para-suicidal. Important considerations include managing clinician counter transference and family burn-out to better assure compassionate clinical decision-making for patients with intractable disorders.

MANAGEMENT OF ANOREXIA NERVOSA IN INPATIENT AND PARTIAL HOSPITAL SETTINGS

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

SUMMARY:

Severity of symptomatology is the basis of guidelines for partial hospitalization or inpatient treatment for eating disorder patients. Although, unfortunately, the length of hospitalization is primarily determined by managed care companies and health maintenance organizations these days, guidelines based on expert clinical consensus is ordinarily far more preferable for patients and families. There are no randomized, controlled studies to determine the evidence-based criteria for either hospitalization or discharge from the hospital. Subjecting severely medically ill patients with anorexia nervosa to randomized, controlled treatment studies has been nearly impossible. However, open studies have shown that a multifaceted treatment approach is most effective. This treatment includes medical management, psychoeducation, and individual therapy that involves both cognitive and behavior therapy principles. If the patient is under the age of 18, family counseling or therapy is essential and depending on the individual case may be highly desirable for those over age 18. Nutritional counseling is often part of the ward milieu program and pharmacological intervention may be necessary in specific cases. This chapter will review criteria for hospitalization and partial hospital programs as well as giving specific treatment information for each of these intensive therapies.

BULIMIA NERVOSA AND BED

James E. Mitchell, M.D., NRI, 120 8TH ST S, 1375 Elm Circle NE, Fargo, ND 58107, NA

SUMMARY:

Recent research in bulimia nervosa has focused on a number of areas. There is growing awareness that there is a genetic diathesis for bulimia nervosa. A large study that used a linkage analysis of a large sample of multiplex families found a gene on chromosome 10 that may increase risk; however, it is quite clear that both anorexia nervosa and bulimia nervosa are polygenic and a number of additional genes will be found. There is also some evidence of crossover from bulimia nervosa to anorexia nervosa although the reverse crossover is more common. Cognitive-behavioral therapy remains the best validated most widely studied treatment for bulimia nervosa. Signal detection analysis has shown that a reduction in purging behavior of at least 70% by the third week of treatment is an indicator of a high likelihood of response by the end of treatment. There is growing interest in using a stepped-care approach for patients with bulimia nervosa beginning with a supervised self-help format, followed by a full cognitive-behavioral therapy in patients who do not respond. This appears to be a viable and more cost effective treatment sequence. For adolescents with bulimia nervosa, a family-based therapy originally designed at the Maudsley Hospital for adolescents with AN appears to also be quite useful.

WEIGHT, EATING DISORDERS, AND MEDICATIONS

Pauline S. Powers, M.D., Department of Psychiatry and Behavioral Medicine, Health Sciences Center, University of South Florida, 3515 East Fletcher Ave.,, Tampa, FL 33613, Nancy Cloak, M.D.

SUMMARY:

Although the only medication that is currently approved for any eating disorder (ED)is fluoxetine 60 mg. for adults with bulimia nervosa, comorbid conditions are the rule rather than the exception among ED patients and medications that affect weight are commonly prescribed. The majority of medications that cause weight gain are used for psychiatric or neurological conditions, but corticosteroids and some antidiabetic, antihypertensive, and hormonal agents also affect weight. A few medications prescribed for ED patients are weight neutral (including fluoxetine) and a few can cause weight loss. In addition, several medications have been considered for enhancing weight gain in patients with anorexia nervosa (AN), including the antipsychotics. After a review of the multiple factors that affect the homeostatic regulation of energy balance and the comorbid psychiatric disorders most frequently found in ED patients, effects of commonly prescribed medications on weight and activity levels will be described. Off-label use and risk/benefit ratio of medications for enhancing weight gain in AN will be discussed.

REFERENCES:

1. Yager J, Powers PS (eds): Clinical Manual of Eating Disorders,. American Psychiatric Press 2007.
2. American Psychiatric Association. Treatment of Patients Wwith Eating Disorders, Third Edition. American Psychiatric Association. Am J Psychiatry. 2006 Jul;163(7 Suppl):4-54.
3. Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE clinical guidance, January 2004. http://guidance.nice.org.uk/CG9 Beumont P, Hay P, Beumont D, Birmingham L, Derham H, Jordan A, Kohn M, McDermott B, Marks P, Mitchell J, Paxton S, Surgenor L, Thornton C, Wakefield A, Weigall S; Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Anorexia Nervosa. Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa. Aust N Z J Psychiatry 2004; 38:659-70.

ADVANCES IN TREATMENTS OF PSYCHIATRIC DISORDERS

ADVANCES IN TREATMENTS OF PSYCHIATRIC DISORDERS

Chairperson: Glen O. Gabbard, M.D.

AUTISTIC LEARNING DISABILITIES AND AUTISTIC LEARNING STYLES: A FRAMEWORK FOR DEVELOPING INDIVIDUALIZED TREATMENT PLANS FOR AUTISTIC SPECTRUM DISORDERS

Presenter: Bryna Siegel, Ph.D., Children's Center at Langley Porter, Department of Psychiatry, University of California, San Francisco, San Francisco, CA 94143-0984, Bryna Siegel, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the primary treatments for a range of psychiatric disorders, including dementia, schizophrenia, autism spectrum disorders, borderline personality disorder, and depression.

SUMMARY:

Autism has become understood as a spectrum of signs and symptoms varying in severity and number across individuals. As autistic spectrum disorders (ASDs) have become more broadly-defined and widely recognized, there is support for viewing etiologies as heterogeneous—resulting in many "autisms" These can be characterized in terms of genotypic, phenotypic, neuroanatomical, and neurochemical differences. Concurrently, the need to help individuals with ASD has increased, including behavioral, developmental, and educational approaches discussed here. Among clinicians and clinical researchers involved in treatment, there is broad agreement that this heterogeneity means that treatment is not one-size-fits-all, though there is little agreement on a conceptual framework for aligning symptoms/profiles/subtypes with specific treatment approaches. The approach taken here is that ASDs can be reconceptualized as related autism-specific learning disabilities (ALDs) and autism-specific learning styles (ALSs). Symptoms of ASDs can be operationally understood, then deconstructed by viewing them as arising from a matrix of specific disabilities cross-tabulated by preserved abilities. Each ALD can be characterized as the product of specific defects in perception, processing, retention, or expression of some perceptual, affective, or cognitive stimuli. Then, preserved abilities form naturally-arising compensations depending on ALDs, resulting in self-accommodations wherein stronger capacities are deployed when specific neuropathology blocks expression of typical function. The ALD/ALS model has two important applications: (1) It breaks symptoms of ASDs into readily observed endophenotypes (e.g., low affiliative drive) which should be more useful in characterization of etiologic homologues than diagnosis alone, and (2) precisely specifies learning defects so they are addressed with targeted intervention strategies (e.g., pivotal response training for low affiliative drive). Using this model, targeted clinical treatments can be selected accordingly, and seen as taught accommodations that optimize efficiency of self-accommodation processes. This presentation will link specific theory and evidence-based treatments to signs of ASDs using the ALD/ALS model.

PHARMACOLOGICAL AND PSYCHOLOGICAL TREATMENTS FOR THE COMPONENT SYMPTOMS OF SCHIZOPHRENIA

Presenter: Carol A. Tamminga, M.D., Univeristy of Texas, Southwestern Medical Center, 5323 Harry Hines Boulevard, Dallas, TX 75390-7201, Dallas, TX 75390

SUMMARY:

Despite potent treatments for psychosis, people with schizophrenia have difficulty reaching full psychosocial recovery. The reasons for this seem to involve poor recovery in the area of neurocognitive function. It is the schizophrenia-associated dysfunctions in attention, memory, speed of processing, and social cognition that appear to impede recovery. The NIMH-sponsored MATRICS group studied the nature of the cognitive dysfunction in the illness, developed a battery to assess it broadly and projected the molecular targets that might be involved in the dysfunction. Now, several research efforts in government, academia, and/or industry are testing different pharmacological approaches to restore cognition in schizophrenia. Cognition treatments are administered along with antipsychotic compounds, as co-treatments. Moreover, it may be necessary to include cognitive remediation approaches as well.

CURRENT AND FUTURE TREATMENTS FOR NON-ALZHEIMER'S DEMENTIA

Presenter: Steven l. Dubovsky, M.D., 462 Grider St, Buffalo, NY 14226

SUMMARY:

The treatment of three important components of dementia is currently undergoing considerable study. Treatments for the primary dementing process have mostly involved NMDA antagonists, but newer treatments may involve neuroprotective proteins and gene therapy. Treatments of affective components of dementia have mostly involved SSRIs, but novel antidepressants and mood stabilizers are also proving useful. The behavioral component of certain dementias, especially Pick's disease and frontotemporal dementia, has been understudied. Recent research suggests that the atypical antipsychotic drugs are probably not first-line treatments for this problem. Anticonvulsants, certain antidepressants, lithium, and other serotonergic agents such as dextromethorphan, which also may have neuroprotective actions, may be more useful.

REFERENCES:

1. Gabbard GO (Ed.): Gabbard's Treatments of Psychiatric Disorders: Fourth Edition. Arlington, VA. American Psychiatric Publishing, 2007.

ADVANCES IN TREATMENTS OF PSYCHIATRIC DISORDERS

ADVANCES IN TREATMENT OF BORDERLINE PERSONALITY DISORDER

Presenter: John G. Gunderson, M.D., McLean Hospital, 115 Mill Street,, Belmont, MA 02478

SUMMARY:

A generation of accumulated clinical wisdom has set a framework for modern treatments by greatly diminishing the frequency and severity of mistaken misinformed and harmful clinical practices that had largely been responsible for BPD's reputation of untreatability. Amongst the basic frames now widely recognized are: (1) This is not a chronic condition -- but change requires motivation by the patient and agreed-upon goals; (2) Therapists must be active and declarative -- must not be passive or purposely opaque; (3) Therapies must be antiregressive -- calling upon the BPD patient to use their strengths rather than catering to their weaknesses; and (4) Therapies cannot take over or replace life -- the patients' integration into social/community-based functions is an integral process for recovery. Having established this framework, multiple modalities have refined the interventions into manualized forms that facilitate, expedite, and speed the process of recovery. These are briefly summarized: (1) Psychoeducation is an important and almost always useful way to start treatment; (2) Medications are adjunctive -- atypical antipsychotic have risen in usage and value; (3) Family interventions are adjunctive. Efforts to inform and gain support may be prerequisite for treatment; (4) Group therapies have a much more central role than previously recognized -- they provide a focus on social skills and functioning that are easily overlooked within individual therapies; and (5) Four forms of RCT-validated psychotherapies (DBT, TFP, MBT, SFT) now compete for position. Their merits and content are compared. Their common features provide a frame for effective psychotherapies.

PSYCHOTHERAPY OF DEPRESSION: AN UPDATE

Presenter: Michael E. Thase, M.D., 3535 Market Street, Room 689, Philadelphia, PA 19104

SUMMARY:

It is increasingly recognized that several forms of time-limited psychotherapy are useful treatments of depression, both alone - as an alternative to antidepressant medication, for patients suffering from mild-to-moderately severe depressive episodes, and in combination with medication for patients with more severe and/or disabling depressions. This presentation will review the evidence base for these psychotherapies, including cognitive therapy (CT), interpersonal psychotherapy (IPT), cognitive-behavioral analytic system of psychotherapy [CBASP], problem solving therapy [PST], and behavioral activation [BA]. The major empirical advantage of CT has been evidence of a more durable protection against relapse following termination of therapy (comparable to that of continuation-phase pharmacotherapy). Such benefits also may be conveyed by CBASP and mindfulness-based cognitive therapy (MBCT), which is unique in that it can be conducted in large groups prior to withdrawal of antidepressants. Recent modifications to improve availability include delivery of therapy via telephone, internet, or DVD modules.

REFERENCES:

1. Gabbard GO (Ed.): Gabbard's Treatments of Psychiatric Disorders: Fourth Edition. Arlington, VA. American Psychiatric Publishing, 2007.

ADVANCES IN THE TREATMENT OF SUBSTANCE USE DISORDERS

ADVANCES IN THE TREATMENT OF SUBSTANCE USE DISORDERS

Chairperson: Marc Galanter, M.D.

THE RECOGNITION AND TREATMENT OF ALCOHOL USE DISORDERS

Presenter: Kathleen Brady, M.D., 171 Ashley Avenue, Charleston, SC 29425

EDUCATIONAL OBJECTIVES:

At the end of this session, attendees will (1) be introduced to a wide variety of emerging techniques for assessment and management of substance use disorders, and (2) will be better able to apply a sophisticated approach tailored to the specific needs of different patient populations.

SUMMARY:

Alcohol use disorders are among the most common and costly psychiatric problems in the United States today. The morbidity, mortality and associated costs will be discussed. Recent studies have focused on screening for problematic use in primary care settings and early intervention. Definitions and consequences of problematic alcohol use will be discussed. There has been an explosion of information about the neurobiology of alcohol dependence. These studies have lead to exciting avenues of exploration in the treatment of alcohol use disorders. This presentation will give an overview of studies investigating pharmacotherapeutic approaches to the treatment of alcohol dependence. The results of Project Combine, a recently completed multi-site study investigating combination pharmacotherapy with naltrexone and acamprosate will be reviewed. Finally, new findings in relation to cognitive behavioral and other non-medication approaches to the treatment of alcohol use disorders will be reviewed.

OPIOIDS: DETOXIFICATION, MAINTENANCE, & BLOCKADE

Presenter: Herbert D. Kleber, M.D., 1051 Riverside Drive, Unit 66, New York, NY 10032

EDUCATIONAL OBJECTIVES:

At the end of this session, attendees will (1) be introduced to a wide variety of emerging techniques for assessment and management of substance use disorders, and (2) will be better able to apply a sophisticated approach tailored to the specific needs of different patient populations.

SUMMARY:

Withdrawal from short-acting opioids in an office-based setting is best done using the partial opioid buprenorphine with clonidine supplementation as needed. Inpatient detoxification can be similarly done or using the full agonist methadone instead. Maintenance can be either with methadone or buprenorphine. Each has pro's and con's which will be reviewed. For those not wanting opioid maintenance, the narcotic antagonist, naltrexone, can be used for blockade either in the oral form or the 1-month depot injection. Naltrexone is usually poorly accepted by opioid addicts and has a high dropout rate; however, in selected populations it may be the treatment of choice. The good news in the treatment of opioid dependence is that, unlike most of the other drugs of abuse, we have a variety of effective pharmacologic choices.

MANAGEMENT OF COCAINE AND METHAMPHETAMINE DEPENDENCE

Presenter: Thomas R. Kosten, M.D., Baylor College of Medicine, One Baylor Plaza, Houston, TX 77030

EDUCATIONAL OBJECTIVES:

At the end of this session, attendees will (1) be introduced to a wide variety of emerging techniques for assessment and management of substance use disorders, and (2) will be better able to apply a sophisticated approach tailored to the specific needs of different patient populations.

SUMMARY:

Cocaine and methamphetamine addictions continue to be important public health problems worldwide. Currently, there are no proven pharmacotherapies for these addictions. The studies reviewed here revealed a number of emerging targets for their pharmacotherapy. First, disulfiram, a medication with dopaminergic effects, reduced cocaine use in a number of clinical trials and appears to benefit from pharmacogenetic selection of appropriate patients. Second, GABA medications tiagabine and topiramate were found promising in clinical trials. Third, a beta adrenergic blocker, propranolol, may be effective especially among cocaine addicted individuals with high withdrawal severity. Fourth, treatment with a stimulant medication, modafinil, has reduced cocaine use. Lastly, a cocaine vaccine which slows entry of cocaine into the brain holds promise. These promising findings need to be further tested in controlled clinical trials.

INTEGRATED OFFICE-BASED TREATMENT: NETWORK THERAPY

Presenter: Marc Galanter, M.D., Department of Psychiatry, NYU School of Medicine 550 First Avenue, Room NBV20N28,, New York, NY 10016

EDUCATIONAL OBJECTIVES:

At the end of this session, attendees will (1) be introduced to a wide variety of emerging techniques for assessment and management of substance use disorders, and (2) will be better able to apply a sophisticated approach tailored to the specific needs of different patient populations.

SUMMARY:

NT is premised on the finding that rehabilitation of addicted people requires reinforcement of abstinence-based behaviors within their community environment, and it therefore addresses the need of an individual therapist to achieve this reinforcement by access to the patient's social context. NT is compatible with use of contingencies and Twelve-Step programs, and may also be used during residential treatment or as an aftercare approach. This presentation will review relevant research on cognitive-behavioral therapy, with reference to understanding conditioning of drug-seeking stimuli, and describe social support models such as couple's therapy on which NT is based. Illustrative research on NT, such as its use in stabilizing detoxification and buprenorphine maintenance, will illustrate its successful use as an adjunct

to pharmacotherapy. This will be demonstrated with video segments showing how relapse episodes can be averted and dealt with if they occur.

ASSESSMENT OF PATIENTS WITH SUBSTANCE USE DISORDERS

Presenter: Shelly F. Greenfield, M.D., McLean Hospital, 115 Mill Street,, Belmont, MA 02478

EDUCATIONAL OBJECTIVES:

At the end of this session, attendees will (1) be introduced to a wide variety of emerging techniques for assessment and management of substance use disorders, and (2) will be better able to apply a sophisticated approach tailored to the specific needs of different patient populations.

SUMMARY:

Abstract: Clinicians encounter patients with substance use disorders (SUDs) in all clinical settings. Despite the prevalence of these disorders in both general and treatment-seeking populations, SUDs are often undetected and undiagnosed in a variety of clinical settings. Successful treatment of SUDs depends on a careful, accurate assessment and diagnosis. This presentation will review principles of eliciting the history of substance abuse, key elements of the history, formulation of an accurate diagnosis, the use of biological tests, screening tools and standardized questionnaires, interviews with significant others, and enhancement of motivation through the interview.

REFERENCES:

1. Galanter M, et al.: Network therapy: decreased secondary opioid use during buprenorphine maintenance. Journal of Substance Abuse Treatment 26: 313-318, 2004.
2. Kosten TR, Sofuoglu M, Gardner T. Cocaine. In Galanter M, Kleber HD, (Eds.) Textbook of Substance Abuse Treatment, Fourth edition. Washington DC: American Psychiatric Press, 2007.
3. Combined Pharmacotherapies and Behavioral Intervention s for Alcohol Dependence; Raymond F. Anton, Stephanie S. O'Malley, Domenic A. Ciraulo et al., Journal of American Medical Association, 2006; 295:2003-2017.
4. Textbook of Substance Abuse Treatment, 3rd Edition, Eds. Galanter, M., Kleber, H.D., Am Psychiatric Press. 2004. Chapters 23, 24, & 25.

ADVANCES IN MEDICINE

HIV/AIDS IN 2008: PROGRESS AND CHALLENGES

Anthony Fauci, M.D., National Institute of Allergy and Infectious Diseases, National Institutes of Health, Building 31, Room 7A 03 Bethesda, MD, USA, 20892 2520

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Understand the domestic and global epidemiology of the HIV/AIDS pandemic, (2) Understand recent progress and challenges in HIV therapy, (3) Understand priorities and progress in HIV prevention research.

SUMMARY:

Nearly 27 years after the first cases of AIDS were described, much has been accomplished in HIV/AIDS research, notably with regard to understanding HIV pathogenesis and developing effective therapies and tools for prevention. However, with 33.2 million people living with HIV, and 2.5 million new infections and 2.1 million deaths in 2007 alone, much remains to be done. A great deal of information has recently emerged related to the events associated with primary HIV infection, notably the early "seeding" and destruction of gut-associated lymphoid tissue and the establishment of a viral reservoir with a latent component. A further understanding is essential to our efforts to mitigate these early events and prevent infection or alter the course of disease. Much also remains to be done in terms of building on other recent findings related to HIV pathogenesis. More than 25 antiretroviral drugs are available to treat HIV infection and these medications have had an enormous impact in reducing mortality wherever they have been used; however, problems of access persist. New medications such as integrase and entry inhibitors, as well as next-generation reverse transcriptase inhibitors and protease inhibitors are improving an already impressive treatment armamentarium. HIV prevention, with or without a vaccine, will determine the trajectory and burden of the HIV/AIDS pandemic in the years and decades ahead. Half of the 60 million HIV infections projected to occur globally between 2005 and 2015 could be averted with comprehensive scale-up of already proven prevention strategies. Meanwhile, studies are under way to prove the feasibility of delivering adult male circumcision on a large scale in areas of high HIV prevalence. In addition, research is under way on other important HIV prevention approaches such as topical microbicides, pre-exposure chemoprophylaxis, and an HIV vaccine.

REFERENCES:

1. Fauci AS: 25 years of HIV/AIDS science: reaching the poor with research advances. Cell 131(3):429-32, 2007.
2. Fauci AS: Pathogenesis of HIV disease: opportunities for new prevention interventions. Clin Infect Dis 45:S206–S212, 2007.

TRAUMATIC BRAIN INJURY: THE SILENT EPIDEMIC

Ross Bullock, M.D., Department of Neurosurgery, University of Miami Miller School of Medicine, Lois Pope LIFE Center, Room 3-20 1095 NW 14th Terrace, Miami, FL 33136

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand demographics and pathomechanisms of TBI, better diagnose post TBI sequelae, use newer diagnostic modalities, such as ICU monitoring, neuropsych tests, and MRI, and understand newer therapy trials and modalities in TBI.

SUMMARY:

Traumatic brain injury (TBI) effects more Americans under the age of forty than other neurological disorders. Advances in understanding the pathomechanisms and new methods of diagnosis and monitoring have led to steady reductions in mortality rates in recent years, and evidence based guidelines offer the opportunity to standardize management across level one trauma centers both nationally and internationally. Over three million disabled TBI victims are left with an array of disabilities mainly involving cognition and memory. Returning blast injury victims from the Iraq war increased this number, and the difficulty of differentiating mild TBI and post-traumatic stress disorder (PTSD) may confound diagnosis and management. Many new therapies are entering clinical trials, and in animal studies, cell replacement therapies offer great promise for ameliorating this ability in severely injured survivors.

REFERENCES:

1. Guidelines for the management of severe traumatic brain injury. J Neurotrauma,24:suppl 1.2007.
2. Bullock R, Chesnut, R, Ghajaar, J, et al: Guidelines for the surgical management of traumatic brain injury. Neurosurgery 58:S2-1-S2-62.2006.

THE CONFLUENCE OF GENETICS AND ENVIRONMENT LEADING TO A NATIONAL EPIDEMIC

Julio Licinio, M.D., Miller School of Medicine, University of Miami, Department of Psychiatry & Behavioral Sciences (D-28), 1695 NW 9th Avenue, Suite 3100, Miami, Florida 33136

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the contributions of genes and environment to the outcome of obesity. This lecture will explain the current epidemic of obesity in the country, describe when to suspect genetic cases of obesity, and demonstrate the effects of treatment of a genetic form of obesity.

SUMMARY:

Obesity is a behavioral disorder of gene-environmental interactions that represents an alarming epidemic and major public health problem for our country. Obesity is the outcome of two behaviors: food intake and energy expenditure. These two behaviors are controlled by an interactive combination of genetic and environmental influences. The causes of obesity include in a

small number of cases in which there are major contributions of a few genes of large effects while in most cases there are contributions of multiple susceptibility genes of small effects. The genetic load interacts with a plethora of environmental, psychological, social, and economic factors to regulate body weight. Genetic heterogeneity in individual cases of obesity requires personalized treatment heterogeneity that addresses the underlying biology of the disorder. We will present here the exciting results of the first successful endocrine replacement treatment for a genetic form of human obesity in adults. Leptin is a hormone produced by the fat cells that sends a satiety signal to the brain. We showed that recombinant leptin replacement in leptin-deficient individuals effectively treats morbid obesity, corrects endocrine dysfunction, and modifies behavior and brain structure and function. However, leptin is not effective in patients who are not leptin deficient. This is because multiple and redundant biological systems contribute to the behaviors that cause obesity; therefore, intervention at multiple levels will be required to effectively treat the disorder. We propose here that the contemporary approach to obesity is a useful model for understanding and treating psychiatric disorders.

