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ADVANCES IN MEDICINE

MAY 14, 2016

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

Chair: Robert M. McCarron, D.O.

Speakers: Pritham Raj, M.D., Sarah Rivelli, M.D., Shannon Suo, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

Psychiatrists often encounter clinical scenarios that may not have a clear explanation. The Medical Mysteries faculty practice both internal medicine and psychiatry and will collaborate with the audience to review several case-based “medical mysteries.” A relevant and concise update on several “Med Psych” topics will be discussed. A focus will be placed on covering general medical topics that are particularly important to the practice of psychiatry.

MAY 16, 2016

WHEN INFLAMMATION WEEPS: THE EMERGING ROLE OF THE IMMUNE SYSTEM IN DEPRESSION

Chair: Andrew Miller, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify three major findings that indicate that inflammation may contribute to depression; 2) Describe two major symptom complexes that are a consequence of the impact of inflammation on the brain; 3) Identify two neurocircuits and two neurotransmitter systems that are affected by inflammation to change behavior; 4) Describe a reliable biomarker that may identify patients with high inflammation; and 5) Identify at least one treatment implication of the impact of inflammation on the brain and behavior.

SUMMARY:

Increased markers of inflammation have been reliably found in a subgroup of depressed patients, and administration of inflammatory stimuli to otherwise nondepressed individuals leads to depressive symptoms. Moreover, a growing literature suggests that treatments that block inflammation may hold therapeutic promise for depression. Taken together, these findings suggest that inflammation may represent a novel pathway to pathology in neuropsychiatric disorders, with potentially important implications especially for treatment-resistant depression, which has been shown to have a special association with increased markers of inflammation. Much attention has been directed to the mechanisms by which inflammatory stimuli may impact the brain to influence behavior. Data from neuroimaging studies indicate that inflammatory cytokines can alter neurotransmitter systems and neurocircuits that regulate motivation and motor activity as well as anxiety, arousal and alarm. Indeed, cytokine effects on dopamine and glutamate in the basal ganglia have been associated with decreased responsivity to reward and psychomotor slowing. In addition, markers of inflammation such as C-reactive protein (CRP) have been shown to correlate with decreased connectivity within reward-related neurocircuitry involving the ventral striatum and the ventromedial prefrontal cortex, which in turn correlates with anhedonia. Data from nonhuman primates indicate that these effects on connectivity may be mediated in part by the negative impact of inflammation on dopamine release in the basal ganglia. Findings from magnetic resonance spectroscopy suggest that increased glutamate may also be involved. These data suggest that peripheral markers of inflammation may identify subgroups of patients who may preferentially respond to therapeutic strategies that not only target inflammation but also target downstream mediators of the effects of inflammation on the brain, including altered metabolism of dopamine and glutamate. Thus, identifying both medically healthy and medically ill depressed patients with increased inflammation may support efforts to personalize care and make more clearly informed decisions regarding therapeutic strategies based on relevant inflammatory biomarkers such as CRP, which reveal immune-based CNS pathology.

TOP 10 MEDICAL STORIES 2015: A COMPREHENSIVE AND PRACTICAL REVIEW OF WHAT PSYCHIATRISTS NEED TO KNOW

Chair: Monique Yohanan, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the key medical literature published in 2015, emphasizing medical and behavioral conditions that increase cardiovascular risk; 2) Understand the likely impact of selected publications in terms of newsworthiness and potential to affect clinical practice; 3) Perform a critical appraisal of the evidence, including methodology and possible sources of bias; and 4) Apply current best evidence of medical conditions likely to impact people with psychiatric conditions in clinical practice.

SUMMARY:

This session will provide a review of the internal medicine literature published in 2015. Special attention will be devoted to conditions likely to be of interest to psychiatrists caring for patients with comorbid medical conditions. Publications related to cardiovascular risk factors, including hypertension, hyperlipidemia and diabetes, as well as lifestyle and behavioral factors, will be emphasized. The selection of articles for this review will be based on likely clinical impact, including newsworthiness and the potential that this new evidence will alter clinical practice. A critical appraisal of the evidence will be offered, including a discussion of study methodology and potential sources of bias. Application of literature into clinical practice will be discussed.

MAY 17, 2016

CRITICAL ADVANCES IN SLEEP MEDICINE FOR THE PSYCHIATRIST

Chair: Karl Doghramji, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the salient developments in the pathophysiology and management of primary sleep disorders over the past few years; 2) Understand key clinical features of select sleep disorders and develop a rational approach to identifying these disorders in psychiatric practice; and 3) Appreciate the potential impact of the management of primary sleep disorders on psychiatric complaints and conditions.

SUMMARY:

More than half of all psychiatric patients complain of disturbances of sleep and wakefulness. Sleep disorders are associated with impaired daytime function and predict a heightened future vulnerability to psychiatric disease. They also diminish lifespan. Although their presence complicates psychiatric disorders, their management may offer the potential for greater efficacy in the alleviation of emotional symptoms. This Advances seminar will update attendees on new developments in the understanding and management of a variety of sleep disorders, including insomnia, narcolepsy, sleep apnea syndrome, circadian rhythm disorders and the parasomnias. It will also explore the psychiatric comorbidities associated with these conditions and discuss how their management may impact psychiatric complaints and conditions.

THE EVOLVING ROLE OF IMAGING IN OPTIMIZING TREATMENT FOR DEPRESSION: FROM CBT TO DBS

Chair: Helen Mayberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe available imaging options for treatment selection biomarker development for depression; 2) Evaluate strategies to determine accuracy and reliability of any putative biomarker for clinical use; and 3) Appreciate how multimodal imaging is used to guide and optimize patient selection and surgical planning for subcallosal cingulate deep brain stimulation (DBS) for treatment-resistant depression.

SUMMARY:

Despite the effectiveness of antidepressant treatment for many people, there is no reliable method to match an individual depressed patient to their best option. Needed are clinically viable algorithms that both select the best treatment and avoid ineffective ones, while also identifying patients who require alternatives to standard first-line interventions. Toward this goal, various imaging strategies have been used to explore pretreatment scan patterns predictive of differential response to different treatments. With this approach, putative biosignatures have been identified using fludeoxyglucose positron emission tomography (FDG-PET) and complementary resting-state fMRI imaging that stratify patients into two distinct subtypes predictive of likely remission to

escitalopram or cognitive behavior therapy, as well as distinguish those patients who will fail combined treatment. Studies of known treatment-resistant patients provide further evidence of additional depression subtypes with implications for treatment selection at all stages of illness. Extending these studies, patient-specific network maps are currently being used to refine and optimize surgical targeting for deep brain stimulation. Going forward, comparisons of the different imaging modalities as well as development of non-imaging surrogates will be necessary to determine the most accurate and accessible method for clinical use in individual patients. In the meantime, these and related findings lay foundation for continued characterization of brain-based depression subtypes toward an evidence-based, precision medicine approach to the treatment of mood disorders.

ADVANCES IN RESEARCH

MAY 16, 2016

NEW DEVELOPMENTS IN CLINICAL PSYCHIATRY

Chair: Herbert Pardes, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the extensive impact of anxiety disorders on minority young adults and the long-term consequence of inadequate attention; 2) Review exciting treatments for depression, which is rapidly emerging as one of the world's most serious problems for undercutting the function of the average population; 3) Be familiar with the extraordinary impact of depression in older people and understand the interaction between late-life depression and other coexisting illnesses; 4) Discuss the extraordinary possibilities emerging from precision medicine and its impact on individuals with psychiatric illness; and 5) Understand the most recent research findings relevant to the epidemiology and treatment of feeding and eating disorders.

SUMMARY:

Psychiatry is increasing its impact on psychiatric illness in several different ways. New research directions are flowing from many different research laboratories and expanded attention to clinical problems often receiving inadequate attention from the field are being addressed. We have assembled

five of the leading psychiatrists in the country on issues ranging from the treatment of anxiety disorders in youth—particularly minority populations—to new developments in the treatment of older patients suffering from late-life depression and including a focus on the exciting possibilities emerging from precision-based medicine. This range of presentations will offer clinicians an opportunity to hear the latest information about these and other topics. New medications focusing on cognitive control systems, the complexity of psychotherapies, the array of approaches to eating disorders and the perspective that precision medicine brings to illness are all incorporated in this set of presentations. The focus will be both up-to-date descriptions of developments in these various aspects, as well as interaction between presenters and the audience to encourage the clearest and most definitive understanding of these current and very active topics.

NO. 1

TREATMENT OF MINORITY YOUNG ADULTS WITH ANXIETY DISORDERS: CLOSING THE DISPARITY GAP

Speaker: Maria Carolina Zerrate, M.D., M.H.S.

SUMMARY:

It is well known that minority populations are less likely to access mental health treatment. It is estimated that by the year 2050, minority groups will make up more than 50% of the U.S. population, the largest of which continuing to be Latinos. The implementation of the Affordable Care Act has allowed millions to gain health insurance coverage, with the largest groups of newly insured being emergent adults and Latinos. Emergent adulthood is a recently proposed developmental stage encompassing the years between late adolescence and early adulthood. This stage is pivotal to acquire the skills and strengths needed for a successful transition into adulthood. This period is also recognized as high risk for the onset of psychopathology. There is a clear need for the development of programs focused on providing culturally competent mental health services for minority emergent adults. This effort would serve to close the disparity gap and better prepare practitioners to provide treatment to this growing diverse population. This presentation will illustrate the development of an evidence-based treatment program integrated with of relevant cultural factors to adapt treatment strategies and efficiently implement and disseminate a new standard of care

for a population that has been historically underserved. We will also present data from our clinical research initiative to capture and better understand the needs and mental health treatment trajectories of this population.

NO. 2

DEPRESSION: AN UPDATE ON RESEARCH AND NEW TREATMENT OPTIONS

Speaker: Fritz A. Henn, M.D., Ph.D.

SUMMARY:

Depression has a 12-month prevalence of 5.5% in high-income countries. It begins in the mid-20s on average, and current treatments, including ECT, lead to remission in no more than 85% of patients. Thus, there is an enormous need for better treatments. Data on the brain circuits that mediate depression have led to the discovery of some critical areas that appear altered in depression, leading to two new targets for deep brain stimulation (DBS) in intractable cases: area 25 and the lateral habenula. While individual cases have shown full response to DBS in both areas, no large-scale study has shown consistent remissions. This may be due to patient heterogeneity or the need for extraordinarily precise electrode placement. Nonetheless, these studies have pinpointed areas in which molecular pathology appears in animal models of depression. This points to new medications with higher rates of remission, and progress has been made looking at the synaptic glutamate activity. Ketamine, a glutamate antagonist, is effective in up to two-thirds of treatment-resistant patients. Studies have suggested that excess glutamate in cortical synapses can lead to depression, and we are attempting to develop a drug that increases astrocytic uptake of glutamate and does not have psychomimetic effects such as those seen with ketamine. Hopefully, we can use this knowledge to develop next-generation medications with response rates exceeding 90%.

NO. 3

ADVANCES IN THE CARE OF LATE-LIFE DEPRESSION

Speaker: George S. Alexopoulos, M.D.

SUMMARY:

Late-life depression promotes disability, worsens medical outcomes, undermines treatment adherence and has a modest response to pharmacotherapy. Recent attempts to improve the care of late-life depression include studies of the neurobiology of treatment resistance that provide

targets for novel treatment development and development of behavioral interventions focusing on the medical and psychosocial context of late-life depression while taking into consideration the skill set of community clinicians. Clinical neurobiology studies have shown that executive dysfunction and its underlying abnormalities of the cognitive control system (CCS) are common in late-life depression and contribute to poor antidepressant response. A proof of concept study showed that a computerized cognitive remediation intended to induce neuroplastic changes in the CCS can improve depression faster than escitalopram. In theory, transcranial magnetic stimulation may increase synaptic strength of the CCS and augment the action of antidepressants and behavioral interventions in patients with the depression-executive dysfunction syndrome. We used the Research Domain Criteria consensus as a guide to develop Engage, a streamlined, neurobiology-based psychotherapy for late-life depression that may match the skill set of practicing clinicians. Engage is easier to learn and non-inferior to problem solving therapy (PST) in reducing depressive symptoms, inducing remission and ameliorating disability.

NO. 4

INTRODUCTION OF A PRECISION MEDICINE-BASED APPROACH IN PSYCHIATRY

Speaker: Sander Markx, M.D.

SUMMARY:

Precision medicine is poised to customize medical practice based on individual physiological information, such as genetic, molecular and cellular data. This paradigm is already very well established in oncology, and there is a growing body of evidence supporting the potential of precision medicine in neuropsychiatric diseases. In fact, over the last several years, there have been a number of examples of genetically targeted therapies in epilepsy and in a broad range of childhood genetic conditions, often with a dramatic improvement in clinical outcomes. Due to technological advancement, it is now possible to screen large numbers of patients who suffer from severe mental illness for disease-causing mutations. These genetic lesions can then be utilized to develop appropriate model systems, such as stem cell and transgenic animal models, where one can identify critical disease mechanisms and screen large numbers of novel therapeutic compounds. Patients with a given genetic mutation can then be treated with these

novel drugs that specifically target the disease mechanism associated with that particular genetic lesion. As has been demonstrated in other parts of medicine, taking such a precision medicine-based approach in psychiatry will ultimately lead to the development of more targeted and effective treatments that improve the lives of patients who suffer from mental illness.

**NO. 5
EATING DISORDERS**

Speaker: Evelyn Attia, M.D.

SUMMARY:

Feeding and eating disorders are serious psychiatric illnesses associated with high rates of morbidity and mortality. This presentation will review recent research findings relevant to the epidemiology and treatment of feeding and eating disorders. Additionally, the presentation will discuss findings from recent studies using cognitive neuroscience to identify neural circuits used by individuals with eating disorders during food choice tasks.

ADVANCES IN SERIES

MAY 14, 2016

ADVANCES IN PSYCHODYNAMIC PSYCHIATRY

Chair: Elizabeth L. Auchincloss, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Be aware of the importance of psychoeducation in psychodynamic psychiatry; 2) Be aware of advances in the understanding and treatment of narcissistic personality disorders; 3) Be aware of advances in the understanding and treatment of borderline personality disorder; and 4) Be aware of the importance of attachment disorders in psychodynamic psychiatry.

SUMMARY:

This panel will address advances in psychodynamic psychiatry. The first speaker, Dr. Fredric Busch, will address the role of psychoeducation in psychodynamic psychiatry. Then Dr. Eve Caligor will address advances in the understanding and treatment of narcissistic personality disorder, and Dr. Otto Kernberg will address advances in the understanding and treatment of borderline personality disorder. Finally, Dr. Barbara Milrod will

explore the role of separation anxiety in psychodynamic psychiatry. The panel will be chaired by Dr. Elizabeth Auchincloss.

**NO. 1
THE ROLE OF PSYCHOEDUCATION IN
PSYCHODYNAMIC PSYCHIATRY**

Speaker: Fredric N. Busch, M.D.

SUMMARY:

Little emphasis has been paid to the role of the educational aspects of psychodynamic psychotherapy. This lack of emphasis occurs despite research that shows that it is important to educate the patient in many aspects of the treatment. This presentation will focus on the role of education regarding the goals of the treatment, the tasks of the patient, the tasks of the therapist and the psychoanalytic model of the mind that is relevant to the patient's struggles.

**NO. 2
ADVANCES IN THE UNDERSTANDING AND
TREATMENT OF NARCISSISTIC PERSONALITY
DISORDER**

Speaker: Eve Caligor, M.D.

SUMMARY:

This presentation will focus on advances in the understanding and treatment of patients who suffer from narcissistic personality disorder. The author will focus on both object relations theory and on ego psychology in considering these advances.

**NO. 3
ADVANCES IN UNDERSTANDING AND TREATING
BORDERLINE PERSONALITY DISORDER**

Speaker: Otto F. Kernberg, M.D.

SUMMARY:

This presentation will focus on the advances in the understanding and treatment of patients suffering from borderline personality disorder. Both object relations theory and ego psychology will be considered in this presentation.

**NO. 4
THE ROLE OF SEPARATION ANXIETY IN
PSYCHODYNAMIC PSYCHIATRY**

Speaker: Barbara Milrod, M.D.

SUMMARY:

This presentation will consider the important role of separation anxiety in psychodynamic psychiatry. Although this presentation will focus on patients suffering from anxiety and depression, the role of separation anxiety is important in all patients.

MAY 15, 2016

ADVANCES IN MEDICINE: POSITIVE PSYCHIATRY

Chair: Dilip V. Jeste, M.D.

Discussant: Dan G. Blazer II, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the characteristics of positive outcomes such as well-being and positive factors such as resilience, optimism and environmental support; 2) Use positive psychiatric and preventive interventions; and 3) Learn the methods to teach the concepts of positive psychiatry to trainees.

SUMMARY:

Psychiatric practice and research have traditionally focused on elucidating the causes of mental illnesses, developing and using safe and effective treatments, and reducing the associated suffering and disability. These components are, however, not sufficient to fulfill the enormous potential of psychiatry to promote human welfare. A growing body of research shows that higher levels of positive psychosocial characteristics such as resilience, optimism and social engagement are associated with objectively measured better health outcomes, including greater longevity, as well as with subjective well-being. Even so, most research on positive mental health has come from outside of psychiatry, with a few notable exceptions. The time has come to integrate positive mental health into psychiatric practice, training and research and to expand our expertise to encompass the full spectrum of mental functioning. Positive psychiatry is the science and practice of psychiatry that seeks to understand and promote well-being through assessment and interventions aimed at enhancing behavioral and mental wellness. The main objective is greater well-being, which may be achieved through optimal increase in key traits such as resilience and social support. As a branch of medicine, positive psychiatry is rooted in biology and seeks to decipher biological underpinnings of positive traits and eventually promote health and well-being through psychosocial/behavioral and biological interventions.

This symposium will make recommendations for research, clinical practice and training in positive psychiatry from childhood through late life. Empirical data will be presented to suggest that positive traits may be improved through psychosocial and behavioral interventions. Clinicians and researchers are well poised to provide major contributions to the positive mental health movement, thereby impacting health care overall. The speakers include experts in different arenas, including child psychiatry, geriatric psychiatry, prevention and intervention, and reflect broad experience in research, teaching and clinical practice. They also reflect geographic and other diversity. We plan to leave ample time for questions and answers and for general discussion with the audience.

NO. 1

RESILIENCE-BUILDING INTERVENTIONS AND AGING

Speaker: Helen Lavretsky, M.D.

SUMMARY:

This presentation will focus on the definitions of resilience and resilience-building interventions in the context of late-life mood and cognitive disorders. Resilience is a dynamic characteristic of the interaction between individuals and their environments; this construct can be fostered in both younger and older individuals and consequentially leads to better outcomes for medical and mental disorders that come with aging. Resilience-enhancing interventions include well-being therapy, learned optimism training and hardiness training, all of which focus on positive aspects of difficult experiences, thereby promoting more positive perceptions of challenges. Lifestyle factors such as diet, exercise and spirituality can enhance resilience by creating physical and mental well-being. Several studies of complementary and integrative medicine (CIM) allow a holistic approach to wellness that encompasses varied approaches to wellness, including mind-body therapies (e.g., yoga, meditation, tai chi). Neuroimaging studies demonstrate neural substrates, including the prefrontal cortex, hippocampus, amygdale and anterior cingulate, as forming a pathway for resilience. Inflammatory mediators may constitute a link between lifestyle factors, infection and the physiological changes of aging on one hand and risk factors for age-associated diseases on the other and could serve as targets or biomarkers for resilience-building interventions.

NO. 2

PREVENTION IN PSYCHIATRY

Speaker: Carl C. Bell, M.D.

SUMMARY:

Dr. Bell will review an important conceptual framework for behavioral prevention—the theory of triadic influence—along with the seven community field principles for cultivating resiliency and health behavior change, and there will be examples of how these field principles have been used for prevention in psychiatry. In addition, Dr. Bell will review specific prevention interventions in children and adults at the individual and group levels.

MAY 16, 2016

MANAGING THE SIDE EFFECTS OF PSYCHOTROPIC MEDICATIONS

Chairs: Joseph F. Goldberg, M.D., Carrie L. Ernst, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the pharmacodynamic, pharmacokinetic, pharmacogenetic and clinical predictors of adverse drug effects from psychotropic medications; 2) Describe evidence-based strategies for anticipating and managing weight gain and metabolic dysregulation associated with psychotropic medications; 3) Recognize clinical measures, correlates, predictors and management strategies for sexual dysfunction resulting from antidepressants and other psychotropic drugs; and 4) Recognize clinical measures, correlates, predictors and management strategies for sexual dysfunction resulting from antidepressants and other psychotropic drugs.

SUMMARY:

Adverse effects from psychotropic medications account for nearly 90,000 annual visits to emergency departments nationwide, yet remain among the least-studied areas within clinical psychopharmacology. This symposium will provide attendees with an up-to-date overview of key topics regarding the evaluation and management of suspected adverse psychotropic drug effects. Presentations will focus on practical recommendations for identifying risk factors for adverse effects, devising risk-benefit approaches

when choosing treatment options and implementing evidence-based strategies to prevent or mitigate the impact of adverse drug effects. Dr. Goldberg's presentation will review fundamental issues in the assessment and recognition of potential side effects, including pharmacodynamic and pharmacokinetic considerations, pharmacogenetic predictors of adverse effects, nocebo effects, identifying individual propensities, relationships with dosing and time course, and clinical predictors of side effect burden and severity. Dr. McIntyre will describe the prevalence and scope of metabolic dysregulation associated with atypical antipsychotics and other psychotropic agents, discuss risk factors for metabolic and cardiovascular morbidity in patients who are prescribed treatments with high metabolic risk, and review pros and cons of known behavioral and pharmacological strategies to manage iatrogenic weight gain and metabolic dysregulation. Dr. Clayton will summarize current information about state-of-the-art measurement of sexual dysfunction caused by psychotropic drugs and their differentiation from primary illness symptoms; she will review and compare incident rates of sexual dysfunction among antidepressants in randomized trials, describe outcomes after medication changes in response to sexual dysfunction, and describe strengths and weaknesses of pharmacotherapies used to counteract drug-induced sexual dysfunction. Finally, Dr. Ernst will discuss risk factors for cardiac arrhythmias caused or exacerbated by antipsychotics and antidepressants, discuss pharmacokinetic and pharmacodynamic arrhythmogenic considerations, and summarize basic information that psychiatrists should know in order to evaluate and optimize cardiac safety when prescribing psychotropic medications.

NO. 1

CLINICAL AND PHARMACOLOGICAL CONSIDERATIONS IN ASSESSING ADVERSE EFFECTS OF PSYCHOTROPIC DRUGS

Speaker: Joseph F. Goldberg, M.D.

SUMMARY:

This presentation will provide an overview of systematic assessment approaches to suspected adverse drug effects. Concepts will be emphasized regarding patient-specific propensities for incurring iatrogenic effects, including clinical and demographic risk factors, pharmacodynamic and pharmacokinetic considerations (e.g., dosing effects, drug-drug interactions), pharmacogenetic predictors of overall

drug tolerability and specific adverse effects, the role of side effect “expectancy” and the nocebo effect, and methods to discriminate suspected adverse effects from primary illness symptoms.

**NO. 2
EVALUATING AND MANAGING SEXUAL
DYSFUNCTION FROM PSYCHOTROPIC
MEDICATIONS**

Speaker: Anita Clayton

SUMMARY:

Interactions of multiple factors may affect sexual functioning, including genetics, neuroendocrine function, psychiatric/medical conditions, substances/medications and environmental factors, suggesting overlapping etiologic mechanism(s). Sexual function and dysfunction are mediated through the neuroendocrine system, which balances excitatory versus inhibitory hormones, peptides and neurotransmitters. Psychiatric illnesses and the medications used to treat them also impact sexual functioning through these systems, making it difficult to separate the effect of the underlying condition from an adverse effect of treatment. Additionally, comorbid psychiatric (e.g., primary sexual disorders) and medical conditions/medication treatment may confound assessment. Methodological issues such as adequate quantitative measures of sexual functioning, statistical versus clinically-meaningful differences and gender effects may further complicate management. As sexual dysfunction (SD) reduces patients’ quality of life, it is often a reason for medication nonadherence. Thus, provider-initiated, proactive, longitudinal assessment of sexual function and patient preference/satisfaction is essential. Current best-practice management strategies include switching the medication to one associated with less SD or adding a medication for augmentation/antidote.

**NO. 3
AN UPDATE ON CARDIOVASCULAR AND
ARRHYTHMOGENIC RISKS OF PSYCHOTROPIC
DRUGS**

Speaker: Carrie L. Ernst, M.D.

SUMMARY:

This presentation will summarize fundamental information for psychiatrists and other mental health prescribers regarding cardiac safety considerations for patients taking antidepressants, antipsychotics and mood stabilizers. Basic concepts

related to cardiac conduction and repolarization abnormalities will be reviewed alongside patient-specific risk factors, dosing parameters, concomitant medications and predisposing medical comorbidities. Risk-benefit considerations will be discussed when choosing from among medications within a given psychotropic category, along with strategies for proper monitoring and optimal collaboration with other medical specialists for making appropriate treatment decisions.

MAY 17, 2016

**ADVANCES IN TRAUMA DISORDERS AND TRAUMA
PSYCHOTHERAPY**

Chair: James J. Strain, M.D.

Discussant: Darrel A. Regier, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know the key issues concerning stressor-related disorders; 2) Know the variance between the *DSM-5* and the ICD-11 taxonomies; and 3) Be exposed to strategies for further needed research with regard to stressor-related disorders with adjustment disorders as a paradigm.

SUMMARY:

The new chapter in *DSM-5*—“Trauma and Stressor-Related Disorders”—updates the status of several diagnostic entities. Two are almost exclusively utilized for children—reactive attachment disorder and disinhibited social engagement disorder—while four others may be employed across the life cycle—post-traumatic stress disorder, acute stress disorder, adjustment disorders, and other specified trauma- and stressor-related disorders. This latter category includes variants of adjustment disorders, *ataque de nervios* and persistent complex bereavement disorder. Our new book published by APP, *Trauma and Stressor-Related Disorders: Handbook for Clinicians* (2016), highlights the significant changes from the *DSM-IV-TR* as well as the controversies that these stressor-related disorders elicit. Comparisons with the ICD-11 will be offered (e.g., acute stress disorder has been significantly changed in the *DSM-5* and will not appear in the ICD-11). Important conceptual issues will be presented, including the border between normality and pathology, specificity and nonspecificity, the confounds that arise from a taxonomy founded solely on phenomenology, and the addition of prolonged complicated bereavement disorder (PCBD) for a ubiquitous human

experience—loss of a significant other. It is anticipated that these important and frequently encountered diagnostic entities will stimulate important questions for the discussant and the audience.

NO. 1

TRAUMA-CENTERED PSYCHOTHERAPY: CHALLENGES IN CONDUCTING AN INTENSIVE, DETAILED TRAUMA INQUIRY

Speaker: David Johnson, M.D.

SUMMARY:

This presentation will describe frequent attempts by patients to avoid revealing details of their traumatic experiences and the specific techniques that can be effective in respectfully countering this avoidance and reaching the points of strong affect held within the patient's trauma schemas. Having a clear sense of the aim of the inquiry is critical. Managing the disruptions in the therapeutic alliance that often occur when working with traumatized patients, and the specific techniques used in turning these disruptions into opportunities for growth, will be described. Clinical examples of engagement with extremely challenging patients, including highly disassociated patients; young traumatized children; patients with comorbid borderline personality disorder; and angry, litigious patients, will be examined. In each of these cases, the usual therapeutic alliance is broken or severely disrupted, requiring special techniques in sustaining the therapeutic effort and avoiding entangling the therapist in unhelpful and adversarial interactions. The presentation will end by placing trauma-centered psychotherapy into context with other current approaches to trauma treatment.

NO. 2

DO PROFILES OF DEPRESSIVE SYMPTOMS DIFFERENTIATE ADJUSTMENT DISORDER AND DEPRESSIVE DISORDER DIAGNOSES?

Speaker: Patricia R. Casey, M.D.

SUMMARY:

Adjustment disorder (AD) is frequently conflated with major depression because of symptom overlap. Neither the *DSM-5* nor *ICD-10* have any diagnostic criteria based on symptom profiles, although this approach is proposed for *ICD-11*. This study, in a sample of patients with a diagnosis of AD and depressive episode (n=348), examines the variables that allow AD to be distinguished from a depressive

episode. An analysis of variance is used to differentiate one from the other in a number of areas such as social supports and suicidal ideation. In relation to symptoms, latent class analysis is used to estimate the number and nature of classes based on 28 depressive symptoms in order to determine if there were meaningful participant subgroups and if the classes differed qualitatively and quantitatively. As adjustment disorder is currently difficult to distinguish from depressive episode, this study has important implications for the criteria for AD being considered for *ICD-11* and for future research in this area.

NO. 3

LOW-THRESHOLD INTERVENTIONS FOR ADJUSTMENT DISORDERS: DEVELOPMENT AND EVALUATION OF A SELF-HELP MANUAL

Speaker: Rahel C. Bachem, D.Phil.

SUMMARY:

The development and randomized controlled evaluation of the first cognitive-behavioral self-help manual for adjustment disorder (AD) based on the *ICD-11* stress response concept are presented. The results propose that self-help interventions are a feasible and effective treatment for AD.

GUN VIOLENCE AND MENTAL HEALTH

Chair: Liza H. Gold, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Improve their skills in identifying patients at risk for firearm violence and interventions to mitigate risk; 2) Develop clinical skills in discussing firearm safety with patients and/or their families to decrease the risk of suicide by firearm; and 3) Understand and discuss with patients the mental health prohibited categories of firearm owners and their own reporting requirements.

SUMMARY:

The sensational media coverage of horrific mass shootings usually includes calls from all sides to "keep guns out of the hands of the mentally ill." This narrow and mistaken portrayal of both those with mental illness and the problem of gun violence increases the stigma associated with mental illness and has led to a paralyzing political and social debate regarding decreasing the toll of injury and death due to firearms. Contrary to stereotypes, most

individuals with serious mental illness are not violent, and when violent, they rarely use firearms. Suicide, not mass shootings, is the connection between gun violence and mental illness. Approximately 30,000 people in the U.S. die each year from gun violence; of these, 20,000 are suicides. Suicide is the 10th leading cause of death in the U.S., and over 90% of people who commit suicide have a psychiatric disorder. Options to intervene when persons with mental illness may be at increased risk of harming themselves or others are limited. Most individuals with mental illness do not meet statutory firearm restriction criteria; many often do not meet involuntary commitment criteria. At times, even people who meet commitment criteria cannot be hospitalized because a bed is not available. This symposium includes presentations that will discuss the problems of gun violence and mental illness. Liza H. Gold will review clinical issues regarding suicide and firearms. Firearms account for approximately 50% of all suicides, more than all other means combined. Dr. Gold will suggest clinical interventions that may help decrease the toll of firearm suicide. Marilyn Price will discuss the National Instant Criminal Background Check System (NICS), federal mental illness prohibitions, recent legislation increasing psychiatrists' reporting responsibilities (the New York SAFE Act) and if these steps can decrease firearm violence associated with mental illness. Cheryl Wills will discuss issues relating to children and firearms. Children are exposed to firearms violence at an alarming rate. Firearm suicide is a leading cause of death for adolescents; intentional and unintentional firearm deaths involving children and adolescents are a significant problem. Dr. Wills will examine how gun violence affects children evaluated in clinical and forensic settings. James Knoll will discuss the psychology of mass shooters and whether current proposals to further restrict the access of people with mental illness to guns is likely to be effective in decreasing the incidence of these tragedies. Debra Pinals will discuss available and practical preventive interventions when persons with mental illness present increased risk of violence and will review facets of a comprehensive public health strategy to help ensure maximized treatment and minimized morbidity and mortality associated with firearms.

NO. 1

SUICIDE AND FIREARMS

Speaker: Liza H. Gold, M.D.

SUMMARY:

Suicide is the 10th leading cause of death in the United States. Over 40,000 people a year commit suicide: more than half use firearms. Guns are by far the most lethal method of committing suicide. Only two types of interventions have been demonstrated to decrease suicide rates: suicide risk assessment and means reduction. Psychiatrists should understand the principles and practice of suicide risk assessment, particularly in regard to firearms. This presentation will review clinical as well as public health interventions to mitigate risk of firearm suicide.

NO. 2

NICS, MENTAL ILLNESS AND FIREARMS LEGISLATION: WHAT YOU SHOULD KNOW

Speaker: Marilyn Price, M.D.

SUMMARY:

Legislative responses to mass murders by persons with mental illness have resulted in the restriction of the right of certain categories of persons with the mental illness or substance use disorders to purchase firearms. Psychiatrists should be familiar with the National Instant Criminal Background Check System Improvement Amendments Act, the U.S. federal firearm background check database, and state statutes that have further expanded the definition of prohibited persons and, in some states, have placed psychiatrists in the position of having to make reports regarding their clients' risk of violence. We will discuss prohibited categories of persons with mental illness, legal reporting requirements, and the implications for treatment and confidentiality of new legislation that requires psychiatrists to report their patients to a state or federal agency. New York's SAFE ACT will be discussed as an example of the legislation that increases psychiatrists' reporting obligations in regard to their patients and firearm ownership. There are questions about how effective these legislative efforts have been in reducing violence to self and others and what approaches may be more effective.

NO. 3

WHEN FIREARMS AFFECT CHILDREN: CLINICAL AND FORENSIC EVALUATION

Speaker: Cheryl Wills, M.D.

SUMMARY:

Approximately 30% of American households own firearms. Children, therefore, have the potential to

be exposed to firearms violence at an alarming rate. The prevalence of firearms in the home increases risk of suicide, homicide, and unintentional injury and death for everyone in the home, including children. Suicide is the second leading cause of death in adolescents. The firearms used in teen suicide are typically legally bought by an adult who lives in the home. Every day, on average, firearm homicide kills five children and teens. Every day, on average, 48 children and teens (ages 0–19) are shot in murders, assaults, suicides and suicide attempts, unintentional shootings, and shootings in the course of police intervention. This presentation will examine how gun violence affects children who are evaluated in clinical and forensic settings.

NO. 4

MASS SHOOTINGS: MASS DISTRACTIONS AND SOCIOCULTURAL FACTORS

Speaker: James L. Knoll IV, M.D.

SUMMARY:

Mass shootings are extremely rare events influenced by multiple, complex factors, yet most public debate seeks to ascribe them to only one or two primary causes. Thus far, the debate has focused heavily on issues that are 1) Highly politicized; 2) Grossly oversimplified; and 3) Very unlikely to result in productive solutions. Reports of mass murderers' diagnoses are largely anecdotal, and there is little reliable research suggesting that a majority of these rare events were primarily caused by serious mental illness, as opposed to psychological turmoil flowing from other sources. A definitional problem exists in that the lay public may be prone to ascribe a motive of "mental illness" to highly violent acts of horrific desperation. Thus, the behavior and motives of mass murderers have not been clearly distinguished from psychiatric diagnoses. This presentation will discuss what is known about the psychology of mass shooters and why they are unlikely to be thwarted by policies designed to single out persons with serious mental illness. Rather, this represents a regressive, fearful response that provides no substantive answers to the problem of violence in society. Finally, evolving areas of forensic mental health holding greater promise for resolution will be discussed.

NO. 5

FIREARM RISK PREVENTION: CONSIDERING LEGAL AND CLINICAL REFORMS

Speaker: Debra Pinals, M.D.

SUMMARY:

Tragic events have driven media attention to the issue of mass shootings, and firearm-related violence risk prevention has focused on individuals with mental illness. Risk of suicide by firearm is a far more evidence-based concern for persons with mental illness than risk of firearm violence toward others. Regardless, when individuals with behavioral conditions present increased firearm-related risks, it is important to have readily available and practical preventive interventions. This requires approaches from early screening and identification to management of acute situations. These traditionally have included inpatient and outpatient civil commitment provisions, though these may be limited due to strict requirements in most states for dangerousness over need for treatment criteria. Furthermore, they typically focus on a particular population who may not be most at risk of firearm-related violence. Other approaches include mechanisms to legally remove guns in crisis situations and additional outreach and monitoring. Harm reduction may also benefit from enhanced engagement strategies. This presentation will review facets of a comprehensive public health strategy to help maximize treatment and minimize morbidity and mortality associated with firearms.

CASE CONFERENCE

MAY 15, 2016

EARLY NEUROIMAGING FOR ATYPICAL PSYCHIATRIC SYMPTOMS

Chair: Ricardo M. Vela, M.D.

Speakers: Sahil Munjal, M.D., Alexander C.L. Lerman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand functions of the frontal lobe; 2) Explore the use of neuroimaging as a routine workup in initial psychiatric presentations; and 3) Review the literature on the interplay between intracranial tumors and psychiatric symptoms.

SUMMARY:

As we know, patients do not always present with textbook symptoms of an illness. I am going to present a case of a 59-year-old male with a history of

depression treated for the past year, who developed a recent change in behavior, obsessive-compulsive symptoms and disorganization without apparent initial neurological signs or symptoms. Prior to the onset of this depressive episode, the patient had no formal psychiatric history of inpatient or outpatient treatment. Brain imaging showed a mass in the frontal lobe around the corpus callosum with edema and mass effect on the frontal horns and anterior body of the right lateral ventricle in the frontal lobe, later confirmed as glioblastoma multiforme. He subsequently underwent surgical treatment and radiation therapy. Frontal lobe functions include judgment, foresight, motivation, personality, socially appropriate behavior, mood and planning. Space-occupying lesions are a well-known cause of frontal lobe dysfunction. The reported incidence of psychiatric symptoms in brain tumors varies from 50 to 78%. This case shows that brain tumors can present with psychiatric and limited neurological symptoms, emphasizing the need for neuroimaging studies at initial presentation of atypical psychiatric symptoms. In patients presenting with “red flags” like atypical psychiatric symptoms, including late age of onset; no prior psychiatric history; acute behavioral changes; and/or refractoriness to treatment, early neuroimaging should be part of a routine workup.

I JUST WANT TO BE CLEAN

Chairs: Philip R. Muskin, M.D., M.A., Geoffrey P. Taylor, M.D.

Speakers: Donna Chen, M.D., M.P.H., David Lowenthal, M.D., J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explore the legal issues in caring for a psychotic patient whose psychosis causes him to harm himself; 2) Explore the ethical issues in caring for a psychotic patient whose psychosis causes him to harm himself; and 3) Understand the psychiatric management of psychotic patients who require high-level medical intervention.

SUMMARY:

This is the case of a 55-year-old, single, homeless, unemployed Caucasian male with a history of psychosis but no formalized psychiatric history who has a history of battery acid ingestion likely in the context of psychosis, resulting in esophageal stricture requiring multiple dilatations in the past. He

was transferred to Columbia University Medical Center for further management of dehydration and failure to take PO due to his esophageal stricture. On this admission, the stricture was found to be completely closed, with upper GI study showing no contrast reaching his stomach. He underwent J-tube placement and began receiving tube feeds. During this time, his psychosis began to interfere with medical treatment. His complex delusional system was both persecutory and grandiose. He attributed his decades of homelessness to the fact that others have stolen his intellectual property and said that he was the inventor of many notable things. He believed that an “Aryan White Brotherhood Women’s Auxiliary Troop” was pursuing him, and he frequently described ways in which he must protect himself. He believed this same troop to be involved in the 9/11 terrorist attack and stated he was next. One strongly held delusional belief was the need to be clean, both inside and out. As such, he began manipulating his J-tube and ingesting unknown substances, despite one-on-one observation. He injected a liquid into his J-tube and was seen to be licking the bleach wipes kept outside of hospital rooms. The patient had no reality testing and an otherwise organized thought process. He denied current and past mood symptoms, denied a psychiatric history, and has no friends or family. According to the patient, he has no need for antipsychotic medication. This case raises many issues. Most obvious is the need for antipsychotic medication in this individual, which he refused. The team grappled with the legality of treating someone over objection with antipsychotic medication on a medical unit and also dealt with resistance from medical/surgical nurses who are less accustomed to treating individuals over objection. In a patient who is presumably neuroleptic-naïve, the potential benefit of treating these deeply held psychotic beliefs is enormous. This is tied to the question of whether or not this patient should be treated with an esophagectomy if his psychosis is not treated, as he has been seen ingesting caustic substances even on the medical unit under close observation. Logistically, the patient was confined to a medical ward for the duration of his hospitalization, given that his J-tube precludes him from admission to the majority of inpatient psychiatric units. Thus, the intensity of the psychiatric care he can receive is limited from the outset. In a patient who has been homeless and living on the street for decades, but presents with a serious medical illness, how do we

care for him and arrive at the ultimate disposition for this patient?

MAY 16, 2016

MULTIDISCIPLINARY APPROACH TO TREATMENT OF PATIENTS WITH FIRST-EPISODE PSYCHOSIS

Chair: S. Charles Schulz, M.D.

Speaker: Sophia Vinogradov, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the early onset of cognitive difficulties and learn about the cognitive remediation treatment; and 2) Be updated on the importance of the initiation of first-episode family psychoeducation and how to structure the approach.

SUMMARY:

This session will provide information on the importance of first-episode family psychoeducation and will explore strategies for structuring effective approaches to family-centered education in patients with psychotic disorders. It is important for clinicians to understand the consequences of early-onset cognitive difficulties and to have a ready supply of tools to use in cognitive remediation treatment. This session will provide participants with those tools.

CATATONIA AND SEROTONIN SYNDROME FOLLOWING ABRUPT CESSATION OF CLOZAPINE: CONSIDERATIONS FOR A CONSULTATION-LIAISON PSYCHIATRIST

Chair: Ewald Horwath, M.D.

Speaker: Mohsina Ahmed, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn to present at a national conference; 2) Learn about the clozapine withdrawal phenomenon; 3) Learn about complications of lorazepam treatment in catatonia; 4) Learn about clozapine-induced gastrointestinal side effects; and 5) Learn about the neuropathophysiology of catatonia and serotonin syndrome following clozapine withdrawal.

SUMMARY:

Background: Catatonic phenomena following abrupt clozapine cessation has been reported in only a small number of case reports, and there are limited guidelines for management. **Case:** We present the

case of a 50-year-old woman admitted for small bowel obstruction who developed symptoms of catatonia and delirium with concern for neuroleptic malignant syndrome (NMS) and serotonin syndrome following abrupt cessation of clozapine and discuss strategies for management of clozapine withdrawal and considerations for the appropriate medical setting. **Methods:** A case report and literature review. **Results:** Abrupt clozapine cessation leads to serotonergic and cholinergic rebound, which places patients at risk for serotonin syndrome, autonomic instability and NMS. Our patient ultimately responded to treatment with lorazepam and olanzapine (chosen for its similar pharmacology to clozapine). Her response to treatment rapidly progressed when transferred to the appropriate medical telemetry unit, where her treatment could be advanced more aggressively. There were no guidelines in our literature search to help determine the appropriate level of care for management of catatonia in clozapine withdrawal, but historically, patients with concern for malignant syndromes are monitored in intensive care settings. **Conclusion:** Catatonia, malignant syndromes and autonomic instability can occur following clozapine cessation due to its unique pharmacology. Given these potential medical risks, we suggest that patients for whom clozapine use has become acutely contraindicated should be closely monitored for symptoms of catatonia, serotonin syndrome and NMS if clozapine is abruptly discontinued. Olanzapine appears to be effective in treating clozapine withdrawal, along with lorazepam and adequate cardiovascular support, and would advocate for monitoring in a telemetry unit until catatonic features have resolved.

CONVERSATIONS

MAY 16, 2016

DIVERSITY 3.0: FROM FAIRNESS TO EXCELLENCE

Speaker: Marc Nivet

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Differentiate between diversity and inclusion and learn about how these concepts are interdependent; 2) Gain an understanding of diversity and inclusion as a driver of organizational excellence; 3) Learn how to align diversity and inclusion goals to their wider organizational mission;

and 4) Become aware of and be able to apply resources and strategies to advance diversity and inclusion goals and objectives.

SUMMARY:

Health and health care are critical national priorities that require a broad range of strategic approaches to meet public needs in the United States. Since the publication of landmark reports, such as “Unequal Treatment,” there has been a growing awareness of the importance of increasing diversity in the health professions. Despite concerted efforts to integrate diversity and inclusion, there is still much work to be done, as evidenced by the continued health disparities for underserved communities, demographic makeup of our medical school students, faculty, physician workforce and challenges with inclusiveness. The Diversity 3.0 framework provides a historical perspective on how medicine has evolved in its diversity efforts stemming from fairness and progressing to excellence. This presentation will provide leadership insights and share tools and resources that can be leveraged to accelerate the eradication of health care disparities and promote better health for all.

COURSES

MAY 14, 2016

CONVERSION DISORDER: UPDATE ON EVALUATION AND MANAGEMENT

*Directors: Gaston Baslet, M.D., John Barry, M.D.
Faculty: W. Curt LaFrance Jr., M.D., M.P.H., Adriana Bermeo-Ovalle, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Perform a clinical evaluation of patients with conversion disorder in collaboration with a neurologist and communicate the diagnosis in a way that reinforces engagement in treatment; 2) Recommend, seek advice on or execute the most appropriate treatment plan based on the current evidence from medical literature; and 3) Understand the complexity and heterogeneity of this population and recognize various modifiable risk factors that should be considered targets for treatment.

SUMMARY:

Conversion disorder (also named functional neurological symptom disorder in *DSM-5*) is

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

COGNITIVE BEHAVIOR THERAPY FOR SEVERE MENTAL DISORDERS: BUILDING TREATMENT SKILLS THAT WORK

*Director: Jesse H. Wright, M.D., Ph.D.
Faculty: David Kingdon, M.D., Douglas Turkington, M.D., Michael E. Thase, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe empirical evidence for the effectiveness of cognitive behavior therapy (CBT) for severe mental disorders; 2) Detail methods for developing effective antisuicide plans with CBT; 3) Describe key strategies for using CBT to modify delusions; 4) Describe key strategies for using CBT to modify hallucinations; and 5) Detail methods for behavioral interventions for patients who are stuck in chronic and severe depression.

SUMMARY:

There is growing evidence that CBT is an effective method for treating patients with chronic and severe mental disorders such as treatment-resistant depression and schizophrenia. This course helps clinicians gain CBT skills that can be added to pharmacotherapy when medication does not give adequate relief of symptoms. Common clinical problems targeted in the course include hopelessness and suicide risk, delusions, hallucinations, and entrenched maladaptive behaviors. Course faculty, who have helped develop and test CBT methods for severe mental illness, will demonstrate key methods with role play and videos. Participants will have the opportunity to discuss the application of CBT for their own patients. Examples of skills that will be learned are developing an effective antisuicide plan, modifying delusions with CBT, teaching patients coping methods for hallucinations, engaging difficult-to-treat patients, using creative methods for behavioral activation and enhancing treatment adherence.

MOOD DISORDERS IN LATER LIFE: ACHIEVING ACCURATE DIAGNOSIS AND EFFECTIVE TREATMENT

Directors: James M. Ellison, M.D., M.P.H., Yusuf Sivrioglu, M.D.

Faculty: Donald A. Davidoff, Ph.D., Brent Forester, M.D., M.Sc., Grace C. Niu, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe and explain an evidence-based approach to the recognition and effective management of late-life mood disorders; 2) Differentiate between the cognitive effects of normal aging, depression and dementia syndrome of depression; 3) Recognize the common and unique features of bipolar disorder in later life and understand the elements of assessment and evidence-based management; and 4) Describe psychotherapy's role in treating late life mood disorders, list evidence-based approaches and understand modifications that facilitate treatment of older adults.

SUMMARY:

In light of the unprecedented growth of our aging population, clinicians need to be proficient in the diagnostic assessment and effective treatment of late-life mood disorders. These debilitating syndromes are widespread and disabling among older adults, but very treatable through the use of standard and newer approaches drawing on

psychosocial and somatic therapies. This course provides an interdisciplinary overview of late-life mood disorders, emphasizing a biopsychosocial approach. The attendee will acquire an organized approach to assessment and a systematic and evidence-based approach to treatment planning incorporating both psychotherapeutic and somatic interventions. In addition, the attendee will learn to distinguish among the cognitive symptoms associated with mood disorders, the cognitive changes associated with normal aging, and the impairments associated with major neurocognitive disorder. The discussion of psychotherapy for older adults with mood disorders will review evidence-based approaches with particular emphasis on cognitive behavior therapy, interpersonal therapy and problem solving therapy. The newly developed ENGAGE protocol will also be described. The discussion of somatic approaches will include a discussion of the syndrome of "vascular depression" and describe an approach to treating resistant disorders. The faculty will lecture using illustrative slides, and there will be ample time for interactive discussion. This course is designed primarily for general psychiatrists seeking greater understanding and expertise in treating older patients. For psychiatric residents and fellows, it will provide an advanced introduction. For geriatric psychiatrists, it will provide a review and update. It will be of greatest practical value to attendees who already possess a basic familiarity with the principles of pharmacotherapy and psychotherapy.

MANAGEMENT OF PSYCHIATRIC DISORDERS IN PREGNANT AND POSTPARTUM WOMEN

Directors: Shaila Misri, M.D., Deirdre M. Ryan, M.B.

Faculty: Barbara Shulman, M.D., Tricia Bowering, M.D., Shari I. Lusskin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Have an increased awareness about mood and anxiety disorders that occur in pregnant and postpartum women; 2) Be familiar with management of bipolar I and II disorders in the perinatal population; and 3) Have an improved ability to manage perinatal psychiatric disorders with pharmacological and nonpharmacological treatments.

SUMMARY:

This course provides a comprehensive and in-depth overview of current clinical guidelines and research

updates in major depressive disorder. An updated perspective with regard to perinatal generalized anxiety disorder, panic disorder and obsessive compulsive disorder will be presented. Trauma-related disorders such as post-traumatic stress and birth-related trauma will be discussed. Bipolar I and II disorders, including treatment challenges for pregnant and postpartum women, will be covered in detail. This course focuses on mother-baby attachment issues, controversy and reality in perinatal pharmacotherapy, and nonpharmacological treatments, including various types of psychotherapies, augmentation therapies, light therapy and infant massage. New findings with mindfulness-based cognitive behavior therapies in perinatal women will be presented. This course is interactive, and the audience is encouraged to bring forward their complex patient scenarios or case vignettes for discussion. The course handouts are specifically designed to update the audience on the cutting-edge knowledge in this subspecialty.

BUPRENORPHINE AND OFFICE-BASED TREATMENT OF OPIOID USE DISORDER

Director: Petros Levounis, M.D.

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the rationale and need for opioid pharmacotherapy in the treatment of opioid dependence and describe buprenorphine protocols for all phases of treatment and for optimal patient treatment; 2) Understand specific information on the legislative and regulatory history of office-based opioid pharmacotherapy; 3) Understand the pharmacological characteristics of opioids and identify common comorbid conditions associated with opioid dependence; 4) Understand treatment issues and management of opioid dependence in adolescents, pregnant women, and patients with acute and/or chronic pain; and 5) Describe the resources needed to set up office-based treatment with buprenorphine for patients with opioid use disorder (OUD).

SUMMARY:

Physicians who complete this course will be eligible to request a waiver to practice medication-assisted addiction therapy with buprenorphine for the treatment of opioid use disorder. The course will describe the resources needed to set up office-based

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

TRANSGENDER AND INTERSEX FOR THE PRACTICING PSYCHIATRIST

Director: William M. Byne, M.D.

Faculty: Evan Eyler, Dan H. Karasic, M.D., Heino F. L. Meyer-Bahlburg, Ph.D., Richard R. Pleak, M.D., Jack Pula, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define and discuss the relevant terminology, including gender dysphoria, disorders of sex development with and without somatic intersexuality, gender variance, transgender, and transsexuality; 2) Describe the components of culturally and clinically competent assessment, diagnosis and care of those with gender concerns, including those seeking hormones and/or surgery for gender transition; 3) Draw on relevant documents for psychiatrists, including the *DSM-5*, the AACAP Practice Parameter on GLBT Youth and the Standards of Care of the World Professional Association for Transgender Health; 4) Distinguish *DSM-5* gender dysphoria from gender concerns arising as epiphenomena of other psychiatric disorders; and 5) Understand how research and society's evolving attitudes toward gender variance influence policies that impact access to transgender health services including hormonal, surgical and mental health care.

SUMMARY:

Transgender people are sufficiently common that even psychiatrists whose practice does not focus on gender variance encounter patients who are

transitioning gender or contemplating gender transition. On the other hand, transgender and other gender-variant people are perceived to be too uncommon in the population for prioritization of their clinical needs in the curricula of medical school and psychiatric residency training programs. Individuals with somatic intersexuality are even less common and receive even less attention in education and training programs despite their and their families' often enormous needs for mental health services beginning from the time of diagnosis, which increasingly occurs prenatally. This course will provide psychiatrists and other mental health professionals with the tools needed to deliver respectful, culturally competent and up-to-date mental health care to gender-variant patients, including those with somatic intersex conditions. An emphasis will be placed on those who are, or who are contemplating, transitioning gender. While the program will provide a useful general overview and roadmap for psychiatrists and other health professionals new to treating gender-variant patients, it will also provide an update for psychiatrists, residents, medical students, nurses and clinical social workers who are already experienced in working with gender-variant individuals. The following areas will be addressed: 1) The evolution of concepts of gender, gender variance and associated terminology; 2) The evolution of medical approaches to gender variance, including the changing roles of mental health professionals in transgender health care as reflected in successive versions of the World Professional Association for Transgender Health Standards of Care (WPATH SOC) and the emergence of informed consent models; 3) Common child and adolescent presentations; evaluation of gender-variant youth; assessment and management of coexisting psychopathology in minors; treatment options, including pubertal suppression; persistence and desistance of gender dysphoria of childhood; and family concerns; 4) Common adult presentations; the process of gender transition and other options for authentic gender expression, assessment and management of concurrent psychiatric illness; and stage of life concerns; 5) Mental health assessments for cross-sex hormones and gender-affirming surgery; 6) Presentation, evaluation and management of gender dysphoria in patients with somatic intersexuality; 7) Recent policy changes, including those of the Affordable Care Act, the Department of Health and Human Services, Medicare and the Veterans Health Administration, that impact access to transgender

health services; and 8) Complex presentations, nonbinary gender identities and the role of the mental health professional in alternative models of treatment.

NEUROPSYCHIATRIC MASQUERADES: MEDICAL AND NEUROLOGICAL DISORDERS THAT PRESENT WITH PSYCHIATRIC SYMPTOMS

Director: Jose R. Maldonado, M.D.

Faculty: Yelizaveta Sher, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the most common clues of presentation suggesting an "organic cause" for psychiatric symptoms; 2) Understand the prevalence, epidemiology and clinical features of the most common endocrine, metabolic, infectious, autoimmune and neurological disorders masquerading as psychiatric illness; 3) Review commonly used pharmacological agents causing behavioral disturbances as common adverse effects; 4) Review diagnostic techniques and evidence-based treatment modalities to address the most common medical disorders masquerading as psychiatric illness; and 5) Understand the neurobiology, diagnosis, and novel delirium and alcohol withdrawal management techniques.

SUMMARY:

Psychiatric masquerades are medical and/or neurological conditions that present primarily with psychiatric or behavioral symptoms. The conditions included in this category range from metabolic disorders (e.g., Wilson's disease and porphyria) to infectious diseases (e.g., syphilis, herpes and HIV) to autoimmune disorders (e.g., SLE, MS) to malignancies (e.g., paraneoplastic syndromes and pancreatic cancer) to neurological disorders (e.g., seizure disorders, NPH, dementia and delirium). In this course, we will discuss the presentation and symptoms of the most common masquerades, focusing on pearls for timely diagnosis, and discuss potential management and treatment strategies.