REFERENCES:

1. Licinio J, Caglayan S, Ozata M, Yildiz BO, de Miranda PB, O'Kirwan F, Whitby R, Liang L, Cohen P, Bhasin S, Krauss RM, Veldhuis JD, Wagner AJ, DePaoli A, McCann SM, Wong M-L: Phenotypic effects of leptin replacement on behavior, morbid obesity, diabetes mellitus, and hypogonadism in leptin-deficient adults. Proceedings of the National Academy of Sciences USA 2004;101:4531-4536.
2. Baicy K, London ED, Monterosso J, Wong ML, Delibasi T, Sharma A, Licinio J: Leptin replacement alters brain response to food cues in genetically leptin-deficient adults. Proceedings of the National Academy of Sciences USA 2007;104:18276-18279.

INTERNAL MEDICINE UPDATE 2007: A JOURNAL ROUNDUP

Monique Yohanan, M.D., San Mateo, CA 94403

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

This session will provide a review of the medical literature and guidelines in internal medicine published in 2007. Areas covered will include those representing important findings likely to impact clinical medical practice, with a special focus on topics common to patients with comorbid psychiatric and medical illness. Additionally, a critical appraisal of the evidence presented in these publications will be offered.

REFERENCES:

1. Straus S, I-Hong Hsu S, Ball C, et al: Evidence-Based Acute Medicine. Oxford Medical Knowledge, 2002.
2. Nay R, Fetherstonhaugh D: Evidence-based practice: limitations and successful implementation. Ann N Y Acad Sci 2007 Oct;1114:456-63.

CASE CONFERENCE

CASE CONFERENCES

1.- POSTTRAUMATIC STRESS DISORDER (PTSD): TREATMENT ACROSS PHARMACOLOGY, PSYCHOTHERAPY, AND COLLABORATIVE CARE

Moderator: Robert Ursano, M.D.; Presenters: David M. Benedek, M.D., Scott Moran, M.D., Douglas F. Zatzick, M.D., Heather L. Shibley, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: (1) understand early treatment of PTSD, (2) describe the psychotherapy of PTSD, and (3) identify core components of collaborative care of PTSD.

SUMMARY:

Treatment of PTSD is the focus of substantial research and clinical care for those exposed to disasters and traumatic events. Katrina, the Iraq war, and the "every-day" traumas of our hospital trauma centers are the source of substantial rates of PTSD requiring thougtful care across medication, psychotherapy, case management, and support. Recent treatment recommendations from the APA, the Department of Defense and VA, the International Society of Traumatic Stress, and the Institute of Medicine provide a substantial database for the clinician to apply thoughtfully to cases of acute and chronic PTSD. Recent work on psychological first aid and prevention of PTSD by treating ASD also are important to clinical care providers. This case conference will review treatment of PTSD across its time course and severity through presentation of two cases and discussions of the treatment of these cases by distinguished clinicians and researchers of PTSD and trauma victim care.

REFERENCES:

1. APA Treament Guidelines for PTSD and ASD, APPI Treatment of PTSD, Instititue of Medicine, National Academies of Science, 2007.
2. Zatzick D, Roy-Byrne P, Russo J, Rivara F, Droesch R, Wagner A, Dunn C, Jurkovich G, Uehara E, Katon W, A Rondomized Effectiveness trial of stepped collaborative care for acutely injured trauma survivors. Arch Gen Psychiatry 61: 498-506 2004.
3. Schnurr PP, Friedman MJ, Engel CC, Foa EB, Shea MT, Chow BK, Resick PA, Thurston V, Orsillo SM, Haug R, Turner C, Bernardy N: Cognitive behavioral therapy for posttraumatic stress disorder in women: a randomized, controlled trial.JAMA 2007 Jun 27;297(24):2694-5.

2.- THE USE OF BENZODIAZEPINE AND STIMULANT MEDICATIONS IN BIPOLAR DISORDER / ALCOHOL ABUSE COMORBIDITY: IS THAT YOUR PRESCRIPTION SIGNATURE?

Moderator: Mark Frye, M.D.; Presenters: Anna Yurchenko, M.D., Daniel Flavin, M.D., Bryan Tolliver, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to review the prevalence rate of this comorbidity and review potential treatment strategies to maximize mood stability in a patient with this dual diagnosis.

SUMMARY:

Bipolar disorder is an illness with substantial Axis I, II, and III comorbidities. This case conference will review the past medical history of a 21-year-old man with bipolar II depression, antidepressant-induce mixed hypomania, alcohol abuse, and and adolescent history of attention-deficit/hyperactivity disorder responsive to stimulant therapy until high school graduation. His current symptoms of panic, anxiety, and depression necessitated a treatment consideration with pharmacotherapy with the potential of abuse. His case and course of illness will be reviewed.

REFERENCES:

1. Frye MA, Salloum IM. Bipolar Disorder and Comorbid Alcoholism: prevalence rate and treatment considerations. Bipolar Disorders 2006, 8: 677-85.
2. Nierenberg AA, Miyahara S, Spencer T, Wisniewski SE, Otto MW, Simon N, Pollack MH, Ostacher MN, Yan L, Siegel R, Sachs GS: Clinical and diagnostic implications of lifetime attention-deficit/hyperactivity disorder comorbidity in adults with bipolar disorder: data from the first 1000 STEP-BD participants. Biological Psychiatry 2005; 57: 1467-73.

4.- PSYCHODYNAMIC PSYCHOTHERAPY: EROTIC TRANSFERENCE AND THE FEMALE THERAPIST

Moderator: Glen O. Gabbard, M.D.; Presenters: Gabrielle Hobday M.D., Lisa Mellman M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the particular complexities involved in erotic transference when the therapist is female and have a good understanding of management strategies.

SUMMARY:

Erotic transference in psychodynamic psychotherapy is almost always a challenge for the therapist. It serves as a major resistance but also provides a window into the central object relations struggles of the patient. When the gender constellation of the therapeutic dyad is male patient-female therapist, a particular set of problems arise that require skillful management. These include the potential of the patient for impulsive action, the risk of shaming the patient, the risk of having the encouragement to elaborate misunderstood, and the acting out of the feelings in extratherapeutic relationships. These problems and others will be considered using a clinical example.

REFERENCES:

1. Gabbard GO: Psychodynamic Psychiatry in Clinical Practice: Fourth Edition, Arlington, VA: American Psychiatric Publishing, 2005.
2. Gabbard GO: Love and Hate in the Analytic Setting. Northvale, NJ: Jason Aronson, 1995.

FOCUS LIVE

1. FOCUS LIVE! MAJOR DEPRESSIVE

Moderators: Deborah H. Hales, M.D., Mark Rapaport, M.D.
Presenter: Charles Nemeroff M.D., 101 Woodruff Circle, #400, Atlanta, GA 30322

EDUCATIONAL OBJECTIVE:

This FOCUS LIVE session will assist clinicians in testing their knowledge on the topic of major depressive disorder, and diagnosis and treatment strategies for MDD. Participants will answer board-type questions designed to increase their knowledge and help them identify areas where they might benefit from more study.

SUMMARY:

Depression accounts for more disability than any other disorder worldwide. It is a significant risk factor for suicide, especially in adolescents, young adults, and the elderly. It is an important risk factor for poor treatment response in patients with cardiovascular disease. There has been a significant increase in our understanding of depression and the efficacy and tolerability of currently available treatments through results of recent studies such as the NIMH-sponsored clinical treatment trial, STAR-D. Combination or augmentation therapies, comprised of more than one antidepressant medication or an antidepressant and a second non-antidepressant, and combination pharmacotherapy/psychotherapy, appear to be associated with better therapeutic responses than monotherapy. Increased side effects often associated with co-prescribing two medications, and the increased cost of treatment with combination psychotherapy and pharmacotherapy or two medications, are major obstacles that prevent their wholesale clinical adoption. Many new findings and research directions have recently emerged that presage rapid changes in clinical practice - in diagnostics, choice of currently available treatments and novel treatment development itself.

In FOCUS LIVE sessions expert clinicians lead multiple choice question-based discussions. Participants test their knowledge with an interactive Audience Response System, which instantly presents the audience responses as a histogram on the screen. Questions in this session will cover major depressive disorder, including diagnosis, treatment, and new developments.

REFERENCES:

1.) Nemeroff CB: Review of Advances in Depression. FOCUS Winter 2008 6.
2.) Fochtmann LF, Gelenberg AJ: Guideline Watch: Practice Guideline for the Treatment of Patients with Major Depressive Disorder, 2nd Edition. FOCUS Winter 2005 3: 34-42.

2. FOCUCS LIVE! SCHIZOPHRENIA

Moderators: Deborah H. Hales, M.D., Mark Rapaport, M.D.
Presenter: Peter Buckley, M.D., Medical College of Georgia, Department of Psychiatry and Health Behavior, 515 Pope Avenue, Augusta, GA 30912

EDUCATIONAL OBJECTIVE:

This FOCUS LIVE session will assist physicians in testing their knowledge and having an increased understanding of schizophrenia and its treatment. Participants will answer board-type questions designed to increase their knowledge and help them identify areas where they might benefit from more study.

SUMMARY:

Schizophrenia is a chronic, debilitating illness affecting 1% of adults. The combination of onset in early adulthood and persistent dysfunction create enormous personal costs. Symptoms of the illness are variable from person to person, with positive symptoms of delusions, hallucinations, and thought disorganization and negative symptoms of blunted affect, social dysfunction, and lack of motivation, along with cognitive impairments, and mood disturbance. Treatment planning has the goals of reducing or eliminating symptoms, maximizing quality of life, and promoting recovery. The biological basis is known to include genetic, environmental, and developmental factors. In this FOCUS LIVE session multiple choice questions covering current issues in schizophrenia will be presented: assessment of symptoms and establishment of a diagnosis, treatment plan and treatment adhearence, treating comorbid conditions, psychosocial treatments and antipsychotic medications, metabolic disturbances during antipsychotic therapy, complex switching and combining of medications, and side-effect management strategies to improve patient outcomes.

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

REFERENCES:

1.) American Psychiatric Association; Steering Committee on Practice Guidelines. Practice guideline for the treatment of patients with schizophrenia, second edition. Am J Psychiatry. 2004 Feb;161(2 Suppl):1-56.
2.) Sajatovic M, Rosch DS, Sivec HJ, Sultana D, Smith DA, Alamir S, Buckley P, Bingham CR. Insight into illness and attitudes toward medications among inpatients with schizophrenia. Psychiatr Serv. 2002 Oct;53(10):1319-21.

3. FOCUS LIVE! OBSESSIVE-COMPULSIVE DISORDER

Moderators: Deborah H. Hales, M.D., Mark Rapaport, M.D.
Presenters: John Greist M.D., Healthcare Technology Systems, 7617 Mineral Point Road, Suite 300, Madison, WI 53717

EDUCATIONAL OBJECTIVE:

As a result of participation in this interactive FOCUS LIVE workshop, participants will review multiple choice questions, test their knowledge of the clinical management of patients, and have increased understanding of approaches to the treatment of obsessive-compulsive disorder.

SUMMARY:

Obsessive-compulsive disorder (OCD) is often hidden by patients who have insight into the inappropriateness of their obsessional concerns and the excessive rituals they feel compelled to perform. Obsessions are unwanted, intrusive, repetitive ideas, images and impulses. Compulsions are urges to do something to lessen distress from obsessions. Rituals are repetitive purposeful behaviors, typically tied to obsessions and intended to diminish obsessions or the discomfort they cause. Contamination obsessions lead to washing and cleaning rituals; doubt produces checking; aggressive obsessions evoke avoidance of the objects of aggression; and worry about loss produces hoarding. Onset in childhood is common and many suffer lifelong with a few becoming incapacitated by incessant demands of their disorder. Once recognized, treatment with CBT and SRIs is often helpful, alone or in combination. This multiple choice question based presentation will provide participants with an opportunity to test their knowledge about diagnosis and treatment of this disorder. In FOCUS LIVE! sessions, expert clinicians lead lively multiple choice question-based discussions. Participants test their knowledge with an interactive audience response system, which instantly presents the audience responses as a histogram on the screen. Questions cover existing knowledge on a clinical topic important to practicing general psychiatrists, including diagnosis, treatment, and new developments.

REFERENCES:

1. Practice Guideline for the Treatment of Patients with Obsessive-Compulsive Disorder 2007. Arlington, VA: American Psychiatric Association 2007.
2. Greist J, Jefferson J. OCD Clinical Synthesis. FOCUS: OCD: Summer 2007 3 p 283-295.

FORUMS

1. -THE DISPOSABLE AMERICAN: LAYOFFS AND THEIR CONSEQUENCES

Chairperson: Louis Uchitell

EDUCATIONAL OBJECTIVES:

My goal is to encourage psychiatrists to recognize and speak about the consequences of layoffs, and in doing so perhaps diminish the number.

SUMMARY:

My name and title are Louis Uchitelle, economics writer at *The New York Times*, a post I've held since 1987. The title of my talk is "The Disposable American: Layoffs and Their Consequences." It is also the title of the book that I wrote on which the talk will be based. The book was published by Knopf in March 2006, and the paperback was issued one year later. My talk will center on a key finding in the book - that an involuntary layoff is a traumatic experience with lasting consequences, even for people who land new work soon after losing a job. This is true even for layoffs that are disguised as early retirements or "voluntary" buyouts. The damage is largely to self-esteem. The point will be made through anecdotal accounts, drawn from my reporting, and also by citing academic studies. A number of psychiatrists have acknowledged to me that layoffs are damaging and a blow to mental health - indeed, a blow to public health given that there have been so many. But no psychiatric organization has been willing so far to label layoffs as dangerous to health. We label cigarette smoking as dangerous to health, but not layoffs.

REFERENCES:

1. Uchitell L: The Disposable American: Layoffs and Their Consequences, Random House, 2007.

2.-THE WORLD ASSOCIATION OF YOUNG PSYCHIATRISTS AND TRAINEES

Chairperson: Victor J. Buwalda, M.D., Presenters: Victor Buwalda, M.D., Nitin Gupta, M.D., Ruksheda Syeda, M.B.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) Understand the way the WAYPT is organized and for whom (2) Learn about the submission of research projects (3) Understand the way the SAARC-AYPT is organized and what they want to achieve and for whom (4) Learn about the STIGMA project the WAYPT initiated and how the WAYPT can use its unique structure.

SUMMARY:

WAYPT is a young organization for young psychiatrists (YPs) and trainees throughout the world. It enables international young colleagues to meet and practice research. This workshop is to initiate new projects on a global level. This symposium is about the structure of WAYPT as a young organization, its website, and yahoo group. Not only will we talk about business issues of the organization, but we are also presenting the new guidelines for organizing international workshops and research projects. We will present how members can initiate new global-wide research, what a reasonable time schedule is, and how to get the process going. As an example, in the second presentation one of our members will present the STIGMA project, initiated at the 160th annual meeting of APA in San Diego last year. The unique position of WAYPT gives us advantages to work on projects like this one. We will present the approach adopted, strategy outlined, research proposal developed, and preliminary findings in the symposium. We need insight in the minds of the YPs and trainees so we can reduce stigma and diminish the problem. The third presentation is about the South Asian Association for Regional Cooperation Association of Young Psychiatrists and Trainees (SAARC-AYPT). It was inspired by the WAYPT and is a collaborative effort by WPA young fellows from the WPA IC in Istanbul in 2006. The aim of the organization would is to extend the basic ideology of SAARC federation, i.e. "one vision, one identity, one community" for the field of mental health. The SAARC-AYPT is a network of young professionals who are cognizant of the diversities in cultural, religious, political, geographical region, but who accept that the factors influencing mental health have underlying similarities. Every presentation will conclude with discussion on the above mentioned topics.

REFERENCES:

1. Treichel JA: New International Group Links Young Psychiatrists. Psychiatric News, 2003; 38; 16-18.
2. Corrigan PW, Watson AC: Understanding the impact of stigma on people with mental illness. World Psychiatry 2002; 1 (1): 16-20.
3. Sartorius N: Fighting Stigma: theory and practice. World Psychiatry 2002; 1 (1): 26-27.
4. Thornicroft G, Rose D, Kassam A, Sartorius N: Stigma: ignorance, prejudice or discrimination? British Journal of Psychiatry 2007; 190: 192-193.

3.-RESEARCH PLANNING FOR *DSM-V*

Chairperson: Darrel Regier, M.D., Presenters: David J. Kupfer, M.D., Joel E. Dimsdale, M.D., David Shaffer, M.D., Kenneth Kendler, M.D., Norman Sartorius, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Summarize the global "state of the science" in three rapidly advancing areas of diagnostic research and the public health implications of diagnostic classifications (2) Identify the current challenges in classification of these areas, and (3) Understand the current activities of the *DSM-V* Task Force and its work groups.

SUMMARY:

Twelve years prior to the anticipated 2012 publication of *DSM-V*, processes were set in motion to assess the research and clinical issues that would best inform future diagnostic classification of mental disorders. The goals of these efforts were to identify the clinical and research needs within various populations, utilize the current state of the science to highlight empirical evidence for improving criteria within and across disorders, and stimulate research in areas that could potentially provide evidence for change

prior to formation of *DSM* revision groups. This forum will: (1) summarize progress to date; (2) provide an overview of a series of international research planning conferences convened by APA/APIRE in collaboration with the World Health Organization and the National Institutes of Health under a cooperative grant funded by NIH (presentation topics include a review of research recommendations generated since the last APA annual meeting that have examined Externalizing Disorders of Childhood, Somatoform Disorders, the relationship of Generalized Anxiety and Major Depressive Disorder, and the global public health implications of the evolving research base in diagnosis-related areas; and (3) how the material generated from the research planning process from 1999 to the present is being utilized to inform the D*SM-V* task force, its 13 diagnostic work groups, and four study groups looking at issues that encompass all areas of diagnosis, such as gender and cultural considerations; the clustering of disorder categories; lifespan developmental issues; and looking at the interface between psychiatry and general medicine.

REFERENCES:

1. American Psychosomatic Society: Psychosomatic Medicine 69:827-978, 2007.
2. Narrow WE, First MB, Sirovatka PJ, Regier DA (eds): Age and Gender Considerations in Psychiatric Diagnosis: A Research Agenda for *DSM-V.* Arlington, VA, American Psychiatric Association, 2007

4.-COMPETENCE TREATING PATIENTS WITH SUBSTANCE–USE DISORDERS AND CO-OCCURRING PSYCHIATRIC DISORDERS – WHAT IS EXPECTED AND WHAT ARE THE IMPLICATIONS FOR PSYCHIATRIC TRAINING?"

Chairperson: John A. Renner, M.D., Presenters: Nora Volkow, M.D., Howard Moss, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe new standards for clinical practice including competence in screening all patients for substance–use disorders and in the long-term treatment of patients with substance–use disorders and co-occurring psychiatric disorders. The participant should also understand the importance of neuroimaging studies and new epidemiologic data for our understanding of the addictions and co-occurring disorders and should appreciate how these findings will impact clinical care and psychiatric training.

SUMMARY:

A recent survey of APA members-in-training explored their attitudes about treating addiction patients and the factors that influence residents to pursue or forgo subspecialty training in addiction psychiatry. Many residents noted that they lacked mentors in this clinical area. Some also expressed negative attitudes toward substance abuse patients and commented that they failed to see how competence in the treatment of substance–use disorders was relevant to the practice of general psychiatry (Dr. Renner). These attitudinal problems will be contrasted with recent data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) that reported a 9.4% incidence of substance–use disorders in the U.S. adult population. NESARC data also indicated that 20% of those individuals with a current substance–use disorder also meet criteria for an independent mood or anxiety disorder. The disparity between this apparent inadequacy in psychiatric training and the high frequency of these problems in the U.S. population suggest the need for revised priorities for psychiatric training (Dr. Moss). The Office of National Drug Control Policy has recently mobilized efforts to insure that all physicians are trained in the screening, brief intervention, referral and treatment (SBIRT) skills needed for the management of substance–use problems seen in most common clinical settings. We will explore the specifics of the SBIRT program and will review models for integrating these skills into standard physician training. Psychiatrists will play an important role in the SBIRT initiative, both as role models for competence in dual–diagnosis treatment and as trainers for physicians in primary care and other medical specialties (Dr.Madras). The final section of this presentation will focus on the importance of neurobiology and neuroimaging findings to our understanding of the mechanisms of action of the drugs- of-abuse and implications for training and for the development of medications to treat the addictive disorders (Dr. Volkow). This session will be of particular interest to residents and medical students. Presentations will be organized to allow for active dialogue with the audience.

REFERENCES:

1. Helping Patients Who Drink Too Much, A Clinician's Guide. U.S. Department of Health & Human Services, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism. NIH Publications No. 07-3769, Revised January 2007.
2. Hasin DS, Stinson FS, Ogburn E, Grant BF: Prevalence, correlates, disability, and comorbidity of *DSM-IV* alcohol abuse and alcoholism in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions. Arch Gen Psychiatry 2007 Jul;64(7);830-42.

5.-MUSIC AND MOOD DISORDERS: TCHAIKOVSKY

Chairperson: Richard Kogan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to appreciate the connection between Tchaikovsky's mental illness and his musical output and will understand some fundamental concepts about creativity.

SUMMARY:

There is a longstanding tradition associating creative genius with mental illness. The glorius music of Peter Ilyich Tchaikovsky (1840-1893), considered by some to be history's greatest composer of melodies, does little to dispel this notion. Tchaikovsky suffered from severe depressive episodes and had suicidal impulses throughout his adult life. His music alternates between anguished cries of inconsolable grief (Pathetique Symphony) and ethereal beauty (Swan Lake and Nutcracker), but it is always intensely personal, either describing his intrapsychic torment or creating an idealized fantasy world into which he could escape. Psychiatrist and award–winning concert pianist Dr. Richard Kogan will perform musical examples in an attempt to demonstrate the connection between the composer's music and his psyche.

Dr. Kogan will discuss the psychological and artistic impact of Tchaikovsky's conflicts over his homosexuality, his brief, disastrous marriage, and his fascinating epistolary relationship with a benefactor whom he never met. There will also be an exploration of the controversy over whether or not Tchaikovsky committed suicide. Dr. Kogan will speculate on what forces conspired to make Tchaikovsky's music so emotionally powerful.

REFERENCES:

1. Holden,A: Tchaikovsky: A Biography, Random House 1995.
2. Neumayr A: Music and Medicine, Volume 3, Medi-Ed Press, 1997.

6.-THE IMPLICATIONS OF THE CURRENT INSOLUBILITY OF THE MIND-BRAIN PROBLEM FOR THE CONTEMPORARY PRACTICE OF PSYCHIATRY

Chairperson: Richard D. Chessick, M.D., Presenters: Richard Chessick, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand better the current confusion over the current mixture of neurological aspects of psychiatric treatment and the psychodynamic aspects, and how and why the two aspects are necessary and irreducible. Participants will become familiar with the current controversies over the relationship of the mind to the brain, that is, how the brain gives rise to conscious experiences, a problem that has been debated for centuries.

SUMMARY:

Even in the so-called era of the brain, there has been no consensual agreement on understanding the relationship of the mind to the brain, the problem that also baffled Freud, the neurologist at the start of his great discoveries. Especially, there has been no progress in solving what is known as the "hard problem," namely how neurophysiological processes in the brain can produce conscious experiences, feelings, and intentions. These constitute the "qualia," the various aspects of the phenomena of consciousness. Some of the predominant positions on the mind-brain problem, from Freud's Project for a Scientific Psychology to the present day, will be described and some of the technical vocabulary will be explained. I will conclude from this review that the "mysterian" position or some derivatives of it such as "anomolous monism" or "agnostic materialism" are probably the most plausible, given the present state of our knowledge and capacities. The latter two positions suggest that we simply do not know enough about the physical world of matter at this time and eventually discoveries about the nature of matter may solve the problem. But as of now, the implication of this impasse is that the introspective data of consciousness are ontologically subjective, pointing to the absolute necessity for our studying these data in theirown domain through introspection. The most meticulous and thorough method for this study is Freud's psychoanalytic psychiatry, which was specifically devised by him for that purpose.

REFERENCES:

1. Chessick R: 2007 The Future of Psychoanalysis. State University of New York Press Albany, N.Y.
2. Chessick R: 2000 Psychoanlytic Clinical Practice. Free Association Books, London.

7.-CAREER DEVELOPMENT IN ACADEMIC PSYCHIATRY: SO WHAT'S ON OFFER FOR ME?

Chairperson: Peter Buckley, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) Understand the state-of-the art in faculty development nationally (2) Understand pathways and challenges in academic careers and (3) Understand strategies for mentoring junior faculty.

SUMMARY:

The American Association of Chairs of Departments of Psychiatry (AACDP) is hosting this new session with a focus on faculty and career development in psychiatry. The session will provide information on faculty development activities nationally in academic medicine as well as, more specifically, career planning in academic psychiatry. The session will also cover diversity and minority faculty development, specific guidance on building a research career, and how to advance a teaching career. The panel of experts will also highlight the departmental chair's role in "protecting" and "promoting" junior faculty. AACDP hopes that this forum will be assistance to conference attendees in considering their own careers, as well as to training directors and leaders who have mentorship responsibilities.

REFERENCES:

1. Jerald Kay J, Silberman EK, Pessar L (eds.): Handbook of Psychiatric Education and Faculty Development. Washington, DC, American Psychiatric Press, Inc., 1999.
2. Bickel J: The role of professional societies in career development in academic medicine. Acad Psychiatry, March-April; 31: 91 - 94, 2007.

8.-SUPPORTING MILITARY MEMBERS AND THEIR FAMILIES DURING TIMES OF WAR: NEEDS, CHALLENGES, AND OPPORTUNITIES

Chairperson: David M. Benedek, M.D.

EDUCATIONAL OBJECTIVES:

Participants will be able to: 1) describe the range of unique challenges and stressors facing military members and families during times of deployments to combat environments; and 2) identify opportunities to and mechanisms for providing psychiatric assistance to family members in their communities.

SUMMARY:

In recent years, the nature of war and the needs of returning service members, their families, and their communities have become more complex than ever. The demographic characteristics of combat veterans have changed. The nature of deployment has changed. The support mechanisms for service members and their families have also changed. The extensive deployment of National Guard and reserve members means an increased number of returning veterans and their families return to, and live in, civil-

ian communities rather than military bases (and the associated military base support services). This presentation will highlight the challenges facing military members and families during and after combat deployment and the evolving environment of care for military families. It will also highlight the places and types of intervention and consultation civilian psychiatrists may provide in their communities in support of our nation's military.

REFERENCES:

1. An Achievable Vision: Report of the Department of Defense Task Force on Mental Health, Falls Church VA, Defense department Health Board (at http;//ha.osd.mil/dhb/mhtf/MHTF-report-Final.pdf
2. Ritchie EC, Owens M: Military psychiatry. Psychiatric Clinics, September, 2004.

9.-PHARMACOLOGICAL PERSPECTIVES AMONG U.S.A. ETHNIC MINORITIES

Chairperson: Pedro Ruiz, M.D., Presenters: William Lawson, M.D., Edmond Pi, M.D., Tarek Okasha, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) Know more about how to clinically treat psychiatric disorders among ethnic minority groups residing in the United States; (2) Understand the roles of pharmacogenetics, pharmacokinetics, and pharmacodynamics in the pharmacological treatment of psychiatric disorders; and (3) Assist in improving treatment compliance among U.S. ethnic minority groups.

SUMMARY:

The introduction of novel pharmacological agents for the treatment of psychiatric disorders is currently on the rise. Despite these new treatment options, little is known about how psychopharmacological agents impact on the different ethnic minority groups who reside in the United States. Issues pertaining to pharmacogenetics, pharmacokinetics, pharmacodynamics, and cultural characteristics are all central to this issue. Some new advances have emerged in the last decade as to how some ethnic groups respond differently to pharmacological agents. For instance, Asian Americans are known to respond better and more effectively to smaller amounts of lithium when treated for bipolar I disorders.It is imperative, therefore, that we address these pharmacological specific issues in order to treat more effectively the rising number of ethnic minorities who live in the United States. We will address, examine, and discuss the most recent pharmacological advances in this very important clinical issue.

REFERENCES:

1. Ruiz P, Varner RV, Small DR, Johnson BA: Ethnic differences in the neuroleptic treatment of schizophrenia. Psychiatric Quarterly 70(2): 163-172, 1999.

2. Pi EH, Gray GE: A cross-cultural perspective on psychopharmacology. Essential Psychopharmacology 2(3): 233-262, 1998.

10.-READY OR NOT - COMING SOON TO A DESKTOP NEAR YOU: PSYCHIATRY AND INFORMATION

Chairperson: Robert Kolodner, M.D., Presenter: Steven Altchuler, M.D., Karen Bell, M.D., John Boronow, M.D., Sarah Wattenberg, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) Describe how the national health information technology (IT) agenda impacts psychiatry; (2) Identify opportunities to further advance psychiatry in the health IT agenda, and (3) Recognize the risks and benefits of using health IT for treatment of psychiatric patients.

SUMMARY:

The adoption and use of health IT by clinicians through electronic health records (EHRs) and applications that allow individuals to access and use their own personal health information has the potential to significantly improve both the psychiatric treatment of patients with mental illness and the coordination of care with their non-psychiatric providers. Through effective use of interoperable health IT, psychiatrists can gain the benefits that health IT can bring to a practice, including increased efficiency within the practice, better coordinated care for their patients, and a reduction in medical errors associated with lack of comprehensive information. However, as in any clinical situation, one must also consider the risks of adopting interoperable EHRs as well as these benefits. Privacy of patient information is a key concern in psychiatry and is a crucial component of the national health IT agenda. Confidentiality, privacy, and security protections are critical before increasing EHR adoption and interoperability to enable electronic health information exchange. Input from all those involved in clinical care is important for us to successfully move the national health IT agenda forward. Psychiatrists share many of the same concerns as other health care providers, and have a unique perspective that needs to be included at the national level in health IT activities. The priorities for the future are being established now, and it is important for psychiatrists to be actively engaged in participating and shaping these priorities.

REFERENCES:

1. Technology is used to access mental health care and information. In Achieving the promise: Transforming mental health care in America. Rockville, MD. New Freedom Commission on Mental Health, 2003. http://www.mentalhealth commission.gov/reports/FinalReport/FullReport-06a.htm (accessed January 24, 2008).
2. Ensuring the National Health Information Infrastructure Benefits Persons with Mental and Substance–use Conditions. In Improving the quality of health care for mental and substance-use conditions, Institute of Medicine (U.S.), Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, 259-285. Washington, DC: National Academies Press, 2006.
3. Owen RR, Thrush CR, Cannon D, Sloan KL, Curran G, Hudson T, Austen M, Ritchie M: Use of electronic medical record data for quality improvement in schizophrenia treatment. J Am Med Inform Assoc 2004 Sep-Oct;11(5):351-7.

11.-APA AND LATIN-AMERICAN PSYCHIATRY: BUILDING BRIDGES, FINDING ROUTES

Chairperson: Renato Alarcon, M.D., Presenters: Edgard E. Belfort, M.D., Enrique Camarena, M.D., Fernando S. Lolas, M.D., Rodrigo Cordoba, M.D., Maria Oquendo, M.D., Pedro Ruiz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) identify a variety of evolving areas in joint institutional, academic, and service-related efforts between APA and the Latin American Psychiatric Association (APAL); (2) become familiar with specific research in clinical and social areas, pertinent to the Spanish-speaking population across the world; (3) outline future areas of cooperation in the context of a globalized world.

SUMMARY:

The globalization process has generated increasing and active connections between different regions of the world. The Spanish-speaking population, particularly in the Western hemisphere, has grown dramatically, reinforced by a variety of factors. Mental health appears to be both a growing area of concern and a significant field of interaction at different levels. Professional organizations such as APA and APAL have been developing significant connections aimed at the study of common problems, and the development of academic, research, and service care-oriented activities. An analysis of cultural similarities and differences will precede the description of areas of convergence and mutual strengthening in the evolvement of our discipline in the American continent. The ethics of such interventions, from a social psychiatry perspective, will be followed by the presentation of specific research pieces on topics of clinical interest as well as public health relevance. The exploration of ways to enhance this work, as well as finding new ways to foster cooperation, mutual interactions, growth, and accentuation of identities, will be reflected in the concept of building bridges across scientific and humanistic perspectives, ethical concerns, and joint examination of problems and solutions.

REFERENCES:

1. Huynen MTE, Martens P, Hilderink HBM: The health impacts of globalization: a conceptual framework. Globalization and Health 2005; 1: 1-14.
2. Alarcon RD: Los mosaicos de la esperanza. Reflexiones en torno a la Psiquiatria Latinoamericana. 462 pp. Publicaciones APAL. Caracas, Venezuela, 2003.

12..-MANAGING THE EFFECTS OF COMBAT TRAUMA: THE EVOLVING PRACTICE AT WALTER REED ARMY MEDICAL CENTER

Chairperson: Harold J. Wain, M.D., Presenters: John Bradley M.D., Geoffrey G. Grammer M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) Identify the complex treatment needs of the battlefield casualty and the family, (2) Discuss the important components of care to optimize recovery of the poly-trauma and psychiatric casualty, (3) Evaluate the dynamic impact that caring for severely traumatized patients over many years has on a health care system; and (4) Recognize the impact of external sources on treatment plans and the esprit de corps of the treatment team.

SUMMARY:

As the recent events of war, combat, and natural disasters have clearly demonstrated, psychiatrists must be prepared to treat various conditions arising from man-made and natural disasters. As the wars in Iraq and Afghanistan continue, increasing numbers of soldiers continue to need complex, comprehensive medical, surgical, and psychiatric care. As the premier tertiary referral center in military medicine, Walter Reed Army Medical Center (WRAMC) receives the vast majority of the medical and psychiatric casualties. Comprehensive and effective evaluations of the injured patient along with evidence-based interventions are essential in the treatment of trauma victims. Using a bio-psychosocial approach in the evaluation and treatment of the trauma patient provides a framework to explore vital issues such as mortality, grief and loss, physical limitations, and anxiety, as well as the impact of personality styles, self-efficacy, resiliency, and any prior traumatic exposure or premorbid medical or psychiatric issues. Myriad tailor-made medical, surgical, supportive, psychotherapeutic and pharmacological state-of-the-art approaches are crafted together to address the unique needs of these patients. Upon returning from the battlefront, these soldiers are not only supported by the medical staff, but also receive support from their families who have frequently uprooted their lives to be at the bedside with their loved one. Peer visitations for the amputees and other polytrauma victims help to set models for recovery. Increasing emphasis on providing total care demands responsive and comprehensive care for the entire support system to include the family as well as the interdisciplinary health care team. An innovative Preventive Medical Psychiatry (PMP) model has been developed on our psychiatry consultation-liaison service (PCLS) for the polytrauma patients to facilitate a therapeutic interaction that is geared toward destigmatizing mental health care.

REFERENCES:

1. Wain HJ, Grammer GG, Stasinos JJ: Psychiatric Intervention for medical surgical patients following traumatic injuries, in Mental Health Interventions in Terrorism and Natural Disasters. Edited by Ritchie EC, Friedman Met al., Guilford Press, 2006, pp 278-298.
2. Wain HJ, Bradley JC, Nam T, Waldrep DA, & Cozza SJ: Psy chiatric interventions with returning soldiers at Walter Reed. Psychiatric Quarterly 2005; 76(4):351-360.
3. Cabrera OA, Hoge CW, Bliese PD, Castro CA, Messer SC: Childhood adversity and combat as predictors of depression and post-traumatic stress in deployed troops. Am J Prev Med 2007; 33(2).
4. Cozza SJ: Combat Exposure and PTSD. PTSD Research Quarterly. 2005; 16(1):1-3.
5. Grieger TA, Cozza SJ, Ursano RJ, Hoge CW, Martinez, PE, Engel CC, Wain HJ: Post-traumatic stress disorders and depression in battle injured soldiers. Am J Psychiatry 2006; 163:1777–1783.
6. Koren D, Norman D, Cohen A, Berman J, Klein EM: Increased PTSD Risk with combat related injury: a matched comparison study of injured and uninjured soldiers experiencing

the same combat events. Am J Psychiatry 2005; 162(2):276-282.

13.-OUT OF SHADOWS

Chairperson: Annelle B. Primm, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) Understand the impact of depression on the personal and family level; 2) Know the challenges of creating a film on depression which simultaneously educates; and 3) Appreciate the importance of life story elements in understanding the variety of ways in which depression is experienced by people from different walks of life.

SUMMARY:

Out of the Shadows, a documentary by filmmaker, Larkin McPhee, is a Twin Cities Public Television production. This remarkable film presents the social and biological impact of one of the most common mental disorders, depression. Out of the Shadows features people who have had depression and their families. They give authentic, and at times, heart wrenching accounts of what it is like to have depression and how difficult it is to watch a loved one experience it. The film stands out from other works on the subject of depression in that a series of intimate stories and perspectives are presented by people from various walks of life who differ in age, gender, developmental stage, race, and occupation. This element of the film underscores that depressive illness is a variation on a theme with the expression of mood, self-esteem, sense of well-being and other symptom domains modified by the personal and socio-cultural context in which they occur. These varied presentations of depressive disorder are extremely moving and powerful.

During this forum, the filmmaker will discuss the goals and purpose of Out of the Shadows and some of the challenges surrounding its creation. She will also talk about her hopes that the film's riveting vignettes will move the audience to truly understand the "lived experience" of depression and how several people and their families have learned to deal with the illness.

REFERENCES:

1. Williams TM, Black Pain: It Just Looks Like We're Not Hurting. Scribner, New York, 2008.

14.-MILITARY PSYCHIATRY TODAY

Chairperson: Elspeth C. Ritchie, Col., M.D., Presenters: Capt. Robert Koffman, Lt. Col. Steve Pflanz

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) Describe current Department of Defense and U.S. mental behavioral health policies, programs, and initiatives in support of combat veterans and their families; (2) Identify the potential roles, responsibilities, challenges, and opportunities associated with military psychiatric practice.

SUMMARY:

The global war on terror has been ongoing for almost seven years. The military is committed to ensuring all soldiers and their Families receive the behavioral health care they need. We anticipate that repeated deployments will lead to increased distress and anxiety, and a higher demand for behavioral health services. An extensive array of behavioral health services has long been available to address the strain on our soldiers and families who have experienced multiple deployments. These services include combat and operational stress control, routine behavioral health care, and suicide prevention. Chaplains, Military One Source, and Army Community Service also offer support. All soldiers are screened with the Post Deployment Health Assessment (PDHA) and Post Deployment Health Re-assessment (PDHRA) upon return and three to six months after return from deployment. We have new initiatives to provide outreach, education, and training, including "Battlemind," updated combat and operational stress control, and RESPECT-MIL. We need to partner with our civilian colleagues to provide the best possible care for service members and veterans.

REFERENCES:

1. An Achievable Vision: Report of the Department of Defense Task Force on Mental Health, Falls Church VA, Defense department Health Board (at http;//ha.osd.mil/dhb/mhtf/MHTF-report-Final.pdf
2. Ritchie EC, Owens M: Military psychiatry. Psychiatric Clinics, September, 2004.

15.-HOW TO DECIDE WHETHER TO, WHAT, AND HOW TO SUBMIT TO THE APA ANNUAL MEETING: UNDERSTANDING MEMBERS' INTERESTS AND DIFFERENT FORMATS

Co-Chairpersons: Donald M. Hilty, M.D., Deborah Spitz, M.D.
Presenters:Michele Pato, M.D., Kenneth Silk, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand (1) How to assess if their idea is suitable and doable for the APA Annual Meeting; (2) The differences in formats of the APA Annual Meeting; and (3) How to increase the likelihood of a successful submission.

SUMMARY:

Attending and presenting at national meetings is a key learning and networking experience for academic and community psychiatrists. Knowing what meetings to attend and what the program is like, are essential in having a positive experience. Likewise, when considering a submission, it is important to know what topics are of interest to attendees, what formats are used, and the methods to best ensure acceptance of the submission. This forum reviews general principles of submitting a good presentation, as well as the formats that the APA uses. These formats will be reviewed in terms of their foci, methods, and expected outcomes.

REFERENCES:

1. APA Annual Meeting web site.

16.-GRADING THE STATE PSYCHIATRIC SYSTEMS

Chairperson: Anand Pandya, M.D., Presenters: Laudan Aron B.S.C., Ronald Honberg J.D., Kenneth S. Duckworth M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to list three different criteria used to assess the quality of mental health care in state systems.

SUMMARY:

Within the United States, each state varies tremendously on the size and structure of its psychiatric systems. For those with serious mental illness, such variations can determine whether or not there is any hope of receiving minimal treatment and evidence-based care. Over the last two decades, there have been multiple attempts to systematically assess the quality of care in all 50 states, culminating in the 2006 NAMI report, Grading the States: A Report on America's Mental Health Care System for Serious Mental Illness. This forum will review the results of that landmark report, the trends over time, and the varying methodology required to make meaningful assessments of complex systems. In addition, the forum will provide a preview of the much-anticipated follow-up report that will grade all 50 states in 2008. This session will be valuable for those who are interested in understanding how their local services compare to wtih those available in other parts of the United States.

REFERENCES:

1. NAMI: Grading the States: A Report on America's Health Care System for Serious Mental Illness. NAMI: Arlington, VA 2006.
2. Torrey EF, Wolfe SM: Care of the Seriously Mentally Ill: A Rating of State Programs. Public Citizen Health Research Group: Washington, DC, 1986.

LECTURES

LECTURE 01- CRITIQUE OF PURE RISK ASSESSMENT

Presenter: Douglas Mossman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Report an improved grasp of how mental health scholars conceptualize and quantify the accuracy of violence predictions; (2) Understand problems with establishing a threshold for making decisions based on probability of future violence, and (3) Describe an alternative interpretation of the events underlying the Tarasoff case and therapists' duties concerning patients who utter threats.

SUMMARY:

After Tatiana Tarasoff was murdered in October 1969, her parents were not content to mourn their daughter's death and see her killer prosecuted. Two months before the slaying, the killer had revealed his lethal ideas to his psychologist, and Ms. Tarasoff's parents sued the therapist and his employer for not making an adequate effort to avert the tragedy. In *Tarasoff v. Regents of the University of California* (1976), the California Supreme Court allowed the parents' suit to go forward, declaring that psychotherapists have a duty to protect the public from their patients' violent acts. More than three decades later, *Tarasoff* remains a focal point of mental disability law. The decision has spawned thousands of publications about violence prediction and has permanently altered how mental health professionals think about their clinical duties. Yet because of scientific advances inspired in part by *Tarasoff*, much more is now known about mental illness, violence prediction, and intervention than was the case in the 1970s. That increased knowledge requires mental health professionals, courts, and legislators to rethink why the *Tarasoff* duty exists and what sorts of events should trigger the duty. Dr. Mossman's lecture will critically examine the assumptions underlying violence risk assessment and explain why courts and clinicians should abandon hope that better methods of evaluating risk will someday lead to better decisions about patients' potential violence. Though this conclusion sounds disappointing, it has two direct benefits. First, it frees mental health professionals from viewing their patients as statistical sources of risk, and instead lets clinicians regard patients as sources of initiative and moral worth. Second, it paves the way for conceiving the duty to protect within a moral framework that makes respect for patients' humanity a supreme value. Requiring therapists to make predictions about their patients' future violence is both scientifically impractical and ethically questionable. But assigning therapists a duty to intervene in response to explicit, credible threats is consistent with the ethical mandate to treat patients—along with all other humans—not merely as means, but always as ends in themselves.

REFERENCES:

1. Warren LJ, Mullen PE, Thomas SD, Ogloff JR, Burgess PM: Threats to kill: a follow-up study. Psychological Medicine 9 Oct 2007, doi:10.1017/S003329170700181X (e-published ahead of print).
2. Torrey EF, Stanley J, Monahan J, Steadman HJ, MacAr thur Study Group: The MacArthur Violence Risk Assessment Study revisited: two views ten years after its initial publica tion. Psychiatric Services 2008; 59:147-152.
3. Swanson JW: Preventing the unpredicted: managing violence risk in mental health care. Psychiatric Services 2008;59:191-193.

LECTURE 02-WHAT WOMEN WANT

Presenter: Gail E. Robinson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the issues women are facing around the world and learn routes to achieving the goal of true equality.

SUMMARY:

Freud was quoted as saying "the great question ……. Which I have not been able to answer, despite my 30 years of research into the feminine soul, is "what does a woman want?". He could not understand why women rejected his choice of solutions: the neurotic one resulting in a general revulsion to sexuality; the "masculine" one in which the girl clings to her defiant self-assertiveness and sublimates her wish for a penis by pursuing an intellectual profession; or the "normal" one resulting in passivity, masochism and narcissism. Although almost a century has passed, many still ask this question. In order to provide an answer, it is essential to review the current status of women in the world. This lecture will review many aspects of women's lives around the world looking at issues of career success, violence, equality, and freedom. It will also look at what women themselves are doing to achieve their goals.

REFERENCES:

1. Statistics Canada. Measuring violence against women. statistical Trends 2006. Catalogue no. 85-570-XIE. www.statcan.ca.
2. Mary Blair-Loy. Competing Devotions: Career and Family among Women Executives. Harvard University Press, 2005.

LECTURE 03-PLANNING, ORGANIZATION, AND EVALUATION OF MENTAL HEALTH SERVICES – IDEALS AND REALITIES

Presenter: Otto W. Steenfeldt-Foss, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to have updated insight into mental health policy, challenges, and pitfalls.

SUMMARY:

An updated overview of the internationally accepted principles for planning, organization, and evaluation of the mental health services is presented. Epidemiologic aspects, service elements, and evaluative procedures are highlighted. Proposals for future challenges and developments with special reference to developing countries are commented.

REFERENCES:
1. Steenfeldt-Foss OW. The planning and management of the mental health services to the community. In: Seva, A. Ed. The European Handbook of Psychiatry and Mental Health. Barcelona: Anthrapos, 1991: 1949-56.
2. World Health Organization, Regional Office for Europe: Mental Health, facing the challenges, building Solutions. Copenhagen: 2005.

LECTURE 04-DEEP-BRAIN STIMULATION FOR TREATMENT, RESISTANT DEPRESSION

Presenter: Helen S. Mayberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to appreciate the scientific rationale for targeting the subcallosal cingulate (BA25) white matter using deep-brain stimulation (DBS) as a treatment for intractable major depression; be familiar with the preliminary safety and efficacy data supporting further study of subcallosal DBS for intractable depression.