UPDATES IN GERIATRIC PSYCHIATRY

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

Faculty: Louis Trevisan, M.D., M.Ed., Ilse Wiechers, M.D., M.H.S., Kirsten Wilkins, M.D., Rajesh R. Tampi, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the epidemiology, neurobiology, assessment and management of neurocognitive disorders and behavioral and psychological symptoms of dementia; 2) Describe the epidemiology, neurobiology, assessment and management of substance use disorders in late life; 3) Describe the epidemiology, neurobiology, assessment and management of mood disorders in late life; 4) Elaborate on the epidemiology, neurobiology, assessment and management of anxiety disorders in late life; and 5) Describe the epidemiology, neurobiology, assessment and management of psychotic disorders in late life.

SUMMARY:

Psychiatric disorders are not uncommon in late life. Illnesses like neurocognitive disorders, behavioral and psychological symptoms of neurocognitive disorders, mood disorders, anxiety disorders, psychotic disorders, and substance use disorders are frequently encountered in older adults. The population of older adults is growing rapidly. This has led to an increase in the number of older adults with psychiatric disorders. In this course, we will review the common psychiatric disorders in late life: neurocognitive disorders, behavioral and psychological symptoms of dementia, mood disorders, anxiety disorders, psychotic disorders, and substance use disorders. We have designed this comprehensive review course for clinicians who want to gain expertise in caring for older adults with these psychiatric disorders. This course will be a one-stop shop for those who intend to receive the most up-to-date information on dementia, behavioral and psychological symptoms of neurocognitive disorders, mood disorders, anxiety disorders, psychotic disorders, and substance use disorders in late life. This course will be taught by award-winning geriatric psychiatrists who have expertise in teaching courses in geriatric psychiatry.

SLEEP MEDICINE: A REVIEW AND UPDATE FOR PSYCHIATRISTS

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

Faculty: Elliott K. Lee, M.D., R. Robert Auger, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the major sleep disorders that can affect patients in their practices; 2) Determine which patients should be referred to a

board certified sleep physician; 3) Help patients with obstructive sleep apnea pursue therapy; 4) Determine if patients experience excessive daytime sleepiness; and 5) Facilitate use of CBT principles to treat insomnia.

SUMMARY:

This course will present information about various sleep disorders important to practicing psychiatrists. The introduction will review basic principles of sleep-wake physiological regulation and a description of polysomnographic features of sleep stages. Clinical vignettes that could be seen in a psychiatric clinic will introduce presentations. Primary and comorbid insomnia will be discussed, as well as pharmacological and cognitive behavioral approaches to therapy. Willis Ekblom disease (restless legs syndrome) will be dealt with additionally. Obstructive sleep apnea, a very prevalent disorder, will be presented as a major source of morbidity for psychiatric patients who are at additional risk because of weight gain associated with psychotropic drugs. Other hypersomnia conditions, such as narcolepsy and idiopathic hypersomnia, will be addressed to further assist participants in distinguishing excessive daytime sleepiness from fatigue and apathy. Discussion of parasomnias will describe behavioral disorders of sleep that can be mistaken for nocturnal manifestations of psychiatric disorders. The course will close with a discussion of sleep disorders associated with various psychiatric disorders.

WHAT EVERY PSYCHIATRIST NEEDS TO KNOW ABOUT EPILEPSY

Director: Rochelle Caplan, M.D.

Faculty: Tatiana Falcone, M.D., Jana Jones, Ph.D., Elia M. Pestana Knight, M.D., Gaston Baslet, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Apply knowledge about the bidirectional relationship between epilepsy and psychiatric disorders to improve interdisciplinary collaboration and the outcomes of the treatment of patients with epilepsy; 2) Perform a comprehensive evaluation of patients with seizures and successfully navigate challenging clinical manifestations that require careful diagnostic clarification; and 3) Design a treatment plan that follows current evidence and that integrates the neurobiological and psychosocial contributions that epilepsy and its treatment have in various psychiatric presentations.

SUMMARY:

Psychiatric disorders are common in patients with epilepsy, beyond what is expected with a chronic medical condition. Both neurobiological and psychosocial factors contribute to the expression of psychopathology in patients with epilepsy. Clinical and translational research demonstrate a bidirectional relationship between epilepsy and a wide range of psychiatric disorders, including depression, anxiety, attention deficit hyperactivity disorder, autism spectrum disorders, psychosis and suicide. Despite these robust data, the mental health needs of many epileptic patients remain unmet and impact the quality of life of these patients and the management of their illness. This course will guide clinicians in how to evaluate the challenging differential diagnoses of epilepsy patients, such as psychiatric disorders that mimic seizures, as well as behavioral and affective symptoms that represent seizure manifestations. We will discuss in detail a wide variety of psychiatric manifestations (including depression, anxiety and attention deficit hyperactivity disorder) in the context of epilepsy. The course will also include a review of current antiepileptic drugs and their impact on mood, behavior and cognition, as well as the impact of psychotropic medications on seizures. Evidence-based psychosocial interventions that address mood, anxiety and executive dysfunction in epilepsy will be discussed in detail. Emphasis will be placed on the need for interdisciplinary collaboration to clarify diagnosis, select appropriate therapies and optimize outcomes. Faculty will include experts in neurology, neuropsychiatry, clinical psychology and neuropsychology who possess a wealth of clinical expertise in the evaluation and treatment of patients with epilepsy with comorbid psychiatric diagnoses. We will present illustrative cases showcasing the complexity of these clinical scenarios. Participation from the audience will be encouraged.

A PSYCHIATRIST'S GUIDE TO PATIENTS WITH SEVERE OBESITY: ASSESSMENT AND BEYOND

Directors: Raed Hawa, M.D., Sanjeev Sockalingam, M.D.

Faculty: Stephanie Cassin, Ph.D., Marlene Taube-Schiff, Ph.D., Susan Wnuk, Ph.D., Kristel Lobo Prabhu, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe predisposing

psychosocial factors to obesity and potential medical and surgical interventions; 2) Identify patient characteristics prior to bariatric surgery that inform patients' postsurgery psychosocial interventions; and 3) Apply pharmacology protocols and brief psychological interventions that improve psychiatric care after bariatric surgery.

SUMMARY:

Psychiatrists are now considered integral to the management of severe obesity in hospital- and community-based settings. Furthermore, bariatric surgery, an effective and growing treatment for severe obesity, has resulted in more psychiatrists involved in pre- and postsurgery patient care. Nearly 60% – 70% of severely obese individuals have a history of a psychiatric illness, and treatments such as bariatric surgery may precipitate additional psychopathology, such as cross-addictive behaviors and de novo eating psychopathology. As a result, psychiatric assessment is now a requirement prior to bariatric surgery by insurers and recommended in best practice guidelines. Therefore, psychiatrists are expected to have an array of skills to manage behavioral, relational and psychiatric aspects of severe obesity management, while also having an understanding of the armamentarium of medical and surgical obesity treatment options. The following course is aimed at psychiatrists and other mental health care providers who are caring for severely obese patients. The course outline will include presentations by an interprofessional team from the University of Toronto Bariatric Surgery Collaborative, a six-hospital collaborative with American College of Surgeons Level 1A certification as a Bariatric Center of Excellence. The presenters have research and clinical experience in the care of severely obese individuals, and content will be derived from previous national and international training programs for health care professionals. Dr. Jackson, a bariatric surgeon, will present on the North American obesity epidemic and current state of obesity management interventions available for severe obesity. Dr. Taube-Schiff will discuss diet interventions in obesity management and bariatric surgery and neuropsychiatric sequelae of bariatric-related nutritional deficiencies. Dr. Hawa, psychiatrist and sleep medicine specialist, will provide an approach to assessing psychiatric readiness for bariatric surgery and will discuss evidence-based assessment tools. He will also provide screening tools and the impact of obstructive sleep apnea. Dr. Wnuk will focus on the

differential diagnosis for eating psychopathology in severe obesity, including a discussion of *DSM-5* eating disorders as they relate to bariatric patients. Dr. Sockalingam will review common postoperative complications related to bariatric surgery, including impact on mood disorders, problematic alcohol use (cross-addiction), suicide risk and body image issues. Dr. Stephanie Cassin will provide practical approaches to integrating motivational interviewing and cognitive behavioral therapy with bariatric psychosocial care of patients. Psychosocial screening tools, best practice psychiatric protocols and practical office-based psychosocial interventions for severe obesity management will be discussed. Participants will be able to practice skills and trial assessment approaches through video cases and role play.

IDENTIFYING AND HELPING OLDER ADULTS WITH MILD NEUROCOGNITIVE DISORDERS

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

Faculty: Jennifer Gatchel, M.D., Ph.D., David P. Olson, M.D., Ph.D., Donald A. Davidoff, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the spectrum of cognitive changes that accompany normal aging, subjective cognitive impairment and mild neurocognitive disorder; 2) Appreciate the role that neuropsychology has played in understanding, assessing and monitoring the progression of milder forms of cognitive impairment associated with typical and pathological aging; 3) List and appreciate the value of the neuroimaging techniques that have clarified the pathology and differential diagnostic issues associated with mild neurocognitive disorders; and 4) Prepare helpful recommendations for a person with mild cognitive changes, including lifestyle factors, medical issues, physical and social activity, cognitive stimulation, and sleep hygiene.

SUMMARY:

Longer survival and more effective management of chronic medical diseases means we are facing an epidemic of mild and major neurocognitive disorders among our aging population. Psychiatrists must be at the vanguard of our efforts to appreciate, evaluate and manage cognitive decline from its earliest stages and even preclinically through preventive interventions. In this course, we will focus on the spectrum of cognitive changes that range from so-called normal cognitive aging through subjective

cognitive impairment to mild neurocognitive disorder. We will discuss the early detection of these conditions and review the medical factors that can impair cognition with emphasis on those that can be reversed. We will review a systematic approach to assessment, including the use of input from neuropsychology and neuroimaging. New and exciting neuroimaging approaches will be described and illustrated. Finally, we will discuss the lifestyle choices that can delay or prevent cognitive decline, focusing on physical activity, cognitive stimulation, nutrition, social engagement, medical disease management and restorative sleep. The teaching will include presentations with case vignettes and interactive discussion.

MELATONIN AND LIGHT TREATMENT OF SAD, SLEEP AND OTHER BODY CLOCK DISORDERS

Director: Alfred J. Lewy, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Use the salivary dim light melatonin onset and sleep time to phase type circadian sleep and mood disorders as to whether they are phase advanced or phase delayed; 2) Treat a patient with appropriately timed bright light exposure (evening or morning) and/or low-dose melatonin administration (morning or afternoon) using the patient's phase type; and 3) Monitor treatment response using the dim light melatonin onset (DLMO)/mid-sleep interval, targeting six hours.

SUMMARY:

This course will enable practitioners to advise patients on how to use melatonin and bright light to treat circadian sleep and mood disorders. There are two categories for these disorders: phase advanced and phase delayed. The prototypical patient with seasonal affective disorder (SAD), or winter depression, is phase delayed; however, some are phase advanced. Shift work maladaptation, non-seasonal major depressive disorder and ADHD can also be individually phase typed and then treated with a phase-resetting agent at the appropriate time. Phase advanced disorders are treated with evening bright light exposure and/or low-dose (about 0.5mg) morning melatonin administration. Phase delayed disorders are treated with morning light and/or low-dose afternoon/evening melatonin administration. High doses of melatonin can be given at bedtime to help some people sleep. The best

phase marker is the circadian rhythm of melatonin production, specifically, the time of rise in levels during the evening. In sighted people, samples are collected under dim light conditions. This can be done at home using saliva. Within a year or two, this test should become available to clinicians. The DLMO occurs on average at about 8:00 or 9:00 p.m.; earlier DLMOs indicate a phase advance; later DLMOs indicate a phase delay. The circadian alignment between DLMO and the sleep/wake cycle is also important. Use of the DLMO for phase typing and guiding clinically appropriate phase resetting will be discussed in detail, focusing on SAD. A jet lag treatment algorithm will be presented that takes into account the direction and number of time zones crossed for when to avoid and when to obtain sunlight exposure at the destination and when to take low-dose melatonin before and after travel. Books instructing the use of light treatment will also be reviewed along with the most recent research findings.

MENTALIZATION-BASED TREATMENT FOR BORDERLINE PERSONALITY DISORDER

Director: Anthony Bateman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate an understanding of the mentalizing problems of borderline personality disorder (BPD); 2) Recognize mentalizing and non-mentalizing interventions; 3) Develop and maintain a mentalizing therapeutic stance; and 4) Use some basic mentalizing techniques in everyday clinical work.

SUMMARY:

Mentalization is the process by which we implicitly and explicitly interpret the actions of ourselves and others as meaningful on the basis of intentional mental states (e.g., desires, needs, feelings, beliefs and reasons). We mentalize interactively and emotionally when with others. Each person has the other person's mind in mind (as well as his or her 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 BPD is characterized by a loss of capacity to mentalize when emotionally charged attachment relationships are stimulated. The aim of mentalization-based treatment (MBT) is to increase this capacity to ensure the development of better regulation of affective states and to increase interpersonal and

social function. In this course, we will consider and practice interventions that promote mentalizing, contrasting them with those that are likely to reduce mentalizing. Participants will become aware of which of their current therapeutic interventions promote mentalizing. The most important aspect of MBT is the therapeutic stance. Video and role play will be used to ensure participants recognize the stance and can use it in their everyday practice. Small-group work will be used to practice basic mentalizing interventions described in the manual. In research trials, MBT has been shown to be more effective than treatment in the context of a partial hospital program, both at the end of treatment and at eight-year follow-up. A trial of MBT in an outpatient setting has also been completed. This shows effectiveness when applied by nonspecialist practitioners. Independent replication of the effectiveness of MBT has been shown in cohort studies, and additional randomized controlled trials are in progress. The course will therefore provide practitioners with information about an evidence-based treatment for BPD, present them with an understanding of mentalizing problems as a core component of BPD, equip them with clinical skills that promote mentalizing and help them recognize non-mentalizing interventions.

MAY 15, 2016

INTERPERSONAL PSYCHOTHERAPY

Director: John C. Markowitz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the basic indications, rationale and techniques of interpersonal psychotherapy (IPT) for depression; 2) Appreciate key research supporting the use of IPT for depression and other disorders; and 3) Recognize some of the adaptations or IPT for other psychiatric diagnoses and formats.

SUMMARY:

Interpersonal psychotherapy, a manualized, time-limited psychotherapy, was developed by the late Gerald L. Klerman, M.D., Myrna M. Weissman, Ph.D., and colleagues in the 1970s to treat outpatients with major depression. Its strategies help patients understand links between environmental stressors and the onset of their mood disorder and to explore practical options to achieve desired goals. IPT has had impressive research success in controlled clinical

trials for acute depression, prophylaxis of recurrent depression and other Axis I disorders such as bulimia and PTSD. This course, now in its 22nd consecutive year at the APA Annual Meeting, presents the theory, structure and clinical techniques of IPT along with some of the research supporting its use. The course is intended for therapists experienced in psychotherapy and treatment of depression who have not had previous exposure to IPT. Please note, the course will not provide certification in IPT, a process that requires ongoing training and supervision. Participants should read the IPT manual: Weissman MM, Markowitz JC, Klerman GL: Clinicians' Quick Guide to Interpersonal Psychotherapy. New York: Oxford University Press, 2007. They may also be interested in Markowitz JC, Weissman MM (Editors): Casebook of Interpersonal Psychotherapy. New York: Oxford University Press, 2012, which contains a wealth of case examples.

GOOD PSYCHIATRIC MANAGEMENT FOR BORDERLINE PERSONALITY DISORDER: WHAT EVERY PSYCHIATRIST SHOULD KNOW

*Directors: John Gunderson, M.D., Paul Links
Faculty: Brian Palmer, M.D., M.P.H.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explain the diagnosis to patients and families and establish reasonable expectations for change (psychoeducation); 2) Manage the problem of recurrent suicidality and self-harm while limiting personal burden and liability; 3) Expedite alliance-building via use of medications and homework; and 4) Know when to prioritize BPD's treatment and when to defer until a comorbid disorder is resolved.

SUMMARY:

This course will describe an empirically validated treatment approach: general psychiatric management (GPM). GPM's emphasis on psychoeducation about genetics and prognosis and its integration of medications is consistent with other good psychiatric care. It uses management strategies that are practical, flexible and commonsensical. Listening, validation, and judicious self-disclosures and admonishments create a positive relationship in which both a psychiatrist's concerns and limitations are explicit. Techniques and interventions that facilitate the patient's trust and willingness to become a proactive collaborator will be described. Guidelines for managing the common

and usually most burdensome issues of managing suicidality and self-harm (e.g., intercession crises, threats as a call for help, excessive use of ERs or hospitals) will be reviewed. How and when psychiatrists can usefully integrate group, family or other psychotherapies will be described.

STREET DRUGS AND MENTAL DISORDERS: OVERVIEW AND TREATMENT OF DUAL DIAGNOSIS PATIENTS

Director: John W. Tsuang, M.D.

Faculty: Tim Fong, M.D., Reef Karim, D.O., Larissa Mooney

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand issues relating to the treatment of dual diagnosis patients; 2) Know the popular street drugs and club drugs; and 3) Know the available pharmacological agents for treatment of dual diagnosis patients.

SUMMARY:

According to the Epidemiological Catchment Area (ECA) study, 50% of general psychiatric patients suffer from a substance abuse disorder. These patients, so-called dual diagnosis patients, are extremely difficult to treat, and they are big users of public health services. This course is designed to familiarize participants with diagnosis and state-of-the-art treatment for dual diagnosis patients. We will first review the different substances of abuse, including club drugs, and their psychiatric manifestations. The epidemiological data from the ECA study for dual diagnosis patients will be presented, stressing issues and difficulties relating to the treatment of dual diagnosis patients. The available pharmacological agents for treatment of dual diagnosis patients and medication treatment for substance dependence will be covered. Additionally, participants will learn the harm reduction versus abstinence model for dual diagnosis patients.

UNDERSTANDING AND TREATING NARCISSISTIC PERSONALITY DISORDER

Directors: Frank E. Yeomans, M.D., Otto F. Kernberg, M.D.

Faculty: Eve Caligor, M.D., Diana Diamond, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand and diagnose the

range of narcissistic pathology; 2) Understand the concept of the pathological grandiose self and how to approach this psychological structure clinically; 3) Understand treatment techniques that address narcissistic resistance and help the patient look beyond his or her rigid narcissistic stance and begin to engage meaningfully with others; and 4) Understand how to help the patient gain awareness of and deal with the anxieties that the pathological grandiose self defends against.

SUMMARY:

Narcissistic disorders are prevalent and can be among the most difficult clinical problems to treat. Narcissistic patients tend to cling to a system of thought that interferes with establishing relations and successfully integrating into the world. Furthermore, these patients can engender powerful countertransference feelings of being incompetent, bored, disparaged and dismissed or, at the other extreme, massively and unnervingly idealized. This course will present a framework for conceptualizing, identifying and treating individuals diagnosed with narcissistic personality disorder (NPD) or with significant narcissistic features. Narcissism encompasses normative strivings for perfection, mastery and wholeness, as well as pathological and defensive distortions of these strivings. Such pathological distortions may present overtly in the form of grandiosity, exploitation of others, retreat to omnipotence or denial of dependency or covertly in the form of self-effacement, inhibition and chronic extreme narcissistic vulnerability. Adding to the difficulties in diagnosing and treating narcissistic disorders is the fact that they can manifest themselves in multiple presentations depending on the level of personality organization, subtype or activated mental state. In this course, we will review the levels of narcissistic pathology. We will go on to discuss a specific theoretical and clinical formulation of narcissism and a manualized psychodynamic, transference-focused psychotherapy that has been modified to treat patients with narcissistic disorders. We will review therapeutic modifications that can help clinicians connect with and treat patients with narcissistic pathology at different levels.

PRACTICAL ASSESSMENT AND MANAGEMENT OF BEHAVIOR DISTURBANCE IN PATIENTS WITH MODERATE TO SEVERE DEMENTIA

Director: Maureen C. Nash, M.D., M.S.

Faculty: Sarah Foidel, O.T.R./L., Maria L. Shindler,

M.S.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how to evaluate persons with dementia symptoms and differentiate the common types of dementia: Alzheimer's, vascular, Lewy body, Parkinson's and frontal temporal lobe; 2) Understand the overlap between delirium and dementia with behavior disturbance and how to differentiate and treat those suffering from these two maladies; 3) Have a framework for person-centered assessment and treatment planning, including nonpharmacological interventions; 4) Understand risks, benefits and alternatives of evidence-based treatments for the common types of dementia with behavior disturbance; and 5) Understand the challenges of identifying pain and the terminal nature of advanced dementia.

SUMMARY:

Preventing and treating moderate to severe behavior disturbance in those with dementia is one of the most challenging problems in geriatric psychiatric clinical practice. The regulatory environment and concerns about the risks of treatment are in the press and on the minds of clinicians and the general public. Successful treatment requires a holistic view of assessment, symptom interpretation and knowledge of the evidence base. This course is designed for psychiatrists, primary care providers and advanced practice nurses who desire to learn how to assess and manage behavior disturbances in those with dementia. This course is designed by and for clinicians with a solid basis in the current evidence. Cases will be used throughout the course to illustrate diagnostic issues and the treatment dilemmas. The course will thoroughly review assessment, nonpharmacological management, pharmacological management and quality-of-life issues. Management for both inpatient and outpatient situations will be covered; however, the emphasis will be on the most difficult situations, typically those who are referred to emergency rooms or who are inpatients in adult or geriatric psychiatry units. The first half will be an overview of behavior disturbance and how to measure it while determining the proper diagnosis. Determining the type of dementia and detecting delirium is emphasized for proper management. There will also be a subsection reviewing the diagnosis and

treatment of delirium and discussion of how it relates to behavior disturbance in those with dementia. Next there will be discussion of practical nonpharmacological interventions and in-depth discussion of the pharmacological management of behavior disturbance in dementia. Current controversies and the regulatory environment in long-term care will be discussed. Cases of Alzheimer's, Lewy body, frontal temporal lobe and other dementias will be used to highlight aspects of diagnosis and successful management of the behavior disturbances unique to each disease. Audience participation will be encouraged throughout and is an integral part of the learning process.

INTEGRATING BEHAVIORAL HEALTH AND PRIMARY CARE: PRACTICAL SKILLS FOR THE CONSULTING PSYCHIATRIST

*Directors: Anna Ratzliff, M.D., Ph.D., Lori Raney, M.D.
Faculty: John Kern, M.D.*

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

Psychiatrists are in a unique position to help shape mental health care delivery in the current rapidly evolving health care reform landscape using integrated care approaches in which mental health care is delivered in primary care settings. In this model of care, a team of providers, including the patient's primary care provider, a care manager and a psychiatric consultant, work together to provide evidence-based mental health care. This course is designed to introduce the role of a psychiatrist functioning as part of an integrated care team. The first part of the course describes the delivery of mental health care in primary care settings with a focus on the evidence base, guiding principles and practical skills needed to function as a primary care consulting psychiatrist. The second part of the course is devoted to advanced skills. Topics include supporting accountable care and leadership

essentials for the integrated care psychiatrist. The course will focus on providing a combination of didactic material, case discussion and practice exercises. Three speakers, including Anna Ratzliff, M.D., Ph.D., from the University of Washington, Department of Psychiatry and Behavioral Sciences; Lori Raney, M.D., Chair, APA Workgroup on Integrated Care; and John Kern, M.D., Chief Medical Officer, Regional Mental Health, will present didactic material and allow ample time for questions and discussion.

PSYCHODYNAMIC PSYCHOPHARMACOLOGY: APPLYING PRACTICAL PSYCHODYNAMICS TO IMPROVE PHARMACOLOGICAL OUTCOMES WITH TREATMENT-RESISTANT PATIENTS

Director: David L. Mintz, M.D.

Faculty: Barri Belnap, M.D., David Flynn, M.D., Samar Habl, M.D., David L. Mintz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the evidence base linking meaning factors and medication response; 2) Develop an integrated biopsychosocial treatment frame; 3) Diagnose common psychodynamics underlying pharmacological treatment resistance; 4) Use psychodynamic interventions in pharmacotherapy to ameliorate psychodynamic contributors to medication issues; and 5) Recognize and contain countertransference contributions to pharmacological treatment resistance.

SUMMARY:

Though psychiatry has benefited from an increasingly evidence-based perspective and a proliferation of safer and more tolerable treatments, outcomes are not substantially better than they were a quarter of a century ago. Treatment resistance remains a serious problem across psychiatric diagnoses. While there are many reasons for this, one likely contributor is a treatment environment that has promoted a symptom-focused and biomedically reductionistic approach to patients that neglects the profound impact of psychological and interpersonal factors on treatment outcome. In this environment, prescribing psychiatrists may not possess the knowledge, skills or attitudes needed to transfer psychotherapeutic skills to the psychopharmacology relationship. As such, we are working without some of our most potent tools for working with troubled patients. Psychodynamic psychopharmacology is an approach to psychiatric

treatment that explicitly acknowledges and addresses the central role of meaning and interpersonal factors in pharmacological treatment. While traditional objective-descriptive psychopharmacology provides guidance about what to prescribe, the techniques of psychodynamic psychopharmacology inform prescribers about how to prescribe to maximize outcomes. The course will review the evidence base connecting meaning and medications, showing that effective pharmacotherapy will involve thoughtful attention to psychological and social factors that promote optimal outcomes. We will review psychodynamic concepts relevant to the practice of psychopharmacology with particular attention to psychodynamics and psychosocial factors that underlie pharmacological treatment resistance. We will explore how a developmental, person-centered approach to prescribing can mobilize patients' strengths in the service of functional growth and optimal use of medication and will outline technical principles of psychodynamic psychopharmacology, providing participants with tools for working with psychodynamic resistances to and from psychiatric medications. The course is intended to be highly interactive, and ample space will be provided for discussion of clinical cases, facilitating skill acquisition and the ability to transfer this learning back into clinical practice.

MAY 16, 2016

RESTORING PROFESSIONALISM: INTEGRATING MIND, BRAIN AND BODY FOR DISTRESSED PHYSICIANS

Directors: A. J. Reid Finlayson, M.D., Linda L. M. Worley, M.D.

Faculty: Ron Neufeld, Ph.D., William H. Swiggart, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the continuum of care for problematic physician behavior health from suicide to healthy lifestyle; 2) Describe the components of a comprehensive fitness-for-duty evaluation for unprofessional physician behavior; 3) Review and discuss three case examples of unprofessional behavior that may undermine patient safety: disrupting the optimal functioning of clinical teams, sexual boundary violations and dangerous prescribing practices; 4) Explain the effects of disruptive physician behavior on other members of

clinical teams; and 5) Identify a variety of psychoeducational approaches to remediate problematic physician behaviors and enhance professionalism.

SUMMARY:

Medical boards or colleges, physician health programs, hospitals and practice groups often seek consultation in dealing with problematic physician behaviors that threaten patient safety or interfere with the optimal functioning of clinical teams. This course will present findings from comprehensive evaluations of over 600 physicians and describe continuing education programs developed to educate over 1,500 physicians with behavior problems that involved prescribing improperly, violating boundaries and distressing clinical teams. Participants will review the 360-degree feedback tool that is used to evaluate professional interactions as a way to reinforce and augment change. They will participate in experiential exercises such as the flooding test, some grounding exercises and DRAN concepts. Available outcome data, including follow-up 360 feedback data, will be presented and discussed. Case studies and self-reflective exercises during the course will illustrate how fitness-for-duty evaluations, transformative learning experiences and practicing self-awareness can be applied not only to manage disruptive behavior but to promote and enhance physician wellness. Participants will have the opportunity to experience several developmental tools used to evaluate and monitor professional behavior, including a 360-degree evaluation process. A self-reflective exercise utilizing a nautical metaphor will be used to integrate the concept of professionalism with well-being of the mind, brain and body.

EXPLORING TECHNOLOGIES IN PSYCHIATRY

Directors: Robert Kennedy, M.D., John Luo, M.D.

Faculty: Carlyle Chan, Steven Chan, M.B.A., M.D., John Torous, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review the various current and emerging technologies and connections that are possible in psychiatry and medicine; 2) Evaluate emerging technologies and how they impact clinical practice today and tomorrow; and 3) Recognize the pros and cons of electronic physician-patient communication.

SUMMARY:

This is a newly revised course that addresses the important aspects of managing information and technology that have become an integral component of the practice of psychiatry and medicine. Finding ways to make technology work both as a means of communication and as a way of keeping up to date on current changes in the field is an important goal. Whether it is collaborating with a colleague over the Internet, using a teleconferencing system, participating in a social network, using a smartphone or tablet to connect via email, obtaining critical drug information at the point of care, or evaluating the impact of various treatments in health care management, there are many ways and reasons to connect. This course is divided into three sections: 1a) Your Practice – Part 1 explores various ways to keep up with important information in the field, maintain your clinical expertise and remain current in your knowledge of psychiatry and medicine, lifelong learning, and online meetings. 1b) Your Practice – Part 2 describes ways to manage patient information such as the electronic medical record, practice information, screening tools, extending your practice, educational resources and educational prescriptions in practice, and patient portals. 2) Your Profession explores your professional identity online; security, privacy, social media and ways to manage them; and how other specialties handle the online world. 3) The Future of Technology in Psychiatry and Medicine reviews technology trends, applications and app development, gadgets, and the future of patient interaction. It will explore the evolving role of tablets and smartphones, how these leading edge technologies have changed our relationship to information, and their widespread adoption by psychiatrists and health care professionals. The movement toward digitizing health care information is making the numerous apps and mobile devices a great way to integrate and streamline all aspects of the medical process for enhanced care. This course will explore many of the ways that clinicians can use technology to manage and improve their practice and connect to colleagues, to needed information and even to patients. This course is not intended for novices. It will bring the experienced computer user up to speed on cutting edge technologies, practice trends and technologies that will impact the profession over the next decade.

EMERGENCY PSYCHIATRY: THE BASICS AND BEYOND

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

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify psychiatric emergencies; 2) Feel more comfortable in creating alliances with patients who may be in a decompensated state; 3) Complete a suicide risk assessment; 4) Treat agitation with de-escalation techniques and medications; and 5) Discuss treatments that can be used in emergency situations.

SUMMARY:

Behavioral emergencies may occur in any setting—outpatient, inpatient and emergency departments, as well as in the community. When psychiatric emergencies do occur, psychiatrists should be prepared to deal with surrounding clinical and system issues. One of the most important challenges is the initial assessment and management of a psychiatric crisis/emergency. This includes differentiating a clinical emergency from a social emergency. This course can serve as a primer or as an update for psychiatrists in the evaluation and management of psychiatric emergencies. The course faculty offer decades of experience in emergency psychiatry. The participants will learn about the role of medical and psychiatric evaluations and the use of risk assessment of patients in crisis. The course faculty will discuss when laboratory or other studies may be necessary and note instances when this information does not change treatment course. Tools, such as protocols, to aid in collaboration with the emergency physician will be examined. The art of creating alliances and tools for engaging the crisis patient will be discussed. The participants will also learn about the management of agitation (de-escalation and medication use), and special emphasis will be given to psychopharmacological treatments in the emergency setting. The course is divided into two parts. The first focuses on evaluation and the second on treatment. To round out the lectures on treatment, the chairperson will ask questions of the presenters to highlight practice differences. A combination of lectures and case discussion cover fundamental and pragmatic skills to identify, assess, triage and manage a range of clinical crises. Course faculty include emergency psychiatrists and an emergency medicine physician

to help provide various viewpoints and allow for rich discussion.

THE CLINICAL ASSESSMENT OF MALINGERED MENTAL ILLNESS

Director: Phillip J. Resnick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate skill in detecting deception; 2) Detect malingered psychosis; 3) Identify four signs of malingered insanity defenses; and 4) Identify five clues to malingered PTSD.

SUMMARY:

This course is designed to give psychiatrists practical advice about the detection of malingering and lying. Faculty will summarize recent research and describe approaches to suspected malingering in criminal defendants. Characteristics of true hallucinations will be contrasted with simulated hallucinations. Dr. Resnick will discuss faked amnesia, mental retardation and the reluctance of psychiatrists to diagnose malingering. The limitations of the clinical interview and psychological testing in detecting malingering will be covered. The session will delineate 10 clues to malingered psychosis and five signs of malingered insanity defenses. Video recordings of three defendants describing hallucinations will enable participants to assess their skills in distinguishing between true and feigned mental disease. Participants will also have a written exercise to assess a plaintiff alleging post-traumatic stress disorder. Handouts will cover malingered mutism and feigned PTSD in combat veterans.

PSYCHODYNAMIC PRINCIPLES WITH TREATMENT-RESISTANT MOOD DISORDERS: BREAKING THROUGH TREATMENT RESISTANCE BY FOCUSING ON COMORBIDITY

Director: Eric M. Plakun, M.D.

Faculty: Edward R. Shapiro, M.D., M.A., David L. Mintz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe evidence that psychosocial factors play a role in the cause and effective treatment of treatment-resistant mood disorders; 2) Explain the contribution to treatment resistance of personality disorders, including associated immature defenses like splitting and projective identification; 3) Define the practice of

“psychodynamic psychopharmacology” and explain its role in effective treatment of treatment-resistant mood disorders; and 4) Utilize specific psychodynamic principles to improve outcomes in patients with treatment-resistant mood disorders.

SUMMARY:

Although algorithms help psychiatrists select biological treatments for patients with treatment-resistant mood disorders, the subset of patients with early adverse experiences and comorbid personality disorders often fails to respond to medications alone. These treatments frequently become chronic crisis management, with high risk of suicide. This course describes a comprehensive approach to this subset of treatment-resistant patients derived from a longitudinal study of patients in extended treatment at the Austen Riggs Center. The course offers an overview of psychoanalytic object relations theory to facilitate an understanding of how immature defenses may lead to treatment resistance. Ten psychodynamic principles extracted from study of successful treatments are presented and illustrated with case examples. Among these are listening beneath symptoms for therapeutic stories, putting unavailable effects into words, attending to transference-countertransference paradigms contributing to treatment resistance, and attending to the meaning of medications- an approach known as “psychodynamic psychopharmacology.” This psychodynamic treatment approach guides the conduct of psychotherapy, but also guides adjunctive family work, helps integrate the psychopharmacological approach, and maximizes medication compliance. Time will be included to allow course participants to discuss their own cases, as well as the case material offered by the presenters. The course is designed to help practitioners improve outcomes with these patients in their own work setting.

INTEGRATING BEHAVIORAL HEALTH AND PRIMARY CARE: PRACTICAL SKILLS FOR THE CONSULTING PSYCHIATRIST

Directors: Anna Ratzliff, M.D., Ph.D., Lori Raney, M.D.

Faculty: John Kern, M.D.

EDUCATIONAL OBJECTIVE:

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

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

SUMMARY:

Psychiatrists are in a unique position to help shape mental health care delivery in the current rapidly evolving health care reform landscape using integrated care approaches in which mental health care is delivered in primary care settings. In this model of care, a team of providers, including the patient's primary care provider, a care manager and a psychiatric consultant, work together to provide evidence-based mental health care. This course is designed to introduce the role of a psychiatrist functioning as part of an integrated care team. The first part of the course describes the delivery of mental health care in primary care settings with a focus on the evidence base, guiding principles and practical skills needed to function as a primary care consulting psychiatrist. The second part of the course is devoted to advanced skills. Topics include supporting accountable care and leadership essentials for the integrated care psychiatrist. The course will focus on providing a combination of didactic material, case discussion and practice exercises. Three speakers, including Anna Ratzliff, M.D., Ph.D., from the University of Washington, Department of Psychiatry and Behavioral Sciences; Lori Raney, M.D., Chair, APA Workgroup on Integrated Care; and John Kern, M.D., Chief Medical Officer, Regional Mental Health, will present didactic material and allow ample time for questions and discussion.

MIND-BODY PROGRAMS: STRESS, ANXIETY, DEPRESSION, PTSD, MILITARY TRAUMA AND MASS DISASTERS: LECTURE AND EXPERIENTIAL (REPLACES YOGA OF THE EAST AND WEST)

Director: Patricia L. Gerbarg, M.D.

Faculty: Richard P. Brown, M.D., Chris C. Streeter, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe how heart rate variability and sympatho-vagal balance contribute to overall well-being and stress-resilience; 2) Apply polyvagal theory to understand how voluntarily regulated breathing practices (VRBPs) help shift the organism from states of defensive disconnection

toward a state of safety and connectedness; 3) Discuss the vagal-gamma-aminobutyric acid theory of inhibition and its potential relevance to treatment of stress-, anxiety- and trauma-related disorders; 4) Experience coherent breathing for stress reduction and learn how VRBPs can be used to reduce anxiety, insomnia, depression and symptoms of PTSD; and 5) Experience open focus attentional training for stress reduction, improved attention, and relief of physical and psychological distress for clinicians and their patients.

SUMMARY:

Many—if not a majority of—psychiatric patients are considered “difficult to treat.” This population is even more challenging when brief treatments are considered. However, recent advances allow for a better understanding as well as a more focused approach with more specific, evidence-based techniques. These are proven to effectively treat “difficult” patients in a time-limited framework. This symposium will consider some general factors that make patients difficult to treat. The presentation on motivational interviewing emphasizes how to engage a range of “difficult” patients in their own care. Prolonged exposure for traumatized patients will be illustrated by the treatment of a rape victim. Another presentation specifies the most important cognitive therapy techniques that are effective in working with “difficult” patients, including those with personality disorders. The presentations are rich in clinical material, practical tips and video, with protected time for interaction with the audience.

ESSENTIALS OF ASSESSING AND TREATING ADHD IN ADULTS AND CHILDREN

Director: Thomas Brown, Ph.D.

Faculty: Anthony Rostain, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize impairments caused by ADHD in adults or children; 2) Understand an updated model of ADHD as the developmental impairment of executive functions; 3) Assess and diagnose adults or children for ADHD using appropriate instruments and methods; 4) Select appropriate medications for treatment of ADHD and comorbid disorders; and 5) Design multimodal treatment for adults or children with ADHD.

SUMMARY:

Once understood as a disruptive behavior of childhood, ADHD is now recognized as developmental impairment of the brain's executive functions. Although initial diagnosis of ADHD is usually in childhood or adolescence, many individuals do not recognize their ADHD impairments until they encounter the challenges of adulthood. This comprehensive, basic course for clinicians interested in treatment of adults and/or children and adolescents will offer research and clinical data to provide 1) An overview of the ways ADHD manifests at various points across the lifespan with and without comorbid disorders; 2) Descriptions of how ADHD impacts education, employment, social relationships and family life; 3) Clinical and standardized psychological measures to assess ADHD; 4) Research-based selection criteria of medications for treatment of ADHD and various comorbid disorders; and 5) Guidelines for integration of pharmacological, educational, behavioral and familial interventions into a multimodal treatment plan tailored for specific adults and/or children or adolescents with ADHD.

EVALUATION AND TREATMENT OF SEXUAL DYSFUNCTIONS

Director: Waquih William IsHak, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Acquire practical knowledge and skills in the evaluation of sexual disorders; 2) Acquire practical knowledge and skills in the treatment of sexual disorders; and 3) Learn to apply gained knowledge/skills to real examples of sexual disorders.

SUMMARY:

The course is designed to meet the needs of psychiatrists who are interested in acquiring current knowledge about the evaluation and treatment of sexual disorders in everyday psychiatric practice. The participants will acquire knowledge and skills in taking an adequate sexual history and diagnostic formulation. The epidemiology, diagnostic criteria and treatment of different sexual disorders will be presented, including the impact of current psychiatric and nonpsychiatric medications on sexual functioning. Treatment of medication-induced sexual dysfunction (especially the management of SSRI-induced sexual dysfunction) as well as sexual disorders secondary to medical conditions will be presented. Treatment interventions for sexual

disorders will be discussed, including psychotherapeutic and pharmacological treatments. Clinical application of presented material will be provided using real world case examples brought by the presenter and participants. Methods of teaching will include lectures, clinical vignettes and group discussions.

RISK ASSESSMENT FOR VIOLENCE

Director: Phillip J. Resnick, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

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

ACUTE BRAIN FAILURE: NEUROBIOLOGY, PREVENTION AND TREATMENT OF DELIRIUM

Director: Jose R. Maldonado, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the strengths and weaknesses of various screening and diagnostic instruments used for the detection of delirium; 2) Recognize the main risk factors for the development of delirium in the clinical setting; 3) Describe the evidence regarding the use of nonpharmacological

techniques (e.g., light therapy, early mobilization) in delirium prevention and treatment; 4) Define the evidence behind the use of antipsychotic agents in the prevention and treatment of delirium; and 5) Recognize the evidence behind the use of nonconventional agents (e.g., alpha-2 agonist, melatonin, anticonvulsant agents) in the prevention and treatment of delirium.

SUMMARY:

Delirium is a neurobehavioral syndrome caused by the transient disruption of normal neuronal activity due to disturbances of systemic physiology. It is also the most common psychiatric syndrome found in the general hospital setting, causing widespread adverse impact to medically ill patients. Studies have demonstrated that the occurrence of delirium is associated with greater morbidity and mortality and a number of short- and long-term problems. In the short term, patients suffering from delirium are at risk of harming themselves (e.g., falls, accidental extubation) and of accidentally injuring their caregivers due to confusion, agitation and paranoia. In the long term, delirium has been associated with increased hospital-acquired complications (e.g., decubitus ulcers, aspiration pneumonia), a slower rate of physical recovery, prolonged hospital stays and increased placement in specialized intermediate and long-term care facilities. Furthermore, delirium is associated with poor functional and cognitive recovery, an increased rate of cognitive impairment (including increasing rates of dementia) and decreased quality of life. This course will review delirium's diagnostic criteria (including new *DSM-5* criteria), subtypes, clinical presentation and characteristics, available diagnostic tools, the theories attempting to explain its pathogenesis, and the reciprocal relationship between delirium and cognitive impairment and will summarize behavioral and pharmacological evidence-based techniques associated with successful prevention and treatment techniques. We will also use delirium tremens (i.e., alcohol withdrawal delirium) as a way to better understand delirium's pathophysiology and discuss novel, benzodiazepine-sparing techniques in order to better control the syndrome and prevent its complications while avoiding the deliriogenic effects of benzodiazepine agents.

NEUROANATOMY OF EMOTIONS

Chair: Ricardo M. Vela, M.D.

Director: Ricardo M. Vela, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the principal brain structures involved in emotional expression; 2) Name the main functional neural circuitry of the limbic system; 3) Discuss abnormal brain structures in autism; 4) Discuss neurodevelopmental brain abnormalities in schizophrenia; and 5) Discuss the role of the subcallosal gyrus in depression.

SUMMARY:

Psychiatry has been revolutionized by the development of brain imaging research, which has expanded our understanding of mental illness. This explosion of neuroscientific knowledge will continue to advance. In April 2013, President Obama called for a major initiative for advancing innovative neurotechnologies for brain research. NIMH has launched the new research domain criteria that conceptualize mental disorders as disorders of brain circuits that can be identified with the tools of clinical neuroscience. Psychiatrists need to access fundamental knowledge about brain neuroanatomy and neurocircuitry that will allow them to understand emerging neuroscientific findings that will be incorporated into the practice of psychiatry. This course will describe the structure of limbic nuclei and their interconnections as they relate to the basic mechanisms of emotions. Neuroanatomical illustrations of limbic nuclei, associated prefrontal and cerebellar structures, and main neurocircuitry will be presented. Drawing from classic neurobiological research studies and clinical case data, this course will show how each limbic structure, interacting with each other, contributes to the expression of emotions and attachment behavior. Three-dimensional relationships of limbic structures will be demonstrated through the use of a digital interactive brain atlas with animated illustrations. The relevance of neuroanatomical abnormalities in autism, PTSD, major depression and schizophrenia will be discussed in the context of limbic neuroanatomical structures.

MAY 17, 2016

EVIDENCE-BASED PSYCHODYNAMIC THERAPY: A PRAGMATIC CLINICIAN'S WORKSHOP

Director: Richard F. Summers, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Become aware of the

substantial evidence base supporting psychodynamic psychotherapy; 2) Improve treatment selection by applying a contemporary and pragmatic framework for delivering psychodynamic therapy; 3) Diagnose core psychodynamic problems and develop a psychodynamic formulation for appropriate patients; and 4) Understand how to develop an effective therapeutic alliance and employ techniques for facilitating change.

SUMMARY:

This course will build the clinician's ability to provide effective and pragmatically focused psychodynamic therapy by reviewing the current evidence base for the treatment, presenting a contemporary and concise conceptual framework for treatment and offering a detailed discussion of psychodynamic techniques. Many video clips with class discussion about technique and a group exercise on defining the core psychodynamic problem of a presented patient will make the course lively and participatory. The course follows the arc of therapy by discussing the central concepts of therapeutic alliance, core psychodynamic problems, psychotherapy focus and strategies for change. Presentation of the relevant evidence is paired with the model and specific techniques to bolster the clinician's confidence in the effectiveness of the method. The video clips and group discussion provide an opportunity for interactive learning.

ECT PRACTICE UPDATE FOR THE GENERAL PSYCHIATRIST

Director: Peter B. Rosenquist, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Consider the indications and risk factors for ECT and estimate likely outcomes based upon patient characteristics; 2) Define the physiologic and neurocognitive effects of ECT as they relate to specific and potentially high-risk patient populations; 3) Review the evidence related to ECT stimulus characteristics and summarize the differences between brief and ultra-brief pulse width stimuli; and 4) Define strategies for optimizing treatment outcomes during the ECT course and maintaining remission over time.

SUMMARY:

This course is designed to appeal to general psychiatrists and other health care providers who are involved in providing ECT or referring patients

for ECT. The five faculty of this course are intimately involved with both research and the administration of ECT on a regular basis. The focus of the activity will be to provide an up-to-date discussion of the current practice of ECT, but this is not intended as a "hands-on" course to learn the technique of ECT. The presentations and discussions will include a review of the psychiatric consultation for ECT beginning with the indications, caveats for use of ECT in special patient populations, anesthesia options, potential side effects from ECT and concurrent use of psychotropic and non-psychotropic medications. The course also includes a practical introduction to the decision making process, guiding the choice of techniques including electrode placement, stimulus dosage and parameter selection, as well as relapse prevention strategies. Also included will be an update on current theories of mechanism of action. Any practitioner who has involvement with ECT, either in administration of the procedure or in the referral of patients for ECT, should consider attending this course.

INTEGRATING BEHAVIORAL HEALTH AND PRIMARY CARE: PRACTICAL SKILLS FOR THE CONSULTING PSYCHIATRIST

*Directors: Anna Ratzliff, M.D., Ph.D., Lori Raney, M.D.
Faculty: John Kern, M.D.*

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

Psychiatrists are in a unique position to help shape mental health care delivery in the current rapidly evolving health care reform landscape using integrated care approaches in which mental health care is delivered in primary care settings. In this model of care, a team of providers, including the patient's primary care provider, a care manager and a psychiatric consultant, work together to provide evidence-based mental health care. This course is designed to introduce the role of a psychiatrist

functioning as part of an integrated care team. The first part of the course describes the delivery of mental health care in primary care settings with a focus on the evidence base, guiding principles and practical skills needed to function as a primary care consulting psychiatrist. The second part of the course is devoted to advanced skills. Topics include supporting accountable care and leadership essentials for the integrated care psychiatrist. The course will focus on providing a combination of didactic material, case discussion and practice exercises. Three speakers, including Anna Ratzliff, M.D., Ph.D., from the University of Washington, Department of Psychiatry and Behavioral Sciences; Lori Raney, M.D., Chair, APA Workgroup on Integrated Care; and John Kern, M.D., Chief Medical Officer, Regional Mental Health, will present didactic material and allow ample time for questions and discussion.

DSM-5 CHANGES: OVERVIEW AND PRACTICAL APPLICATIONS (INCLUDING THE TRANSITION TO ICD-10-CM)

Director: Michael B. First, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Be familiar with the new organization structure of the *DSM-5*; 2) Be familiar with the rationale and implications for the incorporation of a more dimensional approach to the *DSM-5*; 3) Be familiar with the relationship between the ICD-10-CM and the *DSM-5*; and 4) Be familiar with the changes being made throughout the *DSM-5*, including their rationale and practical implications.

SUMMARY:

This course will present a practical and comprehensive overview of the *DSM-5*, focusing on the changes and their clinical applications, as well as some of the controversies that arose during the *DSM-5* process. The presentation begins with a summary of the goals and aspirations of the *DSM-5* revision process and how these impacted the structure of the final product. The presentation then covers general issues in the use of the manual, including an explanation of the relationship between the ICD-10-CM coding system and the *DSM-5* system. The course then continues with a presentation of the changes to the various sections of the *DSM-5*, including Neurodevelopmental Disorders; Schizophrenia Spectrum and Other

Psychotic Disorders; Bipolar and Related Disorders; Depressive Disorders; Anxiety Disorders; Obsessive Compulsive and Related Disorders; Trauma- and Stressor-Related Disorders; Dissociative Disorders; Somatic Symptom and Related Disorders; Feeding and Eating Disorders; Sexual Dysfunctions; Sleep-Wake Disorders; Disruptive, Impulse-Control and Conduct Disorders; Substance-Related and Addictive Disorders; Neurocognitive Disorders; and Personality Disorders. For those changes that have been controversial, the pros and cons of the changes will be presented. The course concludes with a look toward the future in terms of the plans to make *DSM-5* a living document, as well as an overview of the research categories for further study.

TALKING WITH YOUR PATIENTS ABOUT MARIJUANA USE: WHAT EVERY PSYCHIATRIST SHOULD KNOW

Director: Henry S. Levine, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the CNS activity of cannabis and the physiologic actions of cannabis and the cannabinoid system; 2) Discuss the medical usefulness and hazards of cannabis, particularly pertaining to psychiatric and substance abuse disorders; 3) Discuss the medico-legal climate regarding cannabis and legal restrictions on the medical use of cannabis; and 4) Take a relevant history from, listen to, educate and counsel patients who wish to use or are using cannabis for medical treatment or who are using it recreationally while in psychiatric treatment.

SUMMARY:

Marijuana, according to NIDA, is "the most commonly used illicit substance." However, according to state, not federal, laws, medical marijuana is legal in 23 states and the District of Columbia. Four states have also legalized recreational use of marijuana. As the number of states legalizing marijuana grows, more patients are turning to us, their doctors, for advice and information regarding marijuana's risks and benefits. Some patients with psychiatric illness are using marijuana recreationally as well without knowledge of its effects. Both groups deserve education from us based on our scientific knowledge. However, despite research to the contrary, much of it done abroad, the U.S. government still considers marijuana a Schedule I substance "with no currently accepted

medical use and a high potential for abuse." The federal stance has inhibited research on the science of marijuana and has promoted an attitude toward marijuana's risks and benefits that is not scientifically based. We need to be able to counsel and educate our patients based on objective, scientific data. There is too much said with authority about medical aspects of marijuana—pro and con—that is misleading and deceptive. This course will teach the practitioner to understand the risks and benefits, restrictions, and seductions their patients face in considering cannabis use. The faculty will review the 2,500-year-long history of cannabis use in medicine and the more recent history of restrictions on research and use of cannabis in the U.S. We will discuss the cannabinoid system, CB1 and CB2 receptors, and their distribution and function, as well as the endogenous cannabinoids. We will cover cannabis's routes of administration, bioavailability, distribution and elimination, and the unique actions of various cannabinoids. We will then present clinical research and its limitations on the usefulness of cannabis in psychiatric conditions, including anxiety, depression, psychosis, PTSD and sleep and its role in violence. We will also review clinical research on its usefulness in nonpsychiatric medicine, including its actions in patients with inflammation, pain, spasm, loss of appetite, nausea, epilepsy and HIV. We will present data on the FDA-approved cannabinoids. The faculty will detail hazards of cannabis use, including addiction, accidents, psychosis, cognitive deficits, withdrawal, heart and lung illnesses, and other psychiatric symptoms. We will describe the legal restrictions and limitations on psychiatric practitioners who may be asked by their patients to issue a "cannabis recommendation." We will teach the practitioner to take a history relevant to the use of medical cannabis. We will discuss ways to listen to and talk with patients who are interested in using or are actively using cannabis for medical reasons or who are using cannabis recreationally while in treatment for a psychiatric disorder. We will not address screening for or treatment of addiction.

ADVANCED ASSESSMENT AND TREATMENT OF ADHD

Director: Thomas Brown, Ph.D.

Faculty: Anthony Rostain, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explain the new model of ADHD as the developmental impairment of executive

functions and its implications for assessment and treatment; 2) Describe research that supports this new model of ADHD; 3) Utilize research-based criteria to select and fine-tune medications for ADHD, modifying as needed for various comorbid disorders; 4) Design and monitor treatment for patients with ADHD that utilizes effective integrated medication and psychosocial approaches; and 5) Consider strategies for effective treatment of ADHD complicated by other medical or psychosocial problems.

SUMMARY:

This advanced course is designed for clinicians who have completed basic professional education in assessment and treatment of ADHD and have mastered basic concepts and skills for treatment of this disorder. It will discuss implications of the new model of ADHD as the developmental impairment of executive function, highlighting research that supports this model and describing implications for assessment and treatment. A revised model of ADHD comorbidities will be described. Emphasis will be on treatment of adults, adolescents and children whose ADHD is complicated by bipolar disorder, substance abuse, learning disorders, OCD, anxiety disorders or autism spectrum disorders. Discussion of case materials will illustrate ways in which ADHD can be complicated by psychiatric comorbidity and by a diversity of interacting psychosocial factors.

FOCUS LIVE

MAY 16, 2016

FOCUS LIVE! OCD AND RELATED DISORDERS (OCDR): DIAGNOSIS TO TREATMENT

Moderators: Mark H Rapaport, M.D., Tristan Gorrindo, M.D.

Speakers: Michele T. Pato, M.D., Katharine A. Phillips, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review multiple-choice questions; 2) Test their knowledge of the clinical management of patients; and 3) Review recent findings regarding the understanding of these disorders, their symptoms and treatments.

SUMMARY:

Obsessive-compulsive disorder (OCD) has been given increased attention in the *DSM-5*, receiving its own chapter. In this FOCUS LIVE session, using a multiple-choice question format, Drs. Pato and Phillips present information about changes to the diagnostic criteria and symptoms differentiating OCD from other related disorders. The genomics of OCD remain under investigation. Treatment of OCD remains difficult, involving a combination of pharmacotherapy and cognitive behavior therapy, with a large percentage of non-responders to initial treatment. The presentation reviews diagnosis, epidemiology, etiology, psychotherapy and pharmacotherapeutic evidence and recommendations. 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 FXP Touch technology for smartphones, which instantly presents the audience responses as a histogram on the screen. Self-assessment credit will be offered to participants through education.psychiatry.org.

FOCUS LIVE! UNDERSTANDING THE EVIDENCE FOR OFF-LABEL USE OF ATYPICAL ANTIPSYCHOTICS

Moderators: Mark H Rapaport, M.D., Tristan Gorrindo, M.D.

Speakers: David L. Fogelson, M.D., Joel Yager, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review the evidence for the risks and benefits associated with atypical antipsychotic use for off-label indications; 2) Incorporate knowledge about atypical antipsychotic use for off-label indications into practice; and 3) Understand treatment strategies and evidence and relate multiple-choice question-based learning to their own patient care.