SUMMARY:

Critical to development of deep-brain stimulation (DBS) as a novel therapy for treatment-resistant depression, has been the evolving understanding of brain systems mediating normal and abnormal mood states and the ongoing, systematic characterization of neural substrates mediating successful and unsuccessful response to other antidepressant interventions. Based on previous work implicating the subcallosal cingulate (Brodmann Area 25) and its functional connections to specific paralimbic, cortical and subcortical regions in the pathophysiology of depression and antidepressant response mechanisms, we tested the use of chronic high-frequency DBS to modulate BA25 connectivity in patients with treatment resistant depression. The theoretical and data-driven foundation for developing this new procedure as well as long-term clinical, neuropsychological, and imaging findings from the first experimental patients will be presented.

REFERENCES:
1. Mayberg HS, Lozano A, Voon V, McNeely H, Seminowicz D, Hamani C, Schwalb J, Kennedy S: Deep Brain Stimulation for Treatment Resistant Depression; Neuron, 2005; 45: 651-660.
2. Mayberg HS: Defining Neurocircuits in Depression. Psychiatric Annals 36:259-266, 2006.

LECTURE 05-PSYCHOLOGICAL TRAUMA AND THE LESSONS OF HISTORY

Presenter: Micale S. Micale, M.D.

EDUCATIONAL OBJECTIVES:

The aim of this lecture is to bring to the attention of mental health professionals an intriguing, but underappreciated, body of recent scholarship about the history of psychological trauma that complements the better known literatures about PTSD from the fields of psychiatry, psychology, biology, anthropology, and the law.

SUMMARY:

The study of emotional and psychological traumatic experience is among the most rapidly growing and culturally resonant areas of research and therapy in the American mental health world today. In the past ten or so years, professional historians have also taken up the subject. In particular, history scholars in the U.S., Canada, Britain, Germany, and Australia have published intriguing findings about a series of natural and human-made catastrophes occurring over the past two centuries, exploring the clinical profiles, medical theories, therapeutic strategies, social policies, cultural ramifications, and existential aspects of these past events in various Western settings. This presentation describes the best of the "new historical trauma studies" and attempts to draw out from this literature a series of ideas, observations, and insights of particular relevance to mental health practitioners.

REFERENCES:
1. Micale MS, Lerner P, eds: Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870-1930 (2001).
2. Lerner, Paul, Hysterical Men: War, Psychiatry, and the Politics of Trauma in Germany, 1890-1930 (2003).
3. Shephard B: War of Nerves: Soldiers and Psychiatrists in the Twentieth Century (2001).

LECTURE 06- NEUROTRANSMITTERS, DRUGS, AND THE BRAIN: HISTORICAL PERSPECTIVES

Presenters: Solomon Snyder, M.D.

EDUCATIONAL OBJECTIVES:

To review molecular mechanisms of psychoactive drug actions including recent discoveries.

SUMMARY:

Psychiatry is often criticized as being devoid of science. While we may be weak in knowing causes of the major illnesses, we are in the vanguard of understanding mechanisms of therapeutic action. Molecular insights into receptors have revealed mechanisms for most therapeutic actions and many side effects. Psychotropic drugs can be tailored to minimize adverse influences with precision greater than for almost any other class of therapeutic agents in medicine. Discoveries of novel neurotransmitters afford the potential for new generations of more effective and selective drugs.

REFERENCES:
1. Sedlak TW, Snyder SH: Messenger molecules and cell death: therapeutic implications. JAMA. 2006 Jan 4;295(1):81-9.
2. Snyder SH: Forty years of neurotransmitters: a personal account. Arch Gen Psychiatry 2002 Nov;59(11):983-94.

LECTURE 07-CRAZY: A FATHER'S SEARCH THROUGH AMERICA'S MENTAL HEALTH MADNESS

Presenter: Pete Earley, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to see the mental health system from different perspectives. A former reporter with the Washington Post, bestselling author, and father with a son with mental illness and a son who is a student at Virginia Tech, Earley will discuss his personal struggles to get his son help, the criminalization of persons with mental disorders, and explain why jails and prisons have become our new dumping grounds for persons with mental illnesses.

SUMMARY:

Best-selling author and journalist, Pete Earley will describe his college-age son's mental breakdown, how he and his son were refused treatment at an emergency room because of Virginia's involuntary commitment criteria that emphasized imminent danger, and how his son later was arrested after he broke into a stranger's house to take a bubble bath. This prompted Earley to travel to Florida where he spent nine months in the Miami jail shadowing persons with psychiatric problems through the justice system and into the streets. Since the publication of his book, CRAZY: A Father's Search Through America's Mental Health Madness, Earley has visited 26 states and toured more than 70 recovery programs. His speech will describe the personal struggles that he has and continues to face trying to get meaningful treatment for his son, his research in Miami, and what he has discovered during his travels. He will discuss the role of psychiatry in helping persons who are ill and why he believes doctors need to play a more active role in determining mental health laws. His book was one of two finalists for the 2007 Pulitzer Prize.

LECTURE 08-SHOULD PSYCHIATRY EMBRACE A PSYCHO-SPIRITUAL APPROACH TO PATIENT CARE?

Presenter: Albert C. Gaw, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) Understand what is meant by a "psycho-spiritual" approach to patient care, and (2) Understanding the rationale of including the "psycho-spiritual" perspective to the Engelian biopsychosocial paradigm of patient care.

SUMMARY:

Recent interest in the medical profession and among the general public of including patients' perspectives in illness and healing provides psychiatry the opportunity to explore more closely the role of symbolic system of meaning in illness and in healing. Using two patients' case examples—a Christian who is possessed by "legion" of spirits and a Buddhist who wants exorcism—the author argues for the inclusion of a psycho-spiritual perspective to our current biopsychosocial theoretical model in diagnosis and treatment. To underlie the importance of understanding the contextual relevance of the psycho-spiritual perspective, the behavior and character of the prophet Jonah in the Old Testament is studied to elucidate the role of psychological and spiritual factors that may explain why Jonah would plead for death at the height of his success. From these examples, the author recommends that psychiatrists and mental health professionals should pay even greater attention to the psycho-spiritual dimension of patients' illness and healing. Inclusion of a psycho-spiritual perspective to the biopsychosocial model makes it an even more holistic health care paradigm.

REFERENCES:

1. Engel GL: The clinical application of the biopsychosocial model. Am J Psychiatry 1980; 137:5.
2. Gaw AC: The Eyes of the Heart: The Biblical Path to Spirituality and Inner Empowerment. Longwood, Florida, The Xulon Press, 2007.

LECTURE 10-THE YIN AND YANG OF LEADERSHIP

Presenter: Carl Bell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Learn a leadership/management model based on Chinese/Japanese leadership; (2) Learn the five components of a well run community psychiatry business; and (3) Learn the three essential criteria for what makes for a good job in medicine.

SUMMARY:

Dr. Bell will use the metaphor/reality of Yin and Yang to talk about leadership. He will emphasize the need for system's thinking in leadership and the need to think Both/And (Yin/Yang) instead of Either/Or. Other aspects of systems thinking: Collaboration instead of Competition; Big Picture instead of Fragmentation; Patterns instead of Cause-Effect; Deeper Causes instead of Surface Symptoms; Creation/Evolution instead of Reactiveness; On going learning instead of Quick Fix; Process instead of Events; Networks & Cycles instead of Boxes; Reflective/Curious instead of Defensive & Blaming; Looking within instead of Enemy without; Opportunities instead of Threats; Anticipatory instead of Crisis-Driven will also be emphasized. Aspects of: a) Ecology – Interdependency b) Trying to give opportunities for the Ah Ha experience c) Focusing on Paradigms that we all agree on d) Encouraging the group to be Mission Driven e) Facilitating Cooperative Learning within the multidisciplinary team, f) Encouraging Bonding - Attachment on team. g) Doing Win-Win in all negotiations, and h) Making sure that that everyone was grooming their replacement will also be highlighted. Finally, values-based anecdotes will be used to provide "directionally correct" paradigms necessary to "save some lives, make some money, and have some fun," e.g. having a mental health service that takes its direction from the community it serves, is run using state of the art leadership/management technologies, does education, does research, and provides clinical and public health services.

REFERENCES:

1. Bell CC. Keeping Promises: Ethics and Principles in Psychiatric Practice. In The Art and Science of Psychiatry. Boston: Aspatore Books, 2007, p. 7 - 38.
2 Bell CC. The Sanity of Survival: Reflections on Community Mental Health & Wellness. Chicago: Third World Press, 2004.

LECTURE 11-WILLIAM C. MENNINGER MEMO-

RIAL LECTURE

Presenter: Oliver Sacks, M.D.

SUMMARY:

"Defects, disorders, diseases," writes Sacks in An Anthropologist on Mars, "can play a paradoxical role, by bringing out latent powers, developments, evolutions, forms of life, that might never be seen, or even be imaginable, in their absence." Sacks's most recent book, published last fall, is Musicophilia: Tales of Music and the Brain. A music lover himself, Sacks writes about the relationship of music and uncommon brain disorders and how that relationship is marked by power and mystery. He goes beyond the science of the brain as he unfolds the compelling tales of people with different neurological conditions for whom music is or has become a central part of their existence—sometimes to their detriment but most often in paradoxical, healing, or life-changing ways. Sacks, who is probably best known for his books Awakenings, The Man Who Mistook His Wife for a Hat, and An Anthropologist on Mars, was born in 1933 in London into a family of physicians and scientists—including his mother, a surgeon, and his father, a general practitioner. He earned his medical degree at Oxford University and did residencies and fellowship work in the United States. Since 1965 he has lived in New York and practiced neurology. He is now a professor of clinical neurology and clinical psychiatry at Columbia University Medical Center and was named the university's first Columbia Artist. A pivotal event in Sacks's career occurred in 1966. While consulting for a chronic-care hospital in the Bronx, Sacks encountered a group of patients who had spent decades frozen in a statue-like state. He recognized that these patients were survivors of a pandemic of "sleepy sickness" from 1916 to 1927. After treating them with a then-experimental drug, L-dopa, they came back to life. (They later developed tics and seizures as a result of the drug.) He wrote about this experience in his 1973 book Awakenings, later made into a play and movie. Many of the books that Sacks wrote after Awakenings described his experiences with people who had a variety of neurologically-based conditions, including Tourette's syndrome, autism, parkinsonism, musical hallucinations, epilepsy, phantom limb syndrome, schizophrenia, and Alzheimer's disease. He has been a subject of three of his books: as a doctor in Migraine, as a patient in A Leg to Stand On, and as a youth growing up in a family of gifted scientists in Uncle Tungsten: Memories of a Chemical Boyhood. The best-selling author has won numerous awards, including a Guggenheim Fellowship for his writings on the neuroanthropology of Tourette's syndrome and the Lewis Thomas Prize by Rockefeller University, which recognizes the scientist as poet. The Institute for Music and Neurologic Function of Beth Abraham Family of Health Services has honored him twice: in 2000, with its Music Has Power Award, and in 2006, in commemoration of his 40th year at Beth Abraham and for his dedication to his patients.

LECTURE 13- CELLULAR PLASTICITY CASCADES: A WINDOW INTO MOOD DISORDERS

Presenter: Husseini Manji, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to (1) Recognize that impairments of cellular plasticity cascades may play an important role in the pathogenesis and long-term course of severe mood disorders; (2) Describe the role of signaling pathways in the mechanisms of action of mood stabilizing agents; (3) Recognize that mood stabilizing agents exert neurotrophic effects, and that this is leading the development of novel therapeutics.

SUMMARY:

In recent years, research on the biological underpinnings of mood disorders has moved away from focusing on absolute changes in neurochemicals, and instead has begun highlighting the role of neural circuits and synapses, and the plastic processes controlling their function. Thus, these illnesses can best be conceptualized as genetically influenced disorders of synapses and circuits rather than simply as deficits or excesses in individual neurotransmitters. The integration of knowledge derived from different physiological and phenomenological levels continues to help move us towards a more conceptual understanding of the etiology and pathophysiology of mood disorders. A growing body of data supports the contention that mood disorders arise from abnormalities in cellular plasticity cascades, leading to aberrant information processing in synapses and circuits mediating affective, cognitive, motoric, and neurovegetative function. It is now clear that mood stabilizers/antidepressants on signaling cascades ultimately converge to regulate AMPA and NMDA synaptic transmission. Building upon these preclinical data, recent clinical trials have investigated the clinical effects of direct NMDA modulators in subjects with mood disorders. Indeed, NMDA antagonists have demonstrated remarkably rapid antidepressant effects in treatment-refractory depressed patients. These findings are leading to a reconceptualization of the necessity to accept a prolonged lag period in onset of action for the effective treatment of depression. This several week long delay in onset of action has been one of the major limitations of existing therapeutics, but emerging data are suggesting therapeutic strategies to markedly impact of the temporal course of antidepressant action. New genomics and proteomics technologies are also being utilized to facilitate the identification of genes that are regulated by antidepressants and mood stabilizers, and have led to novel and completely unexpected targets, most notably neurotrophic signaling cascades. The growing body of preclinical/clinical data suggests that for many refractory patients, optimal treatment may only be attained by providing both trophic and neurochemical support; the trophic support would be envisioned as enhancing and maintaining normal synaptic connectivity, thereby allowing the chemical signal to reinstate the optimal functioning of critical circuits necessary for normal affective functioning. There are a number of pharmacologic "plasticity enhancing" strategies being investigated that may be of considerable utility in the treatment of severe psychiatric illnesses. This research hold much promise for the development of novel therapeutics for the treatment of severe mood disorders.

REFERENCES:

1. Zarate CA, Singh J, Manji HK: Cellular plasticity cascades: targets for the development of novel therapeutics for Bipolar Disorder. Biological Psychiatry, 59:1006-1020, 2006.
2. Schloesser RJ, Huang J, Klein PS, and Manji HK: Cellular plasticity cascades in the pathophysiology and treatment of

bipolar disorder. Neuropsychopharmacology Reviews, 33: 110-133, 2008.

LECTURE 14-CONFLICTS OF INTERESTS IN PSYCHIATRIC PRACTICE AND RESEARCH

Presenter: Mario Maj, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the most common financial and non-financial conflicts of interest occurring in psychiatric practice and research, and to list currently available modalities to address them.

SUMMARY:

A conflict of interest occurs when a psychiatrist is unduly influenced by a secondary interest (i.e., a personal incentive) in his acts concerning one of the primary interests to which he is professionally committed (i.e., the welfare of patients, the progress of science, or the education of students or residents). Conflicts of interests may be potential or actual, and harmful or non-significant. They may or may not be perceived as such by the involved person. One specific variety of conflicts of interest has almost completely monopolized the attention of scientific and lay press in the past decade: the financial conflicts of interest arising from the relationships between physicians and drug companies. A large literature has described the many, sometimes subtle, ways by which a psychiatrist can be influenced in his prescribing habits, or in his research activities, by his relationships with the industry. Some empirical evidence is now available in this area. On the other hand, it has been pointed out that the current debate on this issue is sometimes "affectively charged," or fails to take into account that the interests of patients, families and mental health professionals and those of the industry may be often regarded as convergent. Other types of conflicts of interest are beginning now to be discussed. There is an emerging evidence about how the allegiance of a researcher to a given school of thought may influence the results of studies comparing different psychotherapeutic techniques, thus colliding with the primary interest represented by the progress of science. There is also a small body of literature concerning political commitment as a source of conflicts of interest. Financial and non-financial conflicts of interests are widespread in psychiatric practice and research. They cannot be eradicated, but must be managed more effectively than is currently the case.

REFERENCES:

1. Maj M: Conflicts of interests in psychiatric research and practice. Die Psychiatrie 2005; 3:138-140.
2. Fava G.A: Financial conflicts of interest in psychiatry. World Psychiatry 2007; 6:19-24.

LECTURE 15-RETHINKING MENTAL DISORDERS: HOW RESEARCH WILL CHANGE PRACTICE

Presenter: Thomas Insel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Understand recent developments in biomedical research with relevance to psychiatry, (2) Learn about the goals of predictive, preemptive, personalized, and participatory medicine, and (3) Consider how these goals can transform psychiatric practice.

SUMMARY:

The Decade of the Brain (1991-2000) established the power of studying mental experience as neural activity. Complex mental states, from emotions to decision making, were mapped on to brain circuits using powerful neuroimaging tools. During this period, mental disorders began to be understood as disorders of brain circuits, although few if any breakthroughs in neuroscience were translated to changes in psychiatric practice. The current decade (2001-2010) might be considered the Decade of Discovery as genomics and more advanced imaging tools have begun to reveal the molecular and cellular variations that contribute to individual differences. These more recent insights have begun to transform many areas of medicine and may revolutionize the diagnosis and treatment of mental disorders. This lecture will review some of the recent breakthroughs in biomedical research with promise for psychiatry. A key insight from recent research in cancer and heart disease is that many disorders can be detected at early stages of risk, often years before signs and symptoms emerge. This insight has led to the "4 Ps" as goals for translational research: predictive, preemptive, personalized, and participatory medicine. How far are we from realizing the "4 Ps" in the treatment of mental disorders? We still need predictive biomarkers for the earliest stages of mental disorders, allowing preemptive interventions that are personalized based on any individual's risk. Participatory approaches that empower the patient and family in treatments will be critical in psychiatry as much as the rest of medicine. NIMH research aims to reduce the morbidity and mortality from mental disorders by discoveries that will transform diagnosis and treatment by very early detection and preemption.

REFERENCES:

1. Insel TR, Scolnick EM: Cure therapeutics and strategic prevention: raising the bar for mental health research. Mol Psychiatry. 2006 Jan;11(1):11-7.

2. Insel TR, Quirion R: Psychiatry as a clinical neuroscience discipline. JAMA 2005 Nov 2;294(17):2221-4.

LECTURE 16-PSYCHOLOGICAL EFFECTS OF WAR: FROM THE BATTLEFRONT TO THE HOME FRONT AND BACK AGAIN

Presenter: Elspeth C. Ritchie, M.D., Col.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) Know the psychological effects of war., including PTSD and mild TBI; 2) Understand the breadth of programs to mitigate the psychological effects.

SUMMARY:

The Army is committed to ensuring all Soldiers and their Families receive the behavioral health care they need. We anticipate that repeated deployments will lead to increased distress and anxiety, and a higher demand for behavioral health services,

and are prepared to respond to that demand. An extensive array of behavioral health services has long been available to address the strain on our Soldiers and Families who have experienced multiple deployments. These services include Combat and Operational Stress Control, routine behavioral health care, and suicide prevention. Chaplains, Military One Source, and Army Community Service also offer support. All Soldiers are screened with the Post Deployment Health Assessment (PDHA) and Post Deployment Health Re-assessment (PDHRA) upon return and three to six months after return from deployment. We have new initiatives to provide outreach, education and training, including "Battlemind", updated Combat and Operational Stress Control, and RESPECT-MIL. Nevertheless there are major challenges that will face our Soldiers, their Families and the nation.

REFERENCES:

1. Ritchie EC, Owens M. Military Psychiatry, Psychiatric Clinics, September, 2004.
2. Ritchie EC, Senior Editor, Combat and Operational Behav ioral Health, Textbook of Military Medicine, Borden Pavil ion. Textbook of Military Medicine. Washington, DC: Office of The Surgeon General, US Department of the Army and Borden Institute; in press.

LECTURE 17-PTSD AND TRAUMATIC STRESS: FROM GENE TO POLICY, INDIVIDUAL TO COMMUNITY, AND TRAUMA TO DISASTER

Presenter: Robert J. Ursano, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Know the primary psychiatric outcomes related to exposure to traumatic events, (2) Understand the public health perspective on care for psychiatric illness after disaster, amd (3) Recognize the developing neurobiology of traumatic stress and traumatic event exposure and recovery.

SUMMARY:

Traumatic events are all too common in modern life. From motor vehicle accidents to rape, from devastating hurricanes and earthquakes to SARS, war and terrorism. PTSD – often best conceptualized as a disorder of forgetting- is not the only psychiatric outcome from trauma exposure, but it is perhaps our best studied. Models of PTSD that link neurobiology, environment and recovery processes are central to the future of treatment. Although resilience is the expected outcome for most exposed to traumatic events, the trajectory of recovery and chronic illness for others is less well known. Depression, altered health-risk behaviors and distress are all the target of intervention at the individual and the population level to care for those exposed to trauma and catastrophic health events. In addition, disaster behaviors, from migration to evacuation and seeking safety have health, community function, and economic consequences. Nearly one-third of those exposed to a serious motor vehicle accident develop PTSD and yet our trauma centers around the nation rarely require psychiatric evaluation. Trauma informed care is needed for primary care as well as specialty care. Understanding individual and population level risk and protective factors is important for planning care in our offices, clinics, hospitals, and communities. Recent neurobiologic models of emotion regulation, forgetting, and gene-environment interaction hold promise for our patients with PTSD and our understanding of the neuroscience of the event-brain interaction at the core of PTSD.

REFERENCES:

1. Textbook of Disaster Psychiatry Eds: R.J. Ursano, C.S. Fullerton, L Weisaeth and B. Raphael, Cambridge University Press, Cambridge UK, 2007.

2. Ursano, R.J., Li, H, Zhang, L, Hough C, Fullerton C.S, Benedek D.M, Grieger, T.A., Holloway, H.C.. Models of PTSD and traumatic stress: the importance of research "from bedside to bench to bedside", Progress in Brain Research 76: 203-215, 2008.

LECTURE 18- WHAT IS WRONG WITH OUR PATIENTS?

Presenter: Ronald O. Rieder, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be more knowledgeable about and better able to educate psychiatric trainees about the mechanisms of psychiatric illness.

SUMMARY:

Psychiatric education has recently been focused on meeting the evaluation requirements of the ACGME's Outcome Project (i.e. the core competencies), adapting evidence-based medicine principles to the psychiatric domain, and teaching newer psychotherapies such as cognitive behavioral therapy. This lecture will focus on a somewhat neglected educational area, namely, what should be taught as to the nature of psychiatric illness. In other words, "what is wrong with our patients, and what are we aiming to treat?" With biological studies of psychiatric disorders being published at a rate that defies reading them, textbooks becoming the size of encyclopedias and the outlines of *DSM-V* being debated, it is important for psychiatric educators to consider this question, and to give guidance to our residents who might otherwise have to grapple with it by themselves, or ignore the question and the dilemma our current state of knowledge poses. Some may consider the answer to the question is self-evident: patients have psychiatric disorders, and we treat these disorders. This lecture will ask that we look more closely at that conception, and consider the following possible answers to the question that is the title of this talk: 1. Disorders/Diagnoses; 2. Elements of Learning or Mind; 3. Genetic or Epigenetic Abnormalities; 4. Neural Circuits; 5. Symptoms; and 6. Nothing Is "Wrong."

REFERENCES:

1. Grob GN: Psychiatry's holy grail: The search for the mechanisms of mental diseases, Bulletin of the History of Medicine 72.2 (1998) 189-219.
2. Kupfer DJ, First MB, Regier DA: A Research Agenda for DSM-V, American Psychiatric Publishing, Inc., 2002. Inc., 2002.

LECTURE 19-SCHIZOPHRENIA AS A DISORDER OF

RECEPTOR TRAFFICKING

Presenter: James Meadow-Woodruff, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to learn about recent research findings suggesting that glutamate transmission is abnormal in schizophrenia, and in particular that intracellular handling of the receptors for this neurotransmitter may be disturbed in this illness.

SUMMARY:

Abnormalities of dopaminergic neurotransmission have long been held to be critical to understanding the pathophysiology of schizophrenia, and most treatments have targeted dopamine receptors. Recent advances have pointed to abnormalities of other neurotransmitters being involved in schizophrenia. This presentation will highlight recent findings pointing to abnormalities of glutamate transmission in this illness. While many findings of abnormal glutamate receptor expression in schizophrenia have been published, findings are subtle or even contradictory. These conflicting studies on the expression of these receptors leads to a reconsideration of the "glutamate hypothesis of schizophrenia" as not "too many" or "too few" receptors, but rather one of alterations in the cell biological processes that manage the total pool of receptors. Recent evidence points to abnormalities of glutamate receptor trafficking, delivery, dendritic localization, recycling, and degradation in the brain in schizophrenia. These recent results suggest that there are changes in glutamate receptors in schizophrenia that involve abnormalities of specific intracellular processes that effectively reduce receptor function even though total cellular levels of these receptors may be normal. While the emphasis of this presentation will be on the glutamate system, this model may be generalizeable to other neurotransmitter systems as well. Accordingly, such findings may be of considerable significance because they point to the complexity of molecular and intracellular-based abnormalities in schizophrenia, and highlight novel sites that may be profitably targeted for new drug discovery and development.

REFERENCES:

1. Beneyto M, Kristiansen LV, McCullumsmith RE, Meador-Woodruff JH: Glutamatergic Mechanisms in Schizophrenia: Current Concepts. Current Psychosis and Therapeutic Reports. 4: 27-33, 2006.
2. Beneyto M and Meador-Woodruff JH: Lamina-specific abnormalities of AMPA receptor trafficking and signaling molecule transcripts in the prefrontal cortex in schizophrenia. Synapse 60: 585-598, 2006.

LECTURE 20- SUICIDAL BEHAVIOR IN BIPOLAR DISORDER: RISK FACTORS AND INTERVENTIONS

Presenter: Maria Oquendo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify risk factors associated with suicidal behavior in bipolar disorder and have an understanding of the evidence for interventions to decrease suicide risk in this condition.

SUMMARY:

Among psychiatric conditions, bipolar disorder has the highest rates of suicide attempts. Estimates of suicide completion among bipolar patients range from 8 to 19% depending on the type of population studied. Several risk factors associated with suicidal behavior in bipolar disorder have been identified. The presence of substance abuse, aggressive behavior, and previous suicidal acts are among them. Interventions to minimize suicide risk in this condition have mostly been studied in naturalistic settings and have focused on the role of lithium. Data from the first randomized, double-blind trial of suicide attempters will be presented.

REFERENCES:

1. Galfalvy, H; Oquendo, MM; Carballo, JJ; Sher, L; Grunebaum, MF; Burke, A; Mann, JJ. Clinical Predictors of Suicidal Acts after Major Depression in Bipolar Disorder: A Prospective Study. Bipolar Disorders. 2006; 8(5 pt 2):586-595.
2. Oquendo, MA; Currier, D; Mann, JJ. Prospective studies of suicidal behavior in major depressive and bipolar disorders: what is the evidence for predictive risk factors? Acta Psychiatrica Scandinavica. 2006; 114(3):151-8.

LECTURE 21- THE NEUROBIOLOGY OF CHILD ABUSE AND NEGLECT: IMPLICATIONS FOR THE PREVENTION AND TREATMENT OF MOOD AND ANXIETY DISORDERS

Presenters: Charles Nemeroff, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) Understand HPA axis alterations in depression, (2) Understand the role of early adverse experiences on the development of depression in adulthood, and (3) Understand the long-term effects of early adverse experience on the central nervous system of adults.

SUMMARY:

Several studies have documented long-term neurobiological consequences of early adverse events in laboratory animals and man including HPA axis hyperactivity in response to stress, and reductions in hippocampal volume. This presentation will summarize new findings that confirm and extend these previous observations. When compared with women without adverse childhood experiences, cerebrospinal fluid (CSF) concentrations of oxytocin (OT), a neuropeptide known to play a role in affiliative behavior, were markedly decreased in women who experienced abuse and neglect, as well as other forms of maltreatment. Moreover, CSF concentrations of corticotropin-releasing factor (CRF) were elevated in women exposed to abuse during childhood, and was correlated with abuse severity and duration. Dex-CRF testing, a sensitive measure of HPA axis activity, revealed marked ACTH and cortisol hypersecretion in men with a history of childhood abuse, and the magnitude of the response was also correlated with abuse severity. The latter study also revealed hypersecretion of inflammatory cytokines associated with depression and child abuse. Genetic polymorphisms of the CRF1 receptor have now been identified that markedly affect the vulnerability to depres-

PRESIDENTIAL SYMPOSIA

1. TODAY'S DYNAMIC PSYCHOTHERAPY: NOT YOUR GRANDPARENTS PSYCHOANALYSIS

American Academy of Psychoanalysis and Dynamic Psychiatry

Chairperson: Joseph P. Merlino, M.D.

1. Dynamic Psychopharmacology: You ARE Doing Therapy
Cesar A. Alfonso, M.D.

2. Psychodynamics of Women's Sexuality
Jennifer I. Downey, M.D.

3. Psychodynamics of Women's Sexuality
Richard C. Friedman, M.D.

4. Psychoanalyst: Internist of the Mind
Sylvia W. Olarte, M.D.

5. The "Y" Model: Integrated, Evidence-Based Teaching of Psychotherapy Competencies
Eric M. Plakun, M.D.

6. Combining Asychotherapies: a Rational Approach to the Order of Operations
Sherry P. Katz-Bearnot, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should 1) Be aware of the interplay between biology and psychodynamic factors in understanding sexuality in female patients; 2) Be able to describe the evidence based core features that differentiate psychodynamic psychotherapy from CBT and supportive therapy within an approach that facilitates teaching all three schools of therapy;3)Be able to understand the role of therapeutic relations with a psychodynamic psychiatrist that span through years in time with varying frequency and intensity geared toward fostering beyond symptom resolution and character change; 4) Be aware of the influences of unconscious phenomenon including transference and countertransference in the provision of medication management services; and 5) Appreciate how different forms of psychotherapy, including dynamic, CBT, and supportive can be used in the same treatment case along with an awareness of the importance of the order of implementation of the various therapeutic interventions.

SUMMARY:

Sigmund Freud may have recently celebrated his 150th birthday but this panel asserts that there is nothing "old" about dynamic psychiatry. Glen Gabbard advises us that, "psychodynamic psychiatrists must situate themselves firmly in a biopsychosocial context that recognizes the need to incorporate the findings of biological psychiatry into our theories about the human mind."

This symposium presented by senior members of the American Academy of Psychoanalysis & Dynamic Psychiatry emphasizes the continued importance of the role of the dynamic therapies in contemporary psychiatric practice. Topics presented include the multifaceted therapeutic issues involved in "only doing medication management." Actual clinical situations are presented to familiarize the practitioner with the dynamic issues involved in prescribing medication. "The Y Model", an integrated, evidence based approach to teaching psychotherapy competencies will be presented allowing participants to describe the evidence based core features that differentiate psychodynamic therapy from CBT and supportive therapy within an approach that facilitates teaching all 3 schools of therapy. Issues of training during residency and during one's career will also be discussed as will novel forms of practice including "PRN dynamic therapy" akin to that of primary care medicine. The practice of "combination therapy", utilizing various approaches in tandem, will also be explored with a discussion of "when to use which therapy first."

Ample time will be allowed for audience participation in direct Q&A's after each talk and a generous allotment of time after all presentations for general discussion with the panelists and audience.

REFERENCES:

1. Plakun, EM, Finding Psychodynamic Psychiatry's Lost Gen eration, Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 2006;1:135-150.
2. Olarte, SW, The Medical Psychoanalyst in Time of Change: The Utility of PRN Therapy, Journal of the American Acad emy of Psychoanalysis and Dynamic Psychiatry, 24:3, 445-456, 1996.
3. Merlino, JP, A Royal Road from Homelessness – The Clini cal Use of Dreams, Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 30(4), 583-594, 2002.
4. Friedman RC and Downey JI, Psychoanalysis and Sexual Fantasies, Archives of Sexual Behavior, 29(6): 567-586, 2000.

2. THE LAST 25 YEARS OF WOMEN IN PSYCHIATRY: CELEBRATING THE PAST, ANALYZING THE PRESENT AND CREATING THE FUTURE

Association of Women Psychiatrists

Chairperson: Tana A .Grady-Weliky, M.D.

1. Women's Progress: Promises and Problems Revisited
Carolyn B. Robinowitz, M.D.

2.The Challenge of Change: Perspectives on Family, Work and Education in 1983, 2008 and 2033
Carol C. Nadelson, M.D.

3.The Necessity of "New Ways of Working"
Sheila Hollins, M.B.

4. Women as the Key to Integration and Wellness in Psychiatric Practice
Mary Jane England, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be able to describe: 1) changes over the past 25 years in psychiatric education and in the profession resulting from increasing leadership by women psychiatrists; 2) challenges facing women medical students, residents and practicing physicians as they address both historic and current responsibilities in their quest for personal fulfillment and career advancement; and 3) the unique contributions

by women in our profession that will be critical in collaboratively addressing some of medicine's current and future challenges.

SUMMARY:

This presentation will provide an update on the status of women in medicine. As the twenty-first century unfolds, women have become more visible in professional life and leadership positions, heading business and academic enterprises, and even mounting strong campaigns for President of the United States. Yet, inequities persist. The salary gap continues in all professions, including medicine; different specialty choices, hours worked and time spent with patients (all related in part to different socialization of women) account for only a percent of the inequities. Women are still viewed as different leaders, and often disparaged or placed in "no win" positions—if they are soft, their strength and ability is challenged, but if seen as ambitious or strong, then they are cold, unfeeling, and unfeminine.

The past quarter century has encompassed much change in the definition of family and in the role and function of women in families and in the workplace. The advent of increasing numbers of women into higher education and professional studies such as law and medicine has impacted the workplace, leading to greater accommodation to such issues as family and maternity leave, child care, flexi- time and place, and part time or shared positions. At the same time, many institutions have shown reluctance to change, and the rising percentages of women have not been reflected in the proportion of women in more senior positions in industry or academia. This presentation will consider changes in the last quarter century, their impact on individuals, families and the work place, as well as suggest directions for the next 25 years.

The Royal College established a gender working group under my leadership which agreed a Gender Equality Statement of Intent in 2004. The statement encompassed a range of concerns and affirmed its commitment to: "gender equality in the promotion and practice of psychiatry by the eradication of unlawful discrimination, and the promotion of equal opportunities with respect to its role as an employer, in the development and implementation of the standards and practice for psychiatrists, and in the development and implementation of College policies and procedures." In this talk I will focus on the changing demography in UK medicine with more than 60% of medical students and 40% of Royal College members now being women, and the particular challenges and opportunities for women, both 25 years ago and today.

A broader point of view, an incisive engagement of all constituents in American psychiatry in leadership conferences (young and old, women and men), and outreach to other professionals enabled women to open doors to integration and wellness in psychiatric practice during the 1990s. Psychiatrist Mary Jane England had been involved in clinics, hospitals, public agencies, government, academe and business when she became the third woman president of APA. Half of England's appointments to APA Committees were women and minorities. Inevitably, a resistant old guard embraced change, shifting from a focus on sickness to the broader concern of wellness, which looked at the whole of people's lives.

3. THE MYTH OF THE MED CHECK

Chairperson: Glen O. Gabbard, M.D.

1. The Myth of Med Check in Psychopharmacology
Charles B. Nemeroff, M.D., Ph.D.

2. Deconstructing the Med Check
Glen O. Gabbard, M.D.

3. Brief Medication Visits: When and How?
Alan F. Schatzberg, M.D

4. Using Targeted General Health Screening and Monitoring to Improve Outcomes and Reduce Adverse Events During Psychiatric Treatment
John W. Newcomer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the challenges inherent in a brief medication check and become familiar with new ways to maximize the therapeutic value of these clinical sessions.

SUMMARY:

The profession of psychiatry is gradually shifting towards what is known as "med check" psychiatry, involving appointments of 15 or 20 minutes focused solely on pharmacotherapy. Economic forces have contributed to this shift, and many psychiatrists have expressed concern that it compromises the clinical implementation of the biopsychosocial model of psychiatry. This symposium will present four different views on the practice and raise questions about the advisability of this model for delivery of psychiatric care. The order of the presentations will be Charles Nemeroff, Glen Gabbard, Alan Schatzberg, John Newcomer, and the discussant will be Martin Keller.

REFERENCES:

1. Gabbard GO and Kay J: The fate of integrated treatment: whatever happened to the biopsychosocial psychiatrist? Am J Psychiatry 158: 1956-1963
2. Schatzberg AF; Rush AJ, Arnow BA; Medication (Nefazo done) or Psychotherapy (CBASP) Is Effective When the Other Is Not. Arch Gen Psychiatry. 2005;62:513-520

4. ADVOCATING WITH ONE VOICE FOR MENTAL HEALTH CARE IN THE UNITED STATES AND UNITED KINGDOM

Chairpersons: Sheila Hollins, M.B., Carolyn B. Robinowitz, M.D.

1. Advocating for Mental Health in Primary Care
Roger Banks, M.D.

2. Advocacy as an Aspect of Professionalism
Dinesh Bhugra, M.D. Ph.D.

3. Advocacy through partnerships with users, carers and Non Governmental Organisations
Sue Bailey, M.D.

4. Advocacy for Government Support for Research And Funding of Mental Health Programs in the United States
Steven S. Sharfstein, M.D.

5. Enhancing Public Awareness on Mental Health by working with the Media in the U.S.
Nada L. Stotland, M.D.

6. Anti-Stigma Campaigns with the aid of Patient/Consumer Groups and High-Profile Individuals in the U.S.
Donna M. Norris, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) become familiar with mental health policies in the United States and United Kingdom; 2) to learn the legislative processes for mental health care changes in the U.S. and UK; 3)to learn how to develop anti-stigma campaigns in the U.S. and UK; and 4) become familiar with media strategies to enhance awareness on mental health issues in the U.S. and UK.

SUMMARY:

The American Psychiatric Association and Royal College of Psychiatrists confront similar concerns in advocating for our patients. Advocacy in the United States and United Kingdom is a very important way for both organizations to shape public policy. These efforts may include lobbying, networking and media campaigns, and promotion of funding, research and education. Other techniques may be used such as educating lawmakers and building coalitions, and working with patient and consumer groups to achieve objectives. Grass-roots lobbying may consist of advocacy on specific legislation and communicating the views of the organization as well as providing information and analysis to legislators and government officials on critical issues. Professional societies compete with other interest groups for the time and attention of policymakers. The number of interest groups has greatly increased in recent years making competition more difficult. This symposium will address how the American Psychiatric Association and Royal College of Psychiatrists can work together to achieve the best outcomes for our patients. Experts from both countries will highlight the key steps that are being taken to ensure that our goals are met.

REFERENCES:

1. Perlick DA, Miklowitz DJ, Link BG et al. Perceived stigma and depression among caregivers of patients with bipolar disorder: The British Journal of Psychiatry. 2007 June: 190: 535-536.
2. Leavey G, King M: The devil is in the detail: partnerships between psychiatry and faith-based organizations. The Brit ish Journal of Psychiatry. 2007 August: 191: 97-98.
3. Day SI: Issues in Medicaid policy and system transforma tion: recommendations to the President's Commission. Psy chiatric Services. 2006 December: 57(12): 1713-1718.
4. Mazade NA, Glover RW: State mental health policy: Pri orities confronting state mental health agencies: Psychiatric Services. 2007 September: 58(9): 1148-1150.
5. Busch K, Batterson B: Area 4 builds effective strategy for influencing political process. Psychiatric News. 2007 June: 43(11):22.
6. Popkin SL: Changing media, changing politics. Perspectives in Politics. 2006 June: 4(2): 327-341.

SMALL INTERACTIVE SESSIONS

SMALL INTERACTIVE 01-MEET THE AUTHOR GROUP DISCUSSION: PROFESSIONALISM AND ETHICS: Q & A SELF-STUDY GUIDE FOR MENTAL HEALTH PROFESSIONALS

Presenter: Laura W. Roberts, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to resolve professional and ethical questions in alignment with an understanding of ethical principles, the standards of their fields, the law, and the expectations of mental health professionals.

SUMMARY:

This first book of its kind for the medical profession brings the real-world translation of ethics to the care of patients, conduct of protocols, and training of professionals. An interactive, case-oriented approach to mental health ethics, Professionalism and Ethics: Q & A Self-Study Guide for Mental Health Professionals consists of questions and answers developed by the authors and fourteen contributors from backgrounds as diverse as family medicine, research ethics, social psychology, and public health. The brief case descriptions that frame each ethical question echo the real-life complexities of clinical practice and are presented in single-answer, multiple-choice format modeled after key medical licensure and specialty certification organizations. Following an overview of ethics and professionalism, questions cover four broad areas: core concepts, clinical care, medical research, and interactions with colleagues and trainees. Explanations following the questions offer background information about relevant ethical concepts and related legal and clinical considerations. A subsequent section features another set of questions for self-assessment, followed by answers with citations to appropriate references. The book's overall approach is geared to underscore the following areas of concern: essential ethical skills, such as understanding how personal values affect patient care, recognizing high-risk situations in which ethical problems arise, and building ethical safeguards. Core ethical principles, including nonmaleficence, beneficence, autonomy, respect, justice, veracity, fidelity, and privacy will be convered. Key clinical ethics issues, including maintaining therapeutic boundaries, patient non-abandonment, informed consent and treatment refusal, alternative decision making and advance directives, confidentiality, reporting colleague misconduct, and caring for difficult patients.

REFERENCES:

1. Roberts LW, Hoop JG: Professionalism and Ethics: Q & A Self-Study Guide for Mental Health Professionals. American Psychiatric Press, Inc.: Washington, DC, 2007 (in press).
2. Roberts LW, Dyer AR: Concise Guide to Ethics in Mental Health Care. American Psychiatric Press, Inc.: Washington, DC, 2004.

SMALINTERACTIVE 02-ADDICTION AND THE BRAIN

Presenter: Nora Volkow, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the particpants will know about the brain circuits involved in addiction and the implications these findings have for successfully treating addiction and preventing relapse.

SUMMARY:

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

REFERERENCES:

1. Baler RD, Volkow ND. Drug Addiction: the neurobiology of disrupted self-control. Trends Mol Medicine 12(12): 559-566, 2006.
2. Kalivas PW, Volkow ND. The neural basis of addiction: a pathology of motivation and choice. Am J Psychiatry 162:1403-1413, 2005.

SMALL INTERACTIVE 03- GRADUATION AND THE PGY4 RESIDENT: CLINICAL AND ETHICAL CHALLENGES IN TERMINATING WITH PATIENTS AT THE END OF TRAINING

Presenter: Joan Anzia, M.D.

EDUCATIONAL OBJECTIVES:

By the end of this interactive session, residents at all levels will achieve a better awareness of the challenges of working through the process of planned terminations with many patients at the end of training, and prepare more thoughtfully for these events.

SUMMARY:

End of training is one of the three most stressful periods during psychiatry residency. While residents generally experience a sense of accomplishment, satisfaction, and excitement as they approach graduation, they often do not anticipate the rollercoaster of other emotions. One of the most difficult of these is sadness at the loss of classmates, colleagues, mentors, teachers – and of the patients with whom they learned their skills. In addition,

residents never truly know how much they have meant to their patients until the termination process begins; this awareness can have a profound impact on the resident's professional identity. Residents can benefit from active assistance in negotiating terminations – their own and their patients – in the last six months of training. This supervision should cover a number of dimensions: (1) practical issues such as how/when to schedule the last sessions and whether patients need to be transferred – and to whom, (2) management of one's own schedule as graduation approaches, (3) clinical issues regarding patients' responses to termination (including possible crises, premature departures, gifts, etc.), (4) countertransference issues (especially guilt and sadness), and (5) ethical concerns about primacy of patient welfare and safety. This process can be facilitated through scheduled, active-group supervision with a trusted faculty member, and can result in a richer, more positive learning experience for trainees as well as patients. This interactive session will be an open discussion covering these issues faced by senior residents.

REFERENCES:

1. Roberts L, Dyer A: Ethics: Principles and Professionalism, Ethics in Mental Health Care; American Psychiatric Publishing, Inc. 2004
2. Gabbard G: Working Through and Termination; Long-Term Psychodynamic Psychotherapy; American Psychiatric Publishing, Inc. 2004.

SMALL INTERACTIVE 04-AUTISM AND IMPULSE CONTROL DISORDERS

Presenter: Eric Hollander, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify key clinical symptoms in autism and impulse control disorders, their link to underlying neurobiological mechanisms and identify new pharmacological treatments for specific symptom dimensions.

SUMMARY:

Autism and impulse-control disorders are highlighted and overlap in clinical symptoms, neurobiology, and treatment are described.

REFERENCES:

1. Hollander E, Anagnostou E (eds.): Clinical Manual for the Treatment of Autism. Washington DC: American Psychiatric Publishing, Inc., 2007
2. Hollander E, Stein DJ (eds.): Clinical Manual of Impulse Control Disorders. Washington DC: American Psychiatric Publishing, Inc., 2006.

SMALL INTERACTIVE 06- THE PSYCHIATRIST AS ADVOCATE FOR FAMILY MEMBERS AND CONSUMERS

Presenter: Suzanne Vogel-Scibilia, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to articulate ways to advocate for patients and their families in a way that is consumer and family member oriented and empowering. The participant will be able to discuss the status of current advocacy agendas for U.S. patients and be able to delineate strategies in his/her practice to assist in this process.

SUMMARY:

This small interactive discussion will provide participants with ideas for supporting advocacy by the clinician and for the consumers and family members in grassroots psychiatric practice. Educational discussion will also focus on the use of easily obtainable videos to enhance dialogues with family members and consumers.

REFERENCES:

1. Lefly HP, and Vogel-Scibilia SE: "Consumer Advocacy and Self-Help in the psychological Treatment of Bipolar Disorder. - Edited by Johnson SL, Leahy RI, Guilford Press, October 2003.
2. Frese FJ, Stanley J, Kress K, Vogel-Scibilia SE: Integrating Evidence Based Practices and the Recovery Model, Psychiatric Services, 2001 November, 52 (11) 1462-8.

SMALL INTERACTIVE 07-AN OVERVIEW OF THE ROLE OF PSYCHIATRISTS IN PAIN MEDICINE: TREATING THE COMPLEX PAIN PATIENT

Presenter: Raphael J. Leo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to provide a brief overview of the role of psychiatrists as well as other mental health practitioners in evaluation and assessment, pharmacological management, psychotherapeutic interventions, and comprehensive treatment planning for patients with complex chronic pain.

SUMMARY:

Despite the pervasiveness of chronic pain, most individuals with chronic pain can nonetheless maintain basic functioning in work, relationships and interests. Small proportions of patients with chronic pain are entirely debilitated by the pain and are sometimes referred to as having complex chronic pain. In this subset, one's life becomes centered on pain and disability and being a patient becomes a primary psychosocial state. Numerous psychological factors beset the patient with complex pain, many of which can exacerbate and maintain pain. Patients' experiences of suffering, their language and behaviors, and the neurobiological conception of nociception support a psychological component of pain. Current conceptualizations of pain medicine adopt a biopsychosocial perspective. Pain is viewed as an experience with biological, psychological, and social derivatives. The goal of treatment utilizing the biopsychosocial paradigm addresses relief from pain, while simultaneously addressing the impact of the pain condition on other aspects of one's functioning, relationships, vocational adaptations, and emotional well-being. Comprehensive pain treatment programs involving interdisciplinary, multi-modal treatment approaches become essential to address symptom relief, but also to mitigate related mood disturbances, improve adaptive functioning, and reduce life dissatisfaction that accompanies such complex pain states. Comprehensive pain

treatment programs have emerged as the most efficacious and cost-effective means of addressing chronic pain, even among the most recalcitrant patients. This session will discuss the multiple and varied functions of the psychiatrist enlisted to care for the complex pain patient pivotal to the biopsychosocial approach.