SUMMARY:

Using FXP Touch technology for interactive participation, this multiple-choice question-based discussion will review evidence for off-label use of atypical antipsychotics. In 2011, the Agency for Health Care Quality and Research (AHRQ) published a comprehensive report, "Off-Label Use of Atypical Antipsychotics: An Update, Comparative Effectiveness Review No. 43," summarizing the evidence for off-label use of antipsychotics for

treatment of mental disorders. As described in the report, prescribing of atypical antipsychotics has moved beyond approved indications; however, the effectiveness, benefits and adverse effects of off-label uses are not well understood. This session is supported in part by a grant from the AHRQ (R18 HS021944) to disseminate the conclusions of the AHRQ report and to update clinicians about new developments regarding the evidence. Overall, a class effect of the atypical antipsychotics for each disorder cannot be assumed, and for most atypicals, adequate supporting evidence for either efficacy or comparative effectiveness is still lacking for many indications. The study of the evidence provided in this program will assist the physician in making informed decisions and provide a foundation for discussions with patients about the risks and benefits of this class of medications. In This FOCUS LIVE session, expert clinicians will lead a lively multiple-choice question-based discussion. Participants test their knowledge with an interactive personal computer/smartphone technology that instantly presents the audience responses as a histogram on the screen. The American Psychiatric Association (APA) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The APA designates this live CME activity for a maximum of 2 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. CME credit for this session is included in the overall APA Annual Meeting 2016 CME certificate. The American Board of Psychiatry and Neurology (ABMS) has reviewed Focus Live: Understanding the Evidence for Off-Label Use of Atypical Antipsychotics and has approved this program as part of a comprehensive self-assessment program, which is mandated by the ABMS as a necessary component of maintenance of certification.

FORUM

MAY 14, 2016

LGBT PSYCHIATRY: UPDATE FOR 2016

Chair: Ellen Haller, M.D.

Speakers: Amir Ahuja, M.D., Laura Erickson-Schroth, Ellen Haller, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the epidemiology of psychiatric disorders in LGBT people; 2) Understand key mental health issues faced by trans individuals; 3) Follow psychiatric issues for people with HIV/AIDS, including impact of availability of PREP, mental health for long-term survivors and possibility of getting to zero transmission; and 4) Understand mental health issues for LGBT parents.

SUMMARY:

Lesbian, gay, bisexual and transgender (LGBT) people have seen great strides in their civil rights over recent years, including the repeal of Don't Ask, Don't Tell in the military and full marriage equality in the United States. They've also witnessed growing visibility in mainstream media and vastly greater acceptance across varied settings. However, coming out as LGBT is still fraught with potential challenges and difficulties, including potential rejection from one's family, friends, housing or religion, and in the U.S., there remains no federal law protecting LGBT people from discrimination in the workplace. The idea behind this forum is to present up-to-date information about four aspects of the psychiatric health of LGBT people. First, we will present data on the epidemiology of psychiatric disorders in LGBT people and will discuss possible etiologies for increased rates of some disorders compared to other populations. Second, we will provide an update on critical mental health issues faced by trans individuals and how they are both similar to and different from LGB people. Third, since the 1980s, HIV/AIDS has had a tremendous and devastating impact on the LGBT community, and we will discuss several psychiatric issues for people living with HIV/AIDS, including the impact of the availability of PREP, how mental health plays a critical role in reducing HIV transmission and what's known about the mental health of long-term survivors. Finally, the rates of LGBT people choosing to become parents after coming out has grown steadily over the past 20 years, and we will present unique issues such individuals face, as well as data regarding their children's development and overall mental health.

RAGTIME: THE MIND AND MUSIC OF SCOTT JOPLIN

Chair: Richard Kogan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the beneficial

impact of music on depressed moods; and 2) Recognize the signs and symptoms of neurosyphilis.

SUMMARY:

Music has a tremendous impact on depressed moods in individuals suffering from mood disorders. In this session, Dr. Richard Kogan will introduce participants to the signs and symptoms of neurosyphilis through appreciation of the mind and music of jazz composer Scott Joplin.

MAY 15, 2016

AASP ABRAHAM L. HALPERN HUMANITARIAN AWARD FORUM—ABORTION: WHAT'S HAPPENING AND WHY IT MATTERS TO WOMEN, SOCIETY AND PSYCHIATRY

Chairs: Rama Rao Gogineni, M.D., Kenneth Thompson, M.D.

Speakers: Nada L. Stotland, M.D., M.P.H., Helen Herrman, M.D., M.B., Mary Barber, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand and identify women's reproductive mental health issues; 2) Attain clinical skills in dealing with patients who have made or who face decisions about pregnancy; 3) Identify factors relevant to pregnancy decisions; and 4) Be prepared to advocate for social policies on reproduction that are beneficial to patients and families.

SUMMARY:

The World Health Organization and the United Nations identified mental health problems that may develop as a consequence of reproductive health associated with pregnancy, childbirth and the puerperium. They may struggle with depression, anxiety, self-harm and many other symptoms. Estimates suggest that 26 million legal abortions and 20 million illegal abortions were performed worldwide in 1995. In many countries, women cannot access legal, safe, timely or affordable abortion, and they resort to unsafe, clandestine or "backyard" abortions by unqualified practitioners or to unsafe self-inflicted procedures. Unsafe abortion is one of the major causes of preventable death. Safe abortion is a simple and inexpensive procedure. Worldwide, abortion providers and women seeking abortion are under threat from anti-abortion groups. When accessing abortion-providing health clinics, women can face verbal abuse, intimidation and

violence from people protesting their opposition to abortion outside these clinics. The actions of these groups have led to a significant reduction in abortion services, denial of public funding and increased legal restrictions. Abortion policy poses a paradox; one-third of women in America undergo an abortion, but those figures are not reflected in public discourse or elections. Psychiatric disorders predispose women to, but are not caused by, abortion, making the issue additionally relevant to psychiatric practice. As the nation is inundated with misinformation and restrictions, abortions highlight the interrelation among psychodynamics, the social ethos, and social policy, about which we all have an obligation to learn, inform and advocate.

MAY 16, 2016

RE-EXAMINING ECT: FROM PATIENT PERSPECTIVES ON STIGMA TO BENEFIT FOR VETERAN MENTAL HEALTH

Chairs: Peter Hauser, M.D., Richard Weiner

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

Speakers: Kitty Dukakis, Richard Weiner, Georgios Petrides, M.D., Mark George, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Provide a forum to discuss the stigma of electroconvulsive therapy (ECT); 2) Provide an overview of ECT with a focus on United States veterans; 3) Provide information on novel uses of ECT in people with schizophrenia; and 4) Provide an overview of transcranial magnetic stimulation (TMS).

SUMMARY:

Electroconvulsive therapy, or ECT, is an extremely effective treatment for major depressive disorder (MDD) that has a rapid onset of action and response and remission rates that greatly surpass various antidepressant medications, even for individuals with psychiatric comorbidities, including PTSD, which is so prevalent among the veteran population. In addition, a growing body of evidence has also demonstrated clinically significant ECT efficacy for patients suffering from other psychiatric disorders, including schizophrenia—a condition for which a substantial number of veterans are diagnosed and for which ECT has been substantially underutilized. Within the context of the very high rates of suicide among veterans, promoting the use of ECT as well as increasing the availability of maintenance ECT in the Veterans Health Administration (VHA) could offer

more rapid relief of psychiatric symptoms and could become an important component of a suicide prevention strategy. However, the stigma and stereotyped negative and punitive images of ECT that date back to previous generations remain a major challenge to greater acceptance of this effective modality of treatment. This forum will provide the opportunity for a dialogue about ECT and will begin with a panel discussion with Ms. Kitty Dukakis and veterans who have received ECT. Next Dr. Weiner will present an overview of ECT and its use in VHA facilities and clinics. Dr. Petrides will then present his experiences utilizing ECT as a treatment for people with schizophrenia. Following that presentation, Dr. George will provide an overview of transcranial magnetic stimulation (TMS), a newer form of brain stimulation that has offered promise for treatment of some patients with MDD. The session will end with a moderated discussion focused on strategies to diminish the stigma associated with ECT.

THE FINANCING OF PSYCHIATRIC CARE: PAST, PRESENT AND FUTURE

Chair: Steven S. Sharfstein, M.D., M.P.A.

Speakers: Steven S. Sharfstein, M.D., M.P.A., Frank W. Brown, M.D., Anita Everett, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how the history of the financing of psychiatric care, mostly through states and public programs, influences the present era of privatization, parity and third-party payments; 2) Appreciate the financial incentives that influence the provision of psychiatric care, with a special emphasis on the role of psychiatrist in integrated health care systems and hospitals; and 3) Anticipate the future of psychiatric care by analyzing the trends in the financing of treatment and the expectations of psychiatrists within comprehensive health care reform.

SUMMARY:

How do we pay for psychiatric treatment? How much is available for what kinds of care? And in what settings? Who pays for care? How much from individuals and families, third and fourth parties, public taxpayer dollars? How is the financing of psychiatric care changing over time? Where does psychiatry fit into value-based health care? How do we pay for the psychiatrist's time and effort and share savings in at-risk models that emphasize

integration and care coordination? As there are not enough psychiatrists to meet the demand of care, how do we use nonpsychiatrists, including primary care physicians and other mental health professionals, in an expanded role to meet needs and, at the same time, maintain the safety and quality that we expect as psychiatrists for the patients under our care? What was once primarily a responsibility of the public sector, especially states paying for psychiatric care, is now more a part of the mainstream of medical care financing but with many gaps, including the reluctance of psychiatrists, more than any other medical specialty, to participate in private or public third-party payments. Ongoing discrimination against psychiatric treatment is evident by the lack of parity in Medicare and Medicaid, low fees, and many managed care hassles. This forum will look at the past in order to understand the present state of financial affairs and then to the future for psychiatrists in their professional roles as the quality medical specialists of mental health care.

THE REFUGEE EXPERIENCE: THE PSYCHOLOGICAL AND NEUROBIOLOGICAL IMPACT

Chair: Julio Licinio, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Increase diagnostic awareness of the major psychiatric problems occurring in refugees; 2) Identify particularly vulnerable refugee subgroups; and 3) Understand the neurobiological basis and outcomes of chronic, persistent stress.

SUMMARY:

For centuries, people have forcibly left their homeland in the turmoil of war, ethnic cleansing or genocide. A topical example of the refugee experience is currently occurring in Europe as millions of Middle-Eastern and Asian refugees arrived, and continue to arrive, after long voyages, typically destitute and not speaking the languages of the host countries. The impact of war and violence on the mental and physical health of the civilian population is immense. Traumatization is often experienced sequentially, which leads to a higher risk for developing trauma-related disorders (PTSD, depression and chronic pain). Different cultures tend to experience the refugee experience in different ways. For example, among Cambodian refugees, a typical episode of “thinking a lot” begins with ruminative-type negative cognitions, in particular

worry and depressive thoughts. Next, these negative cognitions may induce mental symptoms (e.g., poor concentration, forgetfulness and “zoning out”) and somatic symptoms (e.g., migraine headache, migraine-like blurry vision such as scintillating scotomas, dizziness and palpitations). Additional problems refugees already deeply traumatized by the war in their home countries experience include further specific stressors related to their status of residence (e. g., application hearing and length of the asylum procedure). Together with limited access to health care, these constitute additional risk factors for developing somatic and psychological illnesses. Due to the cost of the trip from the Middle East, many families send only their unaccompanied young, which results in an even more vulnerable and unprotected group of refugees who are minors. The level of severe and persistent stress in the refugee population, starting in their home countries and persisting in the host countries, results in chronic neurobiological changes in stress-related pathways, with psychiatric and medical consequences. Adequate treatment for this highly vulnerable group requires a multimodal approach facilitated by translators. Trauma-adapted psychotherapeutic treatment has to be complemented by the activities of social workers, medical treatment and legal advice.

CONSTRAINED ACCESS TO PSYCHIATRISTS IN WASHINGTON, DC, AMONG THE LARGEST HEALTH INSURANCE EXCHANGE CARRIERS’ NETWORKS

Chair: Colleen Coyle

Discussants: Steven S. Sharfstein, M.D., M.P.A., Irvin L. Muszynski, J.D.

Speaker: Joyce C. West, Ph.D., M.P.P.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Provide culturally competent care for diverse populations; 4) Describe the utility of psychotherapeutic and pharmacological treatment options; 5) Integrate knowledge of current psychiatry into discussions with patients; and 6) Identify barriers to care, including health service delivery issues.

SUMMARY:

This forum will highlight findings from a recent study examining practice and accessibility trends among

publicly listed network psychiatrists for the three largest health insurance exchange carriers in the Washington, DC, market. Specifically, the study examined such factors as the proportion of callers who were able to schedule an outpatient visit and the number of days to schedule an outpatient visit. The research team telephoned a randomly selected sample of 450 psychiatrists, neurologists and internal medicine physicians publicly listed as network physicians for the three largest health insurance carriers on the DC Health Link Health Insurance Exchange. Results suggest patients have limited access to network psychiatrists among the three largest health carriers in the Washington, DC, market. For example, 79% of the network psychiatrists were unreachable or not taking any new outpatients. Only 21% of callers were able to schedule appointments, with average wait times for new outpatient appointments of more than three weeks. The goal of this forum is to help audiences better understand the constrained availability of network psychiatrists and other physician groups in the United States. Discussants will explore factors that affect psychiatrists' participation in networks to consider whether these findings reflect the results of intentional rationing of psychiatric services.

MAY 17, 2016

CALL TO ACTION FOR MILITARY AND VETERAN MENTAL HEALTH

Lecturer: Gen. Robert Neller

Speakers: William P. Nash, M.D., Robert J. Ursano, M.D., Harold Kudler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Provide culturally competent care for diverse populations; 4) Describe the utility of psychotherapeutic and pharmacological treatment options; 5) Integrate knowledge of current psychiatry into discussions with patients; and 6) Identify barriers to care, including health service delivery issues.

SUMMARY:

General Robert Neller will discuss current stats regarding suicide within the Marine Corps and in those being detached from the Marines, as well as current availability of services for both of those

groups. Opportunities and ways in which nonmilitary psychiatrists can help and specific risk factors for suicide within this group will also be discussed. Reducing rate of military suicide is an important consideration in the modern U.S. armed forces. General Neller will provide participants with guidance on where to direct Marines and other military personnel if there are concerns for the safety and mental well-being of these individuals.

INTERACTIVE SESSIONS

MAY 14, 2016

GRIEF AND BEREAVEMENT

Chair: Sidney Zisook, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand factors leading to the elimination of the bereavement exclusion for the diagnosis of major depressive episodes and the addition of the new disorder "persistent complex bereavement disorder"; 2) Identify diagnostic guidelines for major depressive episodes occurring in the context of bereavement and for persistent complex bereavement disorder (aka, complicated grief); and 3) Discuss the "predicted" and actual consequences of these changes in the *DSM-5*.

SUMMARY:

It has been three years since the *DSM-5* introduced two major changes in the way "grief and bereavement" were conceptualized: 1) Eliminating the bereavement exclusion from the diagnosis of major depressive episode (while keeping V-code of "uncomplicated bereavement" as an "other condition that may be a focus of clinical attention") and 2) Adding the category of persistent complex bereavement disorder (severe and persistent grief and mourning reactions) as an example of "other specified trauma- and stressor-related disorders" and as a "condition for further study." These changes, especially the former, were contentious and subjects of intense professional and public scrutiny, sometimes bordering on vitriol. Dire consequences were predicted. This interactive session will discuss reasons for the changes, how they were operationalized in the *DSM-5* and what the actual consequences have been.

MAY 15, 2016

**PSYCHIATRY AT THE FOREFRONT OF LEADERSHIP:
WHY YOU? WHY NOW?**

Chair: Patrice Harris, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify opportunities for leadership in the profession; 2) Identify the unique skillsets psychiatrists can bring to positions of leadership; and 3) Identify specific examples for leadership in integrated care service delivery and advocacy.

SUMMARY:

Physicians have multiple opportunities for leadership in both traditional and nontraditional sectors. With our training and skillsets, psychiatrists bring unique expertise to leadership at the local, state and national levels both within and external to health care. In this session, Dr. Harris will review opportunities and challenges on the pathway toward leadership and will discuss the “obligation” of psychiatrists to take on the leadership mantle.

LEADING

Chair: Paul Summergrad, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Better understand the differences between leadership and management; 2) Gain a better sense of the current challenges of leadership in health care and educational organizations; and 3) Appreciate resources that may be available to improve leadership skills.

SUMMARY:

Leadership is a complex set of skills that are important for physicians to understand regardless of whether they serve in formal or informal positions of responsibility within organizations. This interactive session will focus on the challenges of leading.

USING THE *DSM-5* CULTURAL FORMULATION INTERVIEW IN DAILY PRACTICE

Chair: Roberto Lewis-Fernandez, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the need for cultural assessment in mental health care and how it fits within the culture-related changes in *DSM-5*; 2)

Describe the three components of the *DSM-5* Cultural Formulation Interview and how to implement them in routine clinical practice; and 3) Identify video- and web-based training approaches to the CFI as well as future directions for research and clinical care with the CFI and cultural assessment in general.

SUMMARY:

Culture shapes every aspect of patient care in psychiatry, influencing when, where, how and to whom patients narrate their experiences of illness and distress, the patterning of symptoms, and the models clinicians use to interpret and understand symptoms in terms of psychiatric diagnoses. Culture also shapes patients’ perceptions of care, including what types of treatment are acceptable and for how long. Even when patients and clinicians share similar ethnic or linguistic backgrounds, culture impacts care through other influences on identity, such as those due to gender, age, class, race, occupation, sexual orientation and religion. Culture affects the clinical encounter for every patient, not only underserved minority groups, and cultural formulation is therefore an essential component of any comprehensive assessment. Cultural misunderstandings, biases and communication gaps between providers and patients also contribute to disparities in the care of diverse populations, including by race/ethnicity, religion, gender identity and sexual orientation, suggesting person-centered evaluation may help reduce care disparities. The Outline for Cultural Formulation (OCF) introduced with the *DSM-IV* provided a framework for clinicians to organize cultural information relevant to diagnostic assessment and treatment planning. However, use of the OCF has been inconsistent, raising questions about the need for guidance on implementation and training in diverse settings. To address this need, the *DSM-5* introduced a cultural formulation interview (CFI) that revises the OCF in line with newer approaches to cultural assessment and with clear guidelines for clinical implementation. The CFI is comprised of three components: a 16-question “core” version for interviewing patients, an informant version for obtaining collateral information and 12 supplementary modules for more comprehensive assessments that expand on the domains of the CFI and guide cultural assessment of specific populations, such as adolescents and older adults. Clinicians may choose to administer one or several of these components with individual patients. This interactive session

provides an opportunity to meet the authors of the *DSM-5 Handbook on the Cultural Formulation Interview*. We will present the CFI, focusing on its implementation in routine clinical practice across a diversity of service sectors and patient groups. We discuss the process of developing the CFI; the format and content of its various components; guidelines for when in treatment and for which populations to administer each component; how the CFI fits within the culture-related changes in the *DSM-5*; the main findings of the international field trial to test its feasibility, acceptability and clinical utility; recommended training approaches, including via video simulations and web-based platforms; and future directions for research and clinical care with the CFI and cultural assessment in general.

MAY 16, 2016

COMORBID MEDICAL ILLNESS IN SERIOUS PSYCHIATRIC DISORDERS

Chair: Henry A. Nasrallah, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify risk factors for primary and secondary medical illness in psychiatric patients; 2) Recognize the various pathways to medical morbidity and early mortality in psychiatric patients; and 3) Participate in collaborative care with primary care physicians for patients with serious mental illness.

SUMMARY:

Numerous studies have reported that persons with major psychiatric disorders suffer from multiple medical illnesses and have an earlier mortality than the general population. There may be multiple pathways to those medical problems in schizophrenia, major depression and bipolar disorder. Some are genetically linked and exist even before the onset of the first episode. Others are related to life style risk factors such as smoking, sedentary living and a high fat/high calorie diet. There is also a well-established iatrogenic risk for serious cardio-metabolic medical morbidity such as weight gain, diabetes, hyperlipidemia and hypertension. Not surprisingly, early mortality is very high in schizophrenia and mood disorders, and the estimates are as high as 20–25 years of potential life years lost in patients with schizophrenia and about 10 years in depression and bipolar disorder. Making things worse is the fact, shown by multiple studies,

that persons with serious mental disorders like schizophrenia or other psychoses have poor access to standard medical treatments and interventions, partly due to stigma, partly due to dysfunctional systems of care and partly because of the patients' self-neglect. It has become very clear that collaborative care between psychiatrists and primary care physicians or other providers is the optimal model of care for the medical care of persons with severe mental illness. It also generates bidirectional benefits in that primary care providers are perennially frustrated with their inability to have their primary care patients be able to be evaluated by a psychiatrist without waiting for several weeks or months. It is vital that collaborative care be adopted across health care settings so that early detection and prompt intervention or prevention can be implemented. Effectively identifying and addressing primary or secondary comorbidity is a critical part of contemporary psychiatric practice.

BOUNDARIES AND BOUNDARY VIOLATIONS

Chair: Glen O. Gabbard, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Educate psychiatrists about the problem of professional boundary violations in psychoanalysis and psychiatry; 2) Inform psychiatrists of the risk factors for boundary violations; and 3) Teach preventive methods to reduce boundary violations in the field.

SUMMARY:

In this meet-the-author, Glen O. Gabbard, M.D., will discuss his new book, *Boundaries and Boundary Violations in Psychoanalysis: second Edition*. He will present an overview of the problem in both psychoanalysis and psychiatry in general. He will include a thorough discussion of both sexual and nonsexual boundary violations. The latter includes such transgressions as breaches of confidentiality, time and length of sessions, meetings outside the usual clinical settings, expensive gifts, excessive self-disclosure, and others. Dr. Gabbard will also discuss the common profiles of therapists who become involved in boundary violations and the typical "slippery slope" phenomena that lead to them. He will also talk about preventive measures that might reduce the frequency of these unethical forms of contact. There will be an interactive discussion following his brief overview so that a thoroughgoing interchange with the author is possible.

WOMEN'S MENTAL HEALTH: WHAT IS IT? HOW TO DO IT? WHY DO IT?

Chair: Gail Erlick Robinson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the reasons women may resist outside intervention in their pregnancies; 2) Know how to evaluate the ethical and legal issues that arise when considering the alleged conflict between the needs of the mother and those of the fetus; 3) Understand the issues covered by the term women's mental health; and 4) Understand some approaches to establishing a women's mental health program.

SUMMARY:

The health of a mother and her unborn child are often intertwined, and many ethical issues come into play during pregnancy. In this session, Dr. Gail Robinson will explore many of these ethical and legal issues in the context of women's mental health and offer some suggestions for navigating the morally grey area at the intersection of women's rights and the rights of her unborn fetus.

THE DIFFICULT PATIENT

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize key features of various personality disorders; 2) Identify the "thought process" of different personality disorders and conceptualize how that impacts the person being a patient; and 3) Conceptualize how each different personality style can be managed in order to obtain necessary medical treatment.

SUMMARY:

Many types of people present difficulties to medical and surgical staff during their hospitalization. Psychotic patients, extremely depressed patients, delirious patients and demented patients can all be "difficult." The most vexing "difficult" patient is one with a personality style that causes reactions from the treating staff resulting in problems in the delivery of care. This session will focus on personality styles that are experienced as difficult in three major categories: antagonistic (paranoid, sadistic, antisocial), needy (dependent, masochistic, histrionic) and narcissistic. Various approaches to

understanding how such patients can be conceptualized will be discussed. As patients with borderline personality disorder often have features of some or all of the categories, they will be discussed separately. Key issues regarding countertransference to such patients will be discussed. The issue of consulting on the "VIP" patient will be addressed. General techniques for management will be explored. The audience will be invited to discuss their own cases, and the presenter will present difficult patients he has treated.

MAY 17, 2016

MEET THE AUTHORS: CLINICAL MANUAL OF PALLIATIVE CARE PSYCHIATRY

Chairs: Nathan Fairman, M.D., M.P.H., Scott A. Irwin, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the historical development of palliative care psychiatry; 2) Recognize opportunities for psychiatric practice within palliative care; and 3) Identify novel clinical approaches to common psychiatric conditions in the palliative care setting.

SUMMARY:

Individuals with serious medical illness often experience significant psychological distress, and there is a great need for the skillful application of psychiatric expertise in palliative care settings. This session will describe the emergence of a field of clinical expertise at the interface of psychiatry and palliative care. The presenters, psychiatrists practicing in inpatient, outpatient and home-based palliative care and hospice clinical settings, have recently published the *Clinical Manual of Palliative Care Psychiatry* (American Psychiatric Association Publishing, 2016). The session will include a brief historical perspective on psychiatric considerations in palliative care, followed by an interactive discussion of opportunities for psychiatrists to contribute to the care of seriously ill and dying patients.

MAY 18, 2016

THE MAKING OF A FORENSIC PSYCHIATRIST: PERSONAL REFLECTIONS

Chair: Phillip J. Resnick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the personality traits that are most likely to lead to a successful career in forensic psychiatry; 2) Identify five types of child murder by parents; and 3) Describe the central role of detecting malingering in forensic psychiatry.

SUMMARY:

This session will present Dr. Resnick's personal reflections on his career trajectory in the field of forensic psychiatry. He will identify the critical incidents that determined his areas of special interest: child murder and malingering. Dr. Resnick will explain the critical role that various types of teaching have had on his career. He will identify the influences that led him to teach APA courses and workshops on the topics of risk assessment for violence, the detection of malingered mental illness, the insanity defense, the psychiatrist as expert witness, child murder by parents, the role of the expert witness in psychiatric malpractice cases and how to give a more effective lecture. His courses at the American Psychiatric Association and the American Academy of Psychiatry and Law led to invitations to provide workshops in 23 countries. Child murder by parents has been a strong thread in his career. The motives for killing newborns (neonaticide) will be distinguished from the killing of children older than 24 hours (filicide). Five categories of child murder will be delineated: altruistic, acutely psychotic, unwanted child, child maltreatment and spouse revenge. The case of Andrea Yates may be used as an example of altruistic filicide. Dr. Resnick will discuss the personality traits that led to a successful career in forensic psychiatry such as communication skills, self-confidence, and tolerance for close scrutiny and attacks by cross-examiners. The gratifications of a career in forensic psychiatry will also be discussed. However, the majority of the session will consist of Dr. Resnick's responses to questions from participants.

LEARNING LAB

MAY 15, 2016

NEW GUIDELINE RECOMMENDATIONS FOR STRENGTHENING PSYCHIATRIC PRACTICE: FROM THE RATIONALE TO THE REAL WORLD

Chair: Michael J. Vergare, M.D.

Discussant: Thomas J. Craig, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the ways in which the amount and quality of relevant research evidence shapes the development of clinical practice guideline recommendations; 2) List at least three APA practice guideline recommendations that aim to identify concomitant physical conditions in an initial psychiatric evaluation; and 3) Describe potential benefits and challenges of using quantitative measures to guide psychiatric evaluation and treatment.

SUMMARY:

The American Psychiatric Association has recently published *Practice Guidelines for the Psychiatric Evaluation of Adults* and the *Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia*. These new guidelines mark a transition in the format and development process of APA practice guidelines. In this symposium, we will compare and contrast two major approaches to developing guideline recommendations depending upon whether or not there is relevant research evidence available. We will also use an audience response system to solicit feedback from attendees on specific guideline recommendations and their clinical utility. As examples, we will focus on aspects of the psychiatric evaluation that relate to physical health as well as on the judicious use of antipsychotic medications in individuals with dementia. We will also review practice guideline recommendations for the use of quantitative measures in psychiatric assessment and tracking of clinical responses to therapy. Discussion will include examples of "lessons learned" from implementing practice guidelines in the Veterans' Administration Health System. Attendees will be asked to share their preferences for accessing guidelines (e.g., web, textbooks, pocket cards, phone apps) and encouraged to give examples of successes and challenges of adopting practice guideline recommendations in their own practices.

NO. 1

DEVELOPING PRACTICE GUIDELINES: WHY AND HOW

Speaker: Michael J. Vergare, M.D.

SUMMARY:

Practice guidelines are of increasing value to psychiatrists, synthesizing advances in research and providing consensus-based guidance when research evidence is unavailable. With the shift to quality-based payment methodologies, practice guidelines will take on even greater importance. Recent changes in the format and development of APA Practice Guidelines are aimed at improving their rigor and utility for clinicians. This presentation will provide an overview of the APA's practice guidelines program, including the recently published *Practice Guidelines for the Psychiatric Evaluation of Adults* and the *Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia*. Challenges for guideline development and plans for future guidelines will also be discussed.

**NO. 2
PHYSICAL HEALTH ASSESSMENT AS PART OF THE
PSYCHIATRIC EVALUATION**

Speaker: Joel J. Silverman, M.D.

SUMMARY:

In the recently published *Practice Guidelines for the Psychiatric Evaluation of Adults*, a number of recommendations address assessments of physical health. The aims of these assessments are to identify possible contributors to psychiatric symptoms, identify factors that may influence choice of treatments and establish baseline observations from which to judge possible side effects of treatment. Physical health comorbidities are common among those with psychiatric illness and have increasingly been associated with morbidity and early mortality in psychiatric patients. In developing guideline recommendations related to physical health assessments, we discovered that there were often gaps between what expert clinicians thought would improve outcomes and what they routinely did in clinical practice. Assessments such as obtaining weights, vital signs, smoking history or review of systems were less widely done than some other parts of the evaluation. We will discuss some of the conflicts that arose in developing recommendations for physical health assessment, as well as the barriers to implementing these assessments in psychiatric outpatient settings. We will also use an audience response system to solicit feedback from attendees on specific guideline recommendations and promote discussion.

NO. 3

**ALIGNING PRACTICE GUIDELINE
RECOMMENDATIONS WITH EVIDENCE: WHEN AND
HOW SHOULD ANTIPSYCHOTICS BE USED IN
INDIVIDUALS WITH DEMENTIA**

Speaker: Victor I. Reus, M.D.

SUMMARY:

Agitation and psychosis are common in individuals with dementia and can have a significant impact on safety and quality of life. Antipsychotic medications have a long history of use in attempting to treat these symptoms, but research evidence increasingly suggests that there are clear harms and minimal benefits of antipsychotic use in the presence of dementia. This presentation will review the recommendations of the recently published *Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia*. It will also discuss the challenges of using available evidence to assess potential benefits and harms of treatment for individual patients and for patients overall. An audience response system will be used to engage attendees and solicit feedback.

**NO. 4
QUANTITATIVE MEASUREMENT IN PSYCHIATRY:
POSITIVES AND PITFALLS**

Speaker: Laura J. Fochtmann, M.D.

SUMMARY:

Quantitative measures, such as psychiatric rating scales, are suggested as part of the psychiatric evaluation and recommended as part of the assessment and longitudinal monitoring of treatment response in individuals with dementia who are treated with antipsychotic medication for agitation or psychosis. Quantitative measures are also being incorporated into routine primary care and integrated models of care. Use of such measures is likely to explode with the rapid development of mobile apps and the growth of information technology infrastructure, such as electronic health records and patient registries. Nevertheless, many clinicians have questions and concerns about the value and use of quantitative measures in psychiatric settings. An audience response system will be used to obtain feedback from attendees on their use and views of quantitative measures.

**CONTROVERSIAL TREATMENT DEBATE: SHOULD I
PRESCRIBE KETAMINE AND MARIJUANA? (PART 1)**

Chair: Erika L. Nurmi, M.D., Ph.D.

Speakers: John Krystal, M.D., J. Michael Bostwick,

M.D., Stephen R. Marder, M.D., James T. McCracken, M.D., Michele T. Pato, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Be introduced to the critical evaluation of the clinical research literature necessary for the responsible practice of psychiatry; 2) Understand the evidence for and against the use of controversial treatments—ketamine and cannabis—in clinical practice; and 3) Be aware of a free online training resource (developed for residents, sponsored by UCLA and supported by the ABPN) to develop further research literacy.

SUMMARY:

The ability to understand the scientific literature and responsibly translate research progress into clinical practice is a critical but challenging skill that every psychiatrist must acquire. Residency programs are tasked with providing necessary education in research literacy; however, available solutions to this problem are lacking, especially at sites with limited access to experts in both clinical and research psychiatry. The UCLA psychiatric residency research track has developed a successful and lauded training program for our residents. With the support of the American Board of Psychiatry and Neurology (ABPN), we will create and publish a free online research literacy module available to psychiatric residency programs throughout the nation. To widely disseminate this program, we will launch our first event at the 2016 APA Annual Meeting with a controversial treatment debate. Prior to the debate, a primer session in critical manuscript review of clinical research will be available online. Evidence for the therapeutic use of commonly abused drugs, ketamine and cannabis, has been emerging over the past decade, and many psychiatrists are currently prescribing these substances. Our debate will address the question of whether there is sufficient evidence to warrant the use of such therapies in clinical practice, and if so, under what circumstances. The workshop will consist of two debates (ketamine and cannabis), parallel in structure. Experts in ketamine and cannabis treatment for mental illness, Drs. John Krystal (Yale University) and Michael Bostwick (Mayo Clinic), will review the literature for and against the use of these treatments in clinical practice. Suggested references will be available online in advance of the meeting. A diverse panel of UCLA and outside experts, joined by past and current UCLA research track residents

seated in the front rows of the audience, will then lead a debate about whether these therapies are useful in treatment today. The discussion will then be open to the audience. We will conduct an anonymous text poll of the audience with live results reporting at the beginning and end of each debate topic to assess knowledge, attitudes and prescribing practice of these drugs. This workshop, and our online module, should be of interest to clinicians, researchers, educators and trainees. Our online module consists of eight sessions that will provide a lively examination, similar to our APA debate format, of recently published, high-impact, clinically relevant publications. The final session will challenge residents to put their newly acquired skills to work and will serve as a synthesis to reinforce valuable skills gained over the course of the module. The goal of our program is to develop an effective, engaging and easily disseminated online teaching module to establish competency in research literacy for psychiatric residents throughout the nation and enhance the training of the next generation of psychiatrists.

PSYCHIATRY INNOVATION LAB—WHERE QUALITY IMPROVEMENT MEETS SILICON VALLEY: PITCH AN IDEA. BUILD A TEAM. DESIGN A VENTURE.

Chair: Nina Vasan, M.D.

Speakers: Grayson Norquist, M.D., Philip Wang, M.D., Dr.P.H., Mary Giliberti, J.D., Kana Enomoto, Dena Bravata, Mirene Winsberg, M.D., Jordan Amadio, Donovan Wong

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand current trends in health care innovation, including the use of technology, big data, personal health and devices to further the delivery of quality mental health care; 2) Learn best practices in creating entrepreneurial health ventures that are effective, measurable, collaborative and sustainable; 3) Develop a pitch around a potential solution for addressing quality improvement problems in psychiatry; 4) Secure feedback and mentorship from experts in quality improvement, digital health, entrepreneurship and venture capital, as well as from peers in psychiatry and behavioral medicine; and 5) Establish a team of collaborators to brainstorm and refine an innovative idea for the delivery of quality care.

SUMMARY:

Economic, social, scientific and political forces have finally pushed psychiatric care onto the top of the public health agenda; these myriad forces are calling for effective and sustainable business models that can deliver quality programs in the prevention and treatment of psychiatric illnesses. The next step in advancing progress for mental health is embracing the spirit of business and entrepreneurship. Compared to our peers in medicine and surgery, as well as our colleagues in other industries, we as psychiatrists have been slower to realize the potential of the tools that are driving the next revolution in health care: technology, big data, personal health and outcomes measurement. We need to draw upon our clinical experience to develop tools and systems that accelerate the delivery of higher-quality psychiatric care to patients, families and communities. The Psychiatry Innovation Lab will catalyze the formation of innovative ventures that improve the delivery of quality mental health care. Through a highly collaborative and hands-on experience guided by a panel of expert coaches in medicine, digital health, health care entrepreneurship and venture capital, this workshop will give participants the process and tools to turn their "idea(lism) to impact." Participants will begin by pitching their own ideas for improving quality care that include mental health information technology, mobile apps, performance and outcome measurements, patient safety, and telepsychiatry. They will discuss innovative ideas that address the needs of our patients, colleagues and the health care system both here at home and around the world as they apply to transforming access to care, disease prevention, diagnosis and treatment. They will form teams with other participants who have similar interests and work together to develop a venture-based solution. These teams will receive education on best practices in social innovation centered around evidence-based practices, measurement, collaboration and sustainability. They will have a hands-on breakout session to brainstorm and problem solve. The workshop will culminate with a series of final pitch presentations from the teams, which will include valuable insight and feedback from the panel of experts as well as audience members. Participants will have an online portal to share their ideas with each other, creating the opportunity for them to continue working together, building a network and developing their ideas after the conference, as well as for other APA members who are not at the session to join.

CONTROVERSIAL TREATMENT DEBATE: SHOULD I PRESCRIBE KETAMINE AND MARIJUANA? (PART 2)

Chair: Erika L. Nurmi, M.D., Ph.D.

Speakers: John Krystal, M.D., J. Michael Bostwick, M.D., Stephen R. Marder, M.D., James T. McCracken, M.D., Michele T. Pato, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Be introduced to the critical evaluation of the clinical research literature necessary for the responsible practice of psychiatry; 2) Understand the evidence for and against the use of controversial treatments—ketamine and cannabis—in clinical practice; and 3) Be aware of a free online training resource (developed for residents, sponsored by UCLA and supported by the ABPN) to develop further research literacy.

SUMMARY:

The ability to understand the scientific literature and responsibly translate research progress into clinical practice is a critical but challenging skill that every psychiatrist must acquire. Residency programs are tasked with providing necessary education in research literacy; however, available solutions to this problem are lacking, especially at sites with limited access to experts in both clinical and research psychiatry. The UCLA psychiatric residency research track has developed a successful and lauded training program for our residents. With the support of the American Board of Psychiatry and Neurology (ABPN), we will create and publish a free online research literacy module available to psychiatric residency programs throughout the nation. To widely disseminate this program, we will launch our first event at the 2016 APA Annual Meeting with a controversial treatment debate. Prior to the debate, a primer session in critical manuscript review of clinical research will be available online. Evidence for the therapeutic use of commonly abused drugs, ketamine and cannabis, has been emerging over the past decade, and many psychiatrists are currently prescribing these substances. Our debate will address the question of whether there is sufficient evidence to warrant the use of such therapies in clinical practice, and if so, under what circumstances. The workshop will consist of two debates (ketamine and cannabis), parallel in structure. Experts in ketamine and cannabis treatment for mental illness, Drs. John Krystal (Yale University) and Michael Bostwick (Mayo Clinic), will

review the literature for and against the use of these treatments in clinical practice. Suggested references will be available online in advance of the meeting. A diverse panel of UCLA and outside experts, joined by past and current UCLA research track residents seated in the front rows of the audience, will then lead a debate about whether these therapies are useful in treatment today. The discussion will then be open to the audience. We will conduct an anonymous text poll of the audience with live results reporting at the beginning and end of each debate topic to assess knowledge, attitudes and prescribing practice of these drugs. This workshop, and our online module, should be of interest to clinicians, researchers, educators and trainees. Our online module consists of eight sessions that will provide a lively examination, similar to our APA debate format, of recently published, high-impact, clinically relevant publications. The final session will challenge residents to put their newly acquired skills to work and will serve as a synthesis to reinforce valuable skills gained over the course of the module. The goal of our program is to develop an effective, engaging and easily disseminated online teaching module to establish competency in research literacy for psychiatric residents throughout the nation and enhance the training of the next generation of psychiatrists.

MAY 16, 2016

A LEADERSHIP BOOT CAMP FOR RESIDENTS AND FELLOWS (PART 1): DEFINING YOUR PROFESSIONAL GOALS, DEVELOPING LEADERSHIP STRENGTHS, GIVING FEEDBACK AND MANAGING DIFFICULT CONVERSATIONS

Chair: Laura Roberts, M.D., M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe attributes of an academic psychiatrist; 2) Outline the context for professional development; 3) Explore leadership in psychiatric education for its importance and value in academic medicine and for its ultimate goals of improving public health and caring for people with mental illness; 4) Observe examples of natural leaders for their relevance to psychiatric education; 5) Identify core skills and attributes salient to leadership in academic psychiatry and the central challenges in psychiatric education; and 6) Identify the various forms of feedback; 7) Learn common missteps in providing feedback and strategies to

avoid them; 8) Engage in role-play of scenarios of difficult conversations to learn management techniques.

SUMMARY:

There are about a million things we wish someone had taught us, told us or at least hinted at when we first assumed leadership roles. Traditional medical training does not always prepare us for leading teams, giving feedback, negotiating with department chairs, networking or a number of other things that we do every day in academic medicine. This session is part of a two-day boot camp for residents, fellows and early career psychiatrists interested in enhancing their leadership skills. These interactive sessions have been developed to promote academic growth, nurture leadership skills, enhance feedback, teach the basics of negotiation and identify strategies for work-life balance. Using role play, small group discussion, vignettes and other techniques for audience engagement, Dr. Roberts will demonstrate models for effective teaching while also helping attendees create a plan for their own growth as leaders in academic medicine.

MOCK TRIAL: LESSONS FOR PSYCHIATRISTS FROM THE BAR AND RISK MANAGEMENT

Chair: Kristen M. Lambert, J.D., M.S.W.

Speakers: Renée Binder, M.D., Anton Bland, M.D., Noel B. Dumas, Holly S. Bell, Ted Lavender

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize potential liability issues facing psychiatrists when treating; 2) Examine the legal procedural process of a lawsuit from inception through trial; 3) Examine mock documentation that may impact the case; and 4) Explore risk management tips that may be helpful in avoiding some of the potential pitfalls that may impact the defensibility of a case.

SUMMARY:

Chaired by Vice President of Risk Management for the APA-endorsed program, Kristen Lambert, Esq., M.S.W., CPHRM, of AWAC Services, a member company of Allied World, mock trial participants will include current APA President Dr. Renée Binder and Dr. Lisa Gold as expert witnesses and Dr. Lama Bazzi; Dr. D. Anton Bland; Ted Lavender, Esq., of Lewis Brisbois Bisgaard and Smith, Atlanta, Georgia; Noel Dumas, Esq., of Morrison Mahoney, LLP, Boston, Massachusetts; and Holly Bell, Esq., of Norman,

Wood, Kendrick and Turner, Birmingham, Alabama. The presentation will include a deposition of a defendant psychiatrist and the phases of a medical professional liability trial, including examination and cross-examination of a defendant psychiatrist, plaintiff and expert witnesses. Risk management principles and tips will be provided throughout the case example. At the end of the presentation, attendees will serve as the jury to decide the outcome of the case via electronic voting.

PARTICIPANT DEBATES: ETHICAL ISSUES IN PSYCHIATRY

Chair: Rebecca Weintraub Brendel, M.D., J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Provide culturally competent care for diverse populations; 4) Describe the utility of psychotherapeutic and pharmacological treatment options; 5) Integrate knowledge of current psychiatry into discussions with patients; and 6) Identify barriers to care, including health service delivery issues.

SUMMARY:

In this session, attendees will be placed in cohorts, each divided into two teams, and given ethical issues to analyze. Each team will shape their argument and debate their opposing cohort. Group discussion, video clips and interactive polling will facilitate dialogue and guide the debates.

MAY 17, 2016

A LEADERSHIP BOOT CAMP FOR RESIDENTS AND FELLOWS (PART 2): DEVELOPING YOUR NEGOTIATION SKILLS, BALANCING PROFESSIONAL AND PERSONAL COMMITMENTS

Chair: Laura Roberts, M.D., M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn strategies to meet the needs of colleagues, subordinates and supervisors without losing sight of their personal goals; 2) Identify developmental challenges encountered in seeking fulfillment and balance in their professional and personal lives; 3) Learn the factors that may enhance or undermine one's positive self-care

efforts across the course of one's career; and 4) Consider their life goals, internally directed versus externally imposed.

SUMMARY:

There are about a million things we wish someone had taught us, told us or at least hinted at when we first assumed leadership roles. Traditional medical training does not always prepare us for leading teams, giving feedback, negotiating with department chairs, networking or a number of other things that we do every day in academic medicine. This session is part of a two-day boot camp for residents, fellows and early career psychiatrists interested in enhancing their leadership skills. These interactive sessions have been developed to promote academic growth, nurture leadership skills, enhance feedback, teach the basics of negotiation and identify strategies for work-life balance. Using role play, small group discussion, vignettes and other techniques for audience engagement, Dr. Roberts will demonstrate models for effective teaching while also helping attendees create a plan for their own growth as leaders in academic medicine.

MAY 18, 2016

COLLABORATIVE CARE LAB: EXPERIENCE THE NEWEST WAY TO PRACTICE

Chairs: Erik Vanderlip, M.D., M.P.H., Lori Raney, M.D. Speakers: Anna Ratzliff, M.D., Ph.D., Lydia Chwastiak, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Attain an in-depth understanding, through an intensive in-vivo "lab," of a collaborative care system and how psychiatric practice is different and fun within these new models of integration; 2) Operationalize the core elements of collaborative care, including population-focused care, evidence-based treatment, measurement-driven care and team-based care; and 3) Critically compare the essential elements of collaborative care to local integrated care efforts through live participation in a fictional CC model.

SUMMARY:

Collaborative care (CC) is an evidence-based approach to integrating behavioral health services within primary care settings. Through over 80 randomized controlled trials, it has proven consistent efficacy in delivering the triple-aim in

health care reform: cost savings, improved outcomes, and improved patient and provider satisfaction and access to care. In spite of this overwhelming and compelling evidence base, CC has many barriers to implementation, halting widespread dissemination aside from several large-scale programs. CC requires psychiatrists to rethink their role in treating individual patients and their relationship to others on the health care team and requires the use of measurement-based, patient-reported outcomes to guide care and recommendations, all skills that many are unfamiliar with and reluctant to engage. Existing courses taught by the APA rely primarily on lecture-type methods to share these principles, and participants are left with a somewhat superficial understanding of the radical framework shift necessary to implement a CC system. This workshop will highlight the essential elements of CC through a time-intensive, problem-based simulation. Ten fictional cases will be presented to the participants, who will then be assigned into small teams of psychiatrist, PCP and care manager in charge of managing those 10 cases for a “month” of time—approximately 20 minutes. The teamlets will also be provided with registry data on outcomes for their team. Round 1 will consist of simple instructions for the teams to “manage” the 10 patients however they see fit. Clinical updates will follow for an additional two rounds, with subsequent updates in the registry to reflect measurement-based outcome changes over the simulated time scale of three months. During the third round, teamlets will be actively encouraged to utilize the data in the registry to organize their team-based discussion. The final 20 minutes will be spent debriefing the exercise and reviewing the essential elements of the CC model and their rationale from the perspective of this intensive simulation.

LECTURES

MAY 15, 2016

WHY HUMANS LIKE TO CRY: TRAGEDY, EVOLUTION AND THE BRAIN

Lecture Chair: Renée Binder, M.D.

Lecturer: Michael Trimble, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know why crying of tears for emotional reasons is an exclusive attribute of *Homo*

sapiens; 2) Better understand the neuroanatomical basis of crying; 3) Understand the epidemiological and sociological importance of crying; and 4) Examine the relationship between emotional crying and the arts, especially music.

SUMMARY:

This lecture will explore the fact that, of all living species, crying for emotional reasons is exclusive to *Homo sapiens*. This requires an explanation in terms of its relevance from an evolutionary perspective. It also requires examination of differences between the neuroanatomy of the human brain and the brains of our nearest primate relatives. The epidemiology of emotional crying (who cries, where and when) will be examined. There are many stimuli that bring on emotional tears, from loss and bereavement to tears of joy. A fundamental difference between human behavior and other species relates to artistic creativity and our emotional responses to the arts. Emotional responses to the arts reveal that music and reading novels provoke more tears than the pictorial arts, sculpture or architecture. Poetry sits somewhere in the middle. This interesting finding will be explored further. First, the importance of mother/infant bonding, separation and the singing of lullabies will emphasize our first exposure to sensuality, especially a baby’s exposure music. Second, the continued ability to release tears in adolescence and adulthood, associated with autobiographical memories, and their provocation in relationship to sadness and joy will lead to speculations about the emergence of tears as a behavioral emblem of internal emotional states, and the importance of the eyes and tears in the development of human evolution will be explored. It will be concluded that our ability to cry emotionally played a fundamental role in the development of *Homo sapiens*. Linked with our ability for compassion and empathy, emotional crying and our response to tears in another person have led to the foundation of what makes us human.

THE PERSON IN PERSONALIZED MEDICINE: LESSONS FROM THE IMAGES STUDY

Lecturer: Gabriel De Erasquin, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the concept and limits of personalized medicine and precision medicine; and 2) Recognize the relevance

of culture, socioeconomic environment, personality traits, cognition, motor function, brain structure and genetic architecture as the descriptors of the person in personalized medicine to understand course of illness and clinical outcome in schizophrenia.

SUMMARY:

The most common definition of person is “a human being regarded as an individual,” but “personalized medicine” has become a generic term used to refer to techniques that evaluate genetic or molecular profiles (genomics, transcriptomics or metabolomics) to match them to the likelihood of beneficial patient outcomes from treatment interventions with increased precision. There is, however, much more to personalization of care than just identifying the biotherapeutic strategy with the highest likelihood of benefit. In its current meaning, “personalized medicine” invokes a reductionistic approach to the concept of personhood, jeopardizing the goal of individually tailored, holistic care that is at the core of the doctor-patient relationship. Thus, enhancing taxonomic accuracy using molecular information is essential in understanding the ideal conditions to matching treatments to individuals, but may not be enough to optimize personalization of treatment delivery, patient adherence, and clinical and functional outcomes. The IMAGES study (Investigation of Movement Abnormalities and Genetics of Schizophrenia) was designed to understand the relationship between genomic profiles, complex phenotypes, and risk and natural course of illness in a sample of subjects with neuroleptic naïve chronic schizophrenia, their unaffected first-degree relatives and matched healthy controls from an indigenous population from the Central Andes Mountains in South America. Assessment tools to evaluate psychopathology, cognition and personality traits were translated, culturally adapted and validated into Kechwa language. Additional assessments included movement disorders, transcranial ultrasound and brain MRI imaging, and genome-wide genotyping (approximately 10,000 SNPs). After the initial evaluation, affected subjects were offered conventional pharmacological treatment, psychoeducation and follow-up. Outcomes were evaluated 10 years after the initial assessment and included severity of psychopathology, dose-years in chlorpromazine equivalents and treatment with clozapine. Using precision medicine tools, we created a map of risk based on many-to-many relations between genotypes and comprehensive

phenotypes. This map reflects the complexity of the risk architecture of schizophrenia and the pleiotropy of its clinical manifestations. We also found that specific personality profiles are the mediator between genetic risk, brain dysfunction, and individual course of illness (duration of untreated psychosis) and clinical outcomes. The lessons learned regarding the impact of cultural models of illness, environmental variables (including social elements such as access to care) and genetic architecture on the individual psychopathology, course of illness and clinical outcome will be discussed in the context of a broader and more accurate definition of personalized medicine.

KEEPING PACE: THE UCSF ALLIANCE HEALTH PROJECT—A COMMUNITY PSYCHIATRY RESPONSE TO THE AIDS EPIDEMIC

Lecture Chair: Robert M. McCarron, D.O.

Lecturer: James Dilley, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify major developments in the trajectory of the medical response to the AIDS epidemic; 2) Describe the effects of these changes on the psychosocial needs of those living with HIV; and 3) Discuss the principles of community psychiatry in responding to a community-level crisis and describe the Centers for Disease Control and Prevention’s Prevention Research Synthesis Project (PRS).

SUMMARY:

The AIDS epidemic was the most significant worldwide public health crisis of the 20th century. Arising suddenly in the early 1980s, the epidemic struck otherwise marginalized populations of gay men, intravenous drug users and those with hemophilia with a vengeance. Death, dying and the suffering of those with a previously unknown and mysterious illness caused an international sensation as images of a modern day plague were promulgated. The mental health and psychosocial consequences of the epidemic were profound. The response to the developing crisis was led not only by leaders in the medical community but also by gay and lesbian community activists as young, previously healthy gay men fell ill and died. Communities of gay men suffered escalating anxiety and uncertainty as more fell ill; advocates demanded answers that were slow in coming. The response to the crisis was shaped not only by medical uncertainties, but by

reactions to those with the disease. Homosexuality itself, only a few years prior having been taken off the official list of psychiatric disorders, was brought “out of the closet” in jarring ways, linked to a deadly and sinister disease. This link further complicated an already complex psychosocial phenomenon of fear of contagion. The recipient of this year’s Adolph Meyer Award, James W. Dilley, M.D., Vice-Chair of the Department of Psychiatry at the University of California, San Francisco, and cofounder of a community-based HIV mental health and HIV prevention program called the Alliance Health Project (AHP) will discuss the mental health response to the AIDS epidemic using the growth and development of AHP’s 35-year history of responding to the psychosocial challenges of the epidemic as a backdrop. He will highlight the role of community psychiatry in addressing the mental health implications of the epidemic and describe a nationally coordinated strategy to bring an evidenced-based prevention practice developed at AHP to the rest of the country.

NEURONAL PLASTICITY AND GENOMIC DIVERSITY

Lecture Chair: Steve H. Koh, M.D., M.P.H.

Lecturer: Fred H. Gage, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Reprogram human somatic cells to neural cells to examine neuronal phenotypes; 2) Differentiate human embryonic stem cells to neurons of specific lineage with functional properties; and 3) Detect functional and genomic alterations in live neurons derived from patients with psychiatric diseases.

SUMMARY:

The first part of the lecture will focus on evidence supporting the birth and maturation of new neurons in the adult dentate gyrus of the hippocampus in the mammalian brain. The mechanism by which the cells integrate and become functional will be discussed. In the second part of the lecture, I will focus on the recent finding that LINE-1 (Long Interspersed Nucleotide Elements-1 or L1) retroelements are active in somatic neuronal progenitor cells (NPCs) providing an additional mechanism for neuronal diversification. Together with their relatives, including Alus and SVAs, retroelement sequences constitute 45% of the mammalian genome, with L1 elements alone representing 20%. The fact that L1 can retrotranspose in a defined window of neuronal

differentiation, changing the genetic information in single neurons in a random manner, allows the brain to develop in distinctly different ways. More recently, new mechanisms that contribute to somatic mosaicism have been discovered. The importance for this genomic mosaicism in evolution, development and disease will be discussed. In general, this characteristic of variety and flexibility may contribute to the uniqueness of an individual’s brain.

FROM GENES TO NEUROBIOLOGY: A ROAD MAP FOR THE NEXT STEPS IN PSYCHIATRIC GENOMICS

Lecture Chair: Steve H. Koh, M.D., M.P.H.

Lecturer: Matthew State, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how the psychiatric genetics field has transitioned from the identification of candidate loci to the discovery of bona fide risk genes; 2) Appreciate at least three challenges inherent in moving from the identification of risk genes to an understanding of neurobiology; 3) Be able to define the key differences between commonly transmitted and rare de novo risk variants; and 4) Know the key biological functions that have been implicated in autism and schizophrenia.

SUMMARY:

The last several years have ushered in a new age in psychiatric genetics. The maturation of analytic strategies and genomic technologies, combined with a more nuanced understanding of the varied genetic architectures of different psychiatric disorders, has led to highly replicable results for several categorical diagnoses. This has transformed the recent literature on schizophrenia, autism spectrum and bipolar disorders from a focus on the identification of candidate genes to the discovery of bona fide, reproducible risk alleles. The challenge for the field now is harnessing these molecular clues to reveal an actionable understanding of pathophysiology. The lecture will review recent discoveries emerging from studies of both transmitted common and rare de novo variation. It will describe several leading strategies for interpreting these findings, including model systems, functional annotation/pathway analyses and studies of developmental risk trajectories, and it will address both the progress and the varied challenges that are associated with each of these approaches in an effort to define a

road map for the next steps in the molecular dissection of complex neuropsychiatric disorders.

THE OXFORD TEXTBOOK OF CORRECTIONAL PSYCHIATRY: A RETURN TO OUR ROOTS

Lecturers: Jeffrey L. Metzner, M.D., Kenneth L. Appelbaum, Robert L. Trestman, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the relative paucity of correctional psychiatry research, policy and presentations despite the need for such work; 2) Describe the role of professional organizations, including those of psychiatrists, to set standards of treatment and care for incarcerated individuals; and 3) Describe opportunities for the development of educational curricula and research agendas for this understudied, yet critical, field.

SUMMARY:

It is often noted that Benjamin Rush is the father of American psychiatry. It is less often recognized that Dr. Rush was also a founding member of the Philadelphia Society for Alleviating the Miseries of Public Prisons. The *Oxford Textbook of Correctional Psychiatry*, the first textbook in this field, reflects a growing recognition of the challenges and opportunities for current and future APA members presented by the incarceration of so many people and of so many people with mental illness. Dr. Appelbaum will begin with a discussion about the limited visibility of correctional psychiatry in APA journals and meetings and the consequences of such sparse recognition. Dr. Metzner will then discuss the role of professional organizations in establishing standards of care in correctional mental health systems. Dr. Trestman will address some of the educational and research needs and frontiers for correctional psychiatry. Audience members will be invited to engage and challenge the speakers regarding these evolving roles and the critical need for psychiatry to lead improvements in correctional mental health care.

ADVANCES IN ASSESSMENT AND MANAGEMENT OF RISK OF VIOLENCE

Lecturer: Dale McNiel, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn an example of a structured method for assessing risk of violence; 2)

Learn a method to assess competency in risk assessment; and 3) Learn the relationship between mental health court participation and reduction of risk for violence.

SUMMARY:

Assessment and management of risk for violence are important components of mental health service delivery in diverse settings. Clinicians are expected to make reasonable decisions about issues such as whether intervention is needed to protect others from patients' violence, when patients pose sufficient risk to justify involuntary civil commitment, when patients who have been hospitalized can be safely discharged, etc. In recent years, a variety of methods have been developed to assist decision making about these issues. Although research demonstrates the potential for decision support tools to enhance the accuracy of risk assessments for violence, adoption of these methods into clinical practice has not kept pace with research advances. This lecture summarizes a program of research on implementation of evidence-based methods to enhance the competency of psychiatrists and psychologists in risk assessment. A second component of the presentation will discuss recent approaches to reducing potential for violence among subgroups of individuals with mental disorders who are at elevated risk. Persons with mental disorders are vastly overrepresented in the criminal justice system. An increasingly widespread approach to reducing criminal justice involvement of persons with mental disorders is mental health courts (MHCs), which aim to reduce criminal behavior through judicially supervised treatment. The presentation will discuss how mental health courts work and review findings on the effectiveness of MHCs in reducing the risk of violence.

MAY 16, 2016

FUTURE OF PSYCHOPHARMACOLOGY: IS NEW TREATMENT INNOVATION "DEAD" AND IS PHARMACOGENOMICS IRRELEVANT?

Lecturer: Stephen M. Stahl, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the causes of slowing innovation in psychopharmacology; 2) Show that a novel approach is to target symptoms in specific brain circuits; and 3) Propose that pharmacogenomics will assist in identifying

subpopulations of patients that will improve the ability to match a specific treatment to a specific symptom in a specific patient.

SUMMARY:

The pace of introducing new drug therapies into psychiatry—especially agents with novel mechanisms that are substantially better than current treatments—has slowed significantly in recent years. Big Pharma is shifting priorities away from the CNS, failed clinical trials and a broken clinical trials apparatus are deterring therapeutic research, new agents are not reimbursed by payors, and there are few if any new validated neurobiological targets for novel psychiatric drugs. This is a bleak situation perhaps in the short run for sure, but there is a paradigm shift afoot and hope that new approaches to subpopulations of patients with traditional psychiatric disorders and diagnoses may be the solution to reignite innovative new therapeutics. That is, new therapeutics are targeting symptoms that cut across a large array of psychiatric disorders, rather than all the symptoms of one specific psychiatric disorder. The hypothesis is that symptoms are the result of inefficient information processing in specific brain circuits. Furthermore, brain circuits are regulated by neurotransmitters that can be targeted by drugs and by genes that can be used to identify potential subpopulations amenable to a novel treatment. Pharmacogenomics is in its infancy in psychiatry and will likely rarely if ever be the sole answer of what drug to give or what drug to avoid, but will more likely add to clinical “equipose” and contribute to the balance of the evidence in matching a specific patient’s psychiatric symptom to a specific psychopharmacological or psychotherapeutic therapy for him or her as a unique individual.

CORRECTIONAL PSYCHIATRY: CURRENT ISSUES AND FUTURE DIRECTIONS

Lecture Chair: Steve H. Koh, M.D., M.P.H.

Lecturer: Jeffrey L. Metzner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Gain knowledge regarding the mental health needs of the current correctional populations within the U.S.; 2) Identify current issues relevant to correctional mental health systems (e.g., suicide prevention, access to appropriate levels of mental health care, the use of segregation, i.e.,

lockdown); and 3) Identify evolving standards pertinent to correctional mental health systems.

SUMMARY:

Mass incarceration in the United States, which began in the 1980s, has resulted in a disproportionately high percentage of African-American and Hispanic men being incarcerated. The number of persons with a mental illness incarcerated has also significantly increased related, in part, to an inadequately funded community mental health system. This lecture will focus on identifying the mental health needs of the current correctional populations within the United States, review established system models for providing adequate correctional mental health services, explore current issues and controversies within the field of correctional mental health care, and attempt to glimpse into the future regarding the field of correctional mental health care. The roles of the American Medical Association, American Psychiatric Association, and American Academy of Psychiatry and the Law in establishing guidelines and/or standards relevant to correctional mental health services designed to meet constitutional standards, developed directly or indirectly through these organizations, will be highlighted. Relevant landmark legal cases will also be reviewed. Treatment issues, not specific to correctional psychiatry, such as access to care, confidentiality, involuntary treatment and discharge planning will be highlighted because they are frequently difficult to implement in a correctional setting due to institutional cultural barriers. The importance of implementing a multidisciplinary quality improvement process will be emphasized. Issues specific to correctional mental health such as the role of mental health staff in the disciplinary infraction process and the use of long-term segregation (i.e., lockdown) housing units will be reviewed from a national perspective. The “Colorado study,” which is one of the few longitudinal studies relevant to the psychological effects of long-term housing in a 23-hour per day lockdown setting, will be summarized with an emphasis on what it found and what it did not find or study.

SAMHSA AND PSYCHIATRY: WORKING TOGETHER TO ADVANCE THE BEHAVIORAL HEALTH OF THE NATION

Lecturer: Kana Enomoto

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the critical value of biopsychosocial approaches in clinical services for behavioral health; 2) Discuss the psychiatrists' perspective on SAMHSA's role in advancing evidence-based approaches to prevention, treatment and recovery for mental and substance use disorders; and 3) Learn about SAMHSA's new office of the Chief Medical Officer and discuss roles and opportunities for partnerships.

SUMMARY:

Ms. Enomoto will discuss SAMHSA's current and future plans for advancing biopsychosocial approaches to treatment for mental and substance use disorders.

SEEKING THE SACRED IN PSYCHOTHERAPY AND IN LIFE

Lecturer: James W. Lomax, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify positive and negative religious coping and spiritual struggles as factors to assess in treatment; 2) Discuss ways to translate research findings to specific clinical situations and assess outcomes of the interventions; and 3) Describe the personal implications of including concepts connected to spirituality and religion when providing treatment for the patient and therapist involved in long-term treatment relationships.

SUMMARY:

The lecture will begin with a short review of positive and negative religious coping, sanctification and spiritual struggles as they influence the development of psychopathology encountered in clinical relationships. The presentation will then move to a clinical story to illustrate these concepts in the care of a patient with a significant mood disorder treated over a considerable length of time. Research about the implications of sharing sacred experiences for both patient and therapists will be discussed. The session will conclude by soliciting comments and observations from the audience to help them begin to consider how similar material has emerged and been experienced in their own practices and the obstacles and benefits they have experienced while "pursuing the sacred" in professional activities.

THE SUDDEN COLLAPSE OF MARIJUANA PROHIBITION: NOW WHAT?

Lecture Chair: Sidney Zisook, M.D.

Lecturer: Richard J. Bonnie, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn the history of marijuana prohibition in the United States; 2) Understand the difference between "decriminalization" and "legalization"; and 3) Understand the implications of libertarian and public health perspectives on policies relating to use of marijuana, alcohol and tobacco; 3) Understand the long-term importance of the choices that states are now making regarding the design of marijuana policies.

SUMMARY:

Marijuana has had a rocky and peculiar history in the United States. The early history of marijuana prohibition is fairly well known, thanks in part to a classic work on the subject, "The Marijuana Conviction" (1974), co-authored by Professor Richard J. Bonnie. However, the modern history of marijuana policy began in 1972 when the National Commission on Marihuana and Drug Abuse, for which Professor Bonnie served as Associate Director, recommended decriminalizing marijuana use, to the surprise of most observers, including President Nixon. However, the Commission also rejected the idea of legalizing and regulating marijuana, expressing major concerns about the public health consequences of taking this approach. While loosening marijuana laws became a mainstream policy idea through the Ford and Carter administrations, a policy of "zero tolerance" took hold in the Reagan White House and evolved into a new and costly war on all illegal drugs. Millions of marijuana arrests ensued. As the drug war's costs accumulated in the early 21st century, support for decriminalizing marijuana returned. Some states defied the federal government by legalizing medical use. Then, suddenly, in 2012, voter initiatives in Colorado and Washington legalized marijuana for recreational use and, in 2014, voters in Oregon, Alaska and Washington, DC, did the same (although Congress has barred the District from implementing the law). Similar bills have been introduced in many other states. The public health concerns identified by the Marijuana Commission in 1972 are no longer hypothetical. The contemporary policy picture is further complicated by the challenges of implementing a regulatory approach at the state level when cultivating, distributing and possessing the drug are still illegal under federal law. Professor

Bonnie, who has both chronicled this story and been a player in it for more than four decades, will reflect on why marijuana prohibition suddenly collapsed and what should happen next.

BEYOND MACARTHUR: THE PAST, PRESENT AND PROBABLE FUTURE OF VIOLENCE RISK ASSESSMENT

Lecture Chair: Lara J. Cox, M.D., M.S.

Lecturer: John Monahan, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn recent and in press findings generated from the dataset of the MacArthur Violence Risk Assessment Study; 2) Appreciate the scientific legitimacy of making inferences about an individual person from data derived from groups of people; and 3) Recognize moral controversies raised by basing punishment for past violence on an offender's likelihood of future violence.

SUMMARY:

The MacArthur Violence Risk Assessment Study was a multidisciplinary effort by a group of psychiatrists, psychologists, sociologists and statisticians to identify valid risk factors for violence to others by people discharged from short-term psychiatric facilities. The principal results of the study were published over a decade ago and are well known. Less well known is the fact that the entire MacArthur dataset was archived online and made available without charge to anyone who wished to perform their own analyses. To date, this dataset has been downloaded hundreds of times by researchers from around the world. In this address, Professor John Monahan—after briefly recapping the methods and principal conclusions of the original MacArthur Study—will describe recent and in-press findings that have been produced using the archived MacArthur data. These analyses have examined in great depth risk factors for violence, including anger, violent fantasies, gender and psychotic symptoms, as well as new outcome variables, including violence to self, violent victimization, violence to strangers and firearm violence. Enduring controversies in violence risk assessment, including the communication of risk estimates to decision makers, the scientific legitimacy of making inferences about an individual person from data derived from groups of people and the moral legitimacy of basing criminal punishment for past violence on an offender's

likelihood of being violent in the future, will be recognized and engaged.

THINKING DIFFERENTLY ABOUT MENTAL ILLNESS AND GUN VIOLENCE: BALANCING RISK AND RIGHTS FOR EFFECTIVE POLICY

Lecturer: Jeff O. Swanson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand and be able to describe, with some international comparisons, the nature and scope of the problem of firearm-related violence and suicide in the U.S. from a public health perspective; 2) Understand and be able to describe current evidence for the link between serious mental illness and firearm-related injury and mortality within the context of the social environment and multiple factors that contribute to gun violence; 3) Understand and be able to describe the history and current state of policy surrounding legal restrictions on the purchase and possession of firearms by certain categories of individuals with mental illnesses and the evidence for effectiveness of certain interventions and policies; 4) Understand and be able to describe emerging roles of psychiatrists and other mental health clinicians as potential “gun gatekeepers” in various clinical and legal contexts and some of the challenges (i.e., privacy and confidentiality concerns)—potential benefits as well as unintended adverse consequences—of clinicians' involvement in risk-based gun restriction practices and policies; and 5) Understand and be able to describe current expert consensus recommendations for policy and legal reforms to reduce gun violence and their implications for psychiatry and mental health services.

SUMMARY:

Following a series of mass-casualty shootings in the U.S., competing ideas about mental illness and guns, safety and civil rights have collided in the public square. Prominent calls to reform the mental health care system as the key to reducing gun violence and an intensified focus on legal restrictions on gun access for persons with mental illness have highlighted the strategic yet ambiguous role of psychiatrists as both advocates for their patients and “gun gatekeepers” in the interest of public safety. A climate of professional uncertainty combines with misinformed public concern and invites a number of questions to be answered with scientific evidence: what is the nature of the small intersection between

gun violence and mental illness, as two important but different public health problems? What is currently known about the link between psychopathology and violent behavior, gun violence in particular? How accurate and useful are clinicians' "predictions" of violence in their patients? How effective is psychiatric treatment in reducing violence risk in people with serious mental illnesses? This lecture will frame such questions in context, describe emerging scientific evidence, and discuss implications for clinicians and mental health stakeholders. Taking a public health perspective, the presentation will summarize the history and current state of policy surrounding legal restrictions on the purchase and possession of firearms by certain categories of individuals with mental illnesses and review evidence for effectiveness of certain interventions and policies. The lecture will address the emerging role of psychiatrists and other mental health clinicians as potential "gun gatekeepers" in various clinical and legal contexts and lay out some of the challenges (i.e., privacy and confidentiality concerns)—potential benefits as well as unintended adverse social consequences—of clinicians' involvement in risk-based gun restriction practices and policies. Finally, the lecture will describe a set of current expert consensus recommendations for policy and legal reforms to reduce gun violence and their implications for psychiatry and mental health service providers.

PSYCHIATRIC FACULTY DEVELOPMENT: CHALLENGES FOR THE 21ST CENTURY

Lecture Chairs: Christopher R. Thomas, M.D., Richard F. Summers, M.D.

Lecturers: Robert E. Hales, M.D., John H. Coverdale, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know the barriers to faculty development; 2) Improve faculty assessment skills; 3) Address faculty burnout; 4) Understand the involvement of faculty in scholarly pursuits; and 5) Disseminate model faculty training.

SUMMARY:

Following presentations by this year's APA Vestermark Award winners, Drs. Robert E. Hales and John H. Coverdale, there will be a panel discussion on psychiatry in the 21st century. There are many challenges facing psychiatric education in the coming years, including new discoveries in neuroscience,

development of new treatments and changes in the mental health care system. Medical education is also changing rapidly as it shifts to a competency-based model of training and assessment. A critical factor in addressing these changes is ensuring that faculty supervisors are prepared to train the next generation of psychiatrists. This panel reviews the problems and opportunities for faculty development in psychiatry through a series of questions with discussion by the panel and audience.

THE SWEET ENCHANTMENT OF "POST-RACIAL" RACISM IN AMERICA

Lecturer: Eduardo Bonilla-Silva, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Educate people about racism; 2) Recognize how race still matters in America; and 3) Propose steps we might take to address racism in America.

SUMMARY:

Is racism on the rise in America? Is Trump's ascent evidence that this is the case? Relatedly, is racism mostly about southern, rural, poor and working-class, uneducated whites? In this lecture, Professor Bonilla-Silva will address all these questions. He will begin by trying to define the term "racism" and argue for the need to understand the phenomenon structurally. Second, he will argue that the death of Jim Crow did not mean the end of systemic racism, as a new regime (the "new racism") took its place in the 1970s. Last, he will contend that, although old-fashioned prejudice is still part of our ideological landscape, the dominant form of prejudice in contemporary America is the suave but deadly colorblind racism. He will conclude his talk by outlining what mental health professionals, social scientists and policy makers alike should do if they want to contribute to the eradication of racism in the nation.

ROLE CONFLICTS IN THE MANAGEMENT OF SEXUAL OFFENDERS

Lecturer: Roy O'Shaughnessy, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Address the demarcation of medical science from social deviance in sexual offenders; 2) Describe limitations in diagnostic assessments of sexual offenders; and 3) Review

outcomes of psychiatric treatment versus criminological rehabilitation of sexual offender populations.

SUMMARY:

The psychiatric assessment of sexual offenders presents complex ethical and philosophical challenges. On the one hand is the potential to assist in the rehabilitation of offenders and reduce the risk for future offending and prevention of harm to potential victims. On the other is the risk of criticism for medicalizing social deviance or acting as agents of social control. Separating mental disorder from social deviance is complicated by diagnostic categories containing value judgments as opposed to medical criteria, limited availability of standardized assessment procedures and criteria, and limitations in confidentiality that restrict access to psychological phenomena. Risk assessment for non-treatment purposes present scientific and ethical dilemmas, especially in light of potential harm that may result to the evaluatee. Despite the general prohibition of combining treatment and forensic roles, treatment of sexual offenders often leads to dual agency of being both treater and evaluator for parole boards or sexually violent predator (SVP) procedures. This lecture will focus on the conflicts inherent in managing sexual offenders with the goal of offering potential clarifications that may assist role clarity.

UNFREEZING THE GUN DEBATE: HOW NEW RESEARCH AT THE INTERSECTION OF GUNS, VIOLENCE AND MENTAL ILLNESS CREATES OPPORTUNITIES FOR POLICY CHANGE

Lecture Chair: Catherine Crone, M.D.

Lecturer: Josh Horwitz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand emerging research seeking to quantify the risk of perpetrating gun violence against self or others among those with mental illness; 2) Identify new policy approaches to reduce gun violence (including self-harm) that are based on actual risk, rather than on popular perception; and 3) Recognize the role that mental health providers, academics and advocates can play in translating research for policy makers and community stakeholders.

SUMMARY:

This lecture is designed to provide mental health providers, academics and advocates with an

overview of the emergence of a risk-based approach to reducing gun violence and how this approach can both drive policy change that will increase community and individual safety while at the same time combating the popular perception that a major driver of gun violence is mental illness. This lecture will detail emerging research at the intersection of guns, public health and mental illness; inform attendees about new efforts to use the risk-based approach to break or unfreeze the policy log jam on new gun policy; and identify how those in the mental health fields can play a catalytic role in developing new policy by translating evidence for community stakeholders and policy makers.

RECIPROCAL REVOLUTION: THE POTENTIAL AND CHALLENGES OF COLLABORATION BETWEEN PSYCHIATRY AND PUBLIC HEALTH

Lecturer: Thomas Frieden, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how collaborations between psychiatry and public health can improve mental health prevention and treatment; 2) Understand specific public health actions and approaches to outcomes assessment that can protect and restore mental health; and 3) Understand public and mental health considerations to help people achieve their full potential.

SUMMARY:

Although psychotherapists treat patients individually while public health deals with entire patient populations, the fields can be synergistic if they learn from each other and collaborate to protect and restore mental health. The work of public health intersects with psychiatry and mental health in many different ways, some more directly than others, but the concept of well-being must necessarily incorporate a mental health aspect. Because much of an individual's mental health trajectory is established in childhood and adolescence, it's critical to consider the public health and mental health steps needed to increase the proportion of children who reach adulthood with the greatest likelihood of achieving their full potential. Accountability for outcomes under real-world conditions is key; tuberculosis control programs provide a model: treating patients as VIPs and tracking and ensuring accountability for outcomes.

MAY 17, 2016

REGULATING THE ENTRY OF INTERNATIONAL MEDICAL GRADUATES INTO U.S. MEDICINE AND PSYCHIATRY AND ENDEAVORING TO CONTRIBUTE TO THEIR PROFESSIONAL DEVELOPMENT: THE ROLE OF THE ECFMG

Lecturer: Emmanuel Cassimatis, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the present and upcoming (202and 3) requirements for entry of IMGs into U.S. GME and, ultimately, for licensure and practice; 2) Explore the role of IMG psychiatrists in the U.S. health care system; 3) Discuss ECFMG and FAIMER initiatives in support of IMGs in the U.S. and around the world.

SUMMARY:

As physicians migrate around the world in pursuit of training and practice opportunities, host nations must protect their public by evaluating the physicians' training and readiness to practice their specialty. In the United States, this regulatory activity has at times focused on the quality of international medical schools, but mostly on the credentials, knowledge and clinical skills of individual physicians. The Educational Commission for Foreign Medical Graduates (ECFMG) has, for the past 60 years, exercised a regulatory role that includes verifying the credentials of international medical graduates (IMGs) and evaluating their medical knowledge and clinical skills before certifying them to enter U.S. graduate medical education (GME) programs. The large number of IMGs practicing in our country (about one-fourth of the total number of physicians) and their remarkable accomplishments speak both to the inherently high quality of these physicians and to the ECFMG's success in screening them to ensure that only appropriately prepared ones are allowed to enter residency training and, ultimately, practice. Although IMGs in the U.S. have distinguished themselves in all specialties, IMGs in our specialty stand out through both their numbers and extraordinary achievements. This lecture will accordingly focus on recent data about IMGs in psychiatry and their many accomplishments and contributions. Finally, even though the ECFMG is primarily a regulatory organization, it has endeavored, since its founding, to assist all IMGs—those who wish to come and practice in the U.S. and those who do not. This endeavor has taken the form of grants and

fellowships that have allowed IMGs to pursue programs in education and research; involved the establishment of acculturation, exchange clerkship and other support programs; and, most importantly, led to the establishment of the Foundation for Advancement of International Medical Education (FAIMER). FAIMER, through its educational institutes, databases and research programs, is contributing to the professional development of IMGs around the world. FAIMER has also pursued partnerships with other organizations such as the World Federation for Medical Education (WFME) and The Network: Towards Unity for Health. One recent partnership with WFME involved the merger of WFME's Avicenna Directories with FAIMER's International Medical Education Directory to establish the new World Directory of Medical Schools.

OPIOIDS AND CANNABIS: MYTHS AND MISPERCEPTIONS

Lecture Chair: John A. Renner Jr, M.D.

Lecturer: Nora Volkow, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand why addiction should be treated as a chronic brain disease; 2) Develop strategies to address the prescription opioid and heroin crises; and 3) Understand the health effects of marijuana and potential therapeutic effects of its constituents.

SUMMARY:

In recent years, dramatic growth in the use and misuse of opioids and the policy changes regarding the legalization of cannabis have taken center stage in addiction science. In the case of the opioid abuse epidemic, this visibility has prompted increased research efforts to prevent and treat opioid use disorders, along with the fatalities associated with opioid overdoses. Opioids—long recognized for their analgesic potency—are particularly beneficial for the management of severe acute pain, but their use for chronic pain is increasingly being questioned. Not only do they rapidly lead to tolerance, necessitating dose increases to sustain analgesia, but their use can result in addiction even in those suffering from pain. Moreover, some individuals addicted to prescription opioids are transitioning to heroin, which is cheaper and easier to procure. Effective medications exist for the treatment of opioid use disorders but they have not been widely utilized. This presentation will

discuss misconceptions that contribute to the opioid epidemic and the inappropriate treatment of opioid use disorders. In the case of cannabis, the push toward its medicalization and legalization requires research to learn more about its negative effects, as well as its potential therapeutic benefits. Despite some areas of uncertainty, a substantial body of research provides evidence that cannabis use is associated with a wide range of adverse consequences for mental health, including interfering with brain development. Of particular interest has been the association of cannabis with psychiatric disorders (psychoses) but also its therapeutic potential in mental illness (e.g., PTSD). This presentation will highlight ongoing research efforts to better understand both the positive and negative potential of cannabis.

PERSPECTIVES ON PHYSICIAN COMPETENCE AND LIFELONG LEARNING

Lecture Chair: Steve H. Koh, M.D., M.P.H.

Lecturer: Larry R. Faulkner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the contribution of physician competence and lifelong learning to quality patient care; 2) Appreciate the underlying philosophical tenets of the ABPN concerning physician competence; and 3) Recognize the role that MOC might play in promoting lifelong learning and documenting physician competence.

SUMMARY:

While the U.S. has the most expensive health care system in the world, serious questions exist about the quality of care that patients receive in that system. There is also evidence that the competence of physicians may deteriorate over time and that physicians may not be good judges of their own competence. While problems in patient care quality are the result of multiple factors, physician competence plays a significant role, underscoring the need for effective lifelong learning and for a specific strategic approach to promote and document ongoing learning. The American Board of Psychiatry and Neurology (ABPN) has developed its maintenance of certification (MOC) program in order to promote and document the lifelong learning of its diplomates. Specific philosophical tenets underscore the ABPN approach to MOC, but there are legitimate questions that must be answered about each aspect of that approach. The ultimate goals of the ABPN

MOC program are to reinforce the hallmark physician characteristics of professionalism, medical knowledge quality improvement, demonstration of acceptable medical knowledge and patient care quality improvement and to document that diplomates not only have the competence to provide quality patient care but that they actually do so. To be effective in fulfilling its goals, the ABPN must address a number of important future dilemmas inherent to the promotion and documentation of physician competence.

HOW THE MIND WORKS: USING TRAUMA AND GRIEF AS MODELS

Lecture Chair: Renée Binder, M.D.

Lecturer: Mardi Horowitz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn several ways to observe for signs of an incomplete processing of a stressful life event; 2) Learn how to formulate reasons for a patient's nonprogression; and 3) Learn therapy techniques for counteracting excessive avoidance in patients who seem to have frozen grief reactions.

SUMMARY:

Normal and abnormal reactions to trauma and loss provide a window into the mind. The initial shock of the event has to be assimilated and accommodated in order for the person to adapt to a changed world. Until that happens, a person may feel overwhelmed by emotions, may feel their identity is impaired and may have a prolonged sense of a loss of control. The person experiences intrusions and avoidances, and these need to be ameliorated. By understanding how the mind accomplishes this task, information can be gleaned about general mental processes. PTSD is one of the only diagnoses that has a clear-cut precipitant, i.e., trauma. By understanding how trauma leads to PTSD symptoms, information is gained about how the mind forms an individual's thought processes, behaviors and social functioning. Symptoms involving numbing and intrusive images reflect over- and undercontrol of attention. Fear conditioning responses in associational pathways of the mind/brain can account for some startle reactions in the intrusive cluster of symptoms and some phobic symptoms in the avoidance cluster. More complex explanations are necessary to understand the formation of other symptoms precipitated by experiences of trauma and loss. These symptoms include distorted thoughts about

self and relationships and irrational cognitions about self-blame and other-blame. The associations to stressor events are derived from complex memory structures. The revision of associated meanings leads to a changed cognitive map that affects the continuities and discords in self-identity and attachment. Regressions occur that degrade identity coherence and produce such states as dissociation, derealization and lapses in self-esteem. Understanding the symptoms of grief enables us to infer how attitudes about self and other in a bonded relationship may remain frozen in outmoded sets of roles and expectations. The relationship schemas before the loss no longer lead to realistic expectations after the loss. Symptoms such as illusions or hallucinations of the deceased or intense intolerable pining for a return may emerge and persist. In addition, the person dealing with grief may activate inner models involving extreme dependency and separation anxiety. When there was preexisting ambivalence toward the deceased, it may be more difficult to recover because of the emergence of feelings of guilt. This may lead to prolonged periods of unregulated panic, self-doubt and despair. To avoid painful affective states, the person may use avoidant operations to attenuate conscious memories and emotions. Understanding post-stressor revisions of cognitive maps using modern theory about the regulation of attention and control of emotion can help clinicians in their therapeutic work. By formulating the likely mental processes of patients who continue to manifest symptoms after trauma and loss, the clinician can understand how and why specific therapeutic techniques may be most effective.

THE COURT AND THE WORLD

Lecture Chair: Renée Binder, M.D.

Lecturer: Stephen Breyer

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Provide culturally competent care for diverse populations; 4) Describe the utility of psychotherapeutic and pharmacological treatment options; 5) Integrate knowledge of current psychiatry into discussions with patients; and 6) Identify barriers to care, including health service delivery issues.

SUMMARY:

In this special session, Justice Stephen Breyer will speak on his book *The Court and the World* in which he examines the work of the Supreme Court of the United States against the backdrop of a globalized modern society. Much of the activity that drives modern society is increasingly interconnected, necessitating the U.S. Supreme Court to consider the far reaching implications of their cases, not just how those decisions affect American legislation and American lives.

PERSONAL TRANSFORMATIONS THROUGH AN ENCOUNTER WITH DEATH: A STUDY OF AKIRA KUROSAWA'S "IKIRU"

Lecture Chair: Robert M. McCarron, D.O.

Lecturer: Francis Lu, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify four existential issues of death, meaninglessness, isolation and freedom in patients as seen in the hero of this film; 2) Empathize and respond compassionately to a patient who is confronting these four existential issues; and 3) Understand the value of film to evoke emotions that can transform our consciousness about ourselves and others.

SUMMARY:

Akira Kurosawa's 1952 film "Ikiru" (the intransitive verb "to live" in Japanese) presents the viewer with a seeming paradox: a heightened awareness of one's mortality can lead to living a more authentic and meaningful life. While confronting the four existential issues of death, meaninglessness, isolation and freedom eloquently discussed by Irvin Yalom in his 1980 book *Existential Psychotherapy*, our hero Kanji Watanabe, an elderly civil servant who heads up the "Citizen's Section" at city hall, traces the path of the Hero's Journey as described by the mythologist Joseph Campbell. His call to adventure takes place in a hospital waiting room and doctors' office, where he learns his fate: death from stomach cancer within six months. He finds two helpers along his way. A writer of cheap novels helps to reframe his situation from one of utter shock to one of feeling deep joy and despair for the first time; he functions as a trickster in Jungian typology to bring about his first transformation. Second, Toyo, a young woman from the office, enlivens and inspires Watanabe through her energy and enthusiasm for life. She is an anima figure in Jungian typology that

catalyzes his second transformation of discovering his agency and freedom, described well in Campbell's words: "At the bottom of the abyss comes the voice of salvation. The black moment is the moment when the real message of transformation is going to come. At the darkest moment comes the light." Here our hero discovers a gift ("boon" in Campbell's schema), which he brings back to the outer world: a neglected plan at his office proposed by a group of women to transform a swampy area into a children's playground. At his wake, his city hall colleagues recount in pithy flashbacks the positive psychological qualities that emerged from Watanabe and led to the approval of the plan by the city hall bureaucrats and the building of the playground: perseverance, hope, courage and humility, among others. The final flashback is that of a policeman who was the last person who saw Watanabe alive swinging on a swing near midnight in the playground he built while singing a song "Life Is so Short." Here is Watanabe's third transformation: his despair while singing the same song earlier has now become serenity as he passes from life to death. Simultaneous to this outward arc of the Hero's Journey, Watanabe experiences an inward arc of transformation of consciousness, taking him from the individual persona to ego, then to the self and finally to the transpersonal. Kurosawa skillfully blends aesthetic concepts and sensibilities both Western (Dostoyevsky, Tolstoy, Goethe's "Faust") and Eastern (Noh, Zen Buddhist) to create one of the greatest cinematic masterworks.

MAY 18, 2016

THE VHA'S PLAN TO TRANSFORM VETERANS' ACCESS TO COMMUNITY CARE

Lecturer: Baligh R. Yehia

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the components of the new streamlined VA community care program; and 2) Understand how the care coordination model will support an integrated mental health and primary care delivery model.

SUMMARY:

Innovation in health care delivery, reimbursement and technology are changing the health care landscape. Concurrently, patients are taking a more active role in their health. Veterans' needs are also changing, with an aging veteran population, a

growing number of rural and women veterans, and a rise in unique mental, physical and chronic conditions resulting from service. The Veterans Health Administration (VHA) recognizes the need to adapt to this changing landscape and is addressing fundamental issues highlighted in an independent assessment (IA) of the Department of Veterans Affairs' (VA) health care system. These include improvements to clarify and simplify VA-purchased care, streamline bureaucratic operations and processes, integrate clinical and business data and tools, and empower leaders with clear authority and priorities. The VA must address these fundamental issues and implement sustainable reforms to meet the changing needs of veterans.

MASTER COURSES

MAY 14, 2016

UPDATE ON PEDIATRIC PSYCHOPHARMACOLOGY

Director: Christopher Kratochvil, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

The primary objective of this course is to provide practical information to clinicians on the use of psychotropic medications in the treatment of children and adolescents in their practices.

Methods: This course will provide an overview and discussion of recent data in pediatric psychopharmacology, with a focus on mood disorders, attention-deficit/hyperactivity disorder, anxiety disorders and autism spectrum disorders. The role of pharmacotherapy in the treatment of these disorders will be addressed, as will practical clinical aspects of using psychotropic medications in the treatment of children and adolescents. Management of adverse effects will be reviewed as well. Awareness of recent research data will help to facilitate an understanding of the basis for current clinical guidelines for the treatment of these

psychiatric disorders. Clinically relevant research will be reviewed within the context of clinical treatment.

Conclusion: Awareness of recent research and practice parameters on the use of pediatric psychopharmacology, and the application of this information to clinical practice, can inform and positively impact patient care.

MAY 15, 2016

ADVANCES IN THE TREATMENT OF BIPOLAR DISORDER

Director: Terence A. Ketter, M.D.

Faculty: Po Wang, M.D., Shefali Miller, M.D., Kiki Chang, M.D., Natalie Rasgon, John Brooks

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Quantify the benefits and harms of different treatment options for bipolar disorder; 2) Provide evidence-based, state-of-the-art treatment, balancing benefits and harms, for individual patients with bipolar disorders across all phases of the illness; and 3) Personalize treatment for individuals with bipolar disorder, accounting for special considerations in children and adolescents, women, and older adults.

SUMMARY:

Treatment of bipolar disorders is rapidly evolving. *DSM-5*, new FDA approvals and clinical studies have raised important new diagnostic and therapeutic issues related to bipolar disorders, including diagnosis and treatment of bipolar depression (including bipolar mixed depression), approaches to antidepressant-induced mood elevation, and diagnosis and treatment of mood and behavioral problems in special populations of bipolar disorder patients, including children and adolescents, women, and older adults. Current FDA-approved bipolar disorder treatments in adults prominently include mood stabilizers (lithium, divalproex, carbamazepine and lamotrigine) and second-generation antipsychotics (olanzapine, risperidone, quetiapine, ziprasidone, aripiprazole, asenapine, lurasidone and cariprazine) that have robust evidence supporting their differential efficacy across bipolar illness phases and varying (and at times challenging) adverse effect profiles. In contrast, although generally providing adequate somatic tolerability and commonly prescribed in bipolar depression, antidepressants lack compelling evidence of efficacy for this problem. There is

currently increasing appreciation of the need for evidence-based, personalized care. Quantitative (numerical) as opposed to qualitative (non-numerical) approaches have the potential to yield more reproducible outcomes. Number needed to treat (NNT) is a quantitative measure of the potential benefit, representing how many patients need to be treated to expect one more favorable outcome (i.e., a therapeutic benefit likelihood metric). Number needed to harm (NNH) is an analogously defined potential therapeutic harm (i.e., side effect risk) likelihood metric. This course includes presentations of therapeutic advances as well as NNT and NNH analyses of approved pharmacotherapies for various phases (acute mania, acute depression and maintenance) of bipolar disorder to facilitate assessments of risks and benefits of treatments in individual patients. Taken together, the information in this course will facilitate clinicians' efforts to translate the latest advances in research into evidence-based, personalized, state-of-the-art care for patients with bipolar disorder.

ASSESSMENT AND TREATMENT OF EATING DISORDERS

Director: B. Timothy Walsh, M.D.

Faculty: Evelyn Attia, M.D., Eve Khlyavich Freidl, M.D., Michael Devlin, M.D., Tom Hildebrandt, Psy.D., Anne Becker, M.D., Ph.D., Deborah Glasofer

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the diagnosis of feeding and eating disorders using *DSM-5* criteria, including the use of the Eating Disorder Assessment for *DSM-5* (EDA-5) app; 2) Identify issues unique to special populations with eating problems, including children and adolescents, males, and culturally diverse samples; and 3) Learn available treatment options for individuals with feeding and eating disorders, including evidence-based psychotherapies and pharmacotherapies.

SUMMARY:

This course aims to provide clinicians with an overview of the identification, assessment and treatment of feeding and eating disorders using *DSM-5* criteria. The course will begin with a review of the *DSM-5* diagnostic criteria for feeding and eating disorders and will introduce a new electronic app that can be used to guide assessment for these conditions. We will review in detail treatment options, including evidence-based psychotherapies

and pharmacotherapies. The assessment and treatment of special populations will be emphasized, including children and adolescents, males, and individuals who are overweight or obese. Additionally, guidelines for culturally sensitive assessment of feeding and eating disorders will be provided. The course will conclude with an interactive, case-based discussion that will incorporate core principles reviewed in the course.

MAY 16, 2016

2016 PSYCHIATRY REVIEW

Director: Robert J. Boland, M.D.

Faculty: Marcia L. Verduin, M.D., Vishal Madaan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify gaps in knowledge in psychiatry and neurology as part of an exercise in lifelong learning; 2) Analyze multiple-choice questions pertinent to clinical topics; 3) Identify preparation strategies for lifelong learning; 4) Demonstrate the ability to search the clinical literature to prepare for lifelong learning; and 5) Convey a working knowledge of the various topical areas likely to be encountered during lifelong learning activities.

SUMMARY:

Essential psychiatric and neurology topics will be reviewed and discussed using multiple-choice questions (MCQ). After a brief introduction covering the basic structure and format of MCQs typically used in psychiatric examinations, participants will review and answer MCQs in various formats using an audience response system. After viewing a summary of the audience responses, faculty members will lead and facilitate a review and discussion of the topic covered by the MCQs. The questions will be grouped by topic and will cover a number of core subjects in psychiatry and neurology. The clinical topics are development, diagnostic methods, psychopathology, psychiatric treatment, neurosciences and neuropsychiatry, research and literature literacy, forensics, ethics, and special topics (e.g., history, administration). Audience members will use the audience response system to respond to the multiple-choice format before correct answers and full explanations and references are provided.

MAY 17, 2016

ESSENTIAL PSYCHOPHARMACOLOGY

Director: Alan F. Schatzberg, M.D.

Faculty: Charles B. Nemeroff, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

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

MEDIA WORKSHOPS

MAY 14, 2016

120 YEARS OF INPATIENT PSYCHIATRY: "STONEHEARST ASYLUM" AND DISCUSSION OF THE EVOLUTION OF PSYCHIATRIC HOSPITALIZATION INTO THE 21ST CENTURY

Chair: Mark Komrad, M.D.

Speakers: Mimi Baird, Steven S. Sharfstein, M.D., M.P.A., Mark Komrad, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify common tropes portrayed by Hollywood in depicting psychiatric treatment and its ethics, often misinforming the public; 2) Understand the state of inpatient psychiatric treatment in the 1930s and 1940s and the legacy for some patients and families; and 3) See what has been preserved and what discarded in the conduct of inpatient psychiatry as it has evolved through the 21st century.

SUMMARY:

This workshop will begin with screening of the film "Stonehearst Asylum" (2014). This is a movie based on the Edgar Allan Poe story "The System of Dr. Tarr and Professor Fether." It depicts some of the

treatments characteristic of psychiatry at the turn of the 20th century, the then-contemporary illness concept of “hysteria,” the notion of “moral treatment” and the role of trauma in causing some mental illnesses. At the same time, it cleverly explores the sometimes ambiguous line between madness and sanity through some very surprising plot twists. Following the screening, Mark Komrad will discuss some of the common tropes shown in this film that often characterize the depiction of psychiatrists, psychiatric treatment and ethics in Hollywood movies. Mimi Baird, author of the book about her father, *He Wanted the Moon: The Madness and Medical Genius of Dr. Perry Baird and His Daughter’s Quest to Know Him* will portray aspects of inpatient “asylum” treatment in New England in the 1930s and 40s, drawn from her physician father’s remarkable memoirs of his hospitalizations in that era for manic depression, which she recently found and published. Steve Sharfstein, CEO of Sheppard Pratt and past president of the APA, will address how inpatient psychiatry has developed since the late 19th and mid-20th centuries, discussing some aspects that may have been preserved as foundational, and are still part of our practice, and others that have been abandoned, modified or superseded. The workshop will conclude with audience discussion with the panelists.

“ASTU—SO BE IT”: THE STRENGTH OF DIGITAL MEDIA IN THE TRAINING OF HEALTH PROFESSIONALS AND IN PUBLIC AWARENESS

Chair: Mohan Agashe

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the phenomenology and behaviors associated with dementia from a unique patient and family perspective; 2) Learn care giver burden and family dynamics when a loved one is afflicted with dementia; and 3) Gain knowledge about advocating for the care of persons with dementia.

SUMMARY:

This media workshop will present a feature film on dementia titled “ASTU. (So Be It)” with English subtitles, which explores the experience of the caregivers and family of an aging father with dementia in India. A retired Sanskrit scholar with Alzheimer’s dementia is by turns philosophical, wise, loving, angry and childlike.

MAY 15, 2016

“INSIDE OUT”: EMOTIONS, IMAGINATION AND GROWING UP

Chairs: Martin K. Huynh, B.S., Harry Siegele, B.S.

Speaker: Alice R. Mao, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify key teaching points for children and their families; 2) Describe the role of imaginary friends in a child’s life; 3) Recognize the presentation of depression in a child and differentiate it from that of an adult; and 4) Understand the importance of sadness in emotional well-being.

SUMMARY:

Disney-Pixar’s 2015 animated film “Inside Out” follows 11-year-old Riley Andersen and her personified emotions: Joy, Sadness, Anger, Fear and Disgust. The emotions run Riley’s mind, guiding her thoughts and actions, generating her memories, and influencing her personality. Riley is plucked from an idyllic life in Minnesota and moves to San Francisco, where she faces the most storied trials of growing up: homesickness, a new school and parents who don’t understand her. Riley’s emotions do not react well to these major changes. Joy, their ebullient self-appointed leader, wants to fix everything and make Riley happy again. Sadness, Joy’s ever-glum colleague, perplexes her. Joy doesn’t understand Sadness’s purpose and sees her as a threat to the most important thing of all: Riley’s happiness. An unfortunate accident removes Joy and Sadness from Riley’s Emotion Headquarters and maroons them in the depths of her mind. It’s up to Joy to get back to Headquarters and make Riley happy again. Meanwhile, Riley grows more irritable and isolated, lashes out against her parents, loses treasured parts of her personality, and impulsively runs away to Minnesota. Eventually, Riley cannot feel anything, falling into numb depression. In the depths of despair, Joy discovers Sadness’s purpose and realizes why Riley needs Sadness. They return to Headquarters and help Riley move on from her childhood in Minnesota and accept her new life in San Francisco. In Pixar tradition, “Inside Out” triumphed at the box office and was the best-reviewed film of the year. It connects with audiences of all ages and carries several subtle and powerful lessons: the impermanence of childhood, the fragility of memory, the dangerous pressure to be

happy all the time and the importance of sadness in emotional well-being. The workshop will begin by screening the film in its entirety (102 minutes). There will be a 10-minute intermission during the end credits. Dr. Alice Mao, child psychiatrist, will begin the post-film presentation by discussing therapeutic take-home points for parents and their children: the pros and cons of different emotions, the importance of acknowledging pain and loss, and the presentation of depression in a child. Co-chair Harry Siegele will then discuss imaginary friends: when they appear, their role in childhood, and how they can be maladaptive or protective. Finally, co-chair Martin Huynh will discuss the societal, parental and personal pressure to be happy all the time; how that pressure can be harmful; and the necessity of sadness for growth and emotional well-being. There will be ample time for audience question/answer and discussion among the participants.

USING THE 2014/15 MOVIE “AMERICAN SNIPER” TO TEACH ABOUT COMBAT’S STIMULI AND STRESSES—AND THE POSITIVE ROLE OF PSYCHIATRY AND TRAINING FOR THE SAME

Chairs: Lawrence K. Richards, M.D., H. Steven Moffic, M.D.

Speaker: Melissa Goelitz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Have a real comprehension of what the U.S.–s infantry personnel experience in combat and how this connects with their families; 2) Have a seriously improved comprehension of how stimuli from combat experiences impact the CNS, resulting in multiple layers of memory that can have both immediate and subsequent effects; 3) Understand how anyone with major traumatic memories is “set up” to seek out substances for quelling the impacting memories and avoid reliving those experiences in their mental lives; 4) Better correlate material presented at prior APA meetings, such as how regulations for contents of “backpacks” results in motivation to use anabolic steroids so as to bear the weight more easily; and 5) Begin to have a better understanding of how today–s early-career psychiatrists have been taught in residency about making diagnoses and planning treatment for stress, trauma and PTSD.

SUMMARY:

This workshop is designed to give psychiatrists’ brains a close-up view of war zone combat stimuli

and stresses without putting them into the zone itself; director Eastwood has achieved that in his movie about Chris Kyle, the most famous U.S. military marksman in Iraq. This is also that rare movie where the role of the psychiatrist is portrayed in a constructive manner. Thus, “American Sniper” can serve in educating psychiatrists through its sensory stimuli and its unfolding story, enabling more psychiatrists to really know what “the patient”/the military personnel/the citizen who volunteers to risk wounds, dismemberment or death in service to our country actually experiences. Then we come to PTSD, TBI and drug abuse; each exacerbates the others and are extant relative to Iraq and Afghanistan, causing their own forms of “dismemberment.” PTSD is a biopsychosocial medical phenomenon that in earlier generations was called combat fatigue, shell shock or soldier heart—all once reasonably and generally diagnosable as traumatic neuroses. This workshop will lead participants in discussing the development of the illness, the making of the diagnosis and the task of formulating a treatment plan. In this latter dynamic, the presenting panel will review how the diagnostic process and the planning and progression of the treatment for stress and trauma are currently taught to residents. To further the latter, a recent graduate of psychiatric training will share the insights she gained in training, these including, on the biological side, a focus on using prazosin as a main medication for nightmares, avoidance of currently available benzos during acute and chronic phases, and use of SSRIs to help increase neuroplasticity; on the psychosocial side, cognitive processing therapy and prolonged exposure were taught as the two gold standards for therapeutic style. Depending on how the audience evolves its discussions, the chair will encourage attendees to share their didactic and post-training operational experiences with PTSD patients, including their ideas on how they would have done it if they were the psychiatrist seeing “this patient” in the movie. Thus, all will get to assess what their training strengths and weaknesses were in this area of psychiatry. Additionally, the participant should grasp the meaningfulness of this movie to a very large segment of the U.S. Comparing the first five months: the Action/Adventure movie “Guardians of the Galaxy,” the top money maker of 2014, took in over \$333,100,000; “American Sniper,” between late December’s opening and mid-May, 2015, took in more than \$349,700,000 in vindicating “votes.” The session chair’s analysis is these “votes” mostly came from U.S. citizens who almost never

voluntarily go to see a psychiatrist; thus, APA members can get some understanding of them by extrapolating from what they see unfolding in "American Sniper." That and this workshop expand the national base of psychiatric expertise.

MAY 16, 2016

REMAKING "THE BAD SEED" IN BLOOD RED

Chair: Lynn Maskel, M.D.

Speakers: Elissa P. Benedek, M.D., Kevin D. Moore, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Illustrate examples of behavior raising concern of developing psychopathy in children and adolescents; 2) Weigh each side of the nature vs. nurture debate of psychopathy in children and adolescents; and 3) Critique this and other media portrayals of psychopathy in children and adolescents.

SUMMARY:

The black and white 1956 psychological thriller, "The Bad Seed," starred a blonde pig-tailed prepubescent Patty McCormick as the murderous psychopath child. Despite a loving and nurturing maternal environment, the genetic contribution of her notorious killer grandmother ultimately ends up ruling the day. Nature gets the black marks. Robert Hare, noted researcher in psychopathy, opens his book *Without a Conscience* with a quote from the novel (*The Bad Seed*) on which the film is based. Fast forward 55 years and meet a different film, "We Need to Talk About Kevin," a fractured developmental chronicle of a boy psychopath from gestation to late adolescence. The debate, nature versus nurture, is not so clear of a contest. The increasing malevolence starts in infancy and crescendos in adolescence, culminating in its own take on Columbine-like killings. This child knows exactly how to wound, reject, deceive and make his mother's soul bleed. Parents' potential culpability squares off with the concept of innate evil. There's little actual blood in "We Need to Talk About Kevin," but director Lynne Ramsay's pervasive use of the color red makes sure that the idea of blood constantly remains in the audience's mind. It is told as a mother's tale but, contrary to the title, she never actually talks about her son. It is her actions and demeanor that broadcast everything. Both before and after the ultimate tragic event, the

viewer is witness to her unrelenting despair, self-loathing and bewilderment. This workshop features a full-length viewing of the 2011 film, "We Need to Talk About Kevin." Cast includes Tilda Swinton, Charles C. Reilly and Ezra Miller. After the two-hour film, presenters will review fledgling psychopathy development in youngsters, including assessment, etiology and treatment, along with informal analysis of filmic elements. Comparison with other films featuring child psychopaths will be offered. Active audience dialogue with the panel child and forensic psychiatrists will be encouraged.

THE RESILIENCE OF THE FAMILY IN FILM: "APARAJITO" (PART 2 OF "THE APU TRILOGY")

Chairs: Francis Lu, M.D., Edmond Hsin T. Pi, M.D.

Speakers: Ramaswamy Viswanathan, M.D., Russell F. Lim, M.D., M.Ed., Jagannathan Srinivasaraghavan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the role of the family in teaching participants how resilience develops over a life course and across generations; 2) Understand how watching films showing how families express love, endure loss and locate their own resilience helps participants see how they may face life's inevitable challenges; and 3) Apply the *DSM-5* Outline for Cultural Formulation to understanding cultural issues seen in this film about South Asian Indian families.

SUMMARY:

This media workshop will present the second film of "The Apu Trilogy" by Satyajit Ray. The trilogy traces the life of Apu as a free-spirited child in rural Bengal who matures into an adolescent urban student and finally a sensitive man of the world. The focus will be to demonstrate the resilience of the family as he and his family members express love, endure loss and find ways of recovery. The *DSM-5* Outline for Cultural Formulation will be utilized to help participants understand the cultural issues. Individual reflection and discussion will help participants process the films in a mindful way. Criterion has restored these masterworks of world cinema on 4K Blu-ray, by which this film will be shown. The great Japanese director Akira Kurosawa has said of Ray: "Not to have seen the cinema of Ray means existing in the world without seeing the sun or the moon." Prior to showing the film, Francis Lu will present a brief overview of the *DSM-5* Outline

for Cultural Formulation (revised from the one in the *DSM-IV*) so participants can watch the film with this cultural competence tool in mind. Following the viewing, there will be individual and group processing in the following ways: 1) Silent reflection about the viewer's experience of the film focusing on the most moving scene; 2) Personal journaling; 3) Dyadic sharing about personal reactions to the film; 4) Large-group discussion starting with sharing participant experiences of the most moving scenes. After the reflection and discussion, Dr. Lu and the discussants will work with the audience in constructing an Outline for Cultural Formulation of the family, showing how to apply this tool in a clinical setting. The Outline for Cultural Formulation consists of five sections: cultural identity, cultural concepts of distress, cultural stressors and supports, cultural features of the clinician-patient relationship, and overall assessment. The focus will be on the first three parts of the Outline, especially on the resilience of the family.

"TIMBUKTU": AN APA FILM SYMPOSIUM

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

Speakers: Mayada Akil, M.D., Lloyd I. Sederer, M.D., Alan Stone, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the methods of mind control used by oppressive groups and regimes; 2) Understand the hypocrisy inherent to these methods; and 3) Consider ways by which individuals and communities might resist totalitarian controls and survive repressive regimes.

SUMMARY:

This Mauritanian film, made with French collaboration, swept the César Awards with seven prizes, including best film, best director (for Sissako with Kessen Tall) and best cinematography (for Sofian El Fani). It was also an Oscar nominee in 2014. Though it lost to the Polish film "Ida" (about the Holocaust, which we used in our symposium last year), "Timbuktu" presents Islamic conflicts and envisions the future. We will show the film, have a brief discussion with the three panelists (Drs. Stone, Akil and Sederer) and then open for audience comments and discussion.

MAY 17, 2016

WHAT HAPPENED, MISS SIMONE?

Chair: Sarah Y. Vinson, M.D.

Speakers: Ruth Shim, M.D., M.P.H., Annelle Primm, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the impact of mental health symptoms described in the documentary; 2) Identify the potential psychological impact of fighting racism and social injustice; 3) Identify social determinants of mental health elucidated by the film; 4) Identify potential impacts of mental health treatment on creativity and art; and 5) Appreciate psychological implications of modern day civil rights issues.

SUMMARY:

The Netflix documentary "What Happened, Miss Simone" offers a rich portrait of the iconic singer and civil rights activist Nina Simone, whose genius and initial commercial success could not inoculate her from the impact of racism, trauma and mental illness. It also elucidates how mental health treatment, often framed in popular culture as a hindrance to creative expression and artistry, enabled a resurgence of her career. Drawing not only from interview and performance clips of Miss Simone, but also interviews with her daughter and former husband, the film displays not only the impact of Miss Simone's mental health symptoms on her own quality of life, but also on her intimate relationships and professional career. The documentary raises many issues rich for discussion, including the experience of racism and social injustice as social determinants of mental health; intimate partner violence; how cultural factors impact the expression and treatment of mental illness; and the tension that can arise between racial, professional and political identities. As discussants, we have Annelle Primm, who is currently the Senior Psychiatrist Advisor for Urban Behavioral Associates in Baltimore, MD, and former Deputy Medical Director and Director of the Division of Diversity and Health Equity of the APA, and Ruth Shim, coeditor of the text *The Social Determinants of Mental Health* and Vice Chair, Education and Faculty Development in the Department of Psychiatry at Lenox Hill Hospital.

MAD MEN (AND WOMEN): IS CHARACTER IMMUTABLE? CASE STUDIES FROM THE TV SERIES

Chairs: Josepha A. Cheong, M.D., Kenneth R. Silk, M.D.

Speaker: Steven E. Hyler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate an understanding of the longitudinal course of personality development and its impact on an individual's coping style; 2) Understand the effect of environmental and relationship factors on a personality style; and 3) Incorporate media into teaching personality disorders and coping mechanisms.

SUMMARY:

Personality style is thought to be unchangeable, persisting as a fundamental psychological phenomenon over time. Television series, especially those on cable networks, with their multi-year format involving the same characters in similar or different situations over time, allow us an opportunity to examine this idea of the consistency of personality and coping style over time. This media workshop will give us the opportunity to study personality, and perhaps personality disorders, over time in the television series "Mad Men." The series covers the years of 1960 to almost 1970, a time of great social change and significant events in American history and culture, including the assassinations of John and Robert Kennedy and Martin Luther King, Jr. The civil rights movement took hold, men walked on the moon and the war in Vietnam became daily front page news. The moral straitjacket of the 1950s was loosening on its way to the sexual revolution, coinciding with the early beginnings of what was to become the women's liberation movement. It is with this turbulent decade in the background that "Mad Men" takes place. This workshop will examine a number of main characters depicted in the program over its nearly 10-year run. We will present clips of these characters early in the series, in the middle of the series and in the final year of the series. The clips will focus on how these characters react to stress at various points in the program, and a discussion will take place as to whether the identified characters show a change in personality or coping style over the years during which the events depicted in the series take place. No taping or recording of the session will be permitted.

MAY 18, 2016

ART OF STORYTELLING: THE HUMAN EXPERIENCE OF BEING A PSYCHIATRIST

Chair: Michelle Furuta, M.D.