REFERENCES:

1. Leo RJ: Clinical Manual of Pain Management in Psychiatry. American Psychiatric Publishing, Inc. Washington, DC, 2007.

SMALL INTERACTIVE 08-CAREER ISSUES FOR THE ACADEMIC PSYCHIATRIST

Presenter: Jonathan F. Borus, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the major professional issues involved in a career in academic psychiatry.

SUMMARY:

This small interactive session will discuss any or all of the following as decided by the participants: (1) Stages in the life of an academic psychiatrist; (2) Career ladders in academic psychiatry; (3) Finding a mentor/sponsor and putting yourself forward; (4) Balancing teaching, research, clinical work, and administrative leadership; (5) Publication; (6) Promotion; and (7) Balancing one's professional and personal life.

REFERENCES:

1. Borus JF: The chair's work: fun, but never done. Acad Psychiatry 2003;27:215-217.
2. Borus JF: Writing for publication. In: Kay J, Silberman ER, Pessar L, eds. Handbook of psychiatric education and faculty development. Washington, DC: American Psychiatric Press, Inc., 1999:57-93.

SMALL INTERACTIVE SESSION 09-HOW NEUROIMAGING HAS CHANGED OUR VIEW OF DEPRESSION

Presenter: Helen S. Mayberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Appreciate the range of neuroimaging strategies and findings in patients with major depression, (2) Identify the distinct scan changes associated with different antidepressant treatments; and (3) Understand the scientific rationale for targeting the subcallosal cingulate white matter using deep brain stimulation (DBS) as a treatment for intractable major depression.

SUMMARY:

Functional neuroimaging has provided an important platform to define critical brain circuits involved in both depression pathogenesis and treatment response. Variability among different depressed patient cohorts as well as differential changes seen across different antidepressant interventions will be discussed in the context of the limbic-cortical network model of depression. Findings will be considered from this perspective highlighting disease, state, and treatment-specific effects using pharmacotherapy, cognitive-behavioral therapy, and deep brain stimulation. Strategies to further characterize scan-pattern variability are highlighted as a critical next step toward the eventual development of imaging-based clinical algorithms to optimize treatment selection in individual patients.

REFERENCES:

1. Goldapple K, Segal Z, Garson C, Lau M, Bieling P, Kennedy S, Mayberg H: Modulation of cortical-limbic pathways in major depression: treatment specific effects of CBT. Arch Gen Psych 61:34-41, 2004.
2. Mayberg, HS, Lozano A, Voon V, McNeely H, Seminowicz D, Hamani C, Schwalb J, Kennedy S: Deep brain stimulation for treatment resistant depression; Neuron, 2005; 45: 651-660.

SMALL INTERACTIVE 10-RECOVERY FROM DISABILITY: REHABILITATION IS THE MISSION

Presenter: Robert P. Liberman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able acquainted with practice-based evidence for rehabilitation of disabling mental disorders. They should be familiar with practicing recovery-oriented, person-centered services including; motivational goal setting, illness self-management, social skills training, teaching families effective communication and problem-solving.

SUMMARY:

Recovery from serious and persisting mental disorders can be defined by functional and experiential criteria. Just as in other medical diseases where recovery signifies a return to active participation in the social, family, work, and recreational realms of life, recovery from a severe mental disorder subsumes that the individual is capable of reasonably normal life functioning. Recovery is the vision and rehabilitation is the mission. Rehabilitation offers clinicians the tools for teaching the skills and mobilizing the professional and natural supports for patients' stepwise progression to functional and meaningful lives. In rehabilitation, the clinician is also a teacher, providing learning opportunities to patients for acquiring and using social and independent living skills. In teaching skills, clinicians use special education techniques that capitalize on the plasticity of the brain and its intact capacities for procedural learning and memory that can compensate for cognitive impairments. Supportive services, such as involvement of family in education programs, self-help programs, supported employment and education, and personal support specialists offer continuity, coordination, and collaboration so that skills will be used effectively in community environments. Recovery also has a subjectively experienced set of attributes. As more functional patients move along the road to recovery from symptoms, cognitive deficits, and disability, they feel empowered to make choices in their goals and treatments, hope for a better future, value and self-efficacy, self-responsibility for medication and money management, and enjoying their improved quality of life that comes with self-directed goals, normalized social roles, meaningful activities, and optimal independent living. The session will include

demonstrations and clinical exercises that will illuminate the functional and experiential dimensions of recovery.

REFERENCES:

1. Liberman RP: Recovery from Disability: Manual of Psychiatric Rehabilitation. Arlington VA: Amer Psychiatric Publishing, 2008
2. Liberman RP, Kopelowicz A: Recovery from schizophrenia: a concept in search of research, Psychiatric Services 56:735-742, 2005.

SMALL INTERACTIVE 11- RESEARCH IN MENTAL HEALTH

Presenter: Thomas Insel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Understand current priorities for research in mental health, (2) Identify opportunities for funding and training, and (3) Recognize the two forms of translation research required to transform practice.

SUMMARY:

This interactive session will feature a discussion with the Director of the NIMH on current priorities for research. The NIMH has a new strategic plan that aims to transform practice in the coming decade by bringing genomics, biomarkers, and neuroscience to the diagnosis, prevention, and treatment of mental disorders. This plan conceptualizes mental disorders as developmental brain disorders and identifies the potential for detecting biomarkers of risk years before symptoms emerge. Research offers an opportunity not only for earlier diagnosis but for earlier interventions, with the promise of better outcomes. A new generation of interventions, some based on identifying molecular and anatomic targets and others based on emerging web-based technologies, are focusing on functional outcomes such as recovery and remission rather than simply the reduction of symptoms. At the same time research will be developing new diagnostics and interventions, NIMH recognizes the urgent need to do better with treatments that we have today. Defining optimal pathways for dissemination and implementation of the best current treatments to a diverse community is also a priority for research. If bench to bedside is the first arm of translation, bedside to practice is the second, equally important arm. By developing both arms of translational research, NIMH supports the research that will transform practice and provide the greatest opportunity for those with mental disorders to lead full and productive lives.

REFERENCES:

1. Insel TR, Scolnick EM: Cure therapeutics and strategic prevention: raising the bar for mental health research. Mol Psychiatry 2006 Jan;11(1):11-7.
2. Insel TR, Quirion R: Psychiatry as a clinical neuroscience discipline. JAMA 2005 Nov 2;294(17):2221-4.

SMALL INTERACTIVE 12-CLINICAL ASPECTS OF GENETICS AND GENOMICS

Presenter: David Mrazek, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) Understand the basic principles guiding the selection of pharmacogenomic testing; (2) Select antidepressant medication with a lower probability of patient intolerance; and (3) Interpret atypical genotypic results to patients.

SUMMARY:

Pharmacgenomic testing is increasingly available to clinicians to provide patient specific information that will improve the safety of psychotropic medication management. The most immediate benefit is the prevention of adverse drug reactions. However, a potentially more significant benefit is the identification of patients who are unlikely to benefit from specific psychotropic medications.

REFERENCES:

1. Kirchheiner J, Nickchen K, et al. (2004) Pharmacogenetics of antidepressants and antipsychotics: the contribution of allelic variations to the phenotype of drug response. Mol Psychiatry, 9, 442-473.
2. Mrazek DA. (2006) Psychiatric pharmacogenomics. Focus IV (3): 339-343

SMALL INTERACTIVE 13-CHILD AND ADOLESCENT PSYCHOPHARMACOLOGY- MEET THE AUTHOR

Presenter: Robert L. Findling, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss fundatmental principals pertinent to the clinical practice of pediatric psychopharmacology.

SUMMARY:

This session will give attendees the chance to discuss the content of the book Dr. Findling has edited entitled "Manual of Clinical Child and Adolescent Psychopharmacology."

SMALL INTERACTIVE SESSION 14-INTEGRATING THE OLD WITH THE NEW IN THE LONG-TERM MANAGEMENT OF RECURRENT AFFECTIVE DISORDERS

Presenter: Fred K. Goodwin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) Understand the importance of including a family member during patient evaluations; (2) Understand the concept of the affective spectrum and appreciate cyclicity as an important parameter independent of polarity; (3)Choose the best stabilizer regimen for long-term prophylaxis based on the individual clinical picture; and (4) Understand both the risks and benefits of the adjunctive use of antidepressants for bipolar patients.

SUMMARY:

This presentation will review the diagnosis and differential di-

agnosis of recurrent mood disorders with an emphasis on depression. Then we will review the data supporting the prophylactic effect of the most well, established mood stabilizer – lithium – with an emphasis on its role in preventing or attenuating depressive episodes and suicide. These data will then be compared with the results for the new mood, stabilizer candidates from the anticonvulsant class and the atypical antipsychotic class. The major unmet public health need for patients with recurrent affective disorder, either bipolar or unipolar, is an effective agent against depression that does not trigger mania or destabilize the course of the illness. Since depression represents the great bulk of the morbidity associated with recurrent affective disorder, the finding that lamotrigine can reduce relapses into depression without activating mania or cycles is quite important, as is the finding of an acute antidepressant effect of quetiapine. Special emphasis will be given to the use of combination treatments – particularly those whose mechanisms of action suggest biological synergy. Then, the risk–benefit ratio for the use of antidepressants in bipolar patients will be discussed. Finally, we will address the question of what do we really know about the prevention of new episodes of recurrent unipolar depression, as opposed to simply preventing relapse back into an acute episode after it's successful treatment.

REFERENCES:

1. Goodwin FK, Jamison KR: Manic-Depressive Illness: Bipolar Disorders and Recurrent Depression. New York: Oxford University Press, 2007.
2. Calabrese JR, Goldberg JF, Ketter TA, Suppes T, Frye M, White R, DeVeaugh-Geiss A, Thompson TR: "Recurrence in bipolar I disorder: a post-hoc analysis excluding relapses in two double-blind maintenance studies. Biological Psychiatry 2006 Jun 1; 59(11): 1061-4.

SMALL INTERACTIVE 15-PSYCHIATRIC GENETICS: APPLICATIONS IN CLINICAL PRACTICE

Presenter: Jordan W. Smoller, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the role of genetic factors in psychiatric disorders and clinical implications of genetic knowledge.

SUMMARY:

The pace of research in genetics and genomics has been accelerating over the past decade. And yet it is clear that we are only beginning to decipher the text that emerged from the sequencing of the human genome in 2001. Nevertheless, a combination of hope, hype, and genuine scientific discovery has created the expectation that genetic research will reveal fundamental insights into the etiology and pathophysiology of a broad range of medical illnesses, including psychiatric disorders. As of this writing, however, few specific genes have been established as contributing to the development of neuropsychiatric disorders. What justification can there be, then, for a book addressing clinical aspects of psychiatric genetics? This book was intended to address several issues that have received little attention elsewhere and that we believe are of importance to clinicians. First, the bewildering array of reported findings in genetics as a field and psychiatric genetics in particular can be difficult, even for researchers in the field to keep up with.

The book provides an accessible guide to understanding the meaning and limitations of genetic discoveries. Second, even without identified susceptibility genes, the importance of familial and genetic factors in psychiatric illness has been established by family, twin, and adoption studies. Another aim of this book, then, is to provide a resource for clinicians who would like more information about the role and content of genetic counseling in psychiatry. Third, there is a body of knowledge regarding the familial risk and genetic basis of psychiatric disorders that we believe is valuable for clinicians to be aware of. Over a series of chapters, the book reviews substantive information about the genetics of mental illnesses and implications for genetic counseling. Finally, the book addresses key ethical, legal, and social implications of genetic research as well as the issues relevant to clinical practice that may emerge in the coming years, including the prospects for genetic testing and personalized medicine.

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1. Smoller JW, Rosen-Sheidley B, and Tsuang MT (eds): Pschi atric Genetics: Applications in Clinical Practice. American Psychiatric Publishing, Inc. Arlington, VA (in press).
2. Finn C, Smoller JW: Genetic counseling in psychiatry. Harv Rev Psychiatry 2006 Mar-Apr;14(2):109-21.

INDEX

A

Abdulrahman, Abdullah ..... Symposium 41
Abenojar,Jimmark ..... Component Workshop 39
Abi-Dargham, Anissa ..... ISS-18 Part 1
Abrams, Karen ..... Symposium 55
Adams, Neal ..... Symposium 72
Addington, Jean ..... Symposium 50
Adler, Karoline ..... Symposium 52
Afkhami, Amir ..... Issue Workshop 59
Ahmad, Samoon ..... Issue Workshop 11
Ahmed, Iqbal ..... Component Workshop 53
Aizenstein, Howard ..... Symposium 27
Akbarian, Schahram ..... Symposium 1
Akerele, Evaristo ..... Component Workshop 25
Akiskal, Hagop ..... Symposium 42
Akiyama, Tsuyoshi ..... Issue Workshop 61
Akman, Jeffrey ..... Component Workshop 42
Alarcon, Renato D. ..... Forum 11
Albrecht, Suzanne ..... Component Workshop 31
Alexopoulos, George ..... Symposium 62, 27
Alfonso, Cesar ..... Presidential Symposium 1
Ali, Farhana ..... Symposium 24
Allen, Jon ..... Symposium 81
Altchuler, Steven ..... Forum 10
Altshuler, Lori ..... Symposium 39
Al-Zuri, Mohammed ..... Issue Workshop 81
Ancoli-Israel, Sonia ISS-9
Andersen, Grethe ..... Symposium 75
Anderson, Allan ..... Component Workshop 45
Anderson, III Otis ..... Component Workshop 39, Issue Workshop 13
Andrade, Naleen ..... Issue Workshop 2, 75
Annan, Jeannie ..... Symposium 15
Ansell, Emily ..... Symposium 53
Anwar, Saman ..... Issue Workshop 59
Anzia, Joan ..... Symposium 19
Appelbaum, Paul ..... Component Workshop 54, Issue Workshop 20, Symposium 5, 49, 52, 77,86
Apter-Danon, Gisèle ..... Symposium 62, 17
Arboleda-Florez, Julio ..... Issue Workshop 68
Arnaout, Bachaar ..... Issue Workshop 27
Arnold, Lesley ISS-4, 9
Aron, Laudan ..... Forum 16
Aronne, Louis ..... ISS- 23
Arora, Lily ..... Issue Workshop 27
Arroyo, William ..... Component Workshop21,32 Symposium 85
Asarnow, Joan ..... Symposium 59
Aziz, Rehan ..... Symposium 80

B

Bahnson, Brenda ..... Issue Workshop 38

Bailey, Rahn ..... Component Workshop 23, Symposium 30,
Bark, Nigel ..... Symposium 92
Baron, David ..... Symposium 23
Barsky, Arthur J. ..... Symposium 7
Bass, Judith ..... Symposium 15
Bateman, Anthony ..... Symposium 81, 31
Bath, Eraka ..... Component Workshop 19
Bauer, Amy ..... Issue Workshop 95
Baum ,Antonia ..... Symposium 13
Beah ,Ishamael ..... Symposium 15
Beardslee, William ..... Symposium 6
Beck, Judith ..... Issue Workshop 51, 40
Beezhold, Julian ..... Issue Workshop 48, 76
Belfer, Myron ..... Component Workshop13, Symposium 15
Belfort, Edgard ..... Forum 11
Bell Carl ..... Component Workshop 12, Symposium 43
Bell, Karen ..... Forum 10
Bellamy, Chyrell ..... Symposium 70
Bender, Donna ..... Symposium 53
Benedek, David ..... Case Conference 1, Forum 8
Benedek, Elissa ..... Issue Workshop 15
Benedek, Lana ..... Issue Workshop 104, 24
Benedict, Kennette ..... Media Presentation 1
Benton, Brian T. ..... Symposium 30
Berko, Anat ..... Symposium 24
Berkowitz, Steven ..... Issue Workshop 19
Berlin, Richard ..... Issue Workshop 14
Bernet, William ..... Symposium 44
Berns, Gregory ..... Symposium 58
Bernstein, Robert ..... Symposium 49
Berrettini, Wade ..... Symposium 20
Berry, Courtney ..... Issue Workshop 82
Bhugra, Dinesh ..... Symposium 19
Bialer, Philip ..... Symposium 30 Component Workshop 22
Bickel, W ..... Issue Workshop 92
Biederman, Joseph ..... ISS-8, Symposium 8
Billick, Stephen ..... Component Workshop 19
Bisaga, Adam ..... Symposium 38
Bishry, Zeinab ..... Issue Workshop 70
Björgvinsson, Thröstur ..... Symposium 81
Black, Donald W. ..... Symposium 37
Black, Jaques ..... Issue Workshop 31
Blair, Karina ..... Symposium 18
Blair, James ..... Symposium 18
Blaustein, Mel ..... Component Workshop 24
Blazer, Dan ..... Component Workshop 50 Lecture 22
Bloch, Andrew ..... Issue Workshop 83
Block, Jerald ..... Issue Workshop 25, Symposium 29
Blumberg, Hilary ..... Symposium 35
Bober, Daniel ..... Component Workshop 40,51
Bobo, William ISS-24
Bogdanich, Radmila ..... Issue Workshop 115
Bokarius, Anna ..... Issue Workshop 118
Boland, Robert J. ..... Issue Workshop 29
Bonnie, Richard ..... Symposium 49
Book, Howard ..... Issue Workshop 52
Boothby, Neil ..... Symposium 15
Booty, Andrew ..... Issue Workshop 7
Boronow, John ..... Forum 10, Component Workshop 31
Borus, Jonathan ..... Small Interactive 8
Boutaeva, Zinaida ..... Issue Workshop 27
Boyer, Edward ..... Issue Workshop 72

INDEX

Brada, Kay .....Component Workshop 12
Bradley, John.....Forum 12
Brady, Kathleen.....Advances in1,Symposium40
Braziel, Farrell .....Component Workshop 31
Bregman, Joel .....Component Workshop 14
Brendel, Rebecca .....Issue Workshop 20
Brent, David.....Symposium 59
Bret, Mary .....Component Workshop 53
Broadway, Jessica .....ISS- 25 Part 1
Brook, David.....Component Workshop 41
Brooks, Beth Ann.....Issue Workshop 75
Bruce, Travis .....Issue Workshop 084
Buchanan, Alec .....Component Workshop 44
Buckley, Peter .....Focus Live 2, Forum 07
Bui, Thu .....Symposium 72
Bukstein, Oscar.....Symposium 03
Bunney, William .....Symposium 26
Burd, Ronald.....Component Workshop 45
Burdick, Katherine.....Symposium 65
Burke, Jeffrey .....Symposium 8
Burkholder, Page.....Issue Workshop 044
Burns, Kathryn.....Component Workshop 46
Burroughs, Tracee.....Component Workshop 10
Bursztajn, Harold J.....Issue Workshop 65
Burt, Vivien.....ISS- 1
Burt, Donald.....Issue Workshop 10
Busch, Alisa .....ISS- 17 Part 1
Bush, George.....ISS- 8
Buwalda, Victor .....Forum 2, Issue Workshop 48, 89, Symposium 83
Buysse, Daniel .....ISS- 16 Part 1
Bybel, Barbara-Ann .....Issue Workshop 83

C

Cabaj, Robert .....Symposium 63
Cadenhead, Kristin.....Symposium 50
Caffo, Ernesto .....Component Workshop 13
Cagande, Consuelo .....Symposium 33
Caivano, Norana .....Issue Workshop 28, 43, 91
Calabrese, Joseph.....ISS 27
Callahan, William .....Issue Workshop 35, 42, Symposium 47
Camarena, Enrique.....Forum 11
Campbell, Jamae.....Component Workshop 30
Campbell, Nioaka .....Component Workshop 42
Campbell, William .....Issue Workshop 21
Cannon, Tyrone.....ISS-11
Capps, Randolph.....Symposium 89
Carlson, Gabrielle .....Issue Workshop 105
Caroff, Stanley .....Symposium 56
Carpenter, Willaim .....ISS- 02
Carpenter, Ken .....Symposium 38
Carroll, Brendan.....Symposium 28
Casey, David .....Component Workshop 35
Cash, Charles .....Issue Workshop 88
Casimir , Georges.....Issue Workshop 85
Castellanos, Daniel .....Component Workshop 49
Castilla-Puentes, Ruby.....Symposium 64
Certa, Kenneth .....Component Workshop 34, Issue Workshop 111
Cerullo, Cathy.....Media Presentation 4
Chaisson, Anne-Marie.....Symposium 87
Champagne, Frances.....Symposium 54
Chan, Pauline .....Symposium 72
Chang, Kiki.....ISS- 18 Part 1
Chappin, Sean .....Media Presentation 4
Chatoor, Irene.....Component Workshop 2
Chaudhry, Haroon .....Issue Workshop 61
Chen, David .....Component Workshop 2
Chen, Chiao-Chicy.....Issue Workshop 61
Chessick, Richard .....Forum 6
Childress, Ann Rose .....Issue Workshop 92
Choi-Kain, Lois.....Symposium 66
Clarke, David .....Symposium 57
Clarke, Greg.....Symposium 59
Clarkin, John .....Symposium 31, 66
Clauw, Daniel.....ISS-4, 9, 29, Symposium 7
Clayton, Paula .....Symposium 9
Clerisme, Joseph .....Issue Workshop 85
Cohen, Lee S.....ISS-14
Cohen, Mary Ann.....Symposium 78
Cohen , Carl .....Component Workshop 53, Symposium 48
Cohn, Tony.A .....Symposium 61
Colenda, Christopher .....Issue Workshop 2, 75
Collins, Pamela .....Component Workshop 9
Combrinck-Graham, Lee .....Component Workshop 41
Compton III, Wilson .....Issue Workshop 12, Symposium 6
Conant-Norville, David.....Symposium 13
Condon, Timothy .....Issue Workshop 72
Conley, Robert R.....ISS-15
Cook, Renee.....Issue Workshop 18
Cora , Gabriela.....Component Workshop 47
Cordoba, Rodrigo.....Forum 11
Coric, Vladimir .....Symposium 76
Cornblatt , Barbara.....ISS-7
Correll , Christoph ISS-12
Coryell, William.....Symposium 42
Costa, Paul .....Symposium 37
Cournos, Francine.....Component Workshop 30
Cournos, Francine.....Issue Workshop 7 Symposium 78
Cowan, Christopher .....Symposium 54
Cox, John .....Symposium 92
Cozza, Stephen.....Issue Workshop 19
Crocker, Robert.....Symposium 87
Crowe, Samantha .....Symposium 18
Cullen, Kathryn.....ISS-7
Currier, Glenn .....Symposium 96
Cutler, Andrew .....Issue Workshop 98
Czaban, Brenda.....Issue Workshop 71

D

Dadabhoy, Dina.....ISS- 9
Dagostino, Lisa .....Symposium 85
D'Alli, Richard .....ISS 28
Dalton, Richard.....Issue Workshop 57
Dang, Kien .....Issue Workshop 24, 104
Davae, Umee.....Component Workshop 22, 52
Dave, Subodh.....Issue Workshop 79
Davidson, Larry .....Symposium 70