Speakers: Linda Do, D.O., Arsalan Malik, M.D., Steve Soldinger, M.D., Mindi Thelen, Tim Thelen

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the concept of the "Art of Psychiatric Medicine" and how the cultivation of this skill aids in patient care, destigmatization and the quality of community among psychiatrists; 2) Utilize the concept as a tool for destigmatization-to work within their communities to build relationships with other mental health professionals and the general public; 3) Be stimulated to think creatively about some of the social and public relational challenges that the profession of psychiatry faces and understand how creativity enhances clinical performance; 4) Enhance interpersonal and communication skills and performance by understanding the difference between taking a psychiatric history and an oral history; and 5) Enhance patient care, skill and clinical performance by viewing the documentary "The Art of Storytelling," which reveals treatment approaches used by three generations of psychiatrists.

SUMMARY:

"The Art of Storytelling" is a documentary about the human experience of being a psychiatrist as told by three generations of psychiatrists in Southern California. The current perceptions of whom psychiatrists are, what their intentions are and what is important to them has largely been distorted and contaminated through the mainstream media and other groups. This film is the first of its kind and highlights the importance of psychiatrists taking a proactive stance in telling their own stories and in doing so conveying the human element of who and what psychiatry is—as told by us. The film follows six psychiatrists who begin with a workshop in oral history taking from a recognized scholar in this area to learn how to take interviews from their colleagues in a way that elicits an authentic personal story. They then embark upon the journey of selecting and interviewing twelve other psychiatrists who range from early to middle and late career. The same questions are asked of each psychiatrist in such a way that personal narratives of each interviewee, as well as a cohesive narrative of the diverse group, can coalesce. The differences in the psychiatrists' life experiences are vast—from growing up as a child of

migrant farm workers to the second African-American psychoanalyst in the country, who grew up in the segregated south to a well-known psychedelic researcher who held on to his dream for 20 years before having the opportunity to pursue it. Their stories are personal, inspiring and moving. Emerging from the diversity of experience is an unexpected thread of commonality—a deep love for connection with others, incredible courage in the face of adversity and an unmatched level of personal resilience. Following the completion of the interviews, the interviewers reconvene to process the experience and in doing so, reveal some of their own surprising personal histories. An additional layer of the story is folded in from the public's perspective—where several random pedestrians are interviewed about their thoughts on psychiatrists and the way mental health is currently perceived to be handled by psychiatry. This project was conceived by the Art of Psychiatric Medicine Committee, a committee of the Southern California Psychiatric Society. It is an example of the work they have done in building community among psychiatrists and creative professional development through various collaborative art projects. Participants will learn about the concept behind the committee, its purpose and mission, and how to start a similar committee in their own local APA district branch. Following the film will be a panel discussion with the creator and chair of the Art of Psychiatric Medicine Committee, interviewers and committee members, and the film's director.

PRESIDENTIAL SYMPOSIA

MAY 15, 2016

ISSUES FOR CHILD AND ADOLESCENT PSYCHIATRY IN THE 21ST CENTURY

Chair: Gregory K. Fritz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify four barriers to widespread adoption of pediatric integrated care; 2) Increase knowledge about the evidence base for the treatment of major depression in children and adolescents; 3) Identify ways to improve children's mental health care globally; and 4) Identify challenges and solutions to problems in treating children with mental illness in the juvenile justice system.

SUMMARY:

This symposium addresses critical issues for child and adolescent psychiatry as identified by four senior leaders in the field. Health care reform must include pediatric mental health and consider the unique aspects that differentiate children's needs and capacities from adults'. Integrated care has the potential to increase access to needed services, but many barriers must be removed for it to have a significant impact. Global mental health is a critical problem for the world's children. The U.S. has a responsibility to partner with other nations and transcend cultural/political boundaries to address what has become a worldwide crisis. Depression in children and adolescents is a serious disorder with widespread, sometimes devastating impact. A substantial evidence base will be reviewed to guide assessment and treatment of pediatric depression. Youth in the juvenile justice system frequently present with co-occurring mental and substance-related disorders that challenge forensic and correctional psychiatrists. Recent developments in these areas will be reviewed. Audience participation in a discussion period is expected.

NO. 1

PEDIATRIC INTEGRATED CARE: CHILDREN ARE NOT SHORT ADULTS

Speaker: Gregory K. Fritz, M.D.

SUMMARY:

Pediatric psychiatric disorders are common and expensive (the most costly of all pediatric medical conditions), but they are often ignored in health care planning. The screening/early intervention prevention model is appealing, and data exist to support it. There are too few child mental health professionals to meet the need; involving primary care providers as front-line mental health resources will improve access to treatment. The Affordable Care Act, mental parity and decreased stigma make it possible that integrated care will actually work, but many barriers exist. Limited empirical data support the benefits of pediatric integrated care, but many pilot studies and a variety of models exist; thorough evaluation of outcomes and cost-benefit analyses are critical.

NO. 2

GLOBAL MENTAL HEALTH: WHY PARTNERSHIPS ARE IMPORTANT

Speaker: Paramjit Joshi, M.D.

SUMMARY:

On a global scale, psychiatric disorders are among the most common medical morbidity. Most psychiatric disorders have their onset in childhood and adolescence, when prevention and early intervention can prevent a lifetime of suffering, disability and stigma. Although psychiatric disorders impact children from all types of families and at all economic levels, there are certain conditions that can increase the need for mental health services. Many of the world's children are subject to the most significant of these conditions: living in poverty, witnessing violence or having a parent who suffers from depression. There are well-researched associations between socioeconomic status and indices of both physical and mental health. The most recent World Health Organization Atlas report suggests that the number of children and adolescents facing significant adversity is growing at an alarming rate and that increasing numbers of children are at risk of deprivation, damaged health, developmental disruption and premature death. With such a severe, chronic problem, the question becomes "who will stand up for the world's children?" We need to seize all opportunities to improve health care for millions of children around the world. Thus, we share in a global responsibility to transcend cultural and political boundaries to identify childhood-onset psychiatric illness as an international public health crisis that demands the attention and efforts of physicians.

NO. 3**MANAGEMENT OF DEPRESSION IN CHILDREN AND ADOLESCENTS**

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

SUMMARY:

Depression in youth is a serious disorder that adversely impacts peer, family and academic functioning. It is important for clinicians to know the evidence base for the treatment of depression in children and adolescents. This presentation will provide an update of available treatments and discuss strategies for the management of depression in children and adolescents.

NO. 4**"ACTING OUT" YOUTH: TIMELY FORENSIC AND CORRECTIONAL APPROACHES**

Speaker: Joseph V. Penn, M.D.

SUMMARY:

This presentation will explore recent developments within juvenile corrections and child and adolescent forensic psychiatry, identifying the phenomenology and presentation of juvenile offenders and effective evaluation and treatment approaches.

TRANSLATING THE EVIDENCE FOR THE NEXT GENERATION: ADDRESSING THE MENTAL HEALTH OF YOUTH AND EMERGING ADULTS OF COLOR

Chair: Lisa R. Fortuna, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the cultural-racial context and social determinants of mental health that impact the well-being of youth and emerging adults of color; 2) Describe the impact of childhood disparities in environment and life circumstances on the educational and mental health outcomes of young people of color; 3) Understand the role of contextual factors on mental health symptoms of depression, post-traumatic stress and substance use among immigrant-origin emerging adults; and 4) Consider how psychiatrists and other mental health professionals can better serve the needs of youth and emerging adults of color in regards to prevention, intervention and treatment.

SUMMARY:

Diversity is increasing among America's youth and emerging adult population because of unprecedented increases in the number of minority children, particularly Hispanic and Asian, as well as a significant decline in the number of non-Hispanic white children. African-American young people also continue to be a significant proportion of youth with increasing engagement in higher educational institutions and the workforce. However, continued racial tensions, economic injustice and structural disparities continue to serve as a psychological burden for young people of color. We must also consider the particular mental health needs of first- and second-generation immigrant emerging adults. Considerable diversity exists among this population in the U.S. with regard to educational and employment opportunities, family and cultural context, and social position relative to the larger society. Important socio-contextual factors exist that have an impact on mental health symptoms of depression, post-traumatic stress and substance use among immigrant-origin emerging adults. Data from the Collaborative Psychiatric Epidemiology Surveys

(CPES) are presented to characterize relevant risk and protective factors, to discuss mental health service use among diverse populations, and to identify implications for clinical practice. Achieving patient-centered health care outcomes involves not only providing the patient with the best information available about treatment options, but also understanding what these options mean to a patient, particularly one who does not share the cultural/racial background of the provider. Patient involvement in decisions about mental health treatment is important for improving treatment quality, particularly for ethnic/racial minority young people. DECIDE is a clinical intervention that shows promise as being effective in increasing minority patients' activation and self-management of mental illness and tests if adding a provider intervention component increases shared decision making between provider and patient. Youth of color in poor communities face barriers to academic achievement because of under-resourced schools, limited cultural capital of parents, and high levels of family and neighborhood stress. Educational outcomes are mediated by mental health diagnoses related to adversity and trauma. Attention to appropriate treatment and support services, increased cultural competence and representation of providers and school staff, and implementation of targeted interventions are critical for youth well-being and academic success. This symposium offers a research- and clinically based understanding of what we know has important influence on mental health for the younger generation and what the psychiatry and mental health fields may need to address and wrestle with in achieving interventions and health services approaches that better serve the well-being of young emerging adults of color.

**NO. 1
BETWEEN TWO WORLDS: CULTURE,
ENVIRONMENT, RACE AND MENTAL HEALTH FOR
FIRST- AND SECOND-GENERATION IMMIGRANT
EMERGING ADULTS**

Speaker: Kiara Alvarez, Ph.D.

SUMMARY:

Considerable diversity exists among first- and second-generation immigrant emerging adults in the U.S. with regard to educational and employment opportunities, family and cultural context, and social position relative to the larger society. This presentation will explore the impact of these contextual factors on mental health symptoms of

depression, post-traumatic stress and substance use among immigrant-origin emerging adults (ages 18–29) representing three racial/ethnic groups: Latino, Asian, and Afro-Caribbean. Data from the Collaborative Psychiatric Epidemiology Surveys (CPES) will be used to characterize relevant risk and protective factors, discuss mental health service use among this population and identify implications for clinical practice.

NO. 2

**CAN WE TRAIN PROVIDERS AND PATIENTS TO DO
SHARED DECISION MAKING IN BEHAVIORAL
HEALTH ENCOUNTERS?**

Speaker: Margarita Alegria, Ph.D.

SUMMARY:

Achieving patient-centered health care outcomes involves not only providing the patient with the best information available about treatment options, but also understanding what these options mean to a patient, particularly one who does not share the provider's cultural/racial background. Patient involvement in decisions about mental health treatment may be important for improving treatment quality, particularly for ethnic/racial minority patients who may hold traditional role expectations against participation in clinical encounters. This presentation discusses the findings of a randomized trial examining if our intervention, DECIDE, is effective in increasing minority patients' activation and self-management of mental illness and if adding a provider component really increases shared decision making.

NO. 3

**WHY CAPABLE YOUNG PEOPLE STRUGGLE:
EDUCATIONAL ATTAINMENT AND MENTAL HEALTH
IN COMMUNITIES OF COLOR**

Speaker: Michelle V. Porche, Ed.D.

SUMMARY:

Youth of color in poor communities face barriers to academic achievement because of under-resourced schools, parents' limited cultural capital, and high levels of family and neighborhood stress. Exposure to adverse events increases the risk of internalizing and externalizing behaviors that interfere with educational performance; often, a disciplinary response is given in lieu of needed mental health services. Attention to appropriate treatment and support services, increased cultural competence and representation of providers and school staff, and

implementation of targeted interventions are critical for youth well-being and academic success.

NO. 4

PSYCHIATRY SERVING THE NEEDS OF A DIVERSE NEXT GENERATION: WHERE WE HIT IT AND WHERE WE MISS IT

Speaker: Lisa R. Fortuna, M.D., M.P.H.

SUMMARY:

Issues of discrimination, racism, poverty, quality of educational systems, neighborhood quality and other social determinants of health have an important impact for youth and emerging adults of color. This presentation offers a synthesis of what we know has important influence on mental health for the younger generations and what the psychiatric and mental health fields may need to address in achieving health supporting interventions and health services approaches that better serve the well-being of young adults of color.

AAGP PRESIDENTIAL SYMPOSIUM: NEW STRATEGIES IN GERIATRIC PSYCHIATRY RESEARCH AND PRACTICE

Chair: Gary W. Small, M.D.

Discussant: Charles F. Reynolds III, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss current methods for assessment and detection of cognitive decline; 2) Describe the benefits of new noninvasive markers of cognitive decline; 3) Discuss current and emerging methods for neuromodulation in late-life depression; 4) Demonstrate knowledge of the link between healthy lifestyle habits and lower risk for major neurocognitive disorders; and 5) Understand how positive psychosocial factors such as resilience, optimism and social engagement are associated with better patient outcomes.

SUMMARY:

Thanks to advances in medical technology, life expectancy has increased, which has led to a greater prevalence of, and concern about, age-related cognitive and mood disorders. By age 65, the risk for a major neurocognitive disorder is 10%, and approximately 15% suffer from major depression. Genetic, neuroimaging and biomarker research has led to better methods for early detection of cognitive decline, and a comprehensive evaluation can differentiate normal aging from mild and major

neurocognitive disorders and depression, as well as varying causes of cognitive decline, such as frontotemporal lobar degeneration, dementia with Lewy bodies and Alzheimer's disease. New noninvasive detection methods offer the advantage of cost-effective screening and early detection and more effective treatments of cognitive issues. For example, detection of olfactory deficits predicts cognitive decline in cognitively intact older adults, progression from mild cognitive impairment to Alzheimer's disease, increased mortality and improvement with cholinesterase inhibitor treatment. Several symptomatic drug treatments provide temporary cognitive, functional and behavioral benefits to patients with major neurocognitive disorders and relieve caregiver burden. However, no disease-modifying treatment is yet available, and the benefits of early drug treatment in patients with minor neurocognitive disorders have not been systematically confirmed. A growing body of evidence supports the connection between healthy brain habits—physical exercise, mental stimulation, a Mediterranean-style diet and stress management—and better cognitive health. Some of these strategies have been linked to improved mood, but for patients with late-life depression, psychotherapy, antidepressant medications and electroconvulsive therapy have been the traditional treatments. However, newer methods for neuromodulation, such as transcranial magnetic stimulation (TMS) and transcranial direct current stimulation (tDCS), offer promise of alternative approaches that can provide additional efficacy in certain patients. The emerging field of positive psychiatry offers further insights to ameliorate the mental health challenges of older adults. A growing body of research strongly suggests that positive psychosocial factors such as resilience, optimism and social engagement are associated with better outcomes, including lower morbidity, greater longevity and a heightened sense of patient well-being. Because most of the research has been conducted outside of the field of psychiatry, it has had relatively little influence on everyday clinical practice. In this symposium, the presenters will review current strategies as well as new research in geriatric psychiatry that provides more effective ways to detect, treat and prevent major and minor psychiatric disorders of late life.

NO. 1

GERIATRIC DEPRESSION

Speaker: William M. McDonald, M.D.

SUMMARY:

Geriatric depression is a significant public health problem associated with increased mortality due to suicide and morbidity due to associated decreases in functional and physical health. In a significant minority of elders, depression is resistant to psychotherapy and medication. In other patients, comorbid medical problems may increase the risks of medication treatment. These factors have led to the increasing use of electroconvulsive therapy (ECT) in the treatment of medication-resistant or life-threatening geriatric depression. Multiple studies have supported the safety and efficacy of ECT in the elderly, even in patients over the age of 75 with multiple medical comorbidities and cognitive impairment, yet up to 20% of elderly patients may not respond to ECT, and the elderly are more susceptible to cognitive side effects including delirium and acute cardiovascular and other medical complications associated with ECT. This presentation will review recent advances in ECT therapy to make it safer in the elderly and also advances in neuromodulation therapies, including more focal convulsive therapies (e.g., magnetic stimulation therapy and focal electrically administered seizure therapy) and subconvulsive therapies (e.g., transcranial magnetic stimulation, transcranial direct current stimulation, deep brain stimulation). These newer therapies will be compared to the limited data in the elderly but also side effect profiles that have advantages in the elderly.

NO. 2**OLFACTORY IDENTIFICATION DEFICITS AND NONINVASIVE MARKERS OF ALZHEIMER'S DISEASE**

Speaker: Davangere P. Devanand, M.D.

SUMMARY:

Olfactory identification deficits in Alzheimer's disease (AD) are associated with the neuropathological findings of neurofibrillary tangles in the olfactory bulb and secondary projection pathways to the piriform and medial temporal cortex, orbitofrontal cortex, and other limbic regions. Odor identification impairment characterizes AD and predicts the clinical transition from mild cognitive impairment (MCI) to AD. Recent epidemiological data indicate that, in cognitively intact older adults, impairment in odor identification predicts cognitive decline, but episodic verbal memory impairment does not. Odor identification impairment has been shown to predict mortality,

particularly in individuals with severe impairment in odor identification. The exact cause is not known, but olfactory deficits may lead to an increase in accidents in the home and increase mortality risk. Acetylcholine is the main neurotransmitter in the olfactory pathway, and there is growing evidence olfactory deficits may predict the likelihood of improvement with cholinesterase inhibitor treatment in patients with MCI and mild AD. An atropine nasal spray challenge with olfactory testing before and after has the potential to improve signal-to-noise ratio in the prediction of response to cholinesterase inhibitor treatment. This range of findings with odor identification impairment will be placed in the context of the potential clinical utility of other putative noninvasive biomarkers of AD.

NO. 3**PARADOXICAL IMPROVEMENT IN MENTAL HEALTH WITH AGING**

Speaker: Dilip V. Jeste, M.D.

SUMMARY:

Our studies in older people with schizophrenia, as well as those in a community-based sample of 1,546 participants aged 21 to 99 selected using random digit dialing, suggest paradoxical improvement in mental health while physical health and cognitive function show accelerated worsening with age. Across the 80 years of cross-sectional data, study participants showed, on average, a 1.5 standard deviation decline in self-reported physical health, a two standard deviation drop in cognitive function and a one standard deviation increase in mental health. Higher levels of resilience and optimism, along with lower levels of depressive symptoms and perceived stress, predicted mental health. The study suggests a need for interventions to enhance positive traits such as resilience and to reduce depression and perceived stress, important strategies to enhance well-being across the adult lifespan.

NO. 4**DETECTION AND PREVENTION OF COGNITIVE DECLINE**

Speaker: Gary W. Small, M.D.

SUMMARY:

Increasing life expectancy has led to a greater prevalence of age-related cognitive decline. By age 65 or older, the risk for major neurocognitive disorder is 10%, and by 85 it is closer to 40%.

Neuropsychological testing can detect evidence of mental decline in people by age 45, and survey data indicate 14% of young adults report memory problems. An evaluation can differentiate normal aging from mild and major neurocognitive disorders, as well as causes of cognitive decline such as frontotemporal lobar degeneration, dementia with Lewy bodies and Alzheimer's disease. Symptomatic drug treatments provide temporary cognitive, functional and behavioral benefits to patients with major neurocognitive disorders, but benefits of early drug treatment in patients with minor neurocognitive disorders has not been systematically confirmed. However, a growing body of evidence suggests healthy brain habits—physical exercise, mental stimulation, a Mediterranean-style diet and stress management—may delay onset of cognitive symptoms. Recent research indicates a 25% reduction in modifiable risk factors could potentially prevent as many as 500,000 cases of Alzheimer's disease in the U.S. and three million cases worldwide. This presentation will review the latest evidence on detection/prevention of cognitive decline and describe strategies for nutrition, physical/mental exercise and stress reduction for maintaining brain health.

ETHICAL ISSUES IN PSYCHODYNAMIC PRACTICE

Chair: Michael Blumenfeld, M.D.

Discussant: Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Become familiar with the principles of medical ethics, with annotations especially applicable to psychiatry through various case examples; 2) Appreciate the difference of opinion and interpretation of the above principles of ethics; 3) Become familiar with a recent case history where refusal to give up confidential treatment information resulted in a malpractice suit; 4) Understand how cultural difference between China and the United States can influence our understanding of ethical behavior; and 5) Appreciate how the issues of undue influence, personal disclosure and aggressive enactments can create ethical dilemmas in the course of psychodynamic therapy.

SUMMARY:

The basis for the ethical code for psychiatrists, including those who do mainly psychoanalysis or psychodynamic psychiatry, has been *The Principles*

of Medical Ethics with Annotations Especially Applicable to Psychiatry, 2013 Edition, published by the American Psychiatric Association. However, there are frequent situations where it is a complicated process to decide upon the proper ethical conduct. One such situation, which Dr. Silvia Olarte will present, involves the therapist's personal disclosures during psychotherapy. This may involve unresolved countertransference feelings, but on the other hand, they can be an important therapeutic tool. Another situation where ethical conduct may be uncertain is when there is the possibility that a positive transference has become "undue influence." Dr. Elizabeth Auchincloss will discuss this complicated subject and will address how we can protect the patient. Dr. Sharon Batista will look at the situation where therapists can experience triangulations in the treatment relationship, which are not limited to just the people in the consultations room. This can include "aggressive enactments," where someone else might be funding the treatment, as well as dealing with colleagues who are treating complex cases in collaboration with you. Dr. Douglas Ingram will share the details of a high-profile case in which the interpretation of how to handle a "Tarasoff-Type" situation resulted in a malpractice suit and an ethical investigation by the New York State Department of Health. Dr. Elise Snyder will then compare the moral/ethical code in varying cultures and specifically how they might apply to doing psychodynamic psychotherapy and psychoanalysis in China. Dr. Paul Appelbaum will discuss all these presentations from his point of view as an expert in the area of ethics. There will be discussion and questions from the audience after each presentation and at the conclusion.

NO. 1

THERAPIST PERSONAL DISCLOSURE AND PSYCHODYNAMIC PSYCHIATRY

Speaker: Silvia W. Olarte, M.D.

SUMMARY:

A therapist's personal disclosure is defined as the therapist's voluntary disclosure of personal information to a patient within the context of a therapy session. Its use can have a therapeutic role in psychodynamic psychiatry if utilized within the framework of a therapeutic intervention. Historically in traditional psychoanalysis, personal disclosure within or outside of the therapy process was avoided. If and when it occurred, it was mainly understood as therapists' acting out of unresolved

countertransference feelings. In the past 30 years, this narrow view of personal disclosure has been challenged. Personal disclosure by the psychotherapist can be a therapeutic tool if conceptually integrated within the therapeutic process. This presentation will elaborate on the current use of personal disclosure. Clinical vignettes extracted from the presenter's longstanding clinical psychodynamic practice will be discussed.

**NO. 2
HELPING THE PATIENT TO CHANGE: THE PROBLEM
OF UNDUE INFLUENCE**

Speaker: Elizabeth L. Auchincloss, M.D.

SUMMARY:

In the early days of psychodynamic psychotherapy, the problem of undue influence was solved by the feeling of Freud and others that the problem did not exist. In other words, Freud's opinion was that the therapist did not influence the patient directly, but used interpretation and insight alone to bring the unconscious into awareness, thereby allowing the patient to change. Anything else was considered "suggestion" and was not part of legitimate practice. However, even Freud felt that the "unobjectionable positive transference" provided the background against which interpretation is useful. Nowadays, we practice in a world in which our theories of therapeutic action take the relationship between therapist and patient for granted; this relationship is no longer considered anathema, but is considered necessary for change. However, along with conceptual dignity for the power of this relationship come new problems and new ethical dilemmas. How do we define which aspects of transference are "unobjectionable?" What is the proper role of the therapist in the patient's mind? What constitutes legitimate help and what constitutes undue influence? This presentation will examine the history of the problem and some of the current issues. Case examples from practice and from supervision will be provided. The presentation will take up the question of how we protect the patient from undue influence, indeed, from us.

**NO. 3
THIRD-PARTY INVOLVEMENTS IN
PSYCHOTHERAPEUTIC AND PSYCHIATRIC
TREATMENT RELATIONSHIPS**

Speaker: Sharon Batista, M.D.

SUMMARY:

Our psychotherapeutic and physician/psychiatrist relationships with our patients do not exist in a vacuum. In reality, many of us experience triangulations in our treatment relationships, and they are not limited to just the people in the consultation room. In this presentation, I will discuss three cases of some recent triangulations experienced via aggressive enactments when another person is funding the treatment as well as when we are called to the aid of physician colleagues who are treating complex patients in collaboration with us. In each case, I experienced a combination of various boundary violations, the challenges of being unable to effectively gratify the needs of all parties involved, and the difficulty of being unable to soothe or contain the people both inside and outside the consultation room. Ultimately, each case demonstrates difference dynamics and power imbalances played out through the psychotherapeutic relationship.

**NO. 4
AN EXPERIENCE AS PLAINTIFF IN A HIGH-PROFILE
TARASOFF-TYPE CASE**

Speaker: Douglas H. Ingram, M.D.

SUMMARY:

In 1986, a licensed physician who was a resident in psychiatry at New York Medical College (NYMC) and a candidate in its psychoanalytic program disclosed several months into his training analysis that he had strong pedophilic interests. He insisted that he had never acted upon these desires. Multiple consultations with outside experts led the treating psychiatrist to revise therapeutic goals. These included sustained strong supportive therapy with an explicit proscription against the patient's acting on these interests and ensuring the confidential nature of the professional relationship. No specific child was a target of the patient's interests. Despite these efforts in therapy, the patient molested two children in Connecticut and was imprisoned for several years. The guardian of one of the children brought action against the analyst and NYMC in federal court (*Almonte v. Ingram and NYMC*). This *Tarasoff*-type case went to jury trial in 1998. Coverage of the matter appeared in the *New York Times*, several news programs and psychiatric publications. The plaintiff succeeded in winning against the psychiatrist, but failed to implicate NYMC. No hospital or professional society investigated the matter. A subsequent ethics investigation by the New York State Department of

Health found no wrongdoing on the part of the psychiatrist.

NO. 5

MORAL AND ETHICAL CODES: SIMILARITIES AND DIFFERENCES IN CHINESE AND AMERICAN PSYCHODYNAMIC PSYCHOTHERAPY

Speaker: Elise Snyder, M.D.

SUMMARY:

This presentation will discuss the difference between moral and ethical codes in all cultures and the similarities in the ethical codes as they pertain to psychodynamic psychotherapy and psychoanalysis in China and the United States. Although the cultures are different, the professional codes are very similar to each other.

MAY 16, 2016

CRITICAL ISSUES IN THE DELIVERY OF PSYCHIATRIC CARE THROUGH VIDEOCONFERENCING

Chair: Jay Shore, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Gain an understanding of available resources for developing telepsychiatric service(s) for both individual and organizational practices, including the new APA web-based toolkit for telepsychiatry; 2) Learn about key policy issues currently impacting administration and practice of telepsychiatric services; and 3) Learn about processes and best practices for delivering telepsychiatry in clinically unsupervised settings, including directly into patients' homes.

SUMMARY:

The field of telepsychiatry, in the form of live, interactive videoconferencing, is rapidly expanding to multiple settings and aspects of psychiatric practice. This symposium brings together national experts to provide an overview of key resources available to teach physicians about telepsychiatry, highlight important pragmatic policy issues impacting the practice of telepsychiatry and provide education on delivering telepsychiatry in clinically unsupervised settings. The symposium will begin with a brief introduction to the topic as well as an update on the APA's Board of Trustees ad-hoc telepsychiatry workgroup, including an overview of the APA's new web-based toolkit for telepsychiatry. This will be followed by a presentation on resources,

methods and processes to receive and provide training in telepsychiatry. A virtual roundtable will be conducted between members of the workgroup at the APA Annual Meeting and workgroup members located at the American Telemedicine Annual Meeting. The interactive roundtable, facilitated by videoconferencing, will attend to current national and regional policy issues impacting the practice of telepsychiatry. This symposium will conclude with a presentation on delivery of telepsychiatry into unsupervised clinical settings (e.g., home and office) that includes a live simulation of a mock patient session in the home. Key clinical strategies for providing this care will be presented. Interaction between the audience and presenters will be encouraged throughout the symposium, including question and answer during each presentation and at the end of the symposium.

NO. 1

APA TELEPSYCHIATRY RESOURCES FOR ADVANCING TELEPSYCHIATRIC CARE AND TRAINING: WEBSITE TOOLKIT AND WORK GROUP

Speaker: Jay Shore, M.D., M.P.H.

SUMMARY:

In 2015, the APA Board of Trustees created an ad-hoc telepsychiatry workgroup to develop resources for APA members interested in delivering telepsychiatry services at the individual and organizational levels and provide the APA with strategic recommendations on telepsychiatry. This workgroup has supported the development of the APA's new web-based telepsychiatry toolkit. This presentation will begin with a brief introduction to the topic as well as an update on the workgroup. An overview of the new web-based APA toolkit will highlight key areas, show the organizational structure of the toolkit, and provide tips on navigation and how to leverage the toolkit as an individual and organizational tool for telepsychiatric training.

NO. 2

TRAINING YOURSELF AND OTHERS IN TELEPSYCHIATRY

Speaker: Jeffrey I. Bennett, M.D.

SUMMARY:

This presentation will focus on methods of training in telepsychiatry. It will begin with a review of current work done to train psychiatric residents and other trainees in the use of clinical

videoconferencing. This will be contrasted with training available to current providers at the individual and organizational levels. Resources for training and education will be reviewed, including the new APA web-based telepsychiatry toolkit, other websites, educational symposia and other available resources. Audience members will receive recommendations on how to develop and structure training based on their roles in telepsychiatry (e.g., administrative, clinical, developmental) and their current level of learning. The presentation will conclude with general recommendations to the field around education and possible future certification in telepsychiatry.

NO. 3

VIRTUAL ROUNDTABLE ON PRACTICAL POLICY ISSUES IN TELEPSYCHIATRY

Speaker: Jay Shore, M.D., M.P.H., Alexander H. von Hafften, M.D., Steven Roy Davis, M.D., Robert Caudill, M.D., Donald M. Hilty, M.D., Peter Yellowlees, M.D.

SUMMARY:

A virtual roundtable will be conducted between members of the APA's Board of Trustees ad-hoc telepsychiatry workgroup at the APA Annual Meeting and workgroup members located at the American Telemedicine Annual Meeting, which is occurring at the same time. The interactive roundtable, conducted through videoconferencing, will attend to current national and regional policy issues impacting the practice of telepsychiatry. Specifically, this group will address issues of interstate licensure, restrictions around prescribing in telepsychiatry, psychiatric standard of care and quality in telepsychiatry, funding and reimbursement issues, credentialing, and key strategic steps for the APA to promote and advocate for telepsychiatry for its membership. This lively discussion will explore pragmatic issues that impact individual psychiatrists and organizations and encourage full audience participation with the roundtable.

NO. 4

DIRECT IN-HOME TELEPSYCHIATRY

Speaker: Meera Narasimhan, M.D., Jay Shore, M.D., M.P.H.

SUMMARY:

This presentation will focus on the delivery of telepsychiatry in unsupervised clinical settings (e.g., home and office). A brief overview of the literature,

guidelines and work in the field to date will be presented. This will be followed by a live simulation of a mock patient session in a patient's home via live, interactive videoconferencing. The session will present key areas that providers need to attend to when conducting telepsychiatry in unsupervised sessions, such as safety management and obtaining and creating an appropriate clinical environment. The presenters will use material from the simulation to generate further discussion with the audience around pragmatic tips for clinical management in this setting.

CORRECTIONAL PSYCHIATRY, CRIMINALIZATION OF THE MENTALLY ILL AND AVOIDING THE CRIMINAL JUSTICE SYSTEM

Chair: Rebecca Weintraub Brendel, M.D., J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify key guiding principles for identifying and engaging ethical challenges in psychiatry; 2) Appreciate APA resources for recognizing and resolving ethical questions in psychiatric practice; and 3) Understand current and anticipate future challenges and opportunities for psychiatric ethics.

SUMMARY:

Ensuring and advancing ethical conduct in psychiatry is critical to the future of the profession. At its December 2015 meeting, the APA Board of Trustees approved the APA Commentary on Ethics in Practice, now available to members as an online tool for psychiatrist to use in identifying and engaging ethical challenges that may arise in the course of practice. Work on this project had begun more than a decade prior, and completion included joint work between members of an APA Ad-Hoc Workgroup and the APA Ethics Committee. This presidential symposium on ethics will begin with a description of the early development of this ethics project and identify the guiding principles and engagement with members of the APA that occurred in the process. Next, the symposium will address the evolution of challenges in psychiatric ethics over the course of the project, highlight current areas of controversy, and anticipate future tensions for psychiatric practice and research. In the second half of the symposium, the focus will shift to mapping the agenda for engaging the future of psychiatric ethics, with specific focus on human rights and professionalism as critical tools for progress. The final presentation will provide critical

perspectives on the interface of psychiatry, biotechnology, biomarkers and genetics, highlighting both promise for the field and potential tensions for ethics.

NO. 1

THE APA COMMENTARY ON ETHICS IN PRACTICE (2015): CURRENT AND EMERGING ETHICAL ISSUES IN PSYCHIATRY

Speaker: Rebecca Weintraub Brendel, M.D., J.D.

SUMMARY:

Dr. Brendel will provide an overview of the new APA Commentary on Ethics in Practice, with a specific focus on the project's purpose and approach to provide practically relevant guidance to APA members. She will highlight the issues that evolved, changed and emerged over the course of the commentary project. Her presentation will conclude with an exploration of current ethical challenges in psychiatry and anticipation of future directions for psychiatric ethics in practice.

NO. 2

UNIVERSAL, UNIFYING ETHICS: THE NEW HOPE

Speaker: Philip Candilis, M.D.

SUMMARY:

Two major ethical themes have arisen from the dramatic changes facing modern psychiatry: professionalism and human rights. As practitioners enter increasingly complex roles with their communities, industry, allied health organizations, educational institutions and government, practitioners are challenged to apply ethical norms that are no longer helpful. Balancing competing obligations to communities and gun owners, acknowledging privacy in a time of security concerns and social media, separating roles in managed systems of care, avoiding conflicts of interest on government panels, strengthening information disclosures in controversial research, and developing other protections from self-interest or patient harm have become commonplace. However, there remains sufficient role confusion and variability to cloud classic obligations to patients and the profession. Indeed, by emphasizing roles over professionalism and human rights, a kind of practice has arisen that elevates the requirements of the setting over the ethics of the profession. Dr. Candilis will offer unifying themes from the professionalism and human rights movements that may help clarify psychiatry's future obligations.

CRITICAL ISSUES IN ADDICTION PSYCHIATRY

Chairs: Laurence Westreich M.D., M.D., Brian S. Fuehrlein, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Cite several examples of philosophical dilemmas in treating addiction; 2) List at least three common problems in addiction psychiatry in the emergency department; 3) Discuss the Veteran's Administration (VA) model for emergency department treatment of opiate use disorder; and 4) List common causes of malpractice in addiction psychiatry.

SUMMARY:

This symposium will address some critical issues within addiction psychiatry: the philosophical underpinnings of treatment, common dilemmas in the emergency department, the specifics of one successful program for managing opioid use disorders in an emergency department and an overview of malpractice litigation in addiction psychiatry. Unfortunately, people with substance use disorders are often reluctant patients who must be convinced, cajoled and (sometimes) forced into treatment. The occasionally conflicting needs of the patient, his or her family, and society present dilemmas for the clinician. Dr. Rosenthal's presentation will explore the ethical and philosophical discourse that informs excellent, respectful and effective work with the addicted person. Dr. Rozel will present practical challenges in emergency addiction psychiatry, which confront all of us, and will promote those practices that promote the best possible outcomes. The management of severely ill patients who manifest denial, varying expectations from loved ones for immediate intervention and the practical assessment of intoxication/withdrawal states around discharge will be addressed. Dr. Fuehrlein will present the Veteran's Administration's program for managing opioid use disorders in the emergency department, including data and case examples from this wide-ranging and thoughtfully constructed program. The indications for the induction of buprenorphine in the emergency department will be reviewed. Finally, Dr. Westreich will summarize some common causes of malpractice litigation in addiction psychiatry, as well as methods for decreasing, if not eliminating, the risk of litigation. A by-definition chaotic situation in the treatment of addiction crises must be managed

with forethought; skill; and a robust understanding of the patients' needs, rights and obligations. Participants will come away with a broader understanding of how experienced clinicians manage the conundrums of addiction psychiatry at the most critical junctures: when the addicted person is in crisis, using lethal substances, causing physical and emotional harm to him or herself, and presenting the risk of malpractice litigation to the clinician.

**NO. 1
CHOICE VERSUS COMPULSION IN ADDICTION
PSYCHIATRY**

Speaker: Richard N. Rosenthal, M.D., M.A.

SUMMARY:

While patients with severe mental disorders frequently elicit philosophical and ethical concerns about paternalism versus autonomy, treating patients with substance use disorders (SUDs) may bring up even more complicated dilemmas and philosophical conundrums. SUDs frequently carry compulsive hallmarks, but are usually the downstream result of what began as volitional behaviors. This presentation will entertain some of the typical philosophical and practical struggles clinicians face when treating patients with SUDs. How much should I push my patient toward sobriety? How much should I lay out alternatives? Does an addicted person exercise choice? What are my responsibilities to the patient? His family? Society? The answers will be determined by our understanding of the addictive process and by how this understanding fits into the greater rubric of medical ethics and public health. For example, abstinence from drugs in a person with a SUD is a well-formed and straightforward idea that has served as the philosophical basis for traditional addiction treatment. The expected behavior of the patient in the traditional abstinence-based recovery mode is surrender and apprenticeship. However, medical treatments, while effective in reducing the symptoms of SUD and mitigating harm, may contradict the principles of abstinence and its accompanying clinical infrastructure.

**NO. 2
COMMON PSYCHIATRIC EMERGENCY DEPARTMENT
PROBLEMS**

Speaker: John S. Rozel, M.D.

SUMMARY:

Substance use disorders are ubiquitous in emergency psychiatry. Addiction is a common reason for presentation to the emergency department and a common comorbidity for patients presenting with other medical and psychiatric issues. Substance use is a critical risk factor for violence and suicide—two issues of vital importance in psychiatric risk management—and a significant confounding condition in the management of many other psychiatric and medical illnesses. The modern emergency psychiatrist needs to be well versed in a variety of addiction-related issues. This presentation will address common presentations and challenges relating to substance use in emergency psychiatry and will provide practical guidance to front-line clinicians. Common presentations include substance use as a comorbid or confounding factor in presentations for other psychiatric and medical emergencies. Also commonly seen are people presenting primarily for addiction concerns—including intoxication and withdrawal symptoms, but also when patients or their loved ones hope for an intervention to shift the course of addiction. The individual's willingness to acknowledge addiction issues or seek support in changing their behaviors can vary significantly. There are also a number of common challenges facing emergency management of addiction issues. Complicated intoxication, including polysubstance intoxication, agitation, and use of unknown or new drugs of abuse, can test clinical skills.

**NO. 3
OPIOID USE DISORDER AND THE PSYCHIATRIC
EMERGENCY ROOM: THE VA MODEL**

Speaker: Brian S. Fuehrlein, M.D., Ph.D.

SUMMARY:

Opioid use disorder is a rapidly growing illness with high rates of morbidity and mortality. Prescription drug overdose has now become the leading cause of injury death in the U.S., with more than half involving opioids. Nearly two million Americans either abuse or are dependent on opioids, which causes nearly one million emergency room visits annually. Patients who abuse opioids often do not seek out care, and the emergency room may be their only contact with the health care system. The psychiatric emergency room at VA Connecticut Health Care System cares for patients with opioid use disorder that range in severity from new-onset pain pill abuse to intravenous heroin users who have nearly died of an overdose. A wide range of levels of

care for patients with opioid use disorder will be discussed. This will be followed by case examples of common psychiatric emergency room presentations of patients with opioid use disorders varying from mild to severe. These patients will be discussed in the context of assessment and treatment planning. Finally, buprenorphine will be introduced and its use in the emergency room setting will be discussed.

NO. 4

MALPRACTICE IN ADDICTION PSYCHIATRY

Speaker: Laurence Westreich M.D., M.D.

SUMMARY:

Clinical work in addiction psychiatry presents multiple opportunities for committing—or being accused of committing—medical malpractice. Patients with substance use disorders are among the most volatile within psychiatry and are prone to endanger themselves, harm others and generally break socially accepted norms. Those who treat addiction must ensure that they practice evidence-based psychiatry, which is to practice above the minimum standard of care; document that care; and prepare themselves for litigious patients, family members and government agencies. After providing some examples of actual malpractice charges brought against addiction psychiatrists, some common methods for avoiding both the appearance and actuality of medical malpractice will be considered. Unfortunately, addiction treaters and addiction treatment facilities present easy targets for malpractice cases, at least in part because of the remaining miasma of stigma that hovers around addiction itself. The addicted person's high risk of suicide, overdose and catastrophic relapse makes their treatment a high-stakes activity for all involved. Other potential causes for malpractice include failure to recognize the need for inpatient treatment; careless (or even criminal) prescribing of controlled substances; and breach of the numerous and sometimes arcane laws, regulations and rules that govern the treatment of the addicted person.

LET'S TALK ABOUT PSYCHIATRY "NOW": A DIFFERENT SORT OF INTEGRATION

Chair: Adrienne L. Bentman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the application of psychotherapeutic principles in single sessions, teams and systems; 2) Describe the impact of

cognitive neuroscience on practical clinical decisions; 3) Explain the important elements in the care of young and older patients; and 4) Describe what excites members of AADPRT about psychiatry today.

SUMMARY:

Population growth, mental health practitioner shortages, the pace of health care provision and the explosion of knowledge present challenges and opportunities to program directors and generalist psychiatrists. This symposium offers ways to meet those challenges by teaching and providing care in new ways, in new roles and in expanded populations. Psychiatrists are challenged by population expansion, a shortage of mental health providers and the breadth of information required to provide modern care. Current residents and generalists in practice are asked to bring their knowledge and skills into new settings, in new roles, at a new pace and at broader ends of the age range. Planning for the "future" of psychiatry sometimes seems to be the focus of the training we are doing right now. Psychiatry remains alive, creative and in "good health." This symposium addresses our future through this lens. Integration has been the theme of recent AADPRT-APA symposia. In recent years we have addressed the integration of the brain and its physiology (cognitive neuroscience) into the conceptualization of illness and the integration of this science into our work with patients, families and colleagues. This year's symposium will continue the theme of integration. We will address areas of education for residents and general psychiatrists that bring old principles into new settings and practical neuroscience to clinical care. We will address issues central to the care of patients at the ends of the "general" age spectrum and will consider the skills needed to work in systems and lead teams. Program director-clinician-educators will provide examples of current educational practices that illustrate these elements.

NO. 1

THE GENERAL PSYCHIATRIST AS TEAM AND SYSTEMS THINKER

Speaker: Adrienne L. Bentman, M.D.

SUMMARY:

Psychiatrists work in many roles: as individuals and as team leaders. This latter role has become increasingly important in an era of population growth, psychiatrist and mental health care provider shortage, and growing awareness of psychiatric

illness and its consequences. In addition, many of us lead these teams in large institutions under pressures from the outside and strains from within. Psychiatrists are in a unique position to consider the impact of these forces on individuals and groups and on their capacity to work collaboratively and effectively. This presentation will consider the role of the team leader, the common challenges they face and the advantages of considering the larger system(s) in this role. Preparatory educational experiences, opportunities to practice this role and supervisory options will be discussed.

NO. 2

LET'S TALK ABOUT PSYCHIATRY "NOW": A DIFFERENT SORT OF INTEGRATION

Speaker: Adam Brenner

SUMMARY:

Psychotherapeutic interventions are used all the time in acute psychiatric settings, but very often, they go unnoticed. For example, effective clinicians have always made very powerful use of the nonspecific factors of psychotherapeutic efficacy when faced with distressed or agitated patients in acute settings. These nonspecific elements (the decrease of the patient's alienation, the sense of shared work, hopefulness and the reassurance of attachment) are often pivotal in providing evidence for treatment collaboration with patients with behavioral distress in the emergency room, on psychiatric units or on a medical service. Similarly, when faced with patients who are reluctant to engage in treatment or are nonadherent with treatment, effective psychiatrists in acute settings have drawn on the concepts and skills learned in psychotherapy. Formulations of a patient's defenses (drawn from psychodynamic psychotherapy) or of maladaptive negative thinking (drawn from CBT) provide a framework for conceptualizing and engaging with a patient when there is a rupture in the treatment alliance. The task for psychiatric educators is to help our clinician-teachers to think systematically and explicitly about how they integrate psychotherapeutic work into their patient care and to support them in teaching these techniques to residents. The AADPRT Psychotherapy Committee is developing tools to aid clinical faculty in this important aspect of our residents' development.

NO. 3

TRANSITIONAL AGE YOUTH/EMERGING ADULTS: BIOPSYCHOSOCIAL CONCEPTS FOR INTEGRATED TRAINING

Speaker: Sanda DeJong, M.D.

SUMMARY:

Individuals between the ages of 16 and 26, an age group referred to as "transitional-age youth" or "emerging adults," present particular challenges for the psychiatrist and psychiatrists-in-training. Biologically, increased organization of neural circuits gradually balances limbic reactivity with frontal lobe oversight; these changes can expand intellectual and self-regulations capabilities, but also expose major mental illness (for example when over-pruning results in schizophrenia). Cannabis abuse, now rampant in many adolescent communities, can develop into potentially more lethal addictions to substances like opioids. Psychologically, youth move from early separation and individuation from parents into more fully developed identity formation across a range of domains, from cognitive to social-emotional to sexual. Earlier childhood experiences, including trauma and loss, will shape this development. Socially, youth increasingly seek to rely on peers rather than parents for self-definition and support. They find ways to define themselves in the context of education, vocation and employment, avocational interests, and intimate and social relationships, and these identity components are lived out in person but also curated online. This session will look at biopsychosocial factors affecting the mental health of this age group and how they interact to determine if a young person will successfully "launch" into an increasingly competitive real world environment.

NO. 4

FOUR FACTS ABOUT OLDER ADULTS IN GENERAL PSYCHIATRIC PRACTICE

Speaker: Art Walaszek, M.D.

SUMMARY:

There are four basic ideas to hold in one's mind when treating older adults: 1) Older adults are prescribed too many medications; 2) Older adults fall down; 3) Older adults benefit from psychotherapy; and 4) Older adults, even those with dementia, have personalities. This presentation will discuss the concepts of polypharmacy, the Beers criteria (medications to be avoided in older adults) and the geriatric mantra of "start low, go slow, but go." The overlap of medical and psychiatric issues in older

adults, including a psychiatrist's responsibility in the domain of "falls," will be addressed. The efficacy of psychotherapy will be taken up, as will the import of focusing on our patients'/families' motivations, values, wants, needs, and sense of purpose and meaning, even as they confront dementing processes.

**NO. 5
NEUROPSYCHIATRY AND COGNITIVE
NEUROSCIENCE IN GENERAL PSYCHIATRIC PRACTICE**

Speaker: Sheldon Benjamin, M.D.

SUMMARY:

Knowledge of cognitive neuroscience and neuropsychiatry impacts diagnosis, formulation and treatment planning and positions practitioners to take advantage of emerging research findings. Understanding a person's areas of strength and weakness in brain function contributes to understanding them as individuals and can play a role in the evolving field of personalized medicine. We will briefly examine some widely held but often unarticulated beliefs that have held psychiatry back from embracing neuropsychiatric paradigms, specify components of neuroscience literacy for psychiatrists and look at a few interventions we can take as a field to move toward greater facility in these areas. Acquiring neuropsychiatric experience and neuroscience knowledge requires a paradigm shift in some aspects of psychiatric training, such as increasing expectations for trainees (reflected in the clinical neuroscience milestones), involving colleagues from other fields of medicine in our case conferences, reevaluating the content of neurology rotations and the attitude toward neurology training for psychiatrists, and providing opportunities for advanced neuropsychiatric formulation through longitudinal clinical curricula during residency. Increased familiarity with neuropsychiatry will better equip us to help our accountable care organizations manage the complex cases increasingly presenting to primary care physicians and increase the value of psychiatric consultation to our patients.

MAY 17, 2016

**NEW NOMENCLATURE FOR MEDICATIONS
(NEUROSCIENCE-BASED NOMENCLATURE – NBN)**

Chair: Maria Oquendo, M.D.

Discussant: Maria Oquendo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe at least one goal of shifting current nomenclature for medications to a neuroscience-based nomenclature (NbN); 2) Delineate the nature of the scientific evidence used to determine inclusion of a given medication in the NbN; and 3) Describe how the NbN might help reduce stigma.

SUMMARY:

Our current psychopharmacological nomenclature is confused and confusing. It does not help clinicians select the best medications for a given patient and tends to perplex patients, as they are often prescribed a drug from a class discordant with their identified diagnosis (e.g., aripiprazole, "an antipsychotic" prescribed for depression). The Taskforce on Nomenclature, launched as an international effort by four colleges—the European College of Neuropsychopharmacology (ECNP), the American College of Neuropsychopharmacology (ACNP), the International College of Neuropsychopharmacology (CINP) and the Asian College of Neuropsychopharmacology (AsCNP)—together with International Union of Clinical and Basic Pharmacology (IUPHAR) were charged to develop pharmacologically based principles for describing and categorizing the most frequently used psychotropic drugs. The project was initiated six years ago when representatives from the four neuropsychopharmacology organizations first met. The aims were to 1) Provide a mode of action (MOA)-driven, rather than indication-based, nomenclature that integrates contemporary neuroscientific understanding of how medicines act; 2) Inform clinical decision making for the next "pharmacological step" in the treatment of patients; 3) Decrease stigma by explicitly indicating the biological system targeted by a drug; and 4) Enhance adherence through a naming system that lays out the rationale for selecting a specific psychotropic drug. The neuroscience-based nomenclature (NbN) has now completed its first phase based on 108 compounds delineated in a booklet and a freely available app. These provide information along five axes: 1) Drug name; 2) Target neurotransmitter system and MOA; 3) Approved indications by major regulatory bodies (e.g., Food and Drug Administration, European Medicines Agency, etc.); 4) Side effects; and 5) Former terminology. Content has been made concise and highlights situations where a compound fell short of approval for a formal indication despite support for its use in

expert guidelines, as well as prevalent or life-threatening side effects. There is obviously the potential for extension by linking its contents to archives or publications. This presentation will describe the NbN and include an introduction of the overall plan (Maria Oquendo) and current advances, which include the development of an app for the overall project (Joseph Zohar). The NbN in action will be presented by Pierre Blier, who will illustrate its use for selection of drugs for treatment of depression, and by Steven Stahl, who will describe the application of the NbN for treatment of psychotic conditions.

NO. 1

HOW NEUROSCIENCE-BASED NOMENCLATURE (NBN) CAN CHANGE YOUR PRESCRIBING PRACTICE

Speaker: Joseph Zohar, M.D.

SUMMARY:

Current psychopharmacological nomenclature remains wedded to an earlier period of scientific understanding. It neither reflects contemporary developments and knowledge nor helps clinicians to make informed prescriptions. Moreover, it is confusing to the patients, as they are being given a drug with a different name compared to their identified diagnosis (e.g., an “antipsychotic” for depression). NbN is a new nomenclature for psychotropics that is pharmacologically driven, focusing on pharmacological target and mode of action. The recommended way to use the NbN is via a specific app that can be downloaded for free at Google Play, the Apple Store or on our website: <http://nbnomenclature.org>. The app includes a sophisticated search engine that is able to combine pharmacology, mode of action, approved indications, efficacy and side effects. For example, if we see a patient with a major depression disorder who is on a serotonin reuptake inhibitor (SRI) and developed a sexual dysfunction, we would like to change to another medication with different pharmacology. Using the NbN app, we push “indication” (depression), “pharmacology” (norepinephrine) and “side effect” (sexual dysfunction), and the app will give us all the relevant options. The NbN website also includes a glossary that helps to “translate” the former nomenclature group term to the “NbN language” (<http://nbnomenclature.org>). In this presentation will include a live demonstration of how to use the NbN app.

NO. 2

HOW NEUROSCIENCE-BASED NOMENCLATURE HELPS REDUCE STIGMA

Speaker: Pierre Blier

SUMMARY:

The use of the word “antidepressants” has generated much confusion and contributed to the false notion of their excessive use. Indeed, selective serotonin reuptake inhibitors represent the first-line pharmacological treatment for most anxiety disorders, which are more prevalent than major depressive disorder (MDD). Duloxetine was first introduced for the treatment of MDD, but is also indicated for chronic pain and, in some countries, for urinary incontinence. Low doses of tricyclic antidepressants have been used for decades in chronic pain, including amitriptyline for the prophylaxis of migraine. Immediate release trazodone is routinely utilized as a sedative. All these medications have been grouped under the umbrella of antidepressants, and their combined use obviously far exceeds the prevalence of MDD. The need for a mechanistically based nomenclature is also crucial because the abovementioned drugs may be effective in distinct diagnostic entities at different doses. For instance, tricyclic antidepressants are generally effective in chronic pain at 25mg/day, whereas about 150mg/day is necessary to achieve a therapeutic action in MDD. Per se, this implies different mechanisms of action. Finally, in treatment-resistant MDD, several medications that are not antidepressants have been used in combination with antidepressants to achieve remission. The best examples are low doses of atypical antipsychotics, which act on a variety of monoaminergic receptors.

NO. 3

NEUROSCIENCE-BASED NOMENCLATURE: FOCUS ON TREATMENTS FOR PSYCHOSIS

Speaker: Stephen M. Stahl, M.D., Ph.D.

SUMMARY:

Treatments for psychosis have many names, not only “antipsychotics,” but several others: first-generation, second-generation, conventional, atypical, neuroleptic, tranquilizer. Adding to the confusion is the fact that many antipsychotics are also antidepressants and antimanic mood stabilizers. We propose a nomenclature based upon pharmacological mechanisms instead of clinical actions. Specifically, older antipsychotics are

generally dopaminergic, especially D2 dopamine antagonists. Newer agents are dopaminergic-serotonergic, especially dopamine 2 and serotonin 2A antagonists. Some agents are also dopamine D2 partial agonists. In addition, agents that treat psychosis, when used to treat mood disorders, may be targeting other serotonin and neurotransmitter receptors, especially 5HT1A, 5HT2C and 5HT7 receptors, among others. Novel so-called antipsychotics may not have any dopamine properties, such as the new selective 5HT2A antagonists. Utilizing neuroscience-based nomenclature that describes the primary pharmacological target(s) is proposed not only to prevent confusion in classification of drugs to treat psychosis, but as a way to help clinicians think about drugs by their mechanism(s) and not by their broad clinical indications.

CORRECTIONAL PSYCHIATRY: JOURNEY INTO THE HEART OF DARKNESS

Chair: Graham D. Glancy, M.B.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Have an appreciation of the history of correctional care in psychiatry; 2) Know the prevalence of mental disorder in the community; and 3) Understand similarities and differences between psychiatric care in the community and psychiatric care in corrections.

SUMMARY:

The prevalence of mental disorders in corrections has greatly increased over the last 40 years and is likely proportionate to the decrease of patients in psychiatric hospitals. There are now more patients with mental disorder in corrections than in psychiatric hospitals. In this symposium, we will discuss the history of psychiatric care in corrections and the case law that has driven and shaped this care. We compare and contrast psychiatric care in the correctional system to psychiatric care in the community.

NO. 1

THE WHAT AND WHY OF CORRECTIONAL PSYCHIATRY

Speaker: Robert L. Trestman, M.D., Ph.D.

SUMMARY:

Correctional psychiatry has evolved rapidly. The number of incarcerated mentally ill and addicted

individuals has more than quadrupled to levels that frequently exceed those in community systems of care. Most sources acknowledge that in much of the U.S., correctional systems are now the de facto mental health systems of care. Complex, comorbid disorders are commonplace presentations in correctional settings. Typically, 20% of men and 30% of women who are incarcerated have a mental illness requiring treatment; 75 to 80% have comorbid substance use disorders. Psychotic disorders, personality disorders, post-traumatic stress disorder, traumatic brain injury and intellectual disability are highly prevalent and challenging to manage in correctional settings. The costs of treatment represent a substantial proportion of correctional health care costs in the context of limited resources and single-payer capitated systems of care. An entire, and distinctly challenging, continuum of care exists in jails and prisons, each level presenting unique demands of collaboration with other disciplines, including custody. Further, effective interventions during incarceration will contribute to successful community reentry. This presentation reviews the context and provides perspective for correctional psychiatry.

NO. 2

SUICIDE PREVENTION IN CORRECTIONAL FACILITIES

Speaker: Jeffrey L. Metzner, M.D.

SUMMARY:

The risk of suicide is a significant concern for incarcerated individuals. This presentation will summarize issues relevant to prevalence, demographics, trends, screening and assessment of suicide risk, as well as identify key factors associated with increased risk in managing that risk safely and appropriately in correctional facilities.

NO. 3

ASSESSMENT AND PRESCRIBING IN CORRECTIONAL SETTINGS

Speaker: Anthony Tamburello

SUMMARY:

Serious mental illness is highly prevalent in correctional institutions, making quality psychiatric evaluation there critically important. Assessments in jails and prisons may be more challenging due to operational limitations. High baseline rates of comorbidities and malingering, none of which are mutually exclusive with serious mental illness, further increase the difficulty. Misuse of prescription

medication, which may involve abuse or diversion of even non-controlled drugs, is a common and especially concerning problem in these settings. In this portion of the symposium, we will discuss the unique aspects, both advantageous and otherwise, of psychiatric assessments in correctional settings, how to work with a medication formulary, motivations for and methods used by inmates to obtain medications for non-clinical purposes, and how to reduce the incidence and risk of such behavior.

NO. 4

GET OUT AND STAY OUT! HELPING INMATES RETURN TO THEIR COMMUNITIES

Speaker: Erik Roskes, M.D.

SUMMARY:

Often neglected as correctional health care providers struggle to meet the needs of their patients, reentry or discharge planning is an important element of any correctional system. This is especially so for inmates with mental disorders, who may be even more disconnected and needy than others. Competent and holistic release planning is important both for continuity of care and in order to reduce the likelihood that inmates will return to incarceration due to an inability to access needed services. Reentry planning efforts are especially complex in that they require ongoing collaboration with correctional-based and community-based health care providers, social services agencies, housing providers and, ideally, inmates' families. This presentation will explore the elements of the release planning process, focusing on case examples and relevant legal standards and guidelines.

ENDING THE CRIMINALIZATION OF MENTAL ILLNESS

Chair: Steven Leifman

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn how and why the "deinstitutionalization" of psychiatric facilities led to the criminalization of mental illness; 2) Understand how the justice system is responding; 3) Witness new and effective strategies that are being developed and employed to transform the mental health and criminal justice systems; and 4) Understand the role psychiatry can play in developing and executing systematic community change.

SUMMARY:

It is estimated that more than two million arrests in the United States each year involve people with serious mental illnesses (SMI). As a result, untrained and unprepared stakeholders in the criminal justice system have been forced to navigate an increasingly scarce system of care for people with mental illnesses. Jails have become places where a disproportionate number of people with SMI spend significant amounts of time, their ties to the community severed, their treatment needs unmet and their illnesses made worse. Judge Leifman will discuss his journey into the mental health system, the legal and medical history that led to America's mental health crisis, and the essential elements necessary to create an effective system of care that will ultimately transform the mental health and criminal justice systems and make jail the last option for people with serious mental illnesses, not the first.

PSYCHOSOMATIC MEDICINE: OFFERING A MULTIFACETED APPROACH TO CLINICAL, EDUCATIONAL AND RESEARCH CHALLENGES IMPACTING PATIENT CARE

Chair: Catherine Crone, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about a new model for inpatient consultations utilizing a proactive case-identifying approach that can offer quality, cost-effective psychiatric care to patients in medical-surgical settings; 2) Gain a greater understanding of the phenomenon of youth suicide and the role of suicide risk screening in pediatric medical settings; 3) Demonstrate updated knowledge about conversion disorder in regards to diagnostic criteria, models of formulation, comorbidities and brain dysfunction that may underlie clinical symptomatology; 4) Derive a greater understanding of the educational needs of trainees, current physicians and other health care providers to enable them; and 5) Obtain a broader grasp of the concept of collaborative care both from a historic view and current updates about present models.

SUMMARY:

Traditional views of psychosomatic medicine are often confined to the idea of caring for patients with comorbid medical and psychiatric conditions on a medical/surgical unit of a general hospital. Often,

patients are seen in response to fears, concerns and frustrations expressed by health care providers. While traditional hospital-based consult services continue to run at many centers, the field of psychosomatic medicine offers much more to the field of psychiatry that spans clinical, educational and research needs impacting patient care. This symposium provides a glimpse of some of the diverse developments in psychosomatic medicine. Included is a novel approach to inpatient consults that provides a proactive stance to the identification of patient needs as well as clinical research efforts involving pediatric patients and the development of a suicide screening tool that may be generalizable to other patient populations. An update on conversion disorder will include discussion of research involving brain dysfunction in the presence of psychogenic movement disorders. The role of psychosomatic medicine in educating future health care providers to better meet the needs to patients with comorbid psychiatric and medical illnesses will also be discussed. With the development in recent years of a more formalized collaborative care model, a final discussion of the history of collaborative efforts within psychosomatic medicine will provide the participant with a broader view of this approach to patient care.

NO. 1

AN UPDATE ON CONVERSION DISORDER

Speaker: Steve E. Epstein, M.D.

SUMMARY:

This presentation will provide an update on conversion disorder from multiple perspectives. *DSM* criteria will be reviewed in the context of the criteria for other somatic symptom disorders. Clinical vignettes will be of patients with conversion disorders with emphasis on psychogenic movement disorder. A brief video will be included. Conversion disorder will also be discussed from multiple perspectives, including both behavioral and psychodynamic formulation models. Descriptive data from a large series of patients with psychogenic movement disorder will include information about psychiatric comorbidities. The presenter will include an update on brain research into psychogenic movement disorders based on NIH research for which he has served as a consultant. This research includes findings related to the role of the temporoparietal junction and connectivity disturbances in this disorder. Finally, intervention

strategies such as cognitive behavior psychotherapy will be discussed.

NO. 2

ASQ: PEDIATRIC SUICIDE RISK SCREENING IN MEDICAL SETTINGS

Speaker: Maryland Pao, M.D.

SUMMARY:

In the U.S., suicide is the second leading cause of death for youth and the 10th leading cause of death for adults. As suicide risk screening in medical settings becomes a national priority, nonmental health clinicians on the front lines of this public health threat require tools for assessing suicide risk in youth. Pediatric psychosomatic medicine researchers at the NIMH Intramural Research Program, in collaboration with multidisciplinary pediatric emergency staff at the Children's National Medical Center (Washington, D.C.), Boston Children's Hospital and Nationwide Children's Hospital (Columbus, OH), developed a risk of suicide screen for pediatric patients in the emergency department that resulted in a validated tool, the four-item ASQ (Ask Suicide Screening Questions), with a 97% sensitivity and a 88% specificity. A total of 524 patients were screened (344 medical/surgical and 180 psychiatric) with 14 of the medical/surgical patients screening positive (four percent) as compared to a 30-item gold standard instrument. The ASQ, a brief, valid, psychometrically sound screening instrument for assessing pediatric suicide risk, is acceptable to nonmental health clinicians who have implemented the ASQ to identify at-risk patients in a variety of medical settings.

NO. 3

PROACTIVE CONSULTATION-LIAISON PSYCHIATRIC SERVICES: A NEW MODEL FOR DELIVERY OF PSYCHIATRIC SERVICE FOR HOSPITALIZED MEDICO-SURGICAL PATIENTS

Speaker: Hochang B. Lee, M.D.

SUMMARY:

Psychiatric comorbidity is common (20–40%) among hospitalized medico-surgical patients and is associated with higher cost of care, poorer clinical outcomes and staff dissatisfaction. Unlike the traditional "reactive," physician-oriented model of traditional consultation-liaison (CL) psychiatry, the proactive CL psychiatry programs such as the Yale Behavioral Intervention Team (BIT) emphasize screening, early prevention and intervention of

behavioral issues, and deployment of a multidisciplinary behavioral health team. Through colocation and coordination of psychiatric services during the medico-surgical stay, these programs aim to provide integrated behavioral and medical care for hospitalized patients. A recent comparative BIT trial based on a “before and after” design at Yale New Haven Hospital examined 15,858 medical inpatient stays over three contiguous years in three different inpatient settings with a total capacity of 92 beds. The BIT model was associated with lower cost of care per care, less utilization of one-to-one staff assignment (“constant companions” or “sitters”) and incremental revenue from new “backfill” cases due to reduction in length of stay. A proactive CL psychiatry model is a promising means of delivering quality, cost-effective psychiatric service on general medical units while providing a high level of care and staff support.

NO. 4

TRAINING FOR COMPLEXITY: PSYCHOSOMATIC MEDICINE AS THE MODEL FOR THE 21ST CENTURY

Speaker: Sanjeev Sockalingam, M.D.

SUMMARY:

The high burden of mental illness in patients with physical health conditions combined with the increasing recognition of physical health burden in patients with severe mental illness has warranted greater focus on integrated care training and greater education in psychosomatic medicine domains. In parallel to this growing recognition of the need for improved education in physical and mental health care, we are faced with a call for medical education reform to better prepare our learners and faculty for managing the complexities in our current health care environment. Psychosomatic medicine training provides an opportunity to repair this divide between complex physical and mental health care in our system. This presentation unravels this complexity and summarizes current training gaps in integrated physical and mental health care in a range of settings. The presentation will discuss the emergence of education technologies, such as simulation and telepsychiatry, and demonstrate how technology services are an additional vehicle for narrowing the mind-body divide and integrating psychiatric care across medical settings. Moreover, the need for an interprofessional, team-based approach to improve patient care aligns with psychosomatic clinicians’ skills in collaboration and liaison across disciplines and professions. The

presentation will focus on the role that psychosomatic medicine training can play in addressing these key training gaps.

NO. 5

COLLABORATIVE CARE: EVOLVING MODELS OF CARE

Speaker: Thomas N. Wise, M.D.

SUMMARY:

The modern history of formal cooperation between psychiatrists and other medical providers began with psychiatric physicians who worked in free-standing asylums visiting general hospitals to consult on specific patients and has been described in both the U.S. and the U.K. After the development of general hospital units, collaboration became more common. The concept of liaison psychiatry (meaning linkage) developed as a clinical relationship first at the University of Colorado and evolved into our current consultation model. These models were “passive” in that they were focused on individual patients identified as needing psychiatric evaluations by nonpsychiatric physicians. The movement to outpatient consultation of medical populations has been growing and has led to newer models of stepped care. Currently, the concept of population health is evolving and demands a more proactive approach. Thus, models are needed that are truly integrated into a medical group practice rather than mere colocation or episodic consultation. New technologies such as computerized case registries and computerized screening allow “stepped” care to assess a total population for specific psychiatric disorders and then rationally prescribe levels of care. The discussion will emphasize that there is currently no one model of collaboration, and perhaps true integration will only be part of the solution to how to best treat the psychiatric issues in patients in medical settings.

BACK TO THE FUTURE: INTEGRATING PRIMARY CARE AND BEHAVIORAL HEALTH 2020

Chair: Lori Raney, M.D.

Discussant: Paul Summergrad, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the role of the psychiatrist on the 2020 collaborative care team, including specific duties and responsibilities ; 2) Explain the psychiatrist’s roles and responsibilities in the overall health of the population with serious

mental illness; and 3) Describe how psychiatrists will be paid for indirect services both on the primary care team and in the overall care of their patients with behavioral health conditions.

SUMMARY:

The integration of behavioral health and primary care is rapidly expanding into many sectors and becoming the new gold standard of care. Psychiatrists are mindful of this transition and striving to meet the workforce needs required to make these models successful through effective consultation in primary care and other medical settings. In public behavioral health locations where the morality gap for patients with serious mental illness continues unabated, models are slowly beginning to emerge along with a changing view of the role of psychiatrists in the overall health care of this population. Solutions to financing the indirect services crucial to delivery of care are being tested and implemented through innovation grants across the country. In 5–10 years, the major barriers to integrated care will be resolved, given the focused attention currently in the clinical, financial and policy arenas fueled by the Affordable Care Act and other health care reform initiatives. This symposium will take the audience into a time machine and propel them forward to the year 2020 to see what the current experts think this transformed health care system will look like and the steps, and missteps, that got us there. The presentations will be from leaders in the integrated care world, including Roger Kathol on successful financial models, Ben Druss on reducing the mortality gap in patients with serious mental illness, Jürgen Unützer on the collaborative care model and Joe Parks on health homes for patients with mental illness. Lori Raney will describe and profile the psychiatrist in 2020 based on these projections. Paul Summergrad, who stewarded the 2011 APA Board of Trustees Workgroup on Health Care Reform, will serve as the discussant and look back on a decade of the field of psychiatry's evolution into a profession on the vanguard of health care reform.

NO. 1 FINANCIAL AND ADMINISTRATIVE MODELS OF CARE INTEGRATION: TRANSITIONING TO SUCCESSFUL AND SUSTAINABLE CARE DELIVERY SUPPORT

Speaker: Roger Kathol, M.D.

SUMMARY:

There are two necessary components for medical and behavioral health integration to be successful: 1) Implementation of value-added integrated care delivery and 2) A financial and administrative infrastructure that sustains the professionals and facilities delivering value-added integrated care in the medical setting. To date, the majority of attention has been given to the development of clinical models of value-added integration. Despite the established cost-saving features of such programs, it is clear that the current independent payment system does not support the financial stability of such programs, nor does it facilitate coordination of their administration in medical settings. Part B of this presentation will summarize the impact segregated payment for psychiatric services from medical services has on desired behavioral health parity and then discuss the transition steps that can be taken between 2016 and 2020 that will support financially and administratively sustainable value-added integration of psychiatric care where the majority of patients with psychiatric need are seen, i.e., the medical setting.

NO. 2 IMPROVING HEALTH AND HEALTH CARE FOR PATIENTS WITH SERIOUS MENTAL ILLNESSES IN A POSTINTEGRATION ERA

Speaker: Benjamin G. Druss, M.D.

SUMMARY:

The current emphasis on integration for people with serious mental illness has focused on improving quality and coordination of care between the medical and mental health systems. In the future, we need to shift our emphasis from systems integration to patient-centeredness and from measuring and managing symptoms to measuring and managing functional outcomes. This is a change that needs to occur in the broader health care delivery system, and public mental health systems should lead the way.

NO. 3 INTEGRATION AT THE STATE LEVEL: A PAYER PERSPECTIVE

Speaker: Joseph Parks, M.D.

SUMMARY:

Payers now realize that persons with chronic medical and behavioral health conditions represent the majority of the high utilizers they are responsible for

and that they will not be able to contain the cost of care without integrating care for this complicated population. How did they come to this population management epiphany? What will they do over the next five years to try to get providers to integrate care? What do they hope that new integrated health care delivery system will look like in 2020? This presentation will take you down a trip through memory lane from the payer perspective and then reveal their hopes, wishes, dreams and schemes for a better integrated future.

SCIENTIFIC AND CLINICAL REPORTS

MAY 14, 2016

WEIGHT ISSUES AND BARIATRIC SURGERY

NO. 1

TORONTO BARIATRIC INTERPROFESSIONAL PSYCHOSOCIAL ASSESSMENT SUITABILITY SCALE (BIPASS): A RETROSPECTIVE PILOT STUDY EVALUATING A NEW CLINICAL TOOL

Speaker: Gurneet S. Thiara, M.D.

Co-Author(s): Richard Yanofksy, Sayed Abdul-Kader, Vincent Santiago, Stephanie Cassin, Allan Okrainec, Timothy Jackson, Raed Hawa, Sanjeev Sockalingam

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Standardize the evaluation process of psychosocial risk factors and their severity; 2) Improve the consistency of risk factor identification that may be amenable to short-term clinical interventions offered as part of routine clinical care; and 3) Determine if the use of this decision making tool can predict bariatric surgery outcomes.

SUMMARY:

Background: Bariatric surgery (BS) is considered a long-term treatment for morbid obesity and management of obesity-related health conditions. Patients who are referred for possible BS intervention undergo a series of assessments conducted by an interdisciplinary health care team to determine suitability for surgery. BS practice guidelines recommend that all patients undergoing this treatment undergo a comprehensive psychosocial assessment due to high rates of psychiatric comorbidity in this population. While medical and surgical criteria have been well

established for the suitability of BS candidacy, psychosocial suitability criteria have lacked clarity and are less standardized. The Bariatric Interprofessional Psychosocial Assessment of Suitability Scale (BIPASS) was developed to address this practice gap. In this presentation, we report the initial validation study of the BIPASS and its relationship to current multidisciplinary psychosocial assessment practices for BS. **Methods:** This study was conducted at the Toronto Western Hospital, a level 1A bariatric surgery center of excellence accredited by the American College of Surgeons. The BIPASS was developed after a comprehensive review of the literature on the psychosocial factors that affect BS outcomes. In phase I, four blinded raters applied the BIPASS to 31 randomly selected BS cases referred to our program to establish inter-rater reliability. In phase II, three raters with clinical experience in bariatric psychosocial care applied the BIPASS to 54 randomly selected BS cases. After completing BIPASS assessments using the subjects' files, the BIPASS scores were compared to the bariatric surgery disposition made by an experienced interdisciplinary psychosocial team at the bariatric center. The operating characteristics, sensitivity and specificity of the BIPASS were calculated. **Results:** Forty-six of the 54 patients were female (85.1%); the median age of all patient cases was 49 years (range: 21–74). Raters' BIPASS scores ranged from 4 to 52, having a mean score of 19.24 (SD=10.38). BIPASS scores were highly predictive of the BS psychosocial outcome (AUC=0.915, 95%CI: 0.844–0.985, $p<0.001$). A BIPASS score of 16 or more was the cutoff score based on a receiver operating characteristic (ROC) curve analysis (sensitivity=0.839; specificity=0.783). The instrument has very good inter-rater reliability (Pearson's correlation coefficient=0.847), even among novice raters. **Conclusion:** The study findings show that BIPASS is a comprehensive screening tool in the psychosocial assessment of BS candidates that will standardize the evaluation process and systematically identify at-risk patients for negative outcomes after BS. The data suggest that the BIPASS tool could be used as a helpful tool for psychiatrists evaluating BS candidacy. Future studies should explore the ability of the BIPASS tool to predict psychosocial and weight loss outcomes following surgery.

NO. 2

EVIDENCE FOR NEUROCOGNITIVE IMPROVEMENT AFTER BARIATRIC SURGERY: A SYSTEMATIC REVIEW

Speaker: Gurneet S. Thiara, M.D.

Co-Author(s): Michela Cigliobianco, Alex Muravsky, Ricardo A. Paoli, Rodrigo Mansur, Raed Hawa, Roger S. McIntyre, Sanjeev Sockalingam

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Evaluate impact of bariatric surgery on long-term neurocognitive functioning and psychological outcomes; 2) Summarize the relationship between adipokines on neurocognitive changes after bariatric surgery influencing psychiatric and psychosocial outcomes; and 3) Review the literature for a standardized approach to a neurocognitive assessment to be used in psychosocial evaluation used to determine bariatric surgery candidacy.

SUMMARY:

Background: Obesity is a major health concern and has been associated with significant psychiatric comorbidity and neurocognitive impairment. Bariatric surgery (BS) is an effective means of weight reduction in severely obese patients and correlates with improvements in quality of life, mental health outcomes and neurocognition, especially in those with high psychosocial burden. The primary purpose of this systematic review was to evaluate impact of BS on long-term neurocognitive functioning and psychological outcomes. A secondary purpose was to summarize the relationship of adipokines on neurocognition following BS. **Methods:** OVID Medline and PsychInfo databases from January 1990 to August 2015 were searched with the key terms and phrases "bariatric surgery" and "cognition." The inclusion criteria for the studies included $n \geq 10$, minimum postoperative follow-up of 12 months and use of formal neurocognitive assessment tools before and after surgery. Three investigators independently reviewed all abstracts, and full text copies of articles were further assessed for inclusion in this review. Any disagreements related to either inclusion or exclusion criteria were resolved by discussion among the three reviewers. **Results:** Our search yielded 422 abstracts, of which 44 warranted further review. A total of 10 studies met the inclusion criteria, and sample sizes ranged from 10 to 156. Postsurgical follow-up time ranged from 12 to 36 months. The neurocognitive domains being assessed included attention and executive function, memory, and language. All 10 studies documented significant improvements of statistical significance ($p < 0.05$) in at least one neurocognitive domain following BS; 10 studies showed improvements in

memory, four studies showed improvement in attention/executive function and two studies showed improvements in language. Of the 10 studies, only one study ($n=84$) measured adipokine levels; after controlling for age, sex and baseline factors, 12-month serum leptin ($p=0.03$) and ghrelin ($p=0.03$) levels predicted 12-month attention/executive function. Specifically, the reduction in serum leptin level and increase in serum ghrelin level following BS was accompanied by improved attention/executive function. **Conclusion:** Psychiatrists should consider the impact of these neurocognitive trends on presurgical psychiatric assessments for BS and implications for psychosocial functioning following surgery. Further research should explore the use of neurocognitive screening tools before surgery and evaluate the impact of changes in neurocognition on psychiatric outcomes following BS.

NO. 3

CHILDHOOD ABUSE ASSOCIATED WITH AN INCREASE IN BODY MASS INDEX (BMI), SLEEP DISTURBANCES, AND PSYCHOLOGICAL AND PHYSICAL SYMPTOMS AMONG MIDLIFE WOMEN

Speaker: Wilma Ines Castilla-Puentes, M.D.

Co-Author(s): Sandra Castilla-Puentes, M.D., Ruby Castilla-Puentes, M.D., Dr.P.H., Carlos Sanchez-Russi, Ph.D., Miguel Habeych, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the impact of childhood physical and sexual abuse on midlife women's health; 2) Determine if childhood abuse exacerbates a woman's risk of increased weight and BMI during menopausal transition; and 3) Appreciate the long-term impact of childhood abuse in women.

SUMMARY:

Objective: This study provides further evidence of the relationship between childhood abuse and its impact in middle-aged women. Our hypothesis is that women exposed to childhood abuse have increased body mass index (BMI), reporting symptoms (physical and psychological) and sleep problems during the menopausal transition. **Methods:** Data on traumatic lifetime experiences, BMI, sociodemographic information, symptoms (physical and psychological, vasomotor), health/behavior characteristics (smoking, drinks, physical activity, use of over-the-counter (OTC) medication, BMI), quality of life and psychosocial

functioning (anxiety, depression CES-D>16, perceived stress, stressful life events) were compiled for 404 women (45–55 years old) during their annual gynecological visit in an outpatient clinic in Duitama, Boyaca, Colombia. We compared abused (n=78) and nonabused women (n=326). Associations between maltreatment, BMI and symptoms were estimated with generalized estimating equations. **Results:** Childhood abuse was associated with increased BMI (odds ratio [OR]=6.75, 95% CI: 3.73–12.21), increased reporting of symptoms (physical [OR]=5.51, 95% CI: 1.44–21.03] and psychological [OR]=5.51, 95% CI: 1.44–21.03]), less physical activity (OR=4.54, 95% CI: 1.64–12.51), more medical conditions (OR=4.22, 95% CI: 0.26–6.68), use of OTC medications (OR=4.22, 95% CI: 0.26–8.23), depression (OR=1.65, 95% CI: 1.23–2.10), and sleep problems (OR=1.23, 95% CI: 0.72–2.10) in age-adjusted models. Results persisted in multivariable models and across several types of abuse. **Conclusion:** The experience of childhood abuse is associated with increased physical and psychological complications reporting in adulthood. The sequelae of childhood abuse may persist well into adulthood to influence the occurrence of BMI medical conditions, use of OTC medications, depression and sleep problems in midlife.

PERIOPERATIVE AND PERIPARTUM SITUATIONS

NO. 1

SEROTONERGIC ANTIDEPRESSANTS AND PERIOPERATIVE BLEEDING RISK: A SYSTEMATIC REVIEW

Speaker: Artin Mahdanian, M.D.

Co-Author(s): Soham Rej, Simon Bacon, Deniz Ozdin, Kim L. Lavoie, Karl Looper

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how serotonergic antidepressants (SADs) are associated with increased perioperative bleeding events, particularly abnormal bleeding and blood transfusions; 2) Show how, from a clinical perspective, the potential bleeding risks of serotonergic antidepressants in surgical settings needs to be carefully weighed against their psychiatric benefits; 3) Know that the current literature is comprised almost exclusively of retrospective observational studies; and 4) Know that future research will need to investigate potential strategies to mitigate SAD-related bleeding risk in the surgical context.

SUMMARY:

Background: Serotonergic antidepressants (SADs) are known to increase bleeding events, with a number of recent studies investigating this risk in surgical settings. Our main objective was to synthesize the current evidence to evaluate the clinical importance of SAD-related bleeding risk in the perioperative period. **Methods:** A systematic review of MEDLINE, Embase and PsychINFO through November 2013 was conducted in compliance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement. We examined the risk of perioperative bleeding adverse events in SAD users in comparison to controls. **Results:** A total of 13 relevant studies were identified across a broad variety of surgical procedures. SADs were associated with an increased risk of perioperative bleeding (OR 1.21–4.14) and blood transfusions (OR 0.93 – 3.71). **Conclusion:** Serotonergic antidepressants (SADs) are associated with increased perioperative bleeding events, particularly abnormal bleeding and blood transfusions. From a clinical perspective, the potential bleeding risks of SADs in surgical settings needs to be carefully weighed against their psychiatric benefits. Future research will need to investigate potential strategies to mitigate SAD-related bleeding risk in the surgical context.

FORENSIC AND MEDICAL-LEGAL ISSUES

NO. 1

EMPIRICAL FINDINGS ON LEGAL DIFFICULTIES AMONG PRACTICING PSYCHIATRISTS

Speaker: James H. Reich, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the risk of medical board discipline of psychiatrists compared to other medical specialties; 2) Understand major risk factors for malpractice actions against psychiatrists; and 3) Understand how, in dollar terms, malpractice actions in psychiatry compare to those of other medical specialties.

SUMMARY:

Background: This presentation reviews the published literature on areas of legal difficulty among practicing psychiatrists. **Methods:** A literature search using PubMed identified studies of malpractice lawsuits or medical board discipline of

psychiatrists between 1990 and 2009. Eight studies of physician discipline in the United States and one from the United Kingdom were identified. Information from three insurance companies and three sets of aggregated insurance company data were also available. One follow-up study of hospitalized psychiatric patients was also reviewed. **Results:** Studies of medical board discipline indicate that, compared to other specialties, psychiatrists are at an increased risk of disciplinary action. Psychiatrists who were female, board certified and in practice for a short period of time had a lower chance of medical board discipline. Psychiatric claims accounted for a very small proportion of overall malpractice claims and settlements. The amount of patient disability secondary to alleged malpractice was the most important variable predicting insurance payout. **Conclusion:** Psychiatrists appear to be disciplined by medical boards at an above-average frequency compared to other medical specialties. However, few malpractice suits reach the courts, and psychiatry represents a very small proportion of overall physician malpractice claims and dollars of settlement.

NO. 2

TRAUMATOPHOBIA: PARADOXICAL AMPLIFICATION OF POST-TRAUMATIC SYMPTOMS AND THE ROLE OF THIRD PARTIES

Speaker: John O. Beahrs, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate how knowledge of trauma's pathogenic effects has induced more fear, thereby amplifying trauma's effects; 2) Appreciate how some interventions paradoxically heighten post-traumatic symptoms; 3) Appreciate how these symptoms can be moderated by eliciting third-party support, standing firm against traumatic reenactment and framing less pathogenic narratives; and 4) Speculate constructively on possible applications to mitigate global terrorism.

SUMMARY:

"Traumatophobia" is fear of fear itself and sensitizes people to the pathogenic effects of specific traumas such as violent crime and terror. It is paradoxically amplified by our increasing scientific understanding of trauma's prevalence and pathogenic effects. Third parties collectively modulate trauma's effects and can either sensitize further or mitigate them. People socially transmit the trauma response through

reenactment, polarizing into victims and perpetrators, and through self-reinforcing mutual suggestion. Some commonly attempted corrective measures are predictably paradoxical. For example, an attempt to either appease or counter-traumatize offending agents can instead amplify their traumatizing effects. To credulously ratify victim narratives or try to rescue traumatization's targets can instead lead to regressive destabilization by undermining these targets' own responsibilities and loci of control. Societal enablement heightens traumatophobia on a huge scale, while coercive social sensitivities nullify corrective problem solving. When such factors are identifiable, psychiatrists can employ alternative strategies to mitigate the trauma response. The first method is simply to be aware of the often subtle power of traumatic reenactment and to stand firm against reenactment at points that are within their loci of control. Next is to mobilize the support of third parties and elicit more health-promoting alternative narratives in all parties. Last is to defend open discourse on conflicting sensitivities. All citizens can identify their sole loci of control, define their personal identities and value priorities, and stand firm against violators' attempts to destabilize them. Data support the effectiveness and safety of these principles when treating patients with disorders of complex trauma who are otherwise at risk of regressive side effects and behavioral acting out. More research is needed to pinpoint the large-scale social effects of traumatic enablement. Perhaps most significant is a strong and yet-untapped potential to mitigate global terrorism, thereby addressing a challenge posed by the Institute of Medicine in 2003.

NO. 3

DEVELOPMENT AND IMPLEMENTATION OF A CORRECTIONAL SKILLS-BASED PSYCHOTHERAPY: START NOW

Speaker: Robert L. Trestman, M.D., Ph.D.

Co-Author(s): Linda Kersten, M.S., Julie Guiher, Psy.D., Andrew Cislo, Ph.D., Kirsten Shea, M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the background and development of a manualized, skills-based, integrated psychotherapy for incarcerated individuals with mental illness; 2) Cite the benefits of using an evidence-informed, highly structured intervention to reduce impulsivity and enhance emotional stability in a population of correctional

mental health patients; and 3) Appreciate and describe the practical application of START NOW, a treatment that is CBT-based, includes functional analysis, and integrates motivational interviewing.

SUMMARY:

Background: START NOW is a skills-based psychotherapy developed with National Institute of Justice funding for incarcerated individuals with emotion dysregulation and/or impulsivity. This report describes implementation in a statewide correctional system, reviews the patient and facilitator experience, and presents results of treatment on reducing behavioral infractions during incarceration. **METHOD:** START NOW is a 32-session manualized cognitive behavior therapy written at a fifth grade reading level that incorporates an array of basic skills using a motivational interviewing framework. It is gender specific, trauma sensitive and integrates a neurocognitive approach. START NOW is implemented as a standard of care in many Connecticut correctional facilities, with routine supervision and fidelity monitoring. Quality assurance questionnaires of facilitator and patient satisfaction were routinely collected and analyzed. A retrospective cohort analysis of 946 program participants (male=873, female=73) was analyzed for potential changes in the rate of disciplinary infractions. **Results:** Both facilitators (n=30) and participants (n=619) rated their START NOW experience highly, with the overall rating at or above 3.4 on a four-point Likert scale for multiple dimensions. Using zero-inflated negative binomial regression, substantial benefit was demonstrated with a dose-response effect and a five percent reduction in the likelihood of future disciplinary infractions for each additional session ($p < 0.001$). This effect held across gender and psychiatric diagnosis. **Conclusion:** START NOW holds significant promise for treating incarcerated individuals with mental illness who demonstrate emotional dysregulation and/or impulsivity.

PTSD AND MILITARY PSYCHIATRY

NO. 1

ACTIVE DUTY WOMEN WITH PTSD ASSOCIATED WITH MILITARY SEXUAL TRAUMA: WHO GETS REFERRED FOR MEDICAL RETIREMENT?

Speaker: Melanie E Roberson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review a recent study of all referrals for active duty women with PTSD submitted between 2011 and 2014; 2) Describe differences in those who returned to full active duty service and those who were referred for medical retirement; and 3) Discuss challenges for the treatment of military sexual trauma in the U.S. Navy.

SUMMARY:

Objective: Elucidate the factors associated with the development of disabling PTSD in active duty servicewomen. **Methods:** This was a retrospective review of disability reports and electronic medical records for 318 active duty servicewomen treated for PTSD by mental health providers from 2011 to 2014 at Naval Medical Center San Diego. 159 of the women were referred into the disability system (IDES) due to PTSD, while the other half did not require disability referral (control group). Analysis evaluated the differences between the two groups and their relationship to PTSD, military sexual trauma (MST) and disability. Logistic regression calculated the degree of disability in these active duty servicewomen. **Results:** In our sample, a majority of MST (97%) was due to sexual assault. 73.6% of IDES-referred individuals had PTSD subsequent to MST versus 42% in the control group, and 40% of the IDES group versus 20% of the control group had chronic pain. MST-precipitated PTSD (OR=3.92, $p < 0.001$) and chronic pain (OR=4.27, $p < 0.001$) was associated with elevated referrals to IDES. Most individuals (93.71%) referred into IDES for PTSD were found "unfit" to continue serving in the military and medically separated from active duty. **Conclusion:** MST is a significant cause of PTSD resulting in disability in active duty servicewomen. Continued efforts should be directed at reducing MST rates in active duty servicemembers and ensuring treatment is available.

NO. 2

PTSD AND RISK OF ALZHEIMER'S DISEASE IN VIETNAM VETERANS: PRELIMINARY AMYLOID PET FINDINGS FROM AIBL-VETS

Speaker: Alby Elias, M.D., M.B.B.S.

Co-Author(s): Tia Cummins, Robert Williams, Vincent Dore, Jeffrey Rosenfeld, Victor Villemagne, Malcolm Hopwood, Michael Weiner, Christopher Rowe

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the prevalence of

post-traumatic stress disorder (PTSD) in Vietnam veterans and understand the association between PTSD and cognitive impairment in this population; 2) Identify the risk of Alzheimer's disease in veterans with PTSD; and 3) Appreciate the role of amyloid imaging in early estimation of the risk of Alzheimer's disease.

SUMMARY:

Background: Post-traumatic stress disorder (PTSD) is prevalent in Vietnam veterans. PTSD is associated with cognitive dysfunction, including deficits in verbal recall and new learning. Epidemiological studies suggest an increased risk of dementia in veterans with PTSD. This study is a collaborative investigation between the Alzheimer's Disease Neuroimaging Initiative (ADNI) and the Australian Imaging Biomarkers and Lifestyle (AIBL) study that aims to use objective imaging measures to assess the risk of developing Alzheimer's disease in veterans with PTSD. We report the preliminary amyloid imaging data from our Australian center (AIBL-VETS). **Objective:** Test the hypothesis that veterans with combat-associated PTSD have higher risk for Alzheimer's disease as measured by amyloid imaging with florbetaben PET. **Methods:** We recruited veterans with PTSD as defined by a Clinician-Administered PTSD Scale (CAPS) score of 40 or above and veteran control subjects as defined by a CAPS score of less than 30. Veterans with ongoing or recent substance abuse, dementia, neurological or severe medical diseases, and psychotic illness were excluded. Florbetaben PET was analyzed with CapAIBL. **Results:** Twenty-nine veterans with lifetime PTSD (19 with ongoing PTSD) and 14 healthy control Vietnam veterans have been scanned to date. Mean age was 68 years (SD=3.4), and there was no significant difference between groups. Eleven (25.6%) veterans had positive amyloid scan as determined by both Standard Uptake Value Ratio (SUVR) with a cutoff value of 1.35 and visual inspection. Independent t-test did not show any significant difference ($p=0.941$) in SUVR between the group with PTSD (mean=1.30, SD=0.26) and the control group (mean=1.30, SD=0.19). There was no association between either lifetime or current PTSD and positive status on PET scan. There was no correlation between SUVR and CAPS score ($r=-0.006$, $p=0.970$). However, there was a trend toward a positive correlation between SUVR and age ($r=0.272$, $p=0.077$). **Conclusion:** The above preliminary findings do not suggest a significant association between PTSD and amyloid deposition, an important

imaging biomarker of Alzheimer's disease. This is preliminary data, and recruitment to improve the power of the study continues.

NO. 3

FIVE ENDURING PSYCHIATRIC RESPONSES TO WAR: FREUD, GONDA, SALMON, RIVERS AND FERENCZI

Speaker: Thomas B. Horvath, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the personal and clinical reactions of five psychiatrists (Freud, Gonda, Salmon, Rivers, Ferenczi) to the Great War based on their cultural and military backgrounds; 2) Identify the tensions in Freud's theoretical and personal interests in War and his clinical indifference to war neurosis in contrast to Ferenczi's weaving together of his military and clinical work; 3) Contrast Salmon's desire to "maintain the fighting strength" and Rivers' desire to provide a healing environment; 4) Assess the relative strengths of Gonda's scientific interest in behavior modification and his ambition for military advancement; and 5) Discuss the persistence of attitudes of clinical indifference, active therapeutic engagement, empathic withdrawal, military expediency and strenuous applications of behavioral change in psychiatry.

SUMMARY:

Background: In 1968, psychiatry showed its ambivalence about "war neurosis" by inadvertently dropping reference to it from the *DSM-II*. The lives and works of five prominent psychiatrists during the Great War, which broke out during the dawn of modern dynamic psychiatry, will be used to demonstrate different attitudes that affected debates around Vietnam and persist in psychiatry today. **Methods:** The biographies or biosketches of Freud, Ferenczi, Salmon, Rivers and Gonda, and their published correspondence, were examined for their cultural background, military service in peace and war, clinical practice with soldiers and veterans, relevant scientific/clinical publications, and expressed opinions. **Results:** 1) Sigmund Freud fulfilled his compulsory year of service in the peacetime KuK army as a young doctor, well before his interests in the mind. In 1914, he supported his two sons' volunteering for front-line service, but by 1915, he turned to psychoanalytic and philosophical speculations about the societal origin of war and preoccupation with death. He referred war-related cases to Ferenczi for analysis. 2) Sándor Ferenczi

trained as a general physician, and respecting his father's 1848 military service, trained in the reserves and did difficult work in an infectious diseases hospital before he met Freud. They were already corresponding, and one can trace his work as a cavalry regiment GMD, his rising interest in war neurosis and his move to military psychiatric work by 1916. He organized the fifth International Psychoanalytic Congress on the theme of war neurosis in 1918, and he was named the head of a short-lived psychoanalytic hospital for war-distressed veterans. The Freud-Ferenczi correspondence shows the development of his active therapeutic style with some of its roots in his military experience. 3) Thomas W. Salmon joined the U.S. Public Health Service in 1901 as a general physician, became interested in the plight of the mentally ill in state hospitals and later in the military, and studied the British management of shell shock. His work became the cornerstone of U.S. military psychiatry, characterized by "treat them within the sounds of artillery." 4) W. H. R. Rivers was a British physician who made major contributions to sensory physiology and psychology before turning to anthropology. He later worked with shell shock at Craiglockhart Hospital for Officers. He provided a humane psychotherapeutic environment that one might call a refuge. 5) Viktor Gonda was a young KuK neurologist who used galvanic electrical treatment for hysterical symptoms with great success amidst ethical controversy. While he became an ECT pioneer, his galvanic work was aversive behavior modification. **Conclusion:** These five attitudes and behavior patterns continue in the ambivalent culture of psychiatry around war, military service, veteran status and suffering.

MAY 15, 2016

TERROR AND COMMUNITY VIOLENCE

NO. 1

HOMICIDES OF MENTAL HEALTH WORKERS BY PATIENTS

Speaker: Michael B. Knable, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the frequency of homicides to mental health workers in the United States; 2) Understand demographic characteristics of homicide perpetrators and victims; and 3)

Understand means to protect the safety of mental health workers.

SUMMARY:

Using electronic search methodologies, we identified 33 cases since 1981 in which mental health workers had been murdered by patients in the United States. Although an apparently rare event, with a frequency of approximately one homicide per year, our data indicate many of these homicides may have been preventable. The group most likely to have been victims of homicidal attacks was young women caseworkers, most of whom were killed during unaccompanied visits to residential treatment facilities. The group most likely to have been perpetrators of violence was males who carried a diagnosis of schizophrenia. The most likely method of homicide was by gunshot (42.4%), but 57.6% of homicides were committed by other means, which may have been prevented by careful implementation of safety protocols. Perpetrators were likely to have had a prior history of violence, criminal charges, involuntary psychiatric hospitalization or nonadherence to medications. Despite convincing evidence for chronic mental illness in the perpetrators, they were more likely to be imprisoned than hospitalized after trial. Safety and public policy recommendations are offered in conclusion.

NO. 2

EXPOSURE TO COMMUNITY VIOLENCE, USE OF MENTAL HEALTH SERVICES AND DEPRESSIVE SYMPTOMS AMONG ADOLESCENTS AND YOUNG ADULTS

Speaker: Wan-Yi Chen, Ph.D., M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the long-term connection between victimization in the community and an individual's report of depressive symptoms; 2) Discuss the use of mental health services among individuals after childhood victimization in the community; and 3) Discuss the role of mental health service use in attenuating the short- and long-term negative psychological influences from these early adverse life experiences.

SUMMARY:

Background: Research on the impact of exposure to community violence tends to define victimization as a single construct. This study differentiates between

direct and indirect violence victimization in their association with mental health problems and mental health service use. **Objective:** This study assesses 1) If subtypes of adolescent victimization are linked to depressive symptoms; 2) If adolescent victimization is linked with mental health service use; and 3) The role of mental health service use in attenuating symptoms arising from victimization. **Methods:** This study focused on data from 8,947 individuals from four waves of the National Longitudinal Study of Adolescent to Adult Health. **Results:** Findings indicate adolescents witnessing community violence were more likely to experience depressive symptoms during adolescence but not during their young adulthood; direct exposure to violence during adolescence does not predict depressive symptoms in adolescence but does in adulthood. Use of mental health services mediates report of depressive symptoms for adolescents witnessing community violence. **Conclusion:** This study describes the interplay among risk, psychosocial processes and treatment utilization in the manifestation of depressive symptoms in persons exposed to violence in adolescence. Further, our finding that direct exposure to violence during adolescence does not predict adolescent depressive symptoms but does for adult depressive symptoms points toward a more complex etiological process whereby a cascade of risk may be activated by violence exposure that is not measurable until adulthood. These results show the need for gateways that enable adults to access mental health services and for comparable or unique strategies for adolescents.

NO. 3

WHAT ARE TERRORISM SURVIVORS' LONG-TERM NEEDS? FORMAL RATING SCALES VERSUS OPEN-ENDED QUESTIONS AND REFLECTIONS

Speaker: Phebe M. Tucker, M.D.

Co-Author(s): Pascal Nitiema, M.D., M.P.H., Tracy Wendling, Dr.P.H., Sheryll Brown, M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss differences between terrorism survivors and nonexposed community members in formal ratings of depression, anxiety, PTSD symptoms, health and health care utilization; 2) Identify survivors' spontaneous descriptions of their most important bombing-related problems and current needs; and 3) Understand the value of open-ended questions exploring survivors' problems and needs, as opposed to formal, structured ratings

quantifying their mental health symptoms, health problems and care received.

SUMMARY:

Background: Formal surveys rating problems and needs of terrorism survivors may miss subjectively stated issues captured by open-ended, nondirective questions. We discuss self-reported psychiatric symptoms, medical problems and medical and mental health care utilization endorsed on formal rating scales for intensely exposed Oklahoma City bombing survivors almost 19 years after the event, as well as survivors' unscripted statements of their most important problems and needs related to the bombing. **Methods:** Telephone surveys compared terrorism survivors (over 80% injured in the bombing) and nonexposed Oklahoma City controls. Rating scales included Hopkins Symptom Checklist, Breslau's PTSD Screen and Health Status Questionnaire-12. Survivors were asked to identify their top problems and needs related to the bombing and were allowed to discuss at length their thoughts about their main problems and needs. Statistical analyses included multivariable logistic regression and linear modeling. **Results:** Survivors and controls did not differ in having major medical problems or medical or mental health care utilization in the past year, except that survivors used more ancillary health services. Rating scales found survivors to have more depression and anxiety symptoms than controls, and 23.2% of survivors met the threshold for probable PTSD. When allowed to freely discuss their most important problems resulting from the bombing, survivors most often discussed their continuing problems from physical injuries, including head injuries and hearing and visual problems, as well as symptoms associated with PTSD, anxiety and depression. Among current bombing-related needs most often cited, survivors needed help for injuries, pain, and hearing and visual problems. Other salient needs were for support with family issues, resources for financial and retirement strains, greater connectedness with others, and a wish for peace and stability. Survivors' poignant reflections about the lasting impact of the bombing on their lives will be shared. **Conclusion:** Rating scales and open-ended interviews capture different, important information related to long-term adjustment after intense exposure to terrorism. While survivors and controls did not differ in major medical conditions or most types of health and mental health care visits in the previous year, survivors had more depression and anxiety, and they

clearly voiced continued needs for specific bombing-related health problems, mental health care, and financial and job support. Rating scales reliably capture aggregate symptoms and health care utilization patterns, but may miss specific problems and needs spontaneously reported by survivors. Using both approaches may best help policy makers identify long-term needs of individuals directly impacted by terrorism, so that extended recovery efforts may provide more informed, evidence-based interventions.

PSYCHIATRIC CONSIDERATIONS IN PRE-OP AND TRANSPLANT

NO. 1

THE STANFORD INTEGRATED PSYCHOSOCIAL ASSESSMENT FOR TRANSPLANTATION (SIPAT): A PROSPECTIVE STUDY OF MEDICAL AND PSYCHOSOCIAL OUTCOMES

Speaker: Jose R. Maldonado, M.D.

Co-Author(s): Yelizaveta Sher, M.D., Amalia Tobon, M.D., Renee Garcia, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the prevalence of psychosocial disorders among medically ill individuals and the extent to which they affect medical care and outcomes; 2) Understand the psychometric properties of the new instrument, SIPAT, as a tool for the psychosocial assessment of solid organ transplant candidates; 3) Understand the usefulness of SIPAT in identifying potential problems and allow for correction and selection of transplant candidates; and 4) Understand the usefulness of SIPAT in predicting post-transplant psychosocial and medical outcomes.

SUMMARY:

Background: Psychosocial and behavioral issues may significantly contribute to post-transplant outcomes. We developed a new assessment tool, the Stanford Integrated Psychosocial Assessment for Transplantation (SIPAT), which demonstrated excellent inter-rater reliability (Pearson's correlation coefficient=0.853) and high predictability of post-transplant psychosocial outcomes ($p<0.001$) in the original study. **Methods:** We conducted a systematized review of our transplant patient-dedicated database to identify every patient who received solid-organ transplants during the period of June 1, 2008 through July 31, 2011. All patients had

been assessed with the SIPAT prior to transplant and were closely followed by our transplant multidisciplinary team afterward. We reviewed and compared prospectively accumulated psychosocial and medical outcomes at the one-year follow-up. The primary outcomes were organ failure and mortality; secondary outcomes included occurrence and number of rejection episodes, occurrence and number of medical rehospitalizations, occurrence and number of infection rates, new psychiatric complications or decompensation of preexisting psychiatric diagnosis, new or recurrent substance abuse, nonadherence, and support system failure. **Results:** 217 subjects were identified and included in the analysis. The average SIPAT score was 12.9 (SD=8.65), with a range of 0–42. The average age at the time of transplant was 51.9 years (SD=13.4), with a range of 20–80 years. Although there was no significant difference in the primary outcome (i.e., organ failure, mortality), due to low occurrence, the data clearly demonstrated that a higher SIPAT score was significantly correlated with the probability of poor medical and psychosocial outcomes. The SIPAT scores predicted various post-transplant medical complications, such as organ rejection episodes ($p=0.02$), medical hospitalizations (e.g., transplant-related complications) ($p<0.0001$) and infection rates ($p=0.02$). Similarly, SIPAT scores also predicted the occurrence of various post-transplant psychosocial complications, such as psychiatric decompensation ($p<0.005$), nonadherence ($p=0.09$) and support system failure ($p=0.02$). When all psychosocial and medical outcomes were combined and logistic regression analysis was performed on these two pooled outcomes, we also found that higher SIPAT scores increase the probability of undesirable medical outcomes ($p=0.04$) and negative psychosocial outcomes ($p=0.03$). **Conclusion:** SIPAT is a comprehensive screening tool designed to assist in the psychosocial assessment of organ transplant candidates while standardizing the evaluation process and helping identify subjects who are at risk for negative outcomes after transplant. SIPAT is a promising pre-transplantation assessment tool whose results may help predict psychosocial and medical outcomes.

NO. 2

PREOPERATIVE OPIOID REDUCTION PROGRAM: A PILOT STUDY

Speaker: Sameer Hassamal, M.D.

Co-Author(s): Itai Danovitch, M.D., Karl Wittnebel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the perioperative risks associated with chronic high-dose opioid treatment and be aware of safe opioid prescribing practices for presurgical candidates; 2) Understand the rationale for implementing a multidisciplinary opioid reduction program in a large medical center, including benefits both to patients and to the health care system; 3) Identify the effects of a multidisciplinary program on mood, anxiety, pain and function in patients enrolled in our pilot study; and 4) Understand the role of psychiatric involvement in a multidisciplinary program designed to reduce opioids in a presurgical population.

SUMMARY:

Background: Chronic high-dose opioid use has long been known to be associated with significant medical and psychiatric complications, including respiratory depression, ileus, hyperalgesia, anxiety and depression. Perioperative complications have also been shown to be significantly higher in patients who take high doses of opioids. Integrated multidisciplinary treatment programs have good evidence in treating patients with chronic pain, but few programs exist with the primary aim of reducing patients' opioid doses, and none exist specifically for the presurgical population. **Objective:** Our study pilots the feasibility and efficacy of an integrative opioid reduction program for presurgical candidates at a large medical center in Los Angeles. Our aims were to assess the practicability of and barriers toward implementing such a program; physician and patient satisfaction with the program; and the effect of the program on patients' operative outcomes and total cost of care, pain levels, anxiety, depression and functioning status. **Methods:** We enrolled patients presenting for spine surgery who were prescribed greater than 80 morphine equivalents daily. The program entailed twice-weekly clinic days and lasted six to eight weeks. Clinic days consisted of medication management sessions aimed at safely and comfortably reducing opioids, psychiatric and psychological assessments and treatment with psychotropics and cognitive behavioral therapy, and physical and occupational therapy appointments. Patients were tested for substance abuse weekly. **Results:** Participants and physicians reported satisfaction with the program. Participants showed decreased anxiety and depression scores by the end of the program, as well as increased functioning.

Perioperative complications seemed to be lower in patients who had completed our program. Though patients were on reduced opioid dosages by the end of the program, their total daily doses tended to increase again after surgery. **Discussion:** Though the program was well received and appeared effective, enrollment remained low throughout the year of our pilot study, likely due to a combination of logistical challenges (transport, frequent visits during working hours), as well as low motivation for participation among many patients. Further research is required to learn how to increase referrals and enrollment. For patients who did enroll, the program appeared effective in its stated aims and would be feasible to implement on a larger scale.

NO. 3**DELIRIUM IN LUNG TRANSPLANT RECIPIENTS AND ITS EFFECTS ON POST-TRANSPLANT OUTCOMES**

Speaker: Yelizaveta Sher, M.D.

Co-Author(s): Gundeep Dhillon, M.D., Joshua Mooney, M.D., Jose R. Maldonado, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the latest literature on the subject of delirium in lung transplant recipients and appreciate why this topic is important in this fragile population; 2) Discuss incidence and characteristics of delirium in lung transplant recipients; and 3) Appreciate correlation of post-lung transplant delirium with post-transplant in-hospital and postdischarge outcomes.

SUMMARY:

Background: Delirium is common in ICU patients, adversely affecting patients' morbidity and mortality. Only a few groups have investigated delirium in lung transplant recipients. The purpose of our study is to study delirium in our larger lung transplant sample. **Methods:** Patients undergoing lung transplantation in our institution from July 18, 2011 through March 18, 2013 were identified. Their electronic medical records were retrospectively examined to determine if patients met *DSM-5* criteria for delirium on a daily basis based on documented symptoms. **Results:** All patients transplanted during the study period and surviving the surgery were included (n=163). Seventy-two patients (44.2%) were found to have delirium during their post-transplant hospitalization or within the first 30 days, whichever was shorter. On average, patients developed delirium on postoperative day

4.1 (SD=4.2), with an average duration of 6.9 days (SD=6.6). Patients with delirium had higher BMI (mean=26.1, SD=4.9 vs. 23.5, SD=4.4, $p=0.0003$) and trended toward older age (mean=52.9, SD=12.5 vs. 48.4, SD=16.2, $p=0.056$). They had longer ICU stay (18.6 days, SD=29.1 vs. 4.2, SD=5.6, $p<0.001$), hospital stay (32.7 days, SD=42.5 vs. 14.0, SD=10.4, $p<0.001$) (for patients surviving hospitalization), time to extubation (16.9 days, SD=39.0 vs. 1.7, SD=2.0, $p<0.001$), in-hospital mortality (13.9% vs. 1.1%, $p=0.001$) and first-year post-transplant mortality (19.4% vs. 8.8%, $p=0.048$). Moreover, 36.2% of all patients ($n=59$; 81.9% of all delirious patients) became delirious during first five days after transplant, the duration of the shortest post-transplant admission. As compared to patients with no delirium during this time, these patients had higher lung allocation score (LAS) (average=59, SD=20.4 vs. 47.9, SD=17.4, $p<0.001$) and higher BMI (mean=26.2, SD=4.8 vs. 23.7, SD=4.5, $p=0.01$). There remained statistically significant differences in in-hospital mortality (12.3% vs. 1.9%, $p=0.001$), time to extubation (17.5 days, SD=42.3 vs. 3.4, SD=8.6, $p=0.001$), and length of ICU (17.8 days, SD=29.5 vs. 6.4, SD=12.4, $p<0.001$) and hospital stays (29.5 days, SD=44.8 vs. 17.7, SD=17.1, $p=0.02$). **Conclusion:** Our study supports and expands prior findings on the prevalence of delirium in the lung transplant population in the largest sample published to date. The findings highlight the occurrence, potentially negative consequences and significance of developing delirium after lung transplant surgery.

CHILDHOOD EXPERIENCES AND ADOLESCENT SUICIDE RISK

NO. 1

PHYSICALLY BULLIED AND CYBERBULLIED ADOLESCENTS: ASSOCIATIONS WITH SUICIDE FEELINGS AND BEHAVIORS IN PRIVATE SCHOOL STUDENTS

Speaker: Stephen Woolley, D.Sc.

Co-Author(s): John W. Goethe, M.D., Julia Golden, B.A., Bonnie L. Szarek, R.N., Peter H. Wells, Ph.D., Rosemary C. Baggish, M.Ed., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss associations between types of bullying experienced and the risk of suicidal ideation or attempts among private high school students; 2) Identify evidence that student risk of suicidal behaviors associated with bullying may be

modified by student alcohol drinking, computer use, connectedness with school and available support; and 3) Discuss the odds of bullying and suicidal behaviors after adjustment for important cofactors that are potentially modifiable by school, family and friends.