INDEX

Davine, Jon .....Issue Workshop 5, Symposium 36
Davis, Glen .....Symposium 15
Davis, Rachel .....Component Workshop 1
Davis, Maryann.....Issue Workshop 66
Daviss, Steven.....Component Workshop 15, Issue Workshop 25
Day, Max.....Issue Workshop 065
de Figueiredo, John.....Symposium 57, Component Workshop 14
DeFrancisci Lis, Lea .....Component Workshop 21
Del Paggio, Douglas .....Symposium 72
delBusto, Elena .....Symposium 82
Desai, Prakash.....Issue Workshop 73
Dewan, Mantosh .....Issue Workshop 45, Symposium 88
Dewar, Amy .....Issue Workshop 99
Dhaliwal , Navdeep.....Component Workshop 9
Dick, Danielle ISS-11
Dickerson, Daniel .....Component Workshop 20
Dickson, Lesley.....Issue Workshop 34
Dickstein, Leah .....Presidential Symposium 2, Issue Workshop 71, 107
Diller, Kathleen.....Issue Workshop 41
Dimsdale, Joel.....Forum 03, Symposium 14
Dobbins, Mary .....Issue Workshop 115
Doghramji, Karl .....ISS- 21, Symposium 82
Donovan, Abigail .....Issue Workshop 48
Douaihy, Antoine .....Symposium 78
Dougherty, Kathleen .....Issue Workshop 111
Douglas, Carolyn .....Issue Workshop 7
Downey, Jennifer .....Presidential Symposium 1
Doyle, Robert.....Symposium 98
Drake, Robert.....Symposium 70
Drevets, Wayne .....Symposium 35
Drossman, Douglas.....Symposium 7
Drubetskiy, Denis.....Issue Workshop 27
Dsouza, Anjali.....Issue Workshop 96
D'Souza, Russell.....Issue Workshop 61
Dube, Sanjay.....Component Workshop 7
Dubovsky, Steven .....Advances in 2
Duckworth, Kenneth S.....Forum 16
Dunkelblau, Ed .....Issue Workshop 118
Dunn, Laura B.....Symposium 86
Dyer, Allen.....Issue Workshop 81

E

Earley, Pete .....Lecture 7
Egnatz, Dennis .....Issue Workshop 86
El Gabalawi, Fayez .....Symposium 52
Elbogen, Eric.....Symposium 77
el-Guebaly, Nady .....Component Workshop 7
Elsayed, Yasser.....Issue Workshop 70
Emslie, Graham.....Symposium 10
England, Mary Jane .....Presidential Symposium 2, Symposium 5
English, Joseph .....Component Workshop 17
Enomoto, Kana .....Issue Workshop 116
Erinoff, Lynda .....Symposium 58
Erman, Milton.....ISS-21
Errichetti, Anthony.....Issue Workshop 33
Evans, Dwight.....ISS-5
Everett, Anita .....Component Workshop 41, 17, Issue Workshop 081
Eyler, A. Evan .....Component Workshop 45

F

Fahnestock, Peter .....ISS- 2
Fahrer, Rodolfo .....Issue Workshop 68
Falcone, Tatiana .....Component Workshop 49, Issue Workshop 108
Fallon, Brian .....Symposium 7
Fallon, April .....Symposium 33
Faraone, Stephen V. .....ISS- 06
Farrer, Lindsay .....ISS- 25 Part 1
Fattal, Omar .....Issue Workshop 108
Fauci, Anthony.....Advances in Medicine 1
Faulkner, Larry.....Issue Workshop 2, 75
Fauman, Beverly .....Symposium 5
Fava, Maurizio .....ISS- 10, 26
Fawcett, Jan.....Symposium 20
Fernandez, Antony .....Component Workshop 07
Fernbach, Harvey .....Symposium 36
Ferrando, Steve .....Symposium 78
Fiedorowicz, Jess .....Symposium 42
Findling, Robert .....ISS-12, Small Interactive 13
Fineberg, Naomi.....ISS-22
Fink, Max .....Symposium 09
Finley, Catherine .....Component Workshop 40
Fishbain, David .....ISS- 9
Fisher, Vicky .....Symposium 49
Fishkind, Avrim.....Symposium 96
Flannery-Schroeder, Ellen .....Issue Workshop 62
Flavin, Daniel.....Case Conference 2
Fleming, James .....Symposium 45
Flint, Alastair.....Symposium 68
Flockhart, David .....Symposium 21
Flynn, Julianne.....Issue Workshop 46
Fochtmann, Laura .....Component Workshop 31,48
Fonagy, Peter.....Symposium 66, 81
Fong, Timothy W .....Component Workshop 27
Fore, Peter .....Component Workshop 31
Forlenza, Nicholas .....Issue Workshop 87
Forstein, Marshall .....Symposium 78
Foubister, Nicole .....Symposium 82
Francis, Andrew .....Symposium 56
Franco, Kathleen .....Issue Workshop 108
Frank, Julia.....Issue Workshop 63, 79, Component Workshop 33, Symposium 57
Frascella, Joseph .....Issue Workshop 12
Frazier, Jean .....ISS-12, Issue Workshop 74
Freudenreich, Oliver ISS-7
Fricchione, Gregory .....Symposium 46
Friedberg, Robert .....Issue Workshop 62
Friedman, Richard .....Presidential Symposium 1
Frye, Mark.....Case Conference 2, ISS17 Part 1, Symposium 39
Fumero-Perez, Ileana .....ISS- 17 Part 1

INDEX

G

Gabbard, Glen.....Advances in 2, Case Conference 4, Presidential Symposium 3, Symposium 66, Issue Workshop 60, Component Workshop 6
Gaebel, Wolfgang.....Symposium 16
Galanter, Marc .....Advances in 1, Symposium 2, 79
Galeno, Roxana.....Symposium 64
Galili-Weisstub, Esti .....Symposium 41
Gallarda, Thierry.....Symposium 62
Galynker, Igor .....Issue Workshop 39
Gandotra, Neeraj .....Issue Workshop 27
Garavan, H .....Issue Workshop 93
Garcia, Jolene.....Issue Workshop 62
Garcia-Sosa, Icelini.....Component Workshop 29
Gay, Tamara .....Symposium 21
Gaymon-Doomes, Aeva.....Component Workshop 39
Geenens, Douglas .....Symposium 13
Gejman, Pablo .....Symposium 12
Gelenberg, Alan .....Component Workshop 48
Gerard, Sanacora.....ISS-10, 26
Ghaemi, S. Nassir .....Symposium 39, 67
Ghanem, Mohamed.....Issue Workshop 70
Giedd, Jay .....Symposium 34
Gifford, Robert.....Component Workshop 8
Giliberti, Mary .....Component Workshop 17
Gill, Mona .....Component Workshop 27
Ginzburg, Harold .....Issue Workshop 57
Gise, Leslie H.....Symposium 36
Glahn, David .....Symposium 65
Glas, Gerrit.....Symposium 71
Glessner, Eric .....Issue Workshop 22
Glick, Rachel.....Component Workshop 41
Glover, Karinn .....Component Workshop 39
Goethe, John .....Symposium 91
Goff, Heather .....Issue Workshop 71
Goforth, Harold.....Symposium 28, 78
Gogineni, R. Rao.....Symposium 33, 89
Gogtay, Nitin.....Symposium 34
Goin, Marcia Kraft.....Symposium 22
Goldberg, David.....Symposium 11
Goldberg, Joseph.....Symposium 65
Goldberg, Terry .....Symposium 74
Goldenberg, Don.....ISS- 9
Goldman, Marina .....Component Workshop 34
Goldner, Brooke.....Issue Workshop 66
Goodkin, Karl .....Issue Workshop 43, 91
Goodwin, Fred .....Small Interactive Session 14
Goodwin, Frederick .....Symposium 39
Gordon, Susan.....Symposium 40
Gordon, Edward.....Component Workshop 45
Gordy, Tracy .....Component Workshop 45, Issue Workshop 42
Gorges, Adele.....Issue Workshop 97
Gorman, Angela .....Issue Workshop 62
Gosch, Elizabeth .....Issue Workshop 62
Gottlieb, Diane.....Issue Workshop 41
Grady-Weliky, Tana .....Presidential Symposium 2
Grafman, Jordan.....Issue Workshop 93
Grammer, Geoffrey .....Forum 12
Grant, Igor.....Symposium 58
Grant, Jon.....Symposium 95
Grant, Steven.....Issue Workshop 93
Grau, Arturo .....Symposium 64
Greden, John .....ISS- 13
Greden, John F. .....Symposium 21
Greely, Henry .....Symposium 86
Green, Melva.....Component Workshop 23,30
Greenberg, Benjamin .....Symposium 76
Greenfield, Shelly .....Advances in 1, Symposium 40
Gregory, Robert.....Symposium 31
Greist, John .....Focus Live 3
Greist, John ISS-13
Griffin, Dauda .....Component Workshop 47
Griffith, James.....Issue Workshop 059, 096, Symposium 57, 79
Guchereau, Michelle .....Issue Workshop 105
Gunderson, John .....Advances in2,Symposium66
Gupta, Nitin.....Forum 2, Issue Workshop 112
Gurrera, Ronald.....Symposium 56

H

Hafeez, Zeba .....Issue Workshop 34
Hafter Gray, Sheila.....Component Workshop 37
Halabjayi, Saman .....Issue Workshop 59
Halaris, Angelos.....Component Workshop 15
Hales, Deborah.....Focus Live 1, 2, 3
Hales, Robert.....ISS 18 Part 1, Component Workshop 6
Haley, Vanessa .....Issue Workshop 14
Halmi, Katherine.....Advances in 3
Halper, James .....Issue Workshop 26
Hamarman, Stephanie .....Component Workshop 14
Hamdan, Sami.....Symposium 41
Hameed, Noumana.....Issue Workshop 87
Hamilton, Tom .....Component Workshop 32
Hammerness, Paul.....ISS- 6
Handon, Barry.....Symposium 72
Haney, Aaron.....Component Workshop 37
Hanin, Edward .....Component Workshop 37
Harding, Kelli .....Symposium 23
Harding, Richard.....Symposium 69, Issue Workshop 106,
Harre, Elizabeth .....Issue Workshop 7
Harrington, John .....Issue Workshop 10, Symposium 32
Harrison, Alexandra .....Symposium 17
Hartmann, Lawrence.....Issue Workshop 68
Harvey, Philip .....ISS- 24
Harvey, Philip D.....Symposium 74
Hatters Friedman, Susan .....Issue Workshop 1
Haupt, Dan .....ISS- 23
Hawkins, J. .....Symposium 6
Heinssen, Robert .....Symposium 50
Henderson, David .....Symposium 46
Hendren, Robert.....Issue Workshop 74
Henggeler, Scott.....Issue Workshop 12
Henin, Aude ISS-6, 28
Henry, N Lynn.....Symposium 21
Hepburn , Brian .....Component Workshop 3
Herbert, Sarah .....Symposium 94

INDEX

Hermann, Richard....Symposium 83
Hernandez, Vanessa....Component Workshop 08
Herrman, Helen....Symposium 92
Herzog, David....Advances in 3
Herzog, Alfred....Symposium 91
Hickling, Frederick....Symposium 92
Hien, Denise....Symposium 40
Higgins Jr, Napoleon....Component Workshop 23,45
Hilty, Don....Forum 15, Symposium 23
Hinrichsen, Gregory....Issue Workshop 49
Hinton, Marynell....Issue Workshop 35
Hirschfeld, Robert....ISS27, Component Workshop 48
Hobday, Gabrielle....Case Conference 4
Hoff, Cathrien....Issue Workshop 100
Hoge, Charles....Component Workshop 37
Hoge, Steven....Component Workshop 44,54
Hollander, Eric....ISS 22, Small Interactive 4, Symposium 95
Hollander, Sheri....Issue Workshop 16
Hollins, Sheila....Presidential Symposium 2
Holman, Christopher....Symposium 93
Holt, Jonathan....Symposium 45
Honberg, Ronald....Forum 16
Hoschl, Cyril....Symposium 16
Hsiao, John....Issue Workshop 94
Hsiung, Robert....Issue Workshop 25
Hua, Liwei....Component Workshop 29
Huang, Alexander....Component Workshop 39
Huang, William....Issue Workshop 17
Huang, Larke....Issue Workshop 116
Huertas-Goldman, Sarah....Component Workshop 49
Hughes, Michael....Issue Workshop 80
Hunt, Robert....Symposium 97
Huremovic, Damir....Issue Workshop 54
Husain, Arshad....Issue Workshop 19, Symposium 51
Hypolite, Iman....Component Workshop 29

I

Iheagwara, Chioma....Issue Workshop 41
Insel, Thomas....Lecture 15
Ireland, Jane....Symposium 43
IsHak, Waguih....Issue Workshop 28, 37, 118
Ismail, Mostafa....Issue Workshop 70
Ivanov, Iliyan....Symposium 97

J

Jabbarpour, Yad....Symposium 49, 91
Jacobs, Petra....Symposium 3
Janigro, Damir....Issue Workshop 108
Javaid, Sadaf....Issue Workshop 087
Jayaram, Geetha....Component Workshop 15, Issue Workshop 32, Symposium 91
Jaycox, Lisa....Issue Workshop 23
Jean-Noel, Pierre....Issue Workshop 85
Jefferson, James....ISS-13
Jenkins, Rachel....Symposium 92
Jeste, Dilip V.....Symposium 61
Joffe, Hadine....ISS 14
Johnson, Kahlil....Issue Workshop 29
Johnson, Janet....Issue Workshop 57
Johnson , Shaneek....Issue Workshop 41
Jones, Edward....Symposium 26
Jorgenson, Linda....Issue Workshop 15
Joseph, Zohar....ISS-22
Joseph, Robert....Issue Workshop 095
Joshi, Paramjit....Symposium 43
Joshi, Gagan....Symposium 98
Judd, Lewis....Symposium 42

K

Kahn, Rene....ISS-18 Part 1
Kahn, Jeffrey....Component Workshop 26
Kalinowski, Coni....Issue Workshop 34
Kambampati, Vikram....Component Workshop 29
Kameny, Franklin....Symposium 63
Kane, John M.....ISS-11
Kaplan, Gabriel....Symposium 97
Kaplan, Sandra....Component Workshop 43
Kaplan, Desmond....Issue Workshop 71
Kapoor, Vinay....Component Workshop 7
Karam, Elie....Symposium 41
Karp, Jordan....ISS-20
Karpela, Totti....Symposium 55
Kasckow, John....Symposium 48
Kataoka, Sheryl....Issue Workshop 23
Katz, Nathaniel P.....Symposium 32
Katz-Bearnot , Sherry....Presidential Symposium 01
Kay, Jerald....Symposium 5, Issue Workshop 45
Kearley, Bob....Component Workshop 40
Keashly, Loraleigh....Symposium 43
Keefe, Richard....Symposium 74
Keller, Martin....Presidential Symposium 3
Kellner, Charles....Symposium 9
Kelsoe, John....Symposium 84
Kemp, David....ISS- 27
Kendler, Kenneth....Forum 3, Symposium 11
Kennedy, David....Issue Workshop 55
Kerfoot, Karin....Symposium 80
Kessler, Ronald....Symposium 11
Ketter, Terence....ISS-17 Part 1,18 Part 1, 27, Symposium 37
Khalil, Afaf....Issue Workshop 70
Khushalani, Sunil....Issue Workshop 32
Kiehl, Kent....Issue Workshop 12, 93
Kim, Jean....Issue Workshop 82
Kim-Cohen, Julia....Symposium 54
Kimmel, Stephen....Symposium 97
Kingdon, David....Issue Workshop 44, 50
Kirkhart, Vincent....Symposium 28
Kirmayer, Laurence....Symposium 14
Kleber, Herbert....Advances in 1, Symposium 2, 38, Component Workshop 25
Klein, Tara....Issue Workshop 43, 91
Klitzman, Robert....Symposium 86
Knapp, Penelope....Symposium 72
Knight, Edward....Symposium 96
Koenigsberg, Harold....Symposium 73
Koffman, Robert....Forum 14

INDEX

Kogan, Richard ..... Forum 5
Kohen, Dora ..... Symposium 56
Kohn, Robert ..... Symposium 57
Kolan, Aravinda ..... Issue Workshop 91
Kollins, Scott ISS-28
Kolodner, Robert ..... Forum 10, Symposium 69
Kool, Simone ..... Symposium 37
Konrad, S. Shane ..... Issue Workshop 58, 69
Kopelowicz, Alex ISS-19
Kordon, Laura ..... Issue Workshop 22
Kosten, Thomas ..... Advances in 1
Kraljic, Helen ..... Issue Workshop 39
Kramer, Milton ..... Issue Workshop 45, 73
Kramer, Elizabeth ..... Media Presentation 7
Kratochvil, Christopher ..... ISS-6, Symposium 97
Kroenke, Kurt ..... Symposium 14
Kroll, Jerome ..... Symposium 85
Krystal, Andrew D. ..... ISS- 21
Kudler, Harold ..... Component Workshop 37
Kunkel, Elisabeth ..... Component Workshop 34, Symposium 33
Kuo, Jack ..... Issue Workshop 17
Kupfer, David ..... Forum 3, Symposium 11

L

Ladavac, April ..... Issue Workshop 041
Lake, Charles ..... Symposium 20
Lake, James ..... Symposium 45
Landa, Yulia ..... Issue Workshop 44
Langley, Audra ..... Issue Workshop 23
Langlieb, Alan ..... Component Workshop 26,47
Lanouette, Nicole ..... Symposium 48
Lauren, Siegel ..... Component Workshop 10
Lauriello, John ISS-19
Lawless, Martha ..... Symposium 70
Lawrence, Kaplan ..... Issue Workshop 16
Lawson, William ..... Forum 09
Lazarus, Arthur ..... Component Workshop 3, Issue Workshop 98
Lazarus, Jeremy ..... Component Workshop 1
Le, Jennifer ..... Component Workshop 29
Lebowitz, Barry ..... Issue Workshop 94
Lee, Allison ..... Issue Workshop39
Lee, Eugene ..... Component Workshop 22,39 Issue Workshop 28
Lee, Joseph W. ..... Symposium 28
Lee, Steven ..... Media Presentation 04
Lehrer, Douglas ..... Issue Workshop 73
Leibenluft, Ellen ..... Symposium 8, 35, 62
Leigh, Hoyle ..... Issue Workshop 117
Lencz, Todd ..... Symposium 84
Leo, Raphael ..... Small Interactive 7
Leon-Andrade, Carlos ..... Symposium 64
Levander, Eric ..... Issue Workshop 6
Levenson, James ..... Issue Workshop 20
Levin, Frances ..... Symposium 38
Levounis, Petros ..... Media Presentation 4
Lewis, Janet ..... Issue Workshop 56
Liang, Han-chun ..... Component Workshop 52
Liberman, Robert ..... Small Interactive 10
Liberto, Joseph ..... Symposium 2
Lieberman, Jeffrey ..... Symposium 60
Lim, Russell ..... Component Workshop 39
Links, Paul ..... Symposium 73
Lipman, George ..... Component Workshop 10
Lipsitt, Don ..... Issue Workshop 117
Lisanby, Sarah ISS-10, 26
Lissek, Shmuel ..... Symposium 18
Liu, Shirley ..... Component Workshop 27, 39, Issue Workshop 58, 69
Livesley, John ..... Symposium 73
Llorente, Maria ..... Component Workshop 53
Lofchy, Jodi ..... Issue Workshop 24
Lolas, Fernando ..... Forum 11
Lopez, Lina ..... Component Workshop 5
Lowenkopf, Eugene ..... Issue Workshop 3
Lowmaster, Sara ..... Symposium 53
Loza, Nasser ..... Symposium 92
Lu, Francis ..... Small Interactive 5, Media Presentation 7, Component Workshop 28, 38, Issue Workshop 116
Lugo, Raquel ..... Issue Workshop 27
Lundt, Leslie ..... ISS-16 Part 1
Lynch, Katherine ..... Issue Workshop 82
Lyons-Ruth, Karlen ..... Symposium 66

M

Maass-Robinson, Saundra ..... Issue Workshop 13
Mack, Avram ..... Component Workshop 32
Mahr, Fauzia ..... Issue Workshop 62
Maj, Mario ..... Lecture 14, Symposium 16, 90
Malhotra, Anil ..... ISS-11, Symposium 84
Malik, Amit ..... Symposium 19
Malmon, Alison ..... Symposium 5
Malmquist, Carl ..... Issue Workshop 15
Manevitz, Alan ..... Issue Workshop 26
Mangurian, Christina ..... Issue Workshop 7, 58, 69
Manji, Husseini ..... Symposium 60
Mann, John ..... Symposium 26
Manring, John ..... Symposium 19, 88
Manu, Peter ..... Issue Workshop 78
March, John S. ..... Symposium 59
Marder, Stephen R. ISS-2
Markov, Dimitri ..... ISS- 21, Symposium 82
Marmar, Charles ..... Symposium 51
Marsch, Lisa ..... Symposium 3
Marsh, Abigail ..... Symposium 18
Martin, Daun ..... Issue Workshop 113
Martinez, Moises ..... Component Workshop 53
Masliah, Eliezer ..... Symposium 58
Massie, Mary Jane ..... Component Workshop 18
Mathew, Sanjay ..... ISS- 1
May, Catherine ..... Component Workshop 33, Issue Workshop 63
Mayberg, Helen ..... Lecture 4, Small Interactive Session 9
Mayeux, Richard ..... ISS -25 Part 1
Mayo, Lorna ..... Issue Workshop 63
McAndrew, Amy ..... Issue Workshop 111
McCommon, Benjamin ..... Symposium 63
McCracken, James ..... Symposium 98
McCue, Colleen ..... Symposium 69

INDEX

McCullough, James.....Issue Workshop 06
McDaniel, William.....Symposium 28
McDermott, Jim.....Symposium 36
McDougle, Christopher.....ISS-12
Mcgahee, Shunda.....Component Workshop 53
McGlashan, Thomas.....Symposium 6, 50
McGorry, Patrick.....ISS- 7
McGough, James.....Symposium 8
McInnis, Melvin.....Symposium 21
McIntyre, Roger.....ISS- 15
McIntyre, John.....Component Workshop 48, Issue Workshop 20, 97
McIntyre, Kevin.....Issue Workshop 107
McLaren, Jennifer.....Issue Workshop 74
McLean, Alexandra.....Symposium 62
McLeod-Bryant, Stephen.....Symposium 30
McMahon, Francis.....Symposium 12, 26, 84
McNicholas, Laura.....Symposium 2
McQuistion, Hunter.....Component Workshop 10
McVoy, Molly.....Issue Workshop 21
Meadow-Woodruff, James.....Lecture 19
Meaney, Michael.....Symposium 1
Medina Mora, Maria. Elena.....Symposium 92
Mehl-Madrona, Lewis.....Symposium 87
Mellman, Lisa.....Case Conference 4
Melonas, Jacqueline.....Issue Workshop 88
Meltzer, Herbert.....ISS-24
Menvielle, Edgardo.....Media Presentation 6, Symposium 94, Component Workshop 05
Menza, Matthew.....ISS-20
Merikangas, Kathleen.....ISS-1
Merlino, Joseph.....Presidential Symposium 1
Metcalfe, Janet.....Issue Workshop 93
Meyers, Barnett.....Symposium 68
Micevski, Aleksandar.....Issue Workshop 110, 054
Michaels, Jennifer.....Symposium 32, Issue Workshop 10, 47
Michels, Robert.....Symposium 93
Mick, Eric.....ISS- 8
Mick, Thomas.....ISS- 22
Miller, Gregory.....Symposium 93
Miller, Mark.....Issue Workshop 49
Miller, Gary.....Issue Workshop 77
Milrod, Barbara.....Component Workshop 16
Mintzer, Jacobo E.....ISS- 25 Part 1
Miranda, Jeanne.....Issue Workshop 55
Mischoulon, David.....Symposium 46
Mitchell, James.....Advances in 3
Moeller, Frederick.....Issue Workshop 92
Moffic, Steven.....Component Workshop 28
Mohamed, Somaia.....Symposium 48
Mohler, Jr. , Richard.....Symposium 25
Monahan, John.....Symposium 77
Montenegro , Roger.....Issue Workshop 68
Moran, Scott.....Case Conference 1
Morciglio, April.....Component Workshop 30
Morrow, Eric.....Symposium 98
Morse, Stephen.....Symposium 86
Moss, Howard.....Forum 4
Moussai, Jacob.....Component Workshop 29
Mozian, Sharon.....Issue Workshop 38
Mrazek, David.....Issue Workshop 75
Mulsant, Benoit.....Symposium 68
Munoz, Rodrigo A.....Symposium 67, 90
Muntasser, Siham.....Symposium 41, Component Workshop 13
Musalek, Michael.....Symposium 16
Musher, Jeremy.....Component Workshop 45
Muskin, Philip.....Symposium 23
Musselman, Dominique L.....Symposium 75
Muzik, Maria.....ISS- 13
Myers, Wade.....Component Workshop 21
Myers, Michael.....Component Workshop 36, Issue Workshop 60, 71, 99