SUMMARY:

Objective: To assess among adolescents the 1) Associations between a history of being physically bullied (Bp)/cyberbullied (Bc) and either suicidal ideation (SI) or attempt (SA) and 2) Contributions of alcohol use (ALC), computer use (C), feeling connected to school (CNCT) and available social support (SUP) to these associations. **Methods:** The Independent School Health Check Survey 2014–2015 assessed 1) The primary analytic factors Bp, Bc, SI and SA and 2) Four groups of covariates (COVs): ALC, C, CNCT and SUP. Bivariate, stratified and logistic regression analyses measured associations by odds ratio (OR). **Results:** Students ($n=15,392$) were ages 12–20 and 55% female. 42% of students were bullied: 27% Bp, 29% Bc, 15% both. Twelve percent reported prior-month SI, 29% of whom had SA. C was substantial (10% spent three or more hours/day on non-school activity), as was ALC (five or more drinks in three hours in 18%). CNCT was low/moderate for 24%. Ninety percent reported SUP from peers. Bivariate analyses showed Bp/Bc are associated with elevated risk of SI/SA: for Bp, SI OR=3.1/ SA OR=3.5; for Bc, SI OR=2.6/ SA OR=3.4. Most COVs were associated with elevated SI/SA risk. For example, increased risk was associated with ALC (SI OR=1.7–5.5/SA OR=2.3–8.0)—the strongest predictor being drinking alone (SI OR=5.5/ SA OR=8.0)—C (SI OR=2.0–3.2/ SA OR=2.1–3.6) and low/moderate CNCT (SI OR=2.4/SA OR=2.9). However, SUP was consistently associated with reductions of odds of SI/SA, e.g., parent interest in student life (SI OR=0.28/ SA OR=0.35). COVs were also associated with increased risks of Bc/Bp, e.g., ALC (OR=1.3–3.2), C (OR=1.5–2.8) and CNCT (Bp OR=1.9/Bc OR=1.8). SUP factors were associated with 18–34% reduction in risk of Bp/Bc. Stratified analyses demonstrated that the role of some COVs varied by bullied-suicidal behavior analysis. For example, compared to bivariate analyses (OR=3.5), in both the high and low/moderate strata of CNCT, the Bp-SA ORs were 3.0, suggesting modest confounding by CNCT. However, the bivariate Bc-SA OR was 3.4, but in high versus low/moderate CNCT strata, the ORs differed (3.5 vs. 2.5), suggesting a CNCT-Bc interaction affecting the Bc-SA association.

Three logistic regression analyses controlling for the same COV found significant associations (ORs>2): Bp-SI, Bp-SA and Bc-SI (but not Bc-SA). Regression analyses for SI and SA including both Bp and Bc found each of Bp and Bc significant (ORs≥1.7). Some factors expected to be significant were not, e.g., binge drinking in all six regressions. **Conclusion:** As expected, bullying was generally associated with increased odds of SI/SA. However, in regression, Bc-SA was not significant unless Bp was also in the model. Results suggest that Bp and Bc independently contribute to SI and SA risks. Drinking alone was associated with an eight-fold increased risk of SA. Also contributing to elevated SI/SA risks were C and CNCT; SUP was consistently associated with reduced Bp/Bc and SI/SA risk.

NO. 2

BULLYING INCREASES RISK OF SUICIDAL BEHAVIOR

Speaker: Nazanin Alavi, M.D.

Co-Author(s): Taras Reshetukha, Eric Prost

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand prevalence of bullying and its effect on children and adolescents; 2) Understand risk factors for suicidal behavior; and 3) Understand the effect of bullying on suicidal behavior.

SUMMARY:

Objective: With an increasing number of adolescents being admitted into the emergency department with suicidal ideation, this study examined the relationship between bullying and suicidal ideation within emergency room settings. **Methods:** A chart review was conducted for all patients under 18 presenting to the emergency department at Kingston General Hospital or Hotel Dieu Hospital in Kingston, Canada, between January 2011 and January 2015. Factors such as age, gender, grade, history of abuse, history of bullying, type of bullying, time of bullying, symptoms and diagnoses were documented. **Results:** 76.29% of adolescents presenting to the emergency room had experienced bullying, while 68.89% of all patients had symptoms of suicidal ideation. Patients who experienced bullying were more likely to present with suicide ideation, $\chi^2(1, n=270)=92.355, p < 0.001$. Both the time of bullying and the type of bullying related to suicidal ideation in patients **Conclusion:** The prevalence of bullying in adolescent patients in the emergency room is high. The relationship between

suicide ideation and bullying demonstrates that clinicians should ask questions about incidents of bullying as a risk factor for suicidal ideation during the assessment of children and adolescents.

NO. 3

EARLY LIFE ADVERSITIES, PERSONALITY FUNCTION, AND SUBSEQUENT DEPRESSION AND SUICIDE RISK IN ADOLESCENCE: EXAMINING THEIR DIRECT AND INDIRECT EFFECTS

Speaker: Diana E. Clarke, Ph.D., M.Sc.

Co-Author(s): Keila D. Barber, M.H.S., Robert F. Krueger, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand some of the potential impacts of early life adversities on personality characteristics/functioning in adolescence; 2) Understand some independent effects of different early life adversities on depression and suicide risk in adolescence; 3) Understand the relationships between personality characteristics/functioning on depression and suicide risk in adolescence; 4) Understand the potential effects of the joint relationships of early life adversities and personality characteristics/functioning on depression and suicide risk in adolescence; and 5) Understand the prevention and treatment implications of examining the direct and indirect effects of early life adversities and personality function on depression and suicide risk in adolescence.

SUMMARY:

Background: Early life adversities (ELAs) can have profound impact on the developmental trajectories of individuals and their vulnerabilities to various psychosocial and health outcomes such as maladaptive personality functioning, depression, suicide, and suicidal ideation and behaviors. Understanding the mechanisms by which these ELAs impact the individual's mental health over the life course is important for treatment and prevention of depression and suicide. This study utilized data from the *DSM-5* Field Trials in Children and Adolescents to examine the independent and joint relationships between ELAs (e.g., sexual abuse, damaging nurturance, early life social relationship problems and caregiver mental health problems), personality functioning, and subsequent depression and suicide risk in children age 11–17. **Methods:** Data on children age 11–17 who were able to read and

understand in English were selected for this study. All children were asked to complete the 36-item Personality Inventory for DSM-5 (PID-5). The 36 items mapped onto six personality functioning domains: negative emotionality, detachment, disinhibition, antagonism, compulsivity and schizotypy. Children's accompanying caregivers and clinicians were asked to complete the caregiver and clinician versions of the Early Development and Home Background measures, respectively. The measures captured information on a child's birth and early life, including physical and sexual abuse, neglect, damaging nurturance, caregiver depression, and early life social relationship problems. Descriptive analyses, path modeling and multivariate regression analyses were conducted using MPlus and SAS software. Weighted analyses using SUDAAN were conducted to account for the stratified sampling nature of the study. **Results:** ELAs were associated with detachment ($\beta=2.5$, 95% CI [0.9, 4.1]) and schizotypy scores ($\beta=3.4$, 95% CI [1.0, 5.8]) on the PID-5. These factors were also related to depression and self and clinician rating of suicide risk in the children. Multivariate models of the association between ELAs and suicidal ideation, plans and attempts and clinician rating of suicide risk with adjustment for age and sex, with personality functioning as mediators, showed that detachment and schizotypy explained the relationship between ELAs and suicide risk and behaviors (β for sexual abuse reduced from 2.5 to 0.1). Similarly, the pathways through detachment and schizotypy explained a significant proportion of the relationship between ELAs and depression. **Conclusion:** The data indicate that ELAs may lead to detachment and schizotypy, which are associated with suicide risk and behaviors as well as depression. Future depression and suicide screening, prevention and intervention efforts can target these characteristics given evidence that detachment, schizotypy and other maladaptive personality functioning are amenable to change via treatments.

SUICIDE

NO. 1

DRIVING SUICIDE TO ZERO: REDESIGNING THE CLINICAL SYSTEM OF CARE TO SYSTEMATICALLY ADDRESS SUICIDE PREVENTION

Speaker: Shareh O. Ghani, M.D.

Co-Author(s): Gary Henschen, M.D., Karen Amstutz, M.D., Sunil Sachdev, M.D., Karen Chaney, M.D.,

Richard Clarke, Ph.D., Gowri Shetty, M.P.H., M.S., Seth Feuerstein, M.D., J.D., David Covington, M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about an organized stepwise systems change approach to addressing suicide prevention; 2) Recognize the need for workforce development, screening and assessment for suicide risk, access to timely care, family participation, and peer support services in developing an effective suicide prevention initiative; 3) Understand the importance of clinical decision support tools (CDS) for interventions based on suicidal risk stratification; and 4) Appreciate the importance of community resources and peer support in creating a suicide prevention system of care with sustained impact.

SUMMARY:

Background: Magellan's Driving Suicide to Zero Initiative developed and analyzed a systematized, data-driven, reproducible model to significantly impact suicide rates in the Maricopa Medicaid Behavioral Health System in Arizona. **Objective:** 1) Prepare the clinical workforce to confidently identify at-risk individuals and improve treatment access and engagement; 2) Integrate a sustainable and replicable clinical and support model and program tools into an electronic medical record system (EMR) to ensure that health care providers can, from a single source, identify, manage and plan for zero suicide through the safe management of those at risk; and 3) Ensure family and community participation to better identify early warning signs, navigate the clinical system and support members at risk. **Methods:** A collaborative committee comprised of clinical leadership from Magellan and health care providers was formed to address the high rates of suicide in Arizona. After an extensive review of best practices, the committee identified the need for workforce development and five components of care: 1) Standardized screening; 2) Suicide risk assessments; 3) Appropriate interventions to ensure safety; 4) Treating and caring for persons at risk of suicide; and 5) Follow-up. Magellan adopted the Applied Suicide Intervention Skills Training (ASIST) as the training component for the behavioral health workforce. This protocol was implemented in 12 outpatient mental health clinics within the Maricopa Behavioral Health System. **Results:** Magellan successfully trained over 90% of the workforce in ASIST and found that after ASIST training, there was

a significant increase in workers who “felt strongly” they could engage and assist those with suicidal desire and/or intent. A comprehensive clinical decision support tool was implemented in the EMR. The screens, risk assessments and interventions used for all members underwent continual review with the clinics, and the taskforce addressed processes, barriers and solutions for improvement. During the first 90 days of implementation, over 15,500 screens were completed. 8.5% of individuals had a positive screen and then received the Suicide Risk Assessment. There were no reported suicides in the Medicaid behavioral health population during this three-month period. The Magellan-led collaborative efforts with the behavioral health community in Arizona have impacted the suicide rate, which decreased 67% for the population and 42% in people with serious mental illness. **Conclusion:** Employing a rigorous, data-driven, scalable and reproducible population health approach to address suicide prevention and create a sustainable ecology of support around the individual and the community is possible. The Magellan Driving Suicide to Zero Initiative successfully incorporated population surveillance, analytics, research, early detection, intervention and monitoring to shift the paradigm from crisis mitigation to early prevention of suicide.

NO. 2

DEPRESSED MULTIPLE SUICIDE ATTEMPTERS: A HIGH-RISK PHENOTYPE

Speaker: Leo Sher, M.D.

Co-Author(s): Michael F. Grunebaum, M.D., Ainsley K. Burke, Ph.D., Sadia Chaudhury, Ph.D., J. John Mann, M.D., Maria A. Oquendo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate that depressed suicide attempters are sicker and more impaired compared to depressed nonattempters; 2) Understand that depressed patients with a history of four or more suicide attempts are at higher risk of dying by suicide compared to suicide attempters with fewer attempts or nonattempters; and 3) Appreciate that multiple suicide attempters require careful evaluation and monitoring by mental and nonmental health professionals.

SUMMARY:

Background: There is strong evidence that suicide attempts are among the most robust predictors of suicide and future suicide attempts. We compared

demographic and clinical features of three groups: depressed patients without a history of suicide attempts (nonattempters), depressed patients with a history of one to three suicide attempts (attempters) and depressed patients with a history of four or more suicide attempts (multiple attempters). We hypothesized that multiple suicide attempters have more psychopathology and have more severe suicidal ideation compared to the other groups. **Methods:** In all, 683 depressed patients with a history of major depressive or bipolar disorder participated in the study. All study participants gave written informed consent as required by the Institutional Review Board for Biomedical Research. Demographic and clinical parameters of study participants were assessed and recorded. **Results:** Attempters and multiple attempters had higher levels of depression, hopelessness, aggression, hostility and impulsivity compared to nonattempters, but did not differ between each other on these measures. Both attempters and multiple attempters had higher suicidal ideation at study entry compared to nonattempters. Multiple attempters had higher suicidal ideation at study entry, higher suicide intent at the time of the most medically serious suicide attempt and more serious medical consequences during their most medically serious suicide attempt compared to attempters. **Conclusion:** Depressed patients with a history of four or more suicide attempts display clinical characteristics that suggest higher risk of dying by suicide compared to suicide attempters with fewer attempts or nonattempters. In clinical practice, multiple suicide attempters are often thought to not be “serious” about wanting to die. To the contrary, our data suggests that multiple suicide attempters require careful evaluation, as their behavior can have serious medical consequences. They need monitoring for suicide risk by both mental health care professionals and the larger health care community.

NO. 3

A RETROSPECTIVE REVIEW OF 100 SUICIDES IN PHOENIX, ARIZ., 2009–2012

Speaker: Shareh O. Ghani, M.D.

Co-Author(s): Gary Henschen, M.D., Karen Amstutz, M.D., Sunil Sachdev, M.D., Karen Chaney, M.D., Richard Clarke, Ph.D., Gowri Shetty, M.P.H., M.S., Seth Feuerstein, M.D., J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the clinical characteristics of individuals who complete suicide; 2) Learn about demographic differences in gender, diagnoses and methods of suicide in completed suicides in this sample; 3) Recognize the need for timely medical/clinical interventions through early identification of suicidal risk; and 4) Understand the impact of nonclinical factors in completed suicides and intervention and treatment at vulnerable times in the lives of those with mental illness.

SUMMARY:

Background: The authors retrospectively reviewed 100 consecutive suicides from 2009 to 2012 in the Medicaid population of Maricopa County (Phoenix), Ariz., to evaluate risk and protective factors for individuals diagnosed with a mental illness who were receiving treatment, as compared to other studies with similar cohorts. **Methods:** The authors completed an extensive review of medical records for 100 consecutive completed suicides during the period from 2009 to 2012. These cases were identified when autopsy reports noted manner of death as suicide. The population included all Medicaid-eligible individuals who were receiving treatment in the community behavioral health system in Maricopa County, Ariz. Diagnoses, as well as other pertinent information (risk and protective factors), were gathered from a review of clinical records. Diagnoses were based on criteria from the DSM IV. We examined risk factors such as means of suicide, number of prior suicide attempts, differences in suicide rates by age bands and identification of any precipitating events leading up to suicide. Additionally, we examined support systems in place for the individuals, as well as adherence to treatment, last behavioral health or other medical provider visit, and recent hospitalizations or crisis interventions. **Results:** Of the 100 suicides, 59% were male. Eighty-one percent were Caucasian, 11% were Latino, four percent were African American and one percent were Native American/Alaskan Native. We found that those diagnosed with bipolar disorder were five times more likely (statistically significant) to commit suicide than those diagnosed with major depressive disorder or schizophrenia. Differences were found in lethal methods used to complete suicide, especially the use of hand guns among young women when compared to other age groupings. We also found that seeking medical or psychiatric treatment prior to suicide was a high-risk indicator, as was

hospitalization and psychiatric evaluation. **Conclusion:** Certain factors appear to provide the basis for improved understanding of those at risk for suicide and may provide the opportunity for appropriate interventions for this vulnerable population. Additional differences were found in regard to age group, gender and use of lethal means that have not been reported or were not found in a literature search on Medscape using the keyword "suicide". These findings warrant additional research into predictive factors, but also differences in risk factors in various populations. A greater understanding of knowing those who are at risk for suicide and the importance of intervention and treatment at vulnerable times in the lives of those with mental illness was clearly evidenced by this study.

MAY 16, 2016

TOPICS IN GERIATRICS

NO. 1

HOMEBOUND OLDER ADULTS: PREVALENCE, CHARACTERISTICS, HEALTH CARE UTILIZATION AND QUALITY OF CARE

Speaker: Stephanie MacLeod, M.Sc.

Co-Author(s): Shirley Musich, Ph.D., Shaohung S. Wang, Ph.D., Kevin Hawkins, Ph.D., Charlotte S. Yeh, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the prevalence and characteristics associated with homebound individuals among AARP Medicare Supplement new enrollees; 2) Estimate the impact of homebound individuals on health care utilization, expenditures and compliance with medication and care pattern recommendations; and 3) Compare compliance with medication adherence and care pattern rules for homebound and non-homebound individuals.

SUMMARY:

Background: Homebound status is generally defined as individual mobility that requires substantial effort or assistance in getting around both inside and outside of the home. Those who meet this definition leave home briefly and infrequently or only when in need of medical care. These criteria can be used to qualify individuals for Medicare home care services. According to previously published studies, the characteristics associated with homebound status

include older, female, obese, poorer health (i.e., more chronic conditions, more prescription medications), lower functional status, lower income, more depression and lonelier. **Objective:** To estimate prevalence rates of homebound status among new enrollees in AARP Medicare Supplement plans, identify characteristics associated with homebound individuals and estimate the impact of homebound status on health care utilization and expenditures. A secondary objective investigated quality of care using evidence-based medicine (EBM) metrics from medical and prescription drug claims to compare compliance with medication adherence and care pattern rules for homebound individuals compared to non-homebound individuals. **Methods:** In 2012–2014, surveys were sent to new enrollees in AARP Medicare Supplement plans, insured by UnitedHealth care Insurance Company (for New York residents, UnitedHealth care Insurance Company of New York) in five states. Homebound status was determined from the survey responses (answering yes) to a series of questions querying mobility issues getting around inside and outside of the home. Multivariate regression models, adjusting for confounding variables, were utilized to determine characteristics associated with homebound status, the impact of homebound status on health care utilization, and expenditures and quality of care patterns. **Results:** Among survey respondents (n=25,725), 19.6% were classified as being homebound—in line with U.S. Census Bureau estimates of ambulatory disabilities. The strongest predictors of being homebound included serious memory loss, being older, having more chronic conditions, taking more prescription medications and having multiple hospitalizations. Homebound individuals had significantly higher utilization of inpatient admissions and emergency room visits and, consequently, higher health care and prescription drug expenditures. Homebound individuals were also significantly more likely to be noncompliant with EBM medication adherence and care pattern rules for their most prevalent chronic conditions. **Conclusion:** Almost 20% of new enrollees in AARP Medicare Supplement plans were classified as homebound. Ongoing screening for homebound status may be warranted, along with programs that provide personalized home-based services that could potentially improve the quality of medical care for these individuals.

NO. 2

DIFFERENTIAL MORTALITY RATES IN LATE-LIFE DEPRESSION AND SUBTHRESHOLD DEPRESSION: 10-YEAR FOLLOW-UP IN THE COMMUNITY

Speaker: Cyrus S. H. Ho, M.B.B.S.

Co-Author(s): T.P. Ng

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Delineate the association between depression and mortality; 2) Compare mortality rates between threshold and subthreshold depression; and 3) Investigate risks factors and disease-specific mortality rates according to the depression threshold levels.

SUMMARY:

Background: Although the association between depression and increased mortality is well established, effects of subthreshold depression on mortality are unclear. We compared increased mortality between threshold and subthreshold depression and investigated risks factors and disease-specific mortality rates according to the depression threshold levels. **Methods:** This study included cross-sectional and longitudinal analyses of data from 1,070 participants aged 55 and above who completed the Singapore Longitudinal Aging Study (SLAS). Baseline depression levels (Geriatric Mental State Examination, GMS), chronic medical comorbidity and instrumental activities of daily living (IADL) were related to baseline and 10-year follow-up of differential mortality rates according to depression threshold level. **Results:** The prevalence of late-life subthreshold and threshold depression was 9.9% and 5.1%, respectively. 26.3% of respondents died by the 10-year follow-up, with a mortality rate of 28.2 per 1,000 person-years. The risk of mortality increased with age, male gender, lower physical activity, multiple medical comorbidities and IADL-disability, but when stratified according to depression status, none of the variables were statistically significant for the subthreshold depression group. Depression, regardless of threshold levels, increased mortality risk by at least 1.6 times, with small difference between the two. Cardiovascular mortality risk was significantly increased by 2.17 time ($p=0.024$) in threshold but not subthreshold depression. **Conclusion:** Both subthreshold and threshold depression increase the risk of excess mortality, though this risk is slightly higher at threshold levels. Subthreshold depression should be regarded as part of the depressive illness spectrum, and more

emphasis on recognition and timely treatment of this disorder should be considered in clinical practice.

NO. 3 STRUCTURAL INTEGRITY AND FUNCTIONAL CONNECTIVITY OF DEFAULT MODE NETWORK UNDERLYING THE COGNITIVE IMPAIRMENT IN LATE-ONSET DEPRESSION

Speaker: Yingying Yin, M.Med.

Co-Author(s): Mingze Xu, Zhenghua Hou, Xiaopeng Song, Yuxiu Sui, Wenhao Jiang, Yingying Yue, Yuqun Zhang, Yijun Liu, Yonggui Yuan

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Investigate the association between the functional changes and the structural lesions of the default mode network (DMN) in late-onset depression (LOD) patients; 2) Determine the dysfunction of the DMN underlying the cognitive impairments in LOD patients; and 3) Discover the imaging evidence for the early diagnosis of LOD and prevent it from developing into dementia.

SUMMARY:

Background: Late-onset depression (LOD) is a clinical syndrome associated with an increased risk for developing Alzheimer's disease due to its cognitive impairments. White matter lesions are believed to play an important role in LOD. Therefore, it is important to determine the association between functional changes and the structural lesions underlying the cognitive impairments in LOD. **Methods:** Thirty-two LOD patients and 39 age-, gender-, cerebrovascular risk factor- and education-matched normal controls (NCs) were recruited and underwent resting state functional MRI and diffusion tensor imaging scans. Cognitive impairments were evaluated with the Mini-Mental State Examination and a battery of neuropsychological measurements. Seed-based correlation analysis was performed to explore the functional connectivity (FC) of the default mode network (DMN). Deterministic tractography between FC-impaired regions was then calculated to examine the structural connectivity (SC). Tracts connecting FC-impaired regions were selected to count fiber number (FN) and to calculate the average fractional anisotropy (FA), axial diffusivity (AD) and radial diffusivity (RD) of all the voxels along these fibers. Partial correlation analyses were applied to examine the cognitive association of altered FC and SC, controlling the effects of age and

education. **Results:** Compared with the NCs, LOD patients showed decreased FC between the posterior cingulate cortex/precuneus (PCC/Pcu) and dorsal anterior cingulate cortex (dACC), as well as the thalamus. Decreased FA and increased RD of these fiber tracks connecting PCC/Pcu with dACC were found in LOD patients, without significant difference in AD and FN. The FC between PCC/Pcu and dACC was positively correlated with the FA of fiber tracks connecting them. The PCC/Pcu-dACC FC and the FA of the fiber tracks between them were both positively correlated with Symbol Digit Modalities Test and Verbal Fluency Test scores, which conversely displayed negative associations with the RD. **Conclusion:** Cognitive impairment in LOD, especially executive speed and semantic memory, might be associated with the decreased FC in the DMN, which probably results from the demyelination of white matter. Our findings provided new imaging evidence for the early diagnosis of LOD to prevent it from developing into dementia.

NO. 4

HELPING AGED VICTIMS OF CRIME (HAVOC) STUDY: THE IMPACT OF CRIME ON OLDER PEOPLE AND THE FEASIBILITY OF A CBT INTERVENTION

Speaker: Marc A. Serfaty, M.D., M.B.B.S.

Co-Author(s): A. Ridgewell, A. Wright, V. Drennan, A. Kessel, C. R. Brewin, G. Laycock, G. Leavey, M. Blanchard

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify mental health problems in older victims of common crime; 2) Provide preliminary data on its prevalence; and 3) Conduct a feasibility randomized controlled trial (RCT) using mixed methods.

SUMMARY:

Objective: Identify mental health problems in older victims of common crime, provide preliminary data on its prevalence and conduct a feasibility randomized controlled trial (RCT) using mixed methods. **Methods:** Police databases identified older victims of crime in selected areas of London, U.K. They were approached (n=1,058) within one month of a common crime by letter, telephone or through police safer neighborhood teams. Respondents (n=581) were screened for psychological distress using the K6 and for anxiety and/or depression and/or post-traumatic stress disorder using the GAD-

2, PHQ-2 and PC-PTSD Scale, respectively. Victims were rescreened (n=486) at three months, and demographic data, type of crime and past psychiatric history were recorded. Those satisfying entry criteria, including a *DSM-IV* diagnosis of depressive disorder and/or anxiety disorder and/or PTSD attributed to the crime and agreeable (n=26) to participate, were randomized to treatment as usual (TAU) or TAU plus our manualized CBT-informed Victim Improvement Package (VIP). Participants were interviewed for 60 minutes using a topic guide to collect their views of 1) Crime and 2) Their experience of the VIP, collected at randomization and post-intervention, respectively. Data were transcribed and analyzed using qualitative software. Outcomes were measured using WHODAS-II, BDI-II, BAI-II and PDS (symptom and severity) for quantitative results and themes and codes, in-line with the topic guide, for interview responses. **Results:** Recruitment, assessment and intervention were feasible and acceptable. At one and three months 149/581 (26%) and 120/486 (25%) were above the cutoff for screening measures, 33 had *DSM-IV* criteria for a psychiatric disorder, and 26 agreed to be randomized to a pilot trial. There were trends in favor of the VIP in all measures except PTSD at six months after the crime. Participants (n=26) reported that crime was upsetting regardless of the type, with the arbitrary nature and “unfairness” making it hard to cope. Victims experienced feeling naïve and helpless, but expressed defiance. Many rationalized that altered feelings were helpful, as the world was more dangerous and fear “legitimized” by the authorities. They did not use their networks of family and friends. Older victims saw modern society as being “less favorable,” with immigration featuring heavily as a concern. Six older victims completed the VIP and reported that it helped with empowerment and gaining confidence. They liked the practical nature of therapy, especially when conducted in their own home, but expressed concern about the stigma of therapy. **Conclusion:** This feasibility RCT is the first step toward improving the lives of older victims of common crime. Without intervention, distress at three and six months after a crime remains high. However, the well-received VIP appeared promising for depressive and anxiety symptoms, but possibly not post-traumatic stress disorder.

MOOD DISORDERS

NO. 1

THE INCLUSION AND EXCLUSION CRITERIA IN PLACEBO-CONTROLLED MONOTHERAPY TRIALS OF BIPOLAR DEPRESSION: A REVIEW OF STUDIES OF THE PAST 20 YEARS

Speaker: Mark Zimmerman, M.D.

Co-Author(s): Carolina Guzman Holst, Heather L. Clark, B.S., Matthew D. Multach, B.A., Emily Walsh, B.A., Lia K. Rosenstein, B.A., Douglas Gazarian, B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the problem with generalizability of monotherapy treatment studies of bipolar depression; 2) Become familiar with the most frequently used inclusion and exclusion criteria used in bipolar depression efficacy trials; and 3) Become familiar with the similarities and differences between antidepressant efficacy trials and bipolar depression trials in their inclusion and exclusion criteria.

SUMMARY:

Objective: We recently conducted a comprehensive review of 170 placebo-controlled antidepressant efficacy trials (AETs) published during the past 20 years. The goal of the present study was to conduct a similarly comprehensive review of placebo-controlled bipolar depression efficacy trials (BDETs) published during the past 20 years and to compare the criteria used for inclusion/exclusion in BDETs to those used in AETs. **Methods:** We conducted a comprehensive literature review of monotherapy placebo-controlled AETs and BDETs published from January 1995 through December 2014. We included trials whether or not the medication has received regulatory approval for the treatment of depression or bipolar depression. **Results:** We identified 22 placebo-controlled BDETs published during the past 20 years. There were six inclusion/exclusion criteria used in at least half of the BDETs: minimum severity on a depression symptom severity scale; significant suicidal ideation; diagnosis of alcohol or drug abuse or dependence; presence of a comorbid nondepressive, non-substance use Axis I disorder; current episode of depression being too long; and current manic symptoms. BDETs were significantly less likely than AETs to exclude patients with a history of psychotic features/disorders, borderline personality disorder and post-traumatic stress disorder. Nearly two-thirds of the BDETs placed an upper limit on the duration of the current depressive episode, more than three times higher than the rate in the AETs. There was no difference on other

variables between the AETs and BDETs. **Conclusion:** Similar to treatment studies of nonbipolar major depressive disorder, the treatment studies of bipolar depression usually excluded patients with comorbid psychiatric and substance use disorders or insufficient severity of depressive symptoms as rated on standardized scales. Thus, concerns about the generalizability of recently approved medications for the treatment of bipolar depression are as relevant as the concerns that have been raised about studies of antidepressants for nonbipolar depression.

NO. 2 PREDICTORS OF LENGTH OF STAY AND READMISSION IN INPATIENTS WITH MOOD DISORDERS

Speaker: John W. Goethe, M.D.

Co-Author(s): Bonnie L. Szarek, R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the variables associated with increased risk of readmission (RA) and increased length of stay (LOS) in the present study; 2) List three variables previously reported to be associated with increased risk of readmission and LOS in patients with mood disorders; and 3) Discuss the advantages and limitations of RA and LOS as outcome measures in psychiatric inpatients.

SUMMARY:

Objective: Among variables reported to be predictors of poor outcome in patients treated for mood disorders are presence of psychosis, receiving more than two psychotropics at hospital discharge and several co-diagnoses (borderline personality disorder [BPD], PTSD, and drug and alcohol abuse). This study examined the associations of each of these six predictor variables with length of stay (LOS) and readmission (RA). **Methods:** The sample included inpatients age 18 and older discharged between January 2000 and December 2013 with a clinical *DSM-IV* diagnosis of bipolar (BD) or major depressive disorder (MDD) (n=12,563). Stepwise logistic regressions examined the associations of each of the six predictor variables with two outcome measures: LOS over nine days (the highest quartile) and RA within one, three, six and 12 months after hospital discharge. Additional regressions determined if any of the associations were unique to MDD or BD. **Results:** RA was common in the sample as a whole (23% within 12 months, 9% at one month or less) and was associated, at all four time points,

with four of the six predictor variables (OR=1.16–1.53); notably, neither drug nor alcohol abuse contributed to increased RA. Significantly more common in BD vs. MDD were BPD (11% vs. 9%), alcohol abuse (28% vs. 26%), drug abuse (37% vs. 27%) and receiving more than two psychotropics at discharge (54% vs. 37%), all $p<0.05$; significantly more common in MDD vs. BD were psychosis (29% vs. 25%) and PTSD (12% vs. 9%), both $p<0.05$. The greatest risk of RA was found in patients with a co-diagnosis of BPD (12 months after discharge or sooner) (OR=1.53). BD unspecified/NOS was associated with increased risk of RA (OR=1.21–1.31); notably, BD mixed was not associated with RA. In the analyses that examined MDD and BP separately, psychosis and BPD were associated with increased RA risk in MDD (OR=1.42–1.71); by contrast, no variables associated with RA were unique to BD. LOS over nine days was associated in the sample as a whole with psychosis (OR=2.08), more than two psychotropics at discharge (OR=1.41) and three BD subtypes (compared to MDD): manic (OR=1.30), depressed (OR=1.34) and mixed (OR=2.59). In the regressions using LOS over nine days as an independent variable, LOS was associated with increased risks for RA at all time points (OR=1.33–1.39). **Conclusion:** This study is the first to examine these six specific clinical features as potential predictors of RA and LOS in a large inpatient sample. The associations suggest that RA risk increases in patients with mood disorders who have certain clinical features, three of which are typically identified in the initial hospital assessment: psychosis, PTSD and BPD; two other characteristics are routinely available at discharge: LOS and receiving more than two psychotropics at discharge. The results are relevant to recent emphasis on early identification of patients at increased risk for rapid RA and extended LOS. Further study is needed.

NO. 3 ROLE OF AGE AND CONCURRENT MEDICATIONS IN TITRATION METHOD FOR SEIZURE THRESHOLD DETERMINATION IN BILATERAL ECT: A RETROSPECTIVE STUDY

Speaker: Preeti Sinha, M.D.

Co-Author(s): Jagadisha Thirthalli, Virupakshappa I. Bagewadi, Abhishek R. Nitturkar, Bangalore N. Gangadhar

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the effect of age

and concurrent medications on the seizure threshold of bilateral ECT; 2) Understand the effect of age and concurrent medications on the increase in the seizure threshold of bilateral ECT over several sessions; and 3) Identify the starting electrical dose for determining seizure threshold by titration method based on the patients' age and information about concurrent medications.

SUMMARY:

Background: Even after many published studies indicating the role of age in determining seizure threshold (ST) in electroconvulsive therapy (ECT), titration method is arguably the most commonly used method instead of formula-based methods using age. Other possible influential factors such as concurrent anticonvulsants or benzodiazepines are not considered while determining ST, as the evidence is not clear. **Objective:** To determine the association of age, anticonvulsants and benzodiazepines with ST and find the groups based on these associations that can improve the titration method. **Methods:** ECT records of 640 patients who received bilateral ECT (BLECT) in 2011 in the National Institute of Mental Health and Neurosciences were studied retrospectively. Their demographic, clinical, pharmacological treatment and ECT details over six sessions of ECT were recorded. As a protocol, during the first ECT session, ST is determined by titration method, starting with 30 millicoulombs (mC) and then increasing in steps of 60mC. ST at the first ECT session was calculated and whether ST increased over the ECT sessions was also noted. The receiver operating characteristic (ROC) curve and the cutoff with high specificity was then calculated for age and ST, followed by nonparametric tests to compare ST and presence of increase in ST over the ECT sessions among groups based on age cutoff and the presence of anticonvulsants and/or benzodiazepines. **Results:** The mean age was 30.98 years (+11.23 years), and mean ST at the first ECT session was 130.36mC (+51.96mC). The area under the ROC curve for two categories of ST based on 120mC or above was 0.784 (SE= 0.2, $p<0.001$). The cutoff age of 40 was chosen since it had a sensitivity of 41% and specificity of 89.8%, and the requirement was of high sensitivity. Among patients under 40, 378/507 (74.5%) had $ST>120mC$; for patients over 40, 90/94 (93.9%) had $ST>120mC$ (OR=5.29, 95% CI [2.52, 11.11], $p<0.001$; Pearson chi-square=23.36, $df=1$, $p<0.001$). Significantly more patients over 40 had an increase in ST between the second ECT session and the sixth (OR=2.42, 95% CI [1.60, 3.65], $p<0.001$; Pearson chi-

square=18.07, $df=1$, $p<0.001$). These figures related to $ST>120mC$ (OR=3.49, 95% CI [1.37, 8.88], $p=0.009$; Pearson chi square=7.73, $df=1$; $p=0.005$) and increase of ST over the ECT sessions (OR=3.88, 95% CI [2.27, 6.62], $p<0.001$; Pearson chi-square=27.28, $df=1$; $p<0.001$) were significant for the patients who were on anticonvulsants with or without benzodiazepines compared to those who were not on an anticonvulsant. These data were not significant with respect to the use of benzodiazepines, sex and psychiatric diagnosis. **Conclusion:** While using the titration method to determine ST with BLECT for patients over 40, one may start at 120mC. The same protocol may be followed for those who are on anticonvulsants. Patients who require ECT can be given benzodiazepines without the fear of increase in ST.

NO. 4

THE CORNELL PERIPARTUM PSYCHOSIS MANAGEMENT TOOL: A CASE SERIES AND TEMPLATE

Speaker: Benjamin Brody, M.D.

Co-Author(s): Janna S. Gordon-Elliot, M.D., Simriti J. Chaudhry, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the epidemiology of pregnancy and treatment adherence in women with schizophrenia and other psychotic disorders; 2) Appreciate the large multidisciplinary team that may be required to facilitate a safe delivery in a psychotic pregnant patient; 3) Understand the legal and ethical challenges that may arise while treating peripartum psychotic patients; and 4) Recognize the common complications of neonatal psychotropic exposure.

SUMMARY:

Background: Under optimal circumstances, the care of pregnant patients with schizophrenia and other psychotic disorders requires collaboration between the patient, her psychiatrist and her obstetrician. In practice, women with psychotic disorders are more likely to have unplanned pregnancies, receive less prenatal care and have higher rates of obstetrical complications than unaffected cohorts. Due to the nature of severe psychiatric illnesses, patients commonly have poor insight into the need for treatment or emerging psychiatric symptoms and may otherwise have difficulty accessing appropriate care. As labor approaches, such patients may require

a team previously unknown to the patient to rapidly integrate the perspectives of multiple disciplines including psychiatry, obstetrics, neonatology, anesthesiology, ethics, hospital legal affairs, nursing, social work and hospital security services to create a comprehensive birth management plan that is safe for the patient and baby. These perspectives are particularly important for patients presenting in a state of acute psychiatric or obstetrical urgency with psychotic symptoms or violent or self-injurious behavior. **Methods:** Over a one year period, we treated three patients who were hospitalized for acute exacerbations of psychosis or bipolar depression during their final weeks of pregnancy. Given the complexity of these cases, we held multidisciplinary meetings with each patient while on the inpatient psychiatry service to create an itemized management plan tailored to the patient's anticipated circumstances during the peripartum period. These management plans addressed the safety of the mother, baby and staff; issues regarding informed consent; surgical questions related to anticipated method of delivery; management of peripartum psychiatric symptoms; neonatal concerns; and guardianship issues. **Results:** From our experience with these cases, we developed the Cornell Peripartum Psychosis Management Tool (CPPMT), which can be used to develop peripartum management plans for similar patients.

MEDICAL CARE REFORM AND PSYCHIATRY

NO. 1

A CENTURY OF HEALTH CARE REFORM: ANALYSIS AND PREDICTIONS FOR THE AFFORDABLE CARE ACT

Speaker: Dora Wang, M.D., M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Become familiar with the history of U.S. health care reform, including the Affordable Care Act, also known as Obamacare; 2) Become aware of how health care reform at the turn of the 20th century resulted in lasting changes, such as the founding of the FDA and the beginning of U.S. drug regulation; 3) Know the role of physicians in the powerful health care reform effort of the previous century; 4) Know the difference in the role of physicians between last century's health care reform and the current Obamacare; and 5) Become aware of the significance of physicians' values and codes of ethics, which were central to last century's reform,

even at a time when medical care was not clearly beneficial to most patients.

SUMMARY:

The Affordable Care Act (ACA), also called Obamacare, is analyzed in comparison to the health care reform effort at the turn of the 20th century, which resulted in the founding of the Food and Drug Administration, and with physicians gaining the sole right to prescribe medications. Five factors are examined: 1) The main reasons for reform; 2) Key proponents; 3) The role of physicians; 4) The role of for-profit entities; and 5) The main values behind each reform effort, a century apart. Historical methods are used, including an analysis of historical texts, such as Paul Starr's Pulitzer Prize-winning *Social Transformation of American Medicine*. **Results:** 1) Both reform efforts were focused on the need for patient protections and the need for cost containment. Access to care, a large factor for Obamacare, was not a major factor in health care reform of the 20th century, given the questionable usefulness of medical care at that time. 2) Physicians, the American Medical Association (AMA) and journalists such as Upton Sinclair played key roles in the previous effort, whereas the current effort has largely been driven by President Barack Obama, a politician and son of a patient. 3) Physicians and the AMA took control of private industry in the previous century by refusing to prescribe medications that were advertised to the general public and refusing to include physicians in the AMA if they worked for corporations. Today, on the other hand, nearly all physicians work for corporations, the AMA initially opposed Obamacare and physicians have not had leading roles. 4) For-profit corporations were villainized and ultimately forbidden from participation in American medicine by a physician-led effort in the early 20th century, and the profit motive was banned from American medicine for nearly a century, until the 1980s. On the other hand, the ACA makes health insurance a legal requirement and limits corporate profit to 15–20%. 5) Whereas the age-old ethic of physicians became central to American medicine at the turn of the 20th century, the current effort has not put the doctor-patient relationship at the heart of health care, nor are physician values widely discussed. **Discussion:** The implications of the difference between last century's successful and enduring health care reform and today's ACA will be discussed. The importance of physicians values, as espoused in codes of ethics since the Hippocratic

Oath, will be analyzed, with attention to the economic implications of these ethics, as well as the fact that these ethics have been entrenched for millennia, prior to medical care becoming clearly useful with the advent of antibiotics and vaccines in the mid-1900s.

NO. 2

CHANGES IN MENTAL HEALTH CARE SPENDING AND QUALITY ASSOCIATED WITH ACCOUNTABLE CARE ORGANIZATIONS IN MEDICARE

Speaker: Alisa B. Busch, M.D., M.S.

Co-Author(s): Haiden A. Huskamp, Ph.D., J. Michael McWilliams, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the association between health care outcomes and spending for patients with comorbid medical and mental health conditions; 2) Understand the financial incentives for accountable care organizations (ACOs) under Medicare MSSP and Pioneer models to improve health care coordination and how they may relate to mental health care; and 3) Understand the early effects of the MSSP and Pioneer ACOs on mental health care quality, service use and spending.

SUMMARY:

Objective: To examine changes in mental health care utilization, quality and spending associated with accountable care organizations (ACO) in the Medicare Shared Savings Program (MSSP) and Pioneer models. Mental health conditions are associated with poorer medical outcomes and higher health care spending, and there is great interest in developing new health care delivery models that can improve mental health outcomes. ACOs may respond to incentives to lower spending below their financial benchmarks by improving the quality of mental health care if they believe it will result in lower total health care costs. Whether ACOs are targeting mental health conditions in efforts to achieve savings is unclear. **Methods:** We use Medicare part A, B and D claims for a random 20% national sample of fee-for-service national Medicare beneficiaries from 2009 to 2013, as well as the 2010–2013 annual Consumer Assessment of Health Care Providers and Systems (CAHPS) surveys of fee-for-service Medicare beneficiaries with linked claims for participants, to assess a range of spending, utilization and quality measures among beneficiaries with diagnoses of depression, anxiety disorders,

bipolar disorder and schizophrenia (or among all beneficiaries where applicable). These measures include total Medicare spending and spending on outpatient mental health care in general and in depression more specifically; mental health hospitalizations, partial hospitalizations and ambulatory care; antidepressant and antipsychotic medication use and adherence; and self-reported mental health status and patient experiences. We conduct difference-in-difference comparisons of changes among beneficiaries attributed to ACOs with changes among a control group of beneficiaries attributed to non-ACO providers in the same geographic areas. **Results:** In preliminary analyses, we have found no effects of ACO contracts on rates of diagnosis of depression or other mental health conditions as measured by claims data or on mental health status or patient experiences as measured by the CAHPS survey. Analyses of other measures are underway. **Conclusion:** Early Medicare ACOs do not appear to change the rates of mental health diagnosis in beneficiaries, nor mental health status or patient experiences as measured in CAHPS surveys. Given the high cost of mental health conditions and emerging efforts to improve mental health care through new models of care delivery, our findings will be of great interest to clinical and policy audiences by characterizing the early effects of Medicare ACOs on mental health care utilization, quality and spending; which types of ACOs—if any—are successfully targeting mental health conditions with value-enhancing interventions; and the potential need for modifying alternative payment models to address outcomes and spending among patients with mental health conditions.

NO. 3

PRIORITIZING QUALITY MEASURES FOR PHYSICAL HEALTH ASSESSMENT IN A COMMUNITY MENTAL HEALTH ORGANIZATION: A STAKEHOLDER-BASED APPROACH

Speaker: Sharat P. Iyer, M.D., M.S.

Co-Author(s): Laura A. Pancake, L.C.S.W., Elizabeth Dandino, Alexander S. Young, M.D., M.S.H.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify existing endorsed quality measures for assessing the physical health of consumers in community mental health organizations; 2) Evaluate the assessment by community mental health stakeholders of quality measures assessing the physical health of consumers

in community mental health organizations; and 3) Recognize the importance of stakeholder perceptions of barriers to the implementation of quality measures assessing the physical health of consumers in community mental health settings.

SUMMARY:

Community mental health organizations (CMHOs) are an ideal venue to address the physical health of people with mental illness. However, CMHOs have struggled to adopt physical health screening guidelines, citing a variety of barriers and uncertainty about the role of CMHOs in assessing treating medical issues. CMHOs' poor rates of adherence to guidelines may also be due to insufficient stakeholder input in guideline development. There has also not been a focused stakeholder-based assessment of quality measures related to addressing the physical health of consumers in mental health settings. This study obtained the input of stakeholders in a community mental health setting, including consumers, on existing quality measures addressing the physical health of consumers using a community-partnered participatory research framework. Stakeholders, including consumers, were recruited from across a large multisite CMHO based in Southern California. A literature search identified existing endorsed quality measures related to addressing the physical health of consumers. Stakeholders were asked to rate identified quality measures on importance, validity and feasibility based on National Quality Forum criteria and using a RAND/UCLA Appropriateness Method Delphi panel approach and were asked to identify a consensus set of priority quality measures. The committee identified 37 total quality measures. Stakeholders rated markers of illness or dysfunction—such as listing physical health conditions and medications, screening for problematic drug and alcohol use, and measuring blood pressure—higher than measures of general physical health or prevention—such as assessing BMI, waist circumference and immunization status. Waist circumference was not only deemed to be less important and valid than other measures, but its feasibility was rated lower than other screening measures normally requiring more resources, such as laboratory assessment. After adjusting for quality measure group and clustering by participant, overall importance ratings were significantly higher than validity and feasibility ratings. Identified implementation issues included segmentation by age or program, frequency of assessment,

reimbursement, scope of practice, and licensing regulations. The stakeholder committee identified a consensus list of seven quality measures to adopt for implementation across the CMHO. Successfully improving physical health outcomes for people with mental illness will require implementation of both screening and behavioral interventions by addressing the challenges identified in this study. The stakeholder ratings of endorsed quality measures and the consensus quality measurement framework may provide a starting point for further studies into larger-scale adoption of quality measurement to address the physical health of consumers in CMHOs.

AVAILABILITY AND COMMUNITY SATISFACTION IN PSYCHIATRY

NO. 1

A CLINICALLY USEFUL SELF-REPORT MEASURE OF PSYCHIATRIC PATIENTS' SATISFACTION WITH THE INITIAL EVALUATION

Speaker: Mark Zimmerman, M.D.

Co-Author(s): Douglas Gazarian, B.A., Matthew Murtaugh, B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the problem of measuring patient satisfaction with care for patients in ongoing treatment; 2) Appreciate the obstacles of incorporating the assessment of patient satisfaction into routine clinical practice; 3) Learn about a new measure that evaluates patient satisfaction with the initial evaluation; and 4) Become familiar with the psychometric properties of the new measure of patient satisfaction.

SUMMARY:

Objective: The past decade has witnessed an increased interest in evaluating the quality and outcome of medical care. Patient satisfaction is one component of quality. Studies of satisfaction in samples of established patients in ongoing treatment are biased because dissatisfied patients are more likely to have dropped out from treatment. We therefore sought to develop a new instrument assessing patients' satisfaction with the initial psychiatric evaluation. In this report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project, we describe the development, reliability and validity of the Clinically Useful Patient Satisfaction Scale (CUPSS). **Methods:**

The CUPSS is a brief, self-administered questionnaire covering four areas: clinician's attitude and behavior, office environment and staff, overall satisfaction, and expectation of improvement. A large sample of psychiatric outpatients (n=431) and partially hospitalized patients (n=500) completed the measure immediately after their initial meeting with the psychiatrist. A subset of patients (n=150) were queried regarding the burdensomeness of scale completion. The scale was completed anonymously. **Results:** More than 90% of the patients considered the questionnaire minimally or not at all burdensome to complete. The scale had high internal consistency, and all item-scale correlations were significant. All items were significantly correlated with each of the indicators of global satisfaction. There was sufficient variability in satisfaction ratings to detect differences among clinicians. **Conclusion:** The results of the present study of psychiatric outpatients and partially hospitalized patients indicate that the CUPSS was minimally to not at all burdensome to complete, had good psychometric properties, and was capable of discriminating between clinicians.

NO. 2

PSYCHIATRISTS' REPORTS OF MENTAL HEALTH AND SUBSTANCE USE TREATMENT ACCESS PROBLEMS

Speaker: Joyce C. West, Ph.D., M.P.P.

Co-Author(s): Diana E. Clarke, Ph.D., M.Sc., Farifteh F. Duffy, Ph.D., Keila Barber, M.H.S., Ramin Mojtabai, M.D., Ph.D., Eve Moscicki, Sc.D., M.P.H., Kristin Kroeger Ptakowski, Saul Levin, M.D., M.P.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand critical gaps in the current availability of specific mental health and substance abuse treatments and services in the United States; 2) Appreciate constraints associated with psychiatrists' ability to spend sufficient time with patients during visits and to provide the number of visits to meet patients' clinical needs; and 3) Recognize the need for enhancements to the mental health and substance abuse treatment, workforce, and services delivery infrastructure for ACA to realize the promise of increased access to care.

SUMMARY:

Background: Although the Affordable Care Act (ACA) reflects a major milestone in expanding health and mental health benefits and improving treatment

access, there are serious concerns regarding the capacity of the available workforce and treatment infrastructure to meet increased demand for mental health services. **Objective:** To assess 1) Critical gaps in the current availability of specific mental health and substance abuse treatments and services and 2) Psychiatrists' ability to spend sufficient time with patients during visits and provide the number of visits needed to meet patients' clinical needs. **Methods:** This cross-sectional, observational study was conducted September through December 2013 using through-the-mail practice-based research methods. 2,800 psychiatrists were randomly selected from the AMA Physician Masterfile; 45% (n=1,188) of the psychiatrists with deliverable addresses responded. Of these, 93% (n=1,099) reported currently practicing psychiatry and treating psychiatric patients, forming the sample for this study. **Results:** Substantial proportions of psychiatrists reported they were unable to provide or find a source of care for many services for individuals in the past 30 days. Approximately one-third of psychiatrists reported not being able to provide or find a source for psychotherapy, housing, supported employment, case management/assertive community treatment and substance use treatment. Approximately 20% of psychiatrists were not able to provide or find a source of care for inpatient treatment, psychosocial rehabilitation, general medical care, pharmacological treatment, and child and adolescent treatment, while approximately 15% of psychiatrists reported being unable to provide or find a source of care for geriatric assessment and treatment. The level of difficulty in finding sources of care for most psychosocial treatments and services differed by practice setting ($p < 0.01$). Psychiatrists reported a mean of 5–14 patients (depending on the treatment or service) for whom they were not able to provide or find a source of care in the past 30 days. Approximately half the psychiatrists reported not having enough time during patient visits in their last typical work week, affecting about 30% of their patients (range by setting=26–57%, $p < 0.001$). Approximately 40% reported not being able to provide the number of visits needed to meet their patients' clinical needs, affecting about 25% of their patients (range by setting=24–41%, $p < 0.001$). **Conclusion:** Findings from this study indicate constrained availability of a range of mental health and substance use services. In order for ACA health insurance and parity expansions to realize the promise of increased access to care, the mental health and substance abuse treatment workforce

and services delivery infrastructure will require significant enhancements.

NO. 3

REDUCING READMISSIONS TO THE ACUTE PSYCHIATRIC SERVICES OF AN INNER CITY COMMUNITY HOSPITAL: A SYSTEMATIC APPROACH

Speaker: Renuka Ananthamoorthy, M.D.

Co-Author(s): Renuka Ananthamoorthy, M.D., Melissa Flanagan, L.C.S.W., Susan Cameron, L.C.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the importance of reducing length of stay and readmissions in acute psychiatric service settings; 2) Learn methods to isolate and prioritize factors contributing to readmissions based on data; and 3) Design and monitor action plans to reduce readmissions in psychiatric emergency and inpatient services.

SUMMARY:

In the current health care environment, readmissions rates are considered a crude indicator of quality of care and treatment outcomes. The pattern of patients returning to the emergency room or an inpatient service within 30 days of discharge and is disruptive to the patients and their caregivers and consumes a significant share of public resources. Decreasing readmissions in conjunction with shorter inpatient lengths of stay is in alignment with the Triple Aim of improving the experience of care, improving population health and reducing per capita costs of health care. **Methods:** We conducted a one-year Performance Improvement Project in Behavioral Health Services of Kings County Hospital Center in Brooklyn, New York. The target of improvement activities was a reduction in behavioral health 30-day readmission rates. Readmission rate for inpatient services was defined as, of those patients discharged from the facility's inpatient psychiatric units in the index month, the proportion who are readmitted to any inpatient service within 30 days of discharge. Standard process steps included 1) Complete a driver analysis of readmissions; 2) Specify a change packet based on that analysis; and 3) Test and monitor the change packet and refine accordingly. The readmission drivers were 1) Emergency room assessment and admission decision not informed by the inpatient treatment team; 2) Readmission factors not addressed in the inpatient treatment plan; and 3) Family's ability to support the patient after

discharge. Implemented interventions included 1) Involving the inpatient treatment team in the assessment and disposition decision in the emergency room; 2) Developing a repeat admission review process; and 3) Developing a family education and engagement program for high readmission risk patients. **Results:** The percentage of patients readmitted to the emergency room within 30 days of discharge decreased from 44 to 26% over five months. The percentage of inpatient treatment plans for readmitted patients addressing factors identified as contributing reasons for readmission increased from 30 to 70%. The number of patients referred to the emergency room by family after recent discharge remained unchanged. The quarterly readmission rate to inpatient services dropped from 9.9% for the first quarter to 7.3% for the fourth quarter. Length of stay concurrently dropped from an average of 21.1 days to 18.6 days. **Conclusion:** Decreasing length of stay and reducing readmissions at the same time is possible and doable in an acute psychiatric services setting at an inner city community hospital. Care team continuity, addressing readmission factors in treatment planning, and engagement of family and community resources seem to be helpful in reducing readmissions when implemented concurrently as part of a systematic approach.

SCHIZOPHRENIA: CAREGIVER TECHNIQUES AND POST-DISCHARGE STRATEGIES

NO. 1

CAREGIVING FOR INDIVIDUALS WITH SCHIZOPHRENIA AND ITS IMPACT ON CAREGIVER EMPLOYMENT AND WORK PRODUCTIVITY

Speaker: Debra Lerner, Ph.D., M.Sc.

Co-Author(s): Carmela Benson, M.S., Hong Chang, Ph.D., Annabel Greenhill, M.A., William H. Rogers, Ph.D., Lisa B. Dixon, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Increase knowledge of employment issues facing the caregivers of family members of friends diagnosed with schizophrenia and/or schizoaffective disorder; 2) Increase understanding of the degree to which caregivers participate in the labor market, as well as specific work roles and settings; 3) Increase knowledge of the stressors associated with maintaining employment and being a caregiver; and 4) Quantify the impact of caregiving on employment outcomes

using validated self-report measures of work absenteeism and presenteeism (at-work performance deficits).