N

Nace, David.....Component Workshop 11, 45
Nadelson, Carol C.....Presidential Symposium 02, Symposium 17
Nagra, Amandeep.....Issue Workshop 110
Nahar, Niru.....Issue Workshop 19
Nakajima, Gene.....Symposium 63
Naqvi, Syed.....Issue Workshop 99
Narasimhan, Meera.....Issue Workshop 84, 106
Narrow, William.....Symposium 63
Nathaniel, Vernon.....Component Workshop 53
Nelson, Craig.....ISS- 10, 26
Nemeroff, Charles.....Focus Live 1,Presidential Symposium 3, ISS-4, 11, Symposium 5, Issue Work shop 74
Nestadt, Gerald.....Symposium 76
Nestler, Eric.....Symposium 1
Neubauer, David.....ISS- 21
Newcomer, John.....ISS -2, Symposium 61
Newcomer, John W.....Presidential Symposium 3
Newcorn, Jeffrey H.....Symposium 97
Newkirk, Cassandra.....Component Workshop 23, 32, 46, Issue Workshop 13
Newman, Katherine.....Symposium 29
Newmark, Thomas.....Symposium 33
Ng, Bernardo.....Symposium 64
Ng, Anthony.....Symposium 96
Nierenberg, Andrew A.....ISS- 20, Issue Workshop 94
Nihalani, Nikhil.....ISS-29
Njenga, Frank.....Symposium 92
Noel, Richard.....Issue Workshop 77
Nora, Rena.....Issue Workshop 34
Norris, Donna.....Symposium 44, Component Workshop 28
Northcott, Colleen.....Component Workshop 35
Notman, Malkah.....Component Workshop 36, Issue Workshop 15
Nugterm, Annet.....Symposium 83, Issue Workshop 100
Nunes, Edward.....Symposium 38, Component Workshop 25

INDEX

O

O'Brien, Charles ..... Symposium 60
O'Brien, Moira ..... Issue Workshop 72
Ochoa-Perez, Melissa ..... Component Workshop 29
Ogundipe, Kehinde ..... Component Workshop 29
O'Hara, Ruth ..... Symposium 4
Okasha, Tarek ..... Forum 09, Component Workshop 13
Olarte, Sylvia W. ..... Presidential Symposium 1
Oldham, John ..... Symposium 31, 53, 81, Component Workshop 6
Olfson, Mark ..... Symposium 10
O'Malley, Mary ..... ISS- 15, 21
Omar, Abdel Naser ..... Issue Workshop 70
Oquendo, Maria ..... Forum 11, Lecture 20
Ortiz, Natalia ..... Issue Workshop 16

P

Pan, Philip ..... Issue Workshop 18
Pandya, Anand ..... Forum 16
Parikh, Rajesh ..... Symposium 46
Paris, Joel ..... Symposium 73
Pato, Michele ..... Froum 15, Issue Workshop 45
Paul, Robindra ..... Issue Workshop 65
Paulson, James ..... Symposium 33
Paulus, Martin ..... Symposium 58
Pavela, Gary ..... Symposium 5
Pearlstein, Teri ..... ISS- 14
Peel, Deborah ..... Symposium 69
Peele, Roger ..... Symposium 90
Pendler, Paul ..... Issue Workshop 64, 86
Perkins, Diana ..... Symposium 50
Perlis, Roy H. ISS-10, 26
Perring, Christian ..... Symposium 67
Person, Ethel ..... Symposium 22
Person, Cheryl ..... Component Workshop 33
Peselow, Eric ..... Issue Workshop 102
Pessar, Linda ..... Component Workshop 4
Peteet, John ..... Symposium 25, 79, Component Workshop 50
Peterson, Stephen ..... Component Workshop 33
Petitjean, Francois ..... Symposium 62
Petrides, Georgios ..... Symposium 9
Petrucelli, Leonard ..... ISS- 3
Pflanz, Steven ..... Froum 14, Component Workshop 26, Issue Workshop 53, 67
Phillips, Katharine ..... Symposium 95, Component Workshop 6
Pi, Edmond ..... Forum 9
Pillard, Richard ..... Symposium 63
Pimstone, Daniel ..... Issue Workshop 17
Pinals, Debra ..... Component Workshop 54
Pine, Daniel ..... Symposium 18
Pivan, Joseph ..... Symposium 34
Plakun, Eric ..... Issue Workshop 103 Presidential Symposium 1, Issue Workshop 8, 103, Component Workshop 16
Pleak, Richard ..... Media Presentation 6, Symposium 94
Plutzky, Jorge ISS-23
Pollock, Jonathan ..... Symposium 54
Poon, Amy ..... Issue Workshop 58, 69
Posey, David ..... Symposium 98
Post, Jerrold ..... Symposium 24, 79, Media Presentation 3
Post, Robert ..... Symposium 39
Postlethwaite, Alejandra ..... Component Workshop 7
Potash, James ..... Symposium 12
Potenza, Marc ..... Symposium 95
Potkin, Steven ..... Symposium 26
Pouncey, Claire ..... Symposium 52, 85
Powell, June ..... Issue Workshop 30
Powers, Pauline ..... Advances in 3
Powsner, Seth ..... Issue Workshop 117
Price, Marilyn ..... Issue Workshop 36, 64, 86
Prier, Ronald ..... Issue Workshop 106
Primm, Annelle ..... Froum 13, Component Workshop 38
Prudic, Joan ..... Symposium 9
Puddester, Derek ..... Component Workshop 36
Pumariega, Andres ..... Symposium 89, Component Workshop 38, 49
Pyles, Robert ..... Component Workshop 41

Q

Quadrio, Carolyn ..... Issue Workshop 52

R

Rabins, Peter V ..... ISS 03
Rafferty, Jason ..... Issue Workshop 65
Ramani, Meena ..... Issue Workshop 87
Ramirez, Jose ..... Symposium 28
Rao, Vani ..... Issue Workshop 32
Rao, Nyapati ..... Issue Workshop 33, 54, 87, 110
Rapaport, Mark ..... Focus Live 1, 2, 3, Issue Workshop 37
Raskin, William ..... Issue Workshop 107
Rasmussen, Steven ..... Symposium 76
Rathod, Shanaya ..... ISS-19, Issue Workshop 50
Ratliff, Brenda ..... Issue Workshop 106
Real, Lawrence ..... Symposium 52
Record, John ..... Issue Workshop 115
Regier, Darrel A. ..... Forum 03
Reich, James ..... Symposium 37
Reid, Michele ..... Component Workshop 23
Reifler, Burton V. ..... Component Workshop 21
Reifler, Burton V. ..... Issue Workshop 75
Reinhard, James ..... Symposium 49
Reiss, David ..... Symposium 6
Reliford, Aaron ..... Issue Workshop 7
Renner, John ..... Forum 4
Ressler, Kerry ..... ISS-5, Symposium 51, 60
Reus, Victor ..... Issue Workshop 2, 75
Reyes, Raymond ..... Issue Workshop 71

INDEX

Riba, Michelle....Symposium 21, Component Workshop 34, Issue Work shop 68, 89, 107
Rief, Winfried....Symposium 14
Rigaud, Marie-Claude....Component Workshop 7, Issue Workshop 36
Riselli, Carleen....Issue Workshop 95
Ritchie, Elspeth Cameron....Component Workshop 30, Forum 14, Lecture 16
Robbins, Michael....Symposium 3
Roberts, Laura W.....Small Interactive 1
Roberts, Nicole....Issue Workshop 115
Robinowitz, Carolyn B.....Presidential Symposium 2, Component Workshop 40
Robinson, Gail....Symposium 17, 30, 55, Component Workshop 43
Robinson, Robert G.....Symposium 27
Robinson, Delbert....Symposium 74
Rodriguez, Carlos....Component Workshop 49
Rodriguez, Carolyn....Issue Workshop 58, 69
Rodriguez-Suarez, Mercedes....Component Workshop 35
Rogers, John....Symposium 32, Issue Workshop 10
Rohde, Luis Augusto....Symposium 8
Roof, Jason....Symposium 91
Roose, Steven....Symposium 75
Rosa, Carmen....Symposium 40
Rosario, Vernon....Symposium 94
Rosebush, Patricia....Symposium 56
Rosenthal, Richard....Component Workshop 25
Roskes, Erik....Component Workshop 32,44
Rothbaum, Barbara....Symposium 51
Rothermundt, Matthias....Issue Workshop 108
Rothschild, Anthony J.....Symposium 23, 68
Rothstein, David....Symposium 24, Media Presentation 1, 3
Rothstein, Mark....Symposium 69
Rouillon , Frederic....Symposium 62
Royster, Terri....Symposium 29
Rudorfer, Matthew....Symposium 9
Ruelaz, Alicia....Issue Workshop 99
Ruiz Pedro....Forum 9, 11, Symposium16, Issue Workshop 61
Runnels, Patrick....Component Workshop 17
Rupp, Agnes....Issue Workshop 23, 55
Rush, A. John....ISS- 13,Symposium 62, Issue Workshop 094
Russakoff, L. Mark....Component Workshop 03
Russell, Jennifer....Symposium 73
Rychik, Abe....Issue Workshop 3

S

Sabo, Alex....Symposium 32, Issue Work shop 10 , 38, 47
Sachs, Gary....ISS17 Part 1, 23, Symposium 39
Sackeim, Harold....Symposium 9
Sadler, John....Symposium 67
Saeed, Sy....Component Workshop 3
Saks, Elyn....ISS-24
Salah, Rima....Component Workshop 13
Salpekar, Jay....Issue Workshop 105
Samorano, Rogelio....Component Workshop 10
Sanchez, Francis....Component Workshop 7
Sanchez-Russi, Carlos....Symposium 64
Sanislow, Charles....Symposium 53
Sanuck, Neil....Issue Workshop 16, 41
Sartorius, Norman....Forum 3, Symposium 90
Satish, Usha....Symposium 88
Savitz, Adam....Issue Workshop 83
Scarcella, Erminia....Component Workshop 33
Scasta, David....Symposium 25
Schatzberg, Alan....ISS 5, Presidential Symposium 3
Schetky, Diane....Symposium 44
Schmidt, Chester....Component Workshop 45, Issue Workshop 042
Schneidman, Barbara....Issue Workshop 75
Schoenbaum, Michael....Issue Workshop 23
Schoener, Gary....Issue Workshop 52, 101
Scholte, Pim....Issue Workshop 4
Schooff , Kenneth....Component Workshop 3
Schulz, S. Charles....ISS-7, Issue Workshop 98
Schulze, Thomas....Symposium 12
Schwartz, Victor....Symposium 5
Schwartz, Harold....Symposium 93
Scott, Marcia....Issue Workshop 36, 64, 86
Scotton, Bruce....Symposium 87
Scully, Jr. , James....Symposium 23, 36, Component Workshop 28
Seale, Deborah....Issue Workshop 115
Sebat, Jonathan....Symposium 12
Secin, Ricardo....Symposium 64
Sederer, Lloyd....Symposium 83, Issue Workshop 97
Seidman, Larry....Symposium 50
Seligman, Roslyn....Media Presentation 02, Issue Workshop 30
Sells, Dave....Symposium 70
Sephton, Sandra....Symposium 4
Sernyak, Michael....Symposium 61
Shaffer, David....Forum 3, Symposium 8
Shalev, Arieh....Symposium 51
Shapiro, Edward....Issue Workshop 8, 103
Sharfstein, Steven....Media Presentation 5, Symposium 5, 36, Component Workshop 17
Shaw, Jon....Symposium 15, Issue Work shop 80
Shaw, Wallace....Symposium 34
Shaw, Janet....Component Workshop 42
Shear, Paula....Symposium 65
Sheehan, Beverly....Component Workshop 42
Sheline, Yvette....Symposium 27
Shen, Hong....Component Workshop 5
Shenoy, Ramakrishnan....Component Workshop 14
Sherbourne, Cathy....Issue Workshop 55
Sherrill, Joel....Symposium 59, Issue Workshop 66
Shibley, Heather....Case Conference 1, Component Workshop 8, Issue Workshop 19
Shihabuddin, Lina....Component Workshop 35
Sholevar, G. Pirooz....Issue Workshop 90
Sholevar, Ellen....Issue Workshop 90

INDEX

Siegel, Bryna.....Advances in 2
Siegel, David.....Symposium 44
Sikich, Linmarie.....Symposium 10
Silberman, Edward.....Issue Workshop 9
Silk, Kenneth R.....Froum 15, Symposium 23
Silverman, Ross.....Issue Workshop 18
Silverstein, Steven.....Issue Workshop 83
Simpson, Helen Blair.....Symposium 76
Singh, Meeta.....ISS-16 Part 1
Singh, Bruce.....Issue Workshop 61
Sizoo, Bram.....Symposium 71
Skodol, Andrew.....Symposium 53
Slattery, Marcia.....Component Workshop 5
Sledge, William.....Symposium 70
Sloninsky, Lucila.....Issue Workshop 109
Small, Gary.....ISS- 3
Smith, Steven.....Symposium 96
Smith, J.D.....Issue Workshop 14
Smoller, Jordan W.....Small Interactive 16
Snow, Sharon.....Issue Workshop 113
Soares, Claudio.....ISS- 14
Solomon, David.....Symposium 42
Soltys, Stephen.....Issue Workshop 18
Sonawalla, Shamsah.....Symposium 46
Sood, Aradhana.....Symposium 89
Sorel, Eliot.....Symposium 16, Component Workshop 13,28
Sørensen, Claus.....Symposium 75
Sorrentino, Renee.....Issue Workshop 1
Sostre, Samuel.....Component Workshop 18
Souza, Anjali D.....Issue Workshop 58, 69
Spack, Norman.....Symposium 94
Spencer, Thomas.....ISS- 8
Sperber, Jacob.....Issue Workshop 33, 54, 110
Spiegel, David.....Symposium 4
Spitz, Deborah.....Froum 15, Issue Workshop 9
Spritz, Melanie.....Issue Workshop 71
Spurgeon, Joyce.....Issue Workshop 46
Srabstein, Jorge.....Symposium 43
Srinivasan, Shilpa.....Issue Workshop 84
Srinivasaraghavan, Jagannathan.....Symposium 30
Sripada, Chandra Sekhar.....Symposium 37
St George-Hyslop, Peter.....ISS-25 Part 1
Stahl, Stephen.....ISS- 16 Part 1, 29
Stanford, Sharon.....ISS- 4
Stankowski, Joy.....Issue Workshop 1
Star, Jodi.....Component Workshop 5, 51
Stearns, Vered.....Symposium 21
Steenfeldt-Foss, Otto W.....Lecture 3
Stefan, Susan.....Symposium 96
Steffens, David.....Symposium 27
Stein, Dan.....ISS-22, Symposium 11, 95
Stern, Daniel.....Symposium 22
Stewart, Donna.....Component Workshop 6
Stewart, W.....Issue Workshop 92
Stoddard, Frederick.....Component Workshop 17
Stolar, Andrea.....Component Workshop 26, Issue Workshop 36, 64,
Stotland, Nada L.....Symposium 17, 33, 63
Stotland, Hanna.....Issue Workshop 107
Stowell, Keith R.....Component Workshop 35
Strain, Eric.....Symposium 2
Stratigos, Katharine.....Presidential Symposium 1
Streeter, Chris.....Symposium 45
Streltzer, Jon.....Issue Workshop 117
Stroup, Thomas.....Issue Workshop 94
Suardi, Enrico.....Component Workshop 33
Subramaniam, Geetha.....Symposium 3
Sudak, Donna.....Issue Workshop 40
Summers, Richard.....Symposium 19
Suomi, Stephen.....Symposium 54
Susman, Virginia.....Symposium 93, Issue Workshop 031, 082
Swanson, James M.....Symposium 10
Swanson, Jeffrey.....Symposium 77
Swartz, Marvin.....Symposium 77
Sweatt, David.....Symposium 1
Sweeney, John.....ISS-19, Symposium 74
Syeda, Ruksheda.....Forum 2

T

Taintor, Zebulon.....Symposium 69
Talbott, John.....Symposium 62
Tamminga, Carol.....Advances in 2
Tampi, Rajesh.....Symposium 80
Tan, Violeta.....Issue Workshop 58
Tan, Violeta.....Issue Workshop 69
Taylor, Craig.....Symposium 4
Taylor, Janet.....Component Workshop 30
Teplin, Linda.....Issue Workshop 12
Terhakopian, Artin.....Component Workshop 8
Terr, Lenore.....Symposium 22
Thase, Michael.....Advances in 2, ISS- 20
Thomas, Jean.....Component Workshop 2
Thompson, Kenneth.....Issue Workshop 116
Throckmorton, Warren.....Symposium 25
Tien, Elizabeth.....Issue Workshop 41
Tillman, Jane.....Issue Workshop 103
Titzler, Robert.....Issue Workshop 63
Tivnan, Patricia.....Issue Workshop 2
Tong, Lowell.....Component Workshop 4
Townsend, Mark.....Component Workshop 4
Tracy, Martin.....Issue Workshop 35, 88
Treisman, Glenn.....Symposium 58
Trevisan, Louis.....Issue Workshop 27
Trinidad, Anton.....Issue Workshop 29
Tross, Susan.....Symposium 40, Issue Workshop 39
Tschan, Werner.....Symposium 55, Issue Workshop 101
Tseng, Wen-Shing.....Lecture 24
Tsuang, Ming.....Symposium 50
Tucker, Phebe.....Issue Workshop 57
Turkington, Douglas.....Issue Workshop 50
Tyano, Professor Sam.....Symposium 92
Tyrer, Peter.....Symposium 37
Tzuang, Dan.....Component Workshop 27

U

Uchitell, Louis.....Forum 1
Udomratn, Pichet.....Issue Workshop 61
Ursano, Robert.....Case Conference 1,Lecture 17, Symposium 51

INDEX

V

Vahia, Ipsit .....Symposium 48
Valera, Eve, M.....ISS- 08
Van Boeijen, Christine .....Issue Workshop 89
van der Gaag, Rutger Jan .....Symposium 71
van Putten, Marijke.....Issue Workshop 100
van Veldhuizen, J. Remmers.....Issue Workshop 100
van Wijngaarden-Cremers, Patricia .....Symposium 71
Vanderpool, Donna .....Issue Workshop 88
Varma, Vijoy .....Issue Workshop 112
Vasa, Monisha.....Issue Workshop 99
Vavrusova, Livia .....Symposium 16
Velligan, Dawn.....ISS-24
Ventevogel, Peter .....Symposium 41, Issue Workshop 4
Verduin, Marcia.....ISS -15
Vergare, Michael .....Component Workshop 34
Vicari, Sandra.....Issue Workshop 115
Vickar, Garry.....Symposium 45
Victoroff, Jeff.....Symposium 24
Vieta, Eduard.....Symposium 65
Viguera, Adele.....ISS-14
Viswanathan, Ramaswamy .....Issue Workshop 20
Vital-Herne, Jacques .....Issue Workshop 85
Vitiello, Benedetto .....Symposium 10, 59
Vito, Jose.....Component Workshop 40, Media Presentation 04
Vocci, Frank .....Issue Workshop 92
Vogel, Albert .....Component Workshop 8
Vogel-Scibilia, Suzanne E.....Small Interactive 6
Volkmar, Fred.....Symposium 98, Issue Workshop 105
Volkow, Nora .....Forum 4, Small Interactive Session 2
Volpp, Serena .....Symposium 63, Component Workshop 22

W

Waddell, Andrea.....Issue Workshop 24, 104
Wagner, Karen .....ISS- 27
Wain, Harold J.....Forum 12
Waldbaum, Marjorie .....Media Presentation 4
Walker, Elaine .....Symposium 50
Walker, Sandra .....Component Workshop 38
Wapenyi, Khakasa.....Component Workshop 9
Watson, Clarence .....Symposium 82
Warner, Megan.....Symposium 53
Watson, Stanley.....Symposium 26
Wattenberg, Sarah .....Forum 10
Weder, Natalie.....Component Workshop 29,49
Weerasekera, Priyanthy.....Symposium 19, 88
Weiden, Peter ISS-19
Weiden, Peter .....Issue Workshop 44
Weinberger, Daniel.....Issue Workshop 74
Weine, Stevan M. .....Symposium 24
Weiner, Elyse .....Issue Workshop 102
Weinstein, Henry .....Component Workshop 32,46
Weisman, Henry.....Issue Workshop 16
Weiss, Kenneth.....Symposium 82
Weisser , Lydia.....Component Workshop 3
Weker, Jonathan .....Component Workshop 11
Wells, Kenneth .....Issue Workshop 55
Welsh, Christopher.....Media Presentation 4
Wessely, Simon .....Symposium 14
Whyte, Ellen .....Symposium 68
Wick, Paul .....Component Workshop 11
Wilens, Timothy ISS-6
Wilkins, Kirsten .....Symposium 80
Wilkins, Jeffery.....Issue Workshop 17
Williams, Margaret .....Symposium 87
Williams, Eric .....Component Workshop 22
Williams, Lori .....Issue Workshop 113
Wilner, Philip .....Issue Workshop 31
Wilsnack, Sharon ISS-1
Winstead, Daniel.....Component Workshop 28
Wise, Michael .....Issue Workshop 76
Wise, Thomas.....Component Workshop 18
Wisner, Katherine.....Issue Workshop 98
Witte, Helen .....Component Workshop 39
Wolpe, Paul .....Symposium 86
Woo, Benjamin.....Component Workshop 35
Woods, Scott .....Symposium 50
Woods, Stephen.....ISS-23
Woody, George.....Symposium 3
Wright, Jesse .....Symposium 88, Issue Workshop 40
Wright, L. Alan .....Component Workshop 21
Wulsin, Lawson .....Component Workshop 18

X

Xenakis, Stephen .....Media Presentation 3

Y

Yaari, Roy .....ISS- 3
Yager, Joel.....Advances in 3
Yanowitch, Philip.....Issue Workshop 39
Yehuda, Rachel .....Symposium 4
Yero, Sergio.....Issue Workshop 27
Yeung, Albert .....Symposium 46
Youdelman, Mara.....Component Workshop 38
Young, Joel.....ISS-28
Young, Keith .....Symposium 47 Issue Workshop 35, 42
Young, Alveth .....Component Workshop 53
Yudofsky, Stuart.....ISS- 18 Part 1
Yurchenko, Anna.....Case Conference 2

Z

Zablotny, Mary.....Component Workshop 24
Zachar, Peter .....Symposium 67
Zarate, Carlos.....Symposium 60
Zatzick, Douglas F. .....Case Conference 1 Symposium 51
Ziegler, Penelope .....Component Workshop 36
Zisook, Sidney .....Symposium 48
Zolovska, Beata.....Issue Workshop 65
Zubieta, Jon-Kar .....Symposium 20, 35

INDEX