SUMMARY:

Background: Family members and friends often assume responsibility for meeting the needs of individuals with schizophrenia and/or schizoaffective disorder. Some caregivers will need and/or want to work; however, information about caregiver employment issues is limited. **Methods:** A population-based cross-sectional web survey included the validated Caregiver Work Limitations Questionnaire (C-WLQ). Ads posted by mental health advocacy organizations and the Dear Abby column invited caregivers to a study website for eligibility screening and possible participation. Eligible caregivers provided unpaid help or arranged for help in the past year to a person with one or both diagnoses and were able to understand English. Descriptive statistics were computed, as were odds ratios for employment versus unemployment using logistic regression. **Results:** Website hits totaled 2,338, with 1,708 consenting, 1,398 eligible for participation and 1,149 with complete data. Most caregivers were female (82.5%), white (89.0%), a parent of the person receiving care (59.6%) and married (66.4%). Mean age was 55.5 years (SD=13.2). Currently employed caregivers comprised 62.4% of the sample (75.0% of those age 65 or older), of which 48.1% were salaried, 41.5% were paid hourly and 10.4% were paid on another basis. Further, 9.6% stopped working within the past two years and 28.0% did not work for at least two years. The odds of current employment versus no employment were significantly greater ($p \leq 0.02$) for caregivers who were female, non-white, unmarried and relatively younger. Reasons for stopping work were retired (41.9%), fired/laid off (14.3%), taking a break (15.2%) and other (28.6%). In this group, 58.1% reported that caregiving had been interfering with their job performance. Among currently employed caregivers, stressors were common: 45.6% had difficulty taking time off for personal matters, 30.6% could not change daily schedules and 27.8% often had required overtime. Additionally, while working, 68.9% had a moderate or high degree of concern about the person under their care. In the past year, 37.3% of working caregivers cut their work hours and 26.8% took a leave of absence. In the prior month, caregiving resulted in a mean loss of 0.7 workdays (SD=1.0), and at-work performance deficits occurred on average 22.1% of the time for

physical tasks and 27.2–29.7% of the time for output tasks, mental and interpersonal tasks, and time management. Productivity was reduced by a mean 15.4% (SD= 23.7) due to absenteeism and 7.7% (SD=5.2) due to presenteeism. However, 58.9% had high job satisfaction. **Conclusion:** Most caregivers were employed, and many experienced stressors related to managing caregiving and work roles. Caregiving consequences included permanent or temporary loss of work hours and decreased work performance and productivity. Helping caregivers who want and/or need to work may benefit the caregivers, those receiving care and employers.

NO. 2

CAREGIVER-DIRECTED PSYCHOSOCIAL INTERVENTIONS IN SCHIZOPHRENIA: SYSTEMATIC REVIEW AND META-ANALYSIS

Speaker: Branislav Mancevski, M.D.

Co-Author(s): Erica Elefant

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand recommendations made by the Institute of Medicine for improving outcomes of psychosocial interventions for those with mental health and substance use disorders; 2) Appreciate the effect of caregiver psychoeducation and skills training on patient outcomes based on findings from a recent meta-analysis; and 3) Become familiar with the FIRST study, which is designed to evaluate the effects of caregiver psychoeducation and skills training compared to usual caregiver support on patient treatment failures.

SUMMARY:

Background: Caring for someone with schizophrenia is challenging, but education and training can positively impact these individuals and their caregivers. The Institute of Medicine has published recommendations for improving the outcomes of psychosocial interventions for those with mental health disorders and has called for additional research to strengthen the evidence base for intervention effectiveness. An exploration into the effectiveness of caregiver-directed psychosocial interventions (CDPIs), specifically for schizophrenia, is under way. This report describes results of a systematic review and meta-analysis of CDPIs that informed the design of the ongoing Family Intervention in Recent-Onset Schizophrenia Treatment (FIRST) study, which is evaluating effects of study-provided caregiver psychoeducation and

skills training versus usual caregiver support on patient treatment failures (i.e., psychiatric hospitalizations, psychiatric emergency department or crisis center visits, arrests/incarcerations, or suicides/suicide attempts) over 12 months.

Methods: We conducted electronic searches of PubMed/Medline, PsychNet and the Cochrane Central Register of Controlled Trials with limitations of 2004–2015, randomized controlled trials and English language. Review articles were retained and hand searched. Two independent reviewers applied inclusion/exclusion criteria and extracted data; discrepancies were adjudicated by a third. Rank- and rating-based outcome data were transformed wherever possible into binary outcomes, which were assessed by relative risk (RR); 95% confidence intervals (CIs) were derived from a random effects model, given heterogeneity among the studies. Analyses were weighted by the sample size of the contributing studies. Relevant available outcomes were patients hospitalized, patients relapsing, major incidents (death, suicide, suicide attempt, other [psych first aid visit, emergency department visit, initiating substance abuse]) and noncompliance (to medication- or nonmedication-related activities). **Results:** Of 693 unduplicated studies identified, 16 were selected for inclusion. Findings showed that CDPI significantly reduced patient hospitalization (RR=0.71, 95% CI [0.57, 0.89], p=0.003) and relapse (RR=0.59, 95% CI [0.45, 0.76], p<0.001) versus treatment as usual. This relationship was strongest during the first 12 months of follow-up for both hospitalizations (RR=0.67, 95% CI [0.49, 0.92], p=0.01) and relapse (RR=0.47, 95% CI [0.32, 0.69], p<0.001). Overall effect of CDPIs for major incidents (a composite of outcomes) appeared favorable, but results were not statistically significant. **Conclusion:** Analysis results were used to select outcomes and design the FIRST study, which will help establish the value of remotely delivered skills training for caregivers of patients recently diagnosed with schizophrenia, schizoaffective disorder or schizophreniform disorder. This research was supported by Janssen Scientific Affairs.

NO. 3

POST-DISCHARGE PHYSICIAN VISITS AND READMISSION RATES IN A POPULATION-BASED SAMPLE OF PATIENTS WITH SCHIZOPHRENIA

Speaker: Paul Kurdyak, M.D., Ph.D.

Co-Author(s): Simone Vigod, Alice Newman, Benoit Mulsant, Alice Newman

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about the postdischarge readmission rate for patients with schizophrenia; 2) Understand the impact of postdischarge physician follow-up on readmission rates for patients with schizophrenia; and 3) Learn about the importance of readmission risk at discharge on the impact postdischarge follow-up has on readmission.

SUMMARY:

Objective: We assessed the impact of physician visits within 30 days after discharge on readmission rates between 31 and 210 days after discharge among schizophrenia patients. **Methods:** We created a cohort of schizophrenia patients discharged between 2007 and 2012 in Ontario, Canada. Patients were classified into one of four groups based on postdischarge physician follow-up: no follow-up (referent group), primary care physician (PCP) only, psychiatrist only, or both PCP and psychiatrist. Secondary analyses stratified the sample based on readmission risk (low, medium, high) at discharge. The primary outcome was psychiatric readmission between 31 and 210 days after discharge. **Results:** Of the 6,706 (34.8%) patients with no physician visit, 1,711 (25.5%) were readmitted between 31 and 210 days after discharge. Readmission rates were lower among those who had a visit by a PCP only (22.2%; aRR=0.88, 95% CI [0.81, 0.96]), a psychiatrist only (21.6%; aRR=0.84, 95% CI [0.77, 0.90]), and PCP and psychiatrist (21.3%; aRR=0.82, 95% CI [0.75, 0.90]). For patients in the medium readmission risk category, all types of physician follow-up reduced readmission rates—no visit (24.5%), PCP only (20.5%; aRR=0.83, 95% CI [0.71, 0.96]), psychiatrist only (18.3%; aRR=0.70, 95% CI [0.60, 0.80]), and PCP and psychiatrist (17.7%; aRR=0.68, 95% CI [0.57, 0.80]). **Conclusion:** Timely follow-up by a PCP or psychiatrist modestly reduces early readmissions, with the greatest readmission reduction occurring among patients at medium risk of readmission at discharge. Since more than one-third of schizophrenia patients had no physician visit within 30 days of discharge, improving physician follow-up rates may help reduce readmission rates on a population level.

BIOLOGICAL PSYCHIATRY

NO. 1

INFLAMMATORY MARKERS IN PTSD: A META-ANALYSIS AND META-REGRESSION STUDY

Speaker: Fang Yang, M.D., Ph.D.

Co-Author(s): Ryan M. Cassidy, Ives Cavalcante Passos, M.D., Ph.D., Joao Quevedo, M.D., Ph.D., Jair Soares, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Confirm increased levels of IL-6, IL-1 β , interferon- \hat{I}^3 and TNF- α in PTSD subjects compared to healthy controls using meta-analysis and meta-regression methods; 2) Understand that “use of psychotropic medications” and “presence of comorbid MDD” are two important variables that may explain the lack of consistency in the results of previous studies; and 3) Indicate the potential role of inflammatory factors as biomarkers for PTSD and know that interventions that address chronic low-grade inflammation may potentially serve as adjunctive therapy for PTSD.

SUMMARY:

Background: Studies investigating inflammatory markers in Post-traumatic Stress Disorder (PTSD) have yielded contradictory results. **Methods:** In this study, we investigated meta-analysis and meta-regression of studies comparing inflammatory markers between subjects with PTSD and healthy control subjects. We also performed subgroup meta-analysis using “presence of comorbid major depressive disorder (MDD)” and “use of psychotropic medication” as predictors. We searched PubMed, Embase, Scopus, Web of Science and PsycInfo. **Results:** A total of 8,057 abstracts were identified, and twenty studies were included. IL-6 (SMD=0.88, $p<0.001$), IL-1 β (SMD=1.42, $p=0.045$) and interferon- \hat{I}^3 (SMD=0.49, $p=0.002$) levels were higher in the PTSD group. Subgroup meta-analysis of unmedicated subjects showed higher TNF- α (SMD=0.69, $p<0.001$) in the PTSD group in addition to the aforementioned cytokines. TNF- α (SMD=1.32, $p<0.001$), IL-1 β (SMD=2.35, $p=0.048$) and IL-6 (SMD=1.75, $p<0.001$) levels remained increased in the PTSD group in subgroup meta-analysis of studies that excluded comorbid MDD. Illness duration was positively associated with IL-1 β levels ($b=0.33$, $p<0.001$) and severity with IL-6 ($b=0.02$, $p=0.042$). A model composed of the variables “presence of comorbid MDD,” “use of psychotropic medications,” “assay performed” and “time of the day the blood was collected” explained the large amount of heterogeneity of IL-1 β , IL-6 and CRP studies. **Discussion:** Our findings show that PTSD is associated with a pattern of immune activation.

Specifically, we found increased levels of IL-6, IL-1 β , interferon- \hat{I}^3 and TNF- α in PTSD subjects compared to healthy controls. Further studies are necessary to explore the potential role of these inflammatory factors as biomarkers for PTSD. Interventions that address chronic low-grade inflammation may potentially serve as adjunctive therapy for PTSD. Additionally, “use of psychotropic medications” and “presence of comorbid MDD” are two important variables that may explain the lack of consistency in the results of previous studies on which cytokines are elevated and to what degree.

NO. 2

ANALYSIS OF BASELINE MENTAL HEALTH DATA FROM THE SONYA SLIFKA LONGITUDINAL MULTIPLE SCLEROSIS STUDY

Speaker: Laura Safar, M.D.

Co-Author(s): Peter A. Arnett, Ph.D., David C. Mohr, Ph.D., Deborah Miller, Ph.D., David C. Hoaglin, Ph.D., Sarah L. Minden, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the prevalence of emotional distress in individuals with multiple sclerosis and its demographic- and illness-related predictors; 2) Discuss the impact of emotional distress on MS patients’ quality of life and functioning; and 3) Describe the general medical care and mental health care characteristics of patients with multiple sclerosis across the U.S., both in rural and urban areas, including obstacles to access to care.

SUMMARY:

Background: Emotional disorders are highly prevalent in multiple sclerosis (MS). The Sonya Slifka Longitudinal MS Study (Slifka Study) is a longitudinal study of 2,156 people with MS that broadly reflects the MS population in the U.S. It provides valuable data to address current gaps in our understanding of mental disorders in MS, including impact of emotional symptoms, their relationship with demographic and disease characteristics, and access to and utilization of mental health services. **Objective:** Estimate the prevalence of emotional distress in the Slifka Study sample and examine its relationship to demographic, disease and health care characteristics. **Methods:** The sample included 1,674 people with established MS and 482 with recently diagnosed MS. The sample was stratified by region (Northeast, South, Midwest and West) and by rural

and urban location. We conducted computer-assisted telephone interviews to collect data on demographics, disease characteristics (duration, course, number of relapses, disability), health care characteristics (use of disease-modifying therapies, type of MS care provider, health insurance), mental health treatment (psychotropic medication, type of mental health professional), and access to mental health care. As our measure of emotional status, we used the five-item version of the Mental Health Inventory. **Results:** Almost half of the respondents experienced some degree of psychological distress during the month before the interviews. For almost all, the distress was moderate, but for some, it was severe. Because of emotional problems, 46% of respondents felt they had accomplished less, and 31% felt they had done work or other activities less carefully than usual. Respondents with psychological distress were more likely to have less education and lower family incomes or to be younger, divorced or never married, and unemployed. Psychological distress was associated with shorter duration of illness, more relapses, moderate disability and poorer perceived general health. Respondents with psychological distress were more likely to endorse MS symptoms, lack health insurance, and have problems accessing medical and mental health care. **Conclusion:** Psychological distress is highly prevalent in MS and has a negative impact on individuals' functioning and quality of life. Further efforts are needed to improve access to mental health care for this population.

NO. 3

BRAIN-DERIVED NEUROTROPHIC FACTOR (BDNF) AS A PREDICTIVE BIOMARKER OF THE OCCURRENCE OF PTSD: PILOT PROSPECTIVE STUDY

Speaker: Hafid Belhadj-Tahar, M.D., Ph.D.

Co-Author(s): Marc Passamar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the trend of brain-derived neurotrophic factor (BDNF) as a predictive biomarker of occurrence of PTSD in patients exposed to a traumatic event; 2) Appreciate initial BDNF rate perspectives in trauma follow-up from peritraumatic reactions to final diagnosis of PTSD; and 3) Identify the benefits of initial BDNF rate in order to screen at risk individuals and focus the resources used in providing victims with more effective, comprehensive and early treatment to prevent or limit the progression of PTSD.

SUMMARY:

Background: Although significant progress has been achieved in the diagnosis and therapeutic management of PTSD, there are still some unknowns about the prognostic factors to predict the outcome for victims exposed to a traumatic event. In this context, we tested brain-derived neurotrophic factor (BDNF) as a biological indicator for the PTSD diagnosis. The pilot study's main objective was to quantify the concentration of BDNF in a group of victims in the early stages of trauma and follow up clinically for three months in order to test the predictive power of BDNF for the occurrence and intensity of PTSD. **Methods:** Twelve volunteers were enrolled in this prospective study and divided into two groups. Seven subjects had recently been exposed to a traumatic event (within 72 hours), and five subjects without trauma exposure served as the control group. Excluded were those with neurological illness, psychiatric disorders, alcohol or substance abuse or dependence, and serious medical illnesses. They were not taking an anti-inflammatory medication during the previous two weeks. The psychiatric assessments included the Trauma History Questionnaire (THQ) at day 1, Peritraumatic Distress Inventory (PDI) at day 1, Peritraumatic Dissociative Experiences Questionnaire (PDEQ) at day 1, Structured Clinical Interview for *DSM-IV* Axis I Disorders (SCID-I) at days 30 and 90 and PTSD Checklist-Specific (PCL-S) at days 30 and 90. Venous blood was collected, centrifuged at 2000g for 20 minutes and stored at -80°C until analysis by RayBio's® ELISA method. The statistical analyses (Student's test and Pearson's correlation coefficients) were carried out by Microsoft Excel 2013. The null hypothesis was rejected at $p < 0.05$. **Results:** The rate of BDNF was significantly lower in the group of volunteers exposed to trauma compared to the control group: $6.20 \pm 1.73 \text{ ng/ml}$ for the group with trauma versus $21.79 \pm 1.76 \text{ ng/ml}$ for the control group, $p < 0.001$. The rate of BDNF is significantly collapsed in victims of physical aggression compared to those who have witnessed a traumatic event: $4.36 \pm 0.37 \text{ ng/ml}$ for the assault group versus $6.94 \pm 1.44 \text{ ng/ml}$ for the control group, $p = 0.03$. The level of BDNF is significantly inversely correlated with the intensity of the peritraumatic distress ($r = -0.75$, $p < 0.05$). Thus, a collapse of BDNF levels is observed whenever distress symptoms are present, with the exception of item seven in relation to the other concern. The rate of BDNF was significantly lower in the group with

PTSD compared to the group with no PTSD: 7.5 ± 0.9 ng/ml in the absence of PTSD ($n=4$) versus 4.5 ± 0.4 ng/ml in the presence of PTSD ($n=3$), $p=0.001$. **Conclusion:** The results highlight the importance of BDNF assay to better target victims at high risk of developing PTSD. A prospective study with more volunteers is in progress to confirm the results of this pilot study.

ADDICTION: TOBACCO

NO. 1

TOBACCO TREATMENT IN HOSPITALIZED PATIENTS WITH ACUTE PSYCHIATRIC AND ADDICTIVE DISORDERS

Speaker: Smita Das, M.D., Ph.D.

Co-Author(s): Judith J. Prochaska, Ph.D., M.P.H., Norval Hickman, Ph.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the increased health risks among smokers with mental illness; 2) Appraise the benefits and merits of providing tobacco treatment to hospitalized psychiatric patients; and 3) Reduce hesitance to provide smoking cessation advice during psychiatric/addiction hospitalizations.

SUMMARY:

Background: Tobacco addiction is prevalent yet under-addressed, and cessation is sometimes discouraged in individuals with mental health and substance use disorders (SUDs). A barrier to treatment has been concerns that quitting smoking may compromise recovery. **Objective:** In a randomized controlled trial, relative to usual care, we evaluated the efficacy of a tobacco intervention among smokers with serious mental illness and co-occurring SUD. **Methods:** Recruited in-hospital from two 100% smoke-free, locked acute psychiatry units in the SF Bay Area and randomized to intervention or usual care, participants met criteria for SUD based on screening measures (AUDIT and DAST). Intention to quit smoking was not required to participate, as the intervention was tailored to readiness to quit smoking and included a computer program, counseling and nicotine replacement therapy (NRT). The usual care condition received NRT during hospitalization only and brief advice to quit. The outcomes of interest were verified seven-day point prevalence abstinence over 12-months after baseline and past-30-day reports of alcohol and illicit drug use. **Results:** Sample ($n=216$, 34% female, 36%

Caucasian, mean 19 cigarettes/day) characteristics did not differ by group at baseline. At 12 months, 22% of intervention versus 11% of usual care participants were tobacco abstinent (RR=2.01, 95% CI [1.05, 3.83], $p=0.03$), and 22% of respondents reported total abstinence from alcohol/drugs in the last 30 days (group difference not significant). At 12 months, there was a significant decrease in cannabis (18% vs. 42%) and alcohol (22% vs. 58%) use in those who quit smoking versus those who did not. **Conclusion:** A tobacco treatment intervention among smokers with co-occurring mental illness and SUD was successful in aiding smoking cessation and did not adversely impact alcohol and illicit drug use. Further, quitting smoking was associated with less alcohol and cannabis use at 12-month follow-up. The findings support efforts to address alcohol, tobacco and drugs (ATOD) in one integrated intervention.

NO. 2

INTRANASAL INSULIN FOR TREATMENT OF TOBACCO ABSTINENCE SYNDROME

Speaker: Ajna Hamidovic, Pharm.D.

Co-Author(s): Muhamed Khafaja, M.D., Gretchen Ray, Pharm.D., Mikiko Yamada, Pharm.D., Joe Anderson, Pharm.D., James Nawarskas, Pharm.D., Mark Burge, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize cognitive impairments during acute withdrawal from nicotine; 2) Understand abstinent smokers' stress response deficiencies; 3) Differentiate cognitive domains that are relieved with intranasal insulin treatment; 4) Know how intranasal insulin restores stress response in abstinent smokers; and 5) Understand future direction of intranasal insulin treatment for smoking cessation.

SUMMARY:

Many cigarette smokers express a desire to quit smoking; however, approximately 85% of cessation attempts fail. In our attempt to delineate genetic modulators of smoking persistence, we have earlier published a finding that a locus within a 250kb haplotype block spanning the 5' UTR region of insulin degrading enzyme (IDE) is associated with serum cotinine levels—our study's measure of smoking quantity. The same locus has been associated with development of Alzheimer's disease. Because insulin enhances cognition in both Alzheimer's disease patients and healthy volunteers,

and since our genetic locus is in or near the UTR region of IDE, we formulated an intranasal insulin (I-I) product (FDA Investigational New Drug #116626) with the goal of increasing central, but not peripheral, insulin levels. Our two hypotheses were that, in acutely abstinent smokers, I-I would reverse nicotine withdrawal-induced cognitive impairment and relieve distress marked by hypothalamus-pituitary-adrenal (HPA) dysregulation. Following a 16-hour withdrawal from nicotine, abstinent smokers (n=40) received I-I 60IU or a placebo. In the first session, subjects completed tasks of episodic memory, attention and psychomotor speed. In the second session, subjects completed the Trier Social Stress Test (TSST). I-I significantly increased short- and long-term memory ($p < 0.05$). In addition, I-I increased Recognition D'—the ability to endorse target items and reject distractor items ($p < 0.05$). I-I had no effect on psychomotor speed and attention tasks. Participation in the TSST resulted in a blunted cortisol response in the placebo group but increased salivary cortisol in the I-I group ($p < 0.05$). Pre- and postmeasurements of serum glucose, insulin and c-peptide revealed no statistically different levels between the groups; we therefore conclude that insulin's effects on memory and HPA response were centrally driven. Olfactory function (i.e., ability to correctly recognize smells) was not different between the two groups. In conclusion, I-I can be safely administered to abstinent smokers. As reduced physiological response and parallel memory deficits are significant predictors of smoking cessation outcome, it is reasonable to further investigate I-I in a larger Phase III clinical trial for smoking cessation.

NO. 3

TAILORED BEHAVIORAL INTERVENTIONS FOR SMOKING CESSATION IN THE HIV-POSITIVE POPULATION: A META-ANALYSIS OF RANDOMIZED CONTROLLED TRIALS

Speaker: Asheena Keith, M.D.

Co-Author(s): Yuelei Dong, M.D., Seth Himelhoch, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the prevalence of smoking in the HIV population ; 2) Learn smoking's specific adverse effects in the HIV population; 3) Understand the four modalities of tailored behavioral interventions for smoking cessation ; and

4) Determine if tailored behavioral interventions are a useful tool for clinical practice.

SUMMARY:

Background: HIV infection has become a chronic disease in the highly active antiretroviral therapy (HAART) era. The prevalence of cigarettes smoking in people living with HIV/AIDS (PLWHA) is about 42–70%, which is nearly two to three times higher when compared to the general adult population in the U.S. Daily smoking results in suboptimal response to antiretroviral therapy through 40% decreased immune and virological response. Cigarette smoking is also an independent indicator of nonadherence to HAART. Tobacco use also confers an increased susceptibility to oral candidiasis and hairy leukoplakia in the HIV-positive population. Cigarette smoking can substantially increase the rate of HIV maternal-fetal transmission and significantly increase the risk of adverse fetal outcome. **Methods:** PubMed (1980 to December 2014) and Cochrane (1980 to December 2014) were searched in December 2014. This search included English language randomized controlled trials of HIV-infected smokers with or without nicotine replacement therapy. The studies were restricted to smokers of 18 years or older with HIV or AIDS and self-reported cigarette use within the past week. Studies tailored behavior interventions (group, individual, telephone or computer) for smoking cessation in the HIV-positive population as compared to standard care. The primary outcome was the expired carbon monoxide seven-day point-prevalence abstinence (PPA) rates being biochemically verified in the behavior intervention and standard care groups. Odds ratio across studies (Stat 10.0: metan command) was calculated for the studies. A random effects model was used. The Q statistic and I² were used to evaluate heterogeneity. Publication bias was evaluated using funnel plots. **Results:** 1,520 subjects from seven studies yielded a statistically significant effect of behavior interventions in improving abstinence in HIV-infected smokers with a large effect size RR 1.69 (95% CI 1.28, 2.23). Aggregate outcome data from the seven studies showed low to moderate risk of bias. There was no publication bias, and the heterogeneity was insignificant. **Conclusion:** Tailored behavior interventions are an effective tobacco treatment strategy for persons living with HIV/AIDS. This efficacy was statistically significant.

MANAGEMENT OF SCHIZOPHRENIA AND PSYCHOSIS

NO. 1

TREATMENT OF NEGATIVE SYMPTOMS OF SCHIZOPHRENIA WITH DEXTROMETHORPHAN/QUINIDINE AUGMENTATION OF ANTIPSYCHOTICS: AN OPEN TRIAL IN 42 PATIENTS

Speaker: Paul J. Markovitz, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the scientific literature supporting theories regarding too much or too little glutamate in the central nervous system of individuals with schizophrenia; 2) Understand the subsequent anatomical and behavioral sequelae resulting from too much glutamate in the central nervous system of individuals with schizophrenia; and 3) Understand the treatment advantages of reducing central nervous system glutamate levels in individuals with schizophrenia.

SUMMARY:

Objective: Schizophrenia is a debilitating illness with poor longitudinal outcome. Current treatments are efficacious at treating positive symptoms of schizophrenia, but have shown minimal improvement in negative symptoms. Negative symptoms represented by social interactions/appropriateness, mood and temperament have the largest impact on short- and long-term outcomes of schizophrenic patients. The bulk of data in the research literature suggest a paucity of glutamate is responsible for negative symptoms in schizophrenia. Raising levels of glutamate directly or via agonism of NMDA receptors has shown little benefit in schizophrenia. An alternative explanation for low glutamate in schizophrenia is that overall production has been reduced secondary to the death of cells producing glutamate. In this case, reducing glutamate at sites where levels are still too high could help with negative symptoms and spare the remaining cells, as high levels of glutamate are neurotoxic. **Methods:** In an open-label trial beginning in June 2013, 42 inpatients with schizophrenia were treated with a combination medication of 20mg dextromethorphan and 10mg quinidine (DMQ) given twice daily. All patients provided informed consent, and their conservators also did so where appropriate. All patients were on either typical or atypical

neuroleptics for treating their schizophrenia. Most were chronically ill, and the majority had spent over half of the previous two years hospitalized in an inpatient facility. Outcomes were initially assessed with a clinical global assessment clinician and subsequently with the Positive and Negative Symptoms of Schizophrenia Negative Symptom Scale (PANSS-N). **Results:** Sixty-nine percent (29 of 42) showed at least a 25% improvement in negative symptoms, and 12 (29%) showed a greater than 50% reduction in negative symptoms. Side effects were minimal, with only one patient reporting diarrhea on the first day of dosing and nursing notes corroborating no side effects of note. **Conclusion:** These findings suggest that reducing glutamate in the central nervous system has a profound impact on reducing negative symptoms in schizophrenia. High levels of glutamate could easily account for the reduction of cortical volume in schizophrenia, since high levels of glutamate are known to be neurotoxic. Two patients with first-break schizophrenia were able to return to work and have remained employed for over 18 months. This suggests the possibility that DMQ may also eliminate the longitudinal neurotoxic effects of glutamate. Controlled trials are needed to corroborate these findings.

NO. 2

CASE CHALLENGE TO MANAGE PSYCHOSIS IN PATIENTS WITH TRISOMY X

Speaker: Sheema Imran, M.D.

Co-Author(s): Gurjot Singh, M.D., Ashley Pearl Mehlman, Samana Zaidi, Hossain Asghar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify psychiatric illness in trisomy X syndrome; 2) Treat psychosis in trisomy X syndrome; and 3) Educate family members of patients about behavioral disturbances in trisomy X.

SUMMARY:

Triple X syndrome affects up to 1 in 1,000 female births. They usually present as being taller than average height, and there is increased risk of learning disabilities, delayed development of speech and language skills. L.S. was a 17-year-old female who was referred to our hospital by her private psychiatrist with treatment-resistant psychotic features. The patient was reportedly having auditory hallucinations, command type, telling her to do negative things like hit others. She also had visual hallucinations of an unusual black character having

large feet that she called “Vox”. She was admitted for having increased episodes of physical agitation toward family members. The patient had been exhibiting these signs and symptoms for the past three years. She had history of five inpatient psychiatric hospitalizations with trials on Latuda, quetiapine, venlafaxine, haloperidol, Saphris, lamotrigine, risperidone and aripiprazole with poor response as per records. The patient’s diagnosis according to the *DSM-IV-TR* was the following: Axis I: psychotic disorder not otherwise specified, pervasive developmental disorder, Provisional: bipolar disorder not otherwise specified, schizoaffective disorder, major depressive disorder recurrent severe, mood congruent with psychotic features. Axis II: Deferred. Axis III: Triple X syndrome, facial acne, no known drug allergies. Axis IV: Problems with primary support group, chronic mental illness. Axis V: Global Assessment of Functioning (GAF) score of 25. During her hospital stay, she was started and gradually uptitrated on clozapine. She responded positively to the treatment with a decrease in her psychotic signs and symptoms and agitation. She was discharged on clozapine 300mg daily with plan to follow up with her private psychiatrist. This case describes a patient with triple X syndrome who exhibited learning deficits and an inability to develop healthy social and coping skills and who later on in life presented with psychosis. Triple X syndrome and its relationship psychosis can be described through its genetic and biological pathogenesis. Both theories nevertheless contribute to the understanding of the psychosis in these patients, especially when discussed within the context of social stressors. Though this case represents a correlation between triple X syndrome and psychosis, further research is needed to identify a causal relationship. We acknowledge the existence of referral bias in our assessment, but with studies that include a large enough sample, we can increase the power and external validity of our study.

NO. 3 PERSONALITY DEFICITS, IMPAIRMENTS IN COGNITION AND EMOTION RECOGNITION: INTERCONNECTIONS AND RELATIONSHIP TO VIOLENCE IN SCHIZOPHRENIA

Speaker: Menahem I. Krakowski, M.D.

Co-Author(s): Pal Czobor

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the importance of

impulsivity, psychopathy, and impairment in cognition and in recognition of fearful affect in the emergence of violence in individuals with schizophrenia; 2) Appreciate how the above deficits in three domains (i.e., personality, cognition and processing of emotions) are interconnected in the form of a more generalized impairment related to violence; and 3) Use their understanding of the role of these deficits in violence and their interconnections in order to develop an integrated management of violent behavior in clinical practice.

SUMMARY:

Background: Research on violence in schizophrenia has focused on a variety of narrowly defined deficits while ignoring the strong interconnections among these impairments. Our goal was to use multivariate methods to investigate interrelations among three important domains related to violence in patients with schizophrenia: 1) Personality deficits, including impulsivity and psychopathy; 2) Cognitive dysfunction; and 3) Impairments in emotion recognition. **Methods:** Impulsivity was assessed with the Barratt Impulsiveness Scale (BIS-11), psychopathy with the Psychopathy Checklist (PCL-SV), cognitive dysfunction with the Wisconsin Card Sorting Test (WCST) perseverative and non-perseverative errors, and recognition of emotions (fearful and neutral emotions) with the Emotion Recognition Test (ER-40). There were three groups of subjects: healthy controls (HC, n=31), violent patients (VS, n=30) and nonviolent patients (NV, n=21) with schizophrenia. **Results:** There were significant differences in the univariate measures. HCs performed better than VSs and NVs on both WCST measures and on the ER-40 ($p<0.01$). VSs evidenced greater psychopathy than either HCs or NVs ($p<0.01$), and more WCST non-perseverative errors than NVs ($p=0.04$). Canonical discriminant analysis was performed to determine how all the measures in the three domains, considered together, distinguished among the groups. It yielded two canonical dimensions: The first represented a generalized impairment with high loadings for all variables, including impairment in the recognition of fearful emotions, but not recognition of neutral emotions. The second dimension was a restricted impairment with high loadings for the WCST perseverative errors and deficits in recognition of neutral emotions. There were significant differences among the three groups for the first ($F=75.4$, $df=2,79$, $p<0.0001$) and second ($F=22.9$, $df=2,79$, $p<0.0001$) dimensions. Mean values for the first

dimension were -1.57, 0.06 and 1.58 for HCs, NVs and VSs, respectively, with significant pairwise differences between all three groups. Thus, VSs evidenced much more severe impairment than the other two groups on this generalized dysfunction. Mean values for the second dimension were -0.42, 1.27, and -0.46 for HCs, NVs and VSs, respectively. Thus, the impairment indexed by this dimension was specific to NVs, who differed significantly from the other two groups. Using a cross-validation approach, we correctly classified with these canonical dimensions 90.3% of HCs, 83.3% of VSs and 85.7% of NVs. **Conclusion:** Violent patients were characterized by a multivariate combination of impulsivity, psychopathy, cognitive difficulties and specific impairment in the recognition of fearful expressions. Nonviolent patients presented with perseverative errors on the WCST and nonspecific difficulties in emotion recognition. This classification has important implications for the integrated management of violent behavior in clinical practice.

MAY 17, 2016

FURTHER TOPICS IN BIOLOGICAL PSYCHIATRY

NO. 1

VAGAL ACTIVITY PREDICTS SURVIVAL IN WOMEN WITH ADVANCED BREAST CANCER

Speaker: David Spiegel, M.D.

Co-Author(s): Janine Giese-Davis, Ph.D., Frank H. Wilhelm, Ph.D., Rie Tamagawa, Ph.D., Oxana Palesh, Ph.D., Eric Neri, B.S., Craig Barr Taylor, M.D., Helena C. Kraemer, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Evaluate cardiovascular and respiratory measures of vagal activity; 2) Understand the relationship between vagal activity and breast cancer progression; and 3) Understand the relationships among vagal activity, inflammation and cancer progression.

SUMMARY:

Objective: High-frequency heart rate variability (HF-HRV) is an accepted measure of parasympathetic nervous system functioning. Higher levels of HF-HRV have been associated with longer survival in patients with myocardial infarction and acute trauma, as well as among patients undergoing palliative care. Animal studies have shown a connection between higher vagal activity and both better immune system

functioning and reduced metastases. We hypothesized that higher HF-HRV would predict longer survival in patients with metastatic or recurrent breast cancer (MRBC). **Methods:** Eighty-seven patients with MRBC participated in a laboratory task including a five-minute resting baseline electrocardiogram. HF-HRV was computed as the natural logarithm of the summed power spectral density of R-R intervals (0.15–0.50 Hz). We tested the association between resting baseline HF-HRV and survival using Cox proportional hazards models. This was a secondary analysis of a study that had demonstrated that steeper (more normal) diurnal cortisol slope predicted longer survival. **Results:** A total of 50 patients died during a median follow-up of 7.99 years. Higher baseline HF-HRV predicted significantly longer survival, hazard ratio 0.75 (95% confidence interval (CI)=0.60–0.92, $p=0.006$). Visceral metastasis status and baseline heart rate were related to both HF-HRV and survival. In addition, a combination of HF-HRV and heart rate further improved survival prediction, with a hazard ratio of 0.64 (95% CI=0.48–0.85, $p=0.002$). **Conclusion:** Vagal activity of patients with MRBC strongly predicted their survival, extending the known predictive window of HF-HRV beyond palliative care to cancer. Vagal activity can be altered through behavioral, pharmacological and surgical interventions and thus may be a promising target for increasing survival in patients with metastatic cancer.

NO. 2

SERUM LEVELS AND MRNA EXPRESSION OF NEUROTROPHIC FACTORS AND RELATED RECEPTORS ARE CRUCIAL IN DIFFERENT SUBTYPES OF DEPRESSION

Speaker: Yingying Yue, M.Med.

Co-Author(s): Haitang Jiang, M.M., Rui Liu, M.D., Yingying Yin, M.M., Yuqun Zhang, M.M., Jinfeng Liang, M.M., Shenghua Li, B.S., Jun Wang, B.S., Jianxin Lu, B.S., Deqin Geng, M.M., Aiqin Wu, M.M., Yonggui Yuan, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Investigate the serum levels and mRNA expression of neurotrophic factors in PSD patients; 2) Investigate the relationships between neurotrophic factors; and 3) Explore the different expression between post-stroke depression and major depressive disorder.

SUMMARY:

Background: Previous studies suggest that neurotrophic factors participate in the development of stroke and depression. However, the change of these factors in post-stroke depression (PSD) and the discrepancy between PSD and major depressive disorder (MDD) are unclear. **Methods:** 159 individuals, including PSD, stroke without depression (Non-PSD), MDD and normal controls (NC), were recruited and examined for the protein and mRNA expression levels of vascular endothelial growth factor (VEGF) and its receptor (VEGFR2), placental growth factor (PIGF), and insulin-like growth factor (IGF-1) and its receptor (IGF-1R). The chi-square test, nonparametric test and one-way analysis of variance were applied to general characteristics and biological changes. In order to explore the role of these factors in different types of depression, binary logistic regression analysis and receiver operating characteristic (ROC) curve were calculated for the PSD and MDD groups. **Results:** The four groups had statistical differences in neurotrophic factors ($p < 0.05$) except VEGF concentration and IGF-1R mRNA ($p = 0.776$ and 0.102 respectively). In logistic analysis, serum PIGF concentration and VEGFR2 transcription were independent predictors of PSD (OR = 1.474 95% CI [1.158, 1.877], $p = 0.002$ and OR = 8.025 95% CI [1.728, 37.262], $p = 0.008$, respectively). Further analysis of ROC found that two factors could respectively serve as a prognostic sign with an area under curve of 0.905 (95% CI [0.839, 0.971], $p < 0.001$) and 0.812 (95% CI [0.718, 0.907], $p < 0.001$). **Conclusion:** This study was first to explore the neurotrophic factors in different types of depression and intriguingly demonstrated PIGF and VEGFR2 might serve as novel indicators in distinguishing subtypes of depression.

NO. 3

HYPOTHALAMIC GASTRIN-RELEASING PEPTIDE RECEPTOR MEDIATES AN ANTIDEPRESSANT-LIKE EFFECT IN A MOUSE MODEL OF STRESS

Speaker: Lihua Yao, M.Psy.

Co-Author(s): Janxin Chen, Hexiang Chen, Dan Xiang, Can Yang, Ling Xiao, Wanhong Liu, Huiling Wang, Gaohua Wang, Fan Zhu, Zhongchun Liu

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the feasibility and effectiveness of the mice depression model established by CUMS; 2) Recognize that GRPR was implicated in depression and plays an important role

in depression; and 3) Explore new therapeutic targets of depression focused on GRPR signaling.

SUMMARY:

Objective: Evidence has shown that gastrin-releasing peptide receptor (GRPR) is involved in responses to stress and anxiety. The primary role of GRPR is to stimulate corticotrophin-releasing hormone (CRH) or adrenocorticotrophic hormone (ACTH) secretion. Thus, the mechanisms of GRPR signaling should be elucidated to discover novel therapeutic targets for treating depression. This study investigated GRPR alterations in the C57 mouse hypothalamus after the animals were subjected to stress and fluoxetine treatments. **Methods:** We subjected mice to isolation and chronic unpredictable mild stress (CUMS) for three weeks to establish an experimental model of depression. These mice were subsequently treated with fluoxetine for three weeks. Then, we performed the sucrose preference test and the open field test and measured food intake and body weight to explore the effects of stress and fluoxetine on activity and anhedonia. After fluoxetine treatment, we also assessed changes in the levels of GRPR expression in the hypothalamus using immunohistochemistry, western blotting and real-time quantitative PCR (RT-PCR). **Results:** We found that stressed mice showed significant reductions in locomotion, food intake/body weight and sucrose preference; these reduced parameters indicated a state of anhedonia. Marked increases in mRNA and protein expression of GRPR in the hypothalamus of CUMS-exposed mice were also observed, although treatment with fluoxetine reversed these stress-induced changes. Our results also demonstrated the feasibility and effectiveness of the C57 mouse model of depression established by CUMS and isolation. After fluoxetine treatment was administered, the animals' depressive symptoms were alleviated, and these behavioral alterations were accompanied by specific changes in mRNA and protein expression of GRPR in the hypothalamus. **Conclusion:** These results suggest that GRPR may be implicated in depression; therefore, new therapeutic targets of depression focused on GRPR signaling should be explored.

NO. 4

PROSPECTIVE VALIDATION STUDY OF THE PREDICTION OF ALCOHOL WITHDRAWAL SEVERITY SCALE (PAWSS): A NEW TOOL FOR THE PREDICTION OF PATIENTS AT RISK FOR AWS

Speaker: Jose R. Maldonado, M.D.

Co-Author(s): Yelizaveta Sher, M.D., Kelsey Hills-Evans, M.D., Smita Das, M.D., Ph.D., Anna Frenklach, M.D., Sermsak Lolak, M.D., Rachel Talley, M.D., Eric Neri, B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the prevalence of alcohol abuse and withdrawal among medically ill individuals and the extent to which it affects medical care and outcomes; 2) Review the detrimental causes of alcohol withdrawal syndrome and the importance of early prophylaxis; and 3) Understand the psychometric properties and clinical potential of PAWSS.

SUMMARY:

Background: Alcohol withdrawal-related seizures occur in about 5–17% of subjects. Delirium tremens (DT) occurs in 10% of patients with alcohol withdrawal syndrome (AWS), resulting in death in up to 20% of cases with certain medical comorbidities. AWS is associated with increases in hospital morbidity and mortality, prolongation in hospital stays, inflated costs, increased burden on nursing and medical staff, and worsened cognitive functioning. Thus, appropriate identification and prevention of severe AWS in subjects at risk can greatly benefit patients by reducing the risk of brain damage and associated neurocognitive decompensation, medical comorbidities, and length of stay. **Methods:** We identified factors associated with AWS severity through a systematic literature review (using PRISMA guidelines). This led to the development of a 10-item scale to predict alcohol-dependent patients at risk for developing moderate to severe AWS (i.e., seizures and DT). A previous pilot study (n=69) demonstrated 100% sensitivity and specificity. The present study is a large (n=409), prospective trial of medically ill subjects consecutively hospitalized in the general medicine units of a large university hospital between May 2012 and April 2013 to test the validity and reliability of the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) in detecting medically ill inpatients at risk for complicated AWS. Subjects were assessed using the PAWSS while independently assessed daily by nurses with the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar), along with clinical monitoring of autonomic system functioning throughout their admission to determine the presence and severity of AWS. Examiners were blind to each other's findings. Careful review of

patient charts allowed us to determine exactly how much medication every patient received. **Results:** 409 patients were tested and grouped by PAWSS score: Group A included those with a PAWSS score less than four and were considered to be at low risk for AWS, while subjects in Group B obtained a PAWSS score higher than four and were considered at high risk for complicated AWS. Two patients in Group A had elevated CIWA-Ar scores or were treated for AWS. As predicted, all but two subjects in Group B required pharmacological treatment for AWS. The results of this study suggest that, using a PAWSS cutoff of four, the tool's sensitivity is 93.5%, specificity is 99.5%, positive predictive value is 93.5% and negative predictive value is 99.5%. **Conclusion:** The results of this prospective study show that PAWSS appears to have excellent psychometric characteristics and predictive value among medically ill inpatients. We propose that PAWSS will help clinicians identify those at risk for moderate to severe AWS and allow them to initiate prophylactic treatment to those at high risk and thus minimize the potential detrimental consequences of AWS and potentially minimize kindling and recidivism of alcohol abuse.

MEASUREMENTS AND SCALES

NO. 1

A SCALE OF PARTNER ADDICTION: UNDERLYING MECHANISMS IN REWARD DEFICITS AND INSECURE ATTACHMENTS AND MANIFESTATIONS IN CLINICAL ISSUES

Speaker: Jacob Mills, B.S.

Co-Author(s): Marc A. Lindberg, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the behavioral and neurological similarities of partner versus substance dependence; 2) Understand the concept of partner addiction and its underlying mechanisms and developmental precursors; 3) Understand the clinical manifestations of partner addiction; and 4) Effectively use the partner addiction screen in clinical practice and research.

SUMMARY:

Background: In line with the reward-deficit model of addiction, recent research has suggested that romantic relationships could take on addictive elements. The purpose of this study was to develop a scale of partner addiction that could demonstrate

excellent discriminate and convergent evidence as well as identify the developmental precursors to such an addiction. **Methods:** Volunteer undergraduate students (n=491) completed two partner addiction scales developed here, as well as a host of other measures, including the Attachment and Clinical Issues Questionnaire (ACIQ), the CAGE measure of alcohol abuse and the DCAGE measure of drug abuse, two tests of borderline personality disorder, measures of partner abuse, and the Adverse Childhood Experiences Questionnaire(ACE). **Results:** Strong concurrent evidence was found, with substantial correlations between the partner addiction scales and the mixed attachment measures of the ACIQ; psychological, physical and sexual abuse while growing up as measured by the ACE; similar patterns of abuse from partners; the borderline scales; and a multitude of clinical issues such as anger, anxiety, need for control, denial of feelings, jealousy, rumination, perfectionism, shame and mistrust. These results demonstrate the ability of the partner addiction scales to predict a plethora of clinically relevant symptomology and insecure attachment patterns. Furthermore, stepwise regression analyses revealed that the best predictors of partner addiction were insecure partner attachments and emotional partner abuse. In summary, the scales of partner addiction tap the expected highs and lows of addiction described in the reward-deficit model, and these measures predict a whole host of psychiatrically relevant dimensions. In terms of developmental precursors, path models will be presented outlining the developmental course of partner addictions coming from the ACE to parent insecure attachments, mixed partner attachments and the partner addiction scale. **Conclusion:** The best partner addiction scale will be presented and discussed in terms of clinical practice and research. This is very important because many experiencing this type of relationship may falsely present as happy in their partner relationship, thereby masking and/or interfering with the treatment of partner abuse, addictions and personality disorders.

NO. 2

SELF-MONITORING AND PSYCHOEDUCATION IN BIPOLAR PATIENTS WITH A SMARTPHONE APPLICATION (SIMPLE) PROJECT: PRELIMINARY RESULTS FROM A FEASIBILITY STUDY

Speaker: Eduard Vieta, M.D., Ph.D.

Co-Author(s): Andrea Murru, María Reinares, Ainoa Mateu, Eduard Vieta, Francesc Colom.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Briefly present the background of the SIMPLE project, the application design process—using user-centered frameworks—and the study protocols to test its feasibility, safety and efficacy; 2) Report the results of the feasibility study's recruitment phase using the SIMPLE app and discuss the implications for future similar projects regarding mobile systems OS fragmentation; and 3) Describe the baseline characteristics of the participants of the feasibility study alongside the preliminary results of the application usage patterns according to the clinical correlates.

SUMMARY:

Background: The SIMPLE project was designed with the objective of developing an app that could monitor and psychoeducate bipolar disorder patients through highly personalized messages from both passive and active sources. The project was based on a face-to-face group program, which has increasing scientific evidence of its efficacy and cost-effectiveness reducing bipolar disorder relapses.

Objective: The main objective of the project is to provide the patient with a cost-efficient tool that can provide a friendly, long-term personalized psychoeducation program in order to prevent relapse. A secondary long-term objective of the SIMPLE project is to integrate clinical correlates, biomarkers and genetics with the mobile behavior information collected in order to determine predictive relapses patterns. **Methods:** The phases of the SIMPLE project involved an iterative process with the active participation of both patients and mental health professionals in the following order: 1) User-centered application development; 2) Feasibility study; and finally, after further improvements, 3) Randomized clinical trial assessing relapse prevention. We present preliminary data from the feasibility study, which was conducted from March 2015 to June 2015. Participation in the study was offered to a consecutive sample of adult patients diagnosed of bipolar disorder I, II or not otherwise specified (NOS) attending the outpatient mental health clinic of the Hospital Clinic of Barcelona, Spain. Their usual psychiatrist explained briefly the aim of the study and offered an invitation. If the patient agreed to participate, they then signed an informed consent. They were assisted to install the application, and basic information about its use was provided. An anonymized username and

password was given to access the app. **Results:** Participation in the study was offered to 72 stable bipolar patients. Forty-three (59.8%) subjects with a mean age of 42.5 years accepted and were enrolled in the study. Two patients did not activate the application after the first interview or used it only once and were considered early dropouts. Among the active participants, 65.9% (n=27) were diagnosed with type I bipolar disorder, 24.4% (n=10) with type II bipolar disorder and 9.8% (n=4) NOS. 56.8% were male. A significant percentage of the patients had a high educational level (40.5%), while 40.5% and 16.2% had medium and low levels, respectively. Since the day the patients were enrolled in the study, the rate of completed daily tests was 0.74 per day and 1.13 per week. A total of nine emergency alerts were received through the application and referred to the patient's psychiatrist. Ninety-five percent of the initial participants remained actively using the app during the three-month study period, during which no relapses were identified. **Conclusion:** These preliminary results suggest a high feasibility of the SIMPLE app on rates of task completion and retention.

NO. 3

THE PROXY TEST FOR DELIRIUM (PTD): A NEW TOOL FOR THE SCREENING OF DELIRIUM BASED ON DSM-5 AND ICD-10 CRITERIA

Speaker: Jose R. Maldonado, M.D.

Co-Author(s): Yelizaveta Sher, M.D., Rachel Talley, M.D., Vidushi Savant, M.D., Renee Garcia, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the most significant differences between DSM-5, ICD-10 and prior delirium diagnosis criteria; 2) Understand the psychometric properties of the new instrument, PTD, as a tool for the screening of delirium in medically ill individuals; and 3) Understand the benefits of using standardized tools, such as PTD, in the prompt identification of patients with delirium to allow for timely intervention and treatment.

SUMMARY:

Background: Delirium is the most prevalent psychiatric disorder found in the general medical setting. It is associated with increased morbidity and mortality, increased health care costs, and a range of other negative outcomes among medically ill patients. While several validated tools are currently used to screen for delirium in the hospital setting,

studies have shown that delirium is misdiagnosed or not detected in over 50% of case across various health care settings, up to 85% in the ICU. This may be partly due to the reliance of these validated tools on the patient's report of symptoms or active participation in the delirium screening tool itself. Instead, a screening tool relying on the observations of nursing staff could potentially provide a more accurate assessment of patient symptoms. **Methods:** We developed a new tool for the recognition of delirium, the Proxy Test for Delirium (PTD), combining DSM-5 and ICD-10 criteria. The instrument was developed in collaboration with members of the nursing staff who assisted in the development of test items and prompts. The PTD eliminates the need for direct patient participation in the assessment; instead, nurses complete the tool at the end of their shift, thus using the full-shift patient interaction to gain the information needed to diagnose delirium. In this pilot study, the PTD is evaluated as compared to a validated tool (i.e., the Confusion Assessment Method [CAM]) and clinical assessment (i.e., DSM-5 criteria). We hypothesize that the PTD will have superior predictive value as compared to these other measures. Patients admitted to the neurology and neurosurgical units were separately and blindly screened for symptoms of delirium utilizing the PTD (performed by the patient's nurse), the CAM (performed by a PM fellow) and a clinical neuropsychiatric evaluation based on DSM-5 criteria (performed by a PM specialist). **Results:** All patients admitted to G1 and H1 were approached for participation in the study. The only exclusion criteria were a patient's unwillingness to participate or their inability to communicate effectively in English. A total of 227 subjects were blindly assessed during the duration of the study. The results suggest that when a cutoff score of three or more is used, the PTD has a sensitivity of 79% and a specificity of 91%. After an initial training period of two weeks, it took the average nurse less than one minute to complete the questionnaire. Nurses reported "liking" the PTD better than the CAM and being "more willing" to complete the PTD than the CAM. The study was approved by Stanford's IRB Committee. **Conclusion:** This is the first diagnostic tool for delirium based on DSM-5 and ICD-10 criteria. The tool is easy to use yet comprehensive and eliminates the problem of a patient's inability to cooperate in the examination. The use of observation-based tools, such as PTD, may enhance the early recognition and diagnosis of delirium.

MARIJUANA AND OPIATES

NO. 1

REASONS FOR RELAPSE AND NATURAL QUITTING IN ADULT RECREATIONAL CANNABIS SMOKERS

Speaker: David Gorelick, M.D., Ph.D.

Co-Author(s): Emeline Chauchard, Ph.D., Kenneth H. Levin, M.D., Marc L. Copersino, Ph.D., Stephen J. Heishman, Ph.D., Fang Liu, M.S., Deanna L. Kelly, Pharm.D., Douglas L. Boggs, Pharm.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize individuals more likely to successfully quit recreational cannabis use without formal treatment (natural recovery); 2) Identify motivational factors and coping strategies that help individuals quit cannabis use without formal treatment; and 3) Understand the role of cannabis withdrawal in relapse during natural recovery attempts.

SUMMARY:

Background: Epidemiological data suggest that many cannabis users quit without formal treatment (natural or spontaneous recovery). **Methods:** We collected retrospective self-report data by computer-administered questionnaire from a convenience sample of 385 community-living adult recreational cannabis smokers (58% men, 80% African American) who had made at least one quit attempt within the prior five years without formal treatment and while not in a controlled environment. Backward stepwise Cox proportional hazard regression analysis was used to identify subject characteristics associated with duration of abstinence and abstinence status at time of study interview. Characteristics included sociodemographic factors, cannabis use history, substance use during the six months prior to the quit attempt, motivations for quitting and coping strategies used to maintain abstinence. **Results:** Subjects were a mean 28.0 (SD=9.3) years old (range 16–64 years) at the start of their quit attempt and had been using cannabis for 13.2 (SD=9.1) years (range 1–42 years). Over the prior six months, 66% smoked daily, 30.6% weekly and 3.4% monthly. 42.6% had little or no confidence that they would succeed in quitting. The index quit attempt lasted 5.6 (SD=9.6) months (median 2; range 1 day–5 years). The most frequently reported reasons for relapse were missing the psychological effects of

cannabis (50%), to feel less bored (38%) and to relax (38%). The most frequently reported coping strategies were getting rid of cannabis (63%) and paraphernalia (53%), avoiding places where cannabis is smoked (56%), not associating with cannabis users (52%), and family encouragement (45%). Subjects who maintained abstinence until the time of interview (46 [12%]) were older (31.7 [SD=10.5] vs. 27.5 [SD=9.0] years) and used fewer days in the prior month (18.8 [SD=11.3] vs. 23.2 [SD=10.2]) than those who relapsed (339 [88%]). In the final Cox model, only the following variables had a significant independent association with abstinence status: greater initial confidence in success, motivation to quit because of legal problems and the coping strategy of making changes in their environment were associated with decreased risk of relapse; social support and self-efficacy regarding controlling use were associated with increased risk. No other variables, including reasons for relapse and *DSM-5* cannabis withdrawal or individual withdrawal symptoms, were significantly associated with successful abstinence. **Conclusion:** These findings suggest that many adult recreational cannabis smokers experience difficulty quitting without formal treatment, but those with high initial confidence in success who avoid environmental cues associated with cannabis use are more likely to be successful. This research was supported by NIH/NIDA/IRP, NIDA Contract HHSN271200599091CADB, and French Interministerial Mission for the Fight against Drugs and Drug Addiction (MILDT).

NO. 2

GENERATING MEDICAL MARIJUANA GUIDELINES AT YOUR INSTITUTION

Speaker: Ilana M. Braun, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recount the scientific evidence base for use of medical marijuana; 2) Discuss the tension between federal and state laws; and 3) Begin generating medical marijuana guidelines or policies at their institutions.

SUMMARY:

Background: While remaining federally illegal, medical marijuana is permissible in 23 states and the District of Columbia. The scientific evidence base for cannabis' medicinal utility is in its infancy. **Methods:** Spearheaded in part by a psychiatrist, the largest

hospital system in Massachusetts assembled a multidisciplinary team drawn from across the enterprise. This workgroup completed comprehensive scientific literature and judicial reviews. It then generated medical marijuana guidelines reflecting the federal legal climate, the Massachusetts legislation and the scientific evidence base. **Results:** The workgroup's conclusions were as follows: 1) Marijuana remains federally illegal, and providers who recommend it assume a small if tolerable degree of legal risk; 2) Registered marijuana dispensaries offer only nonpharmaceutical-grade cannabis; 3) With the exception of neuropathic pain, the scientific evidence base for this product is immature; 4) There is a concerning lack of coherence between the scientific evidence base and regulations in several states, including Massachusetts; 5) The immature evidence base does not negate the exciting medicinal potential of cannabis-based and cannabis-like products. **Discussion:** The medical marijuana guidelines remind health care providers that they are under no obligation to issue certifications; encourage them to exhaust conventional symptom management approaches before considering nonpharmaceutical-grade cannabis; school prudence with regard to patients with milder forms of qualifying conditions or with conditions without a strong evidence base; request that providers avoid recommending medical marijuana regularly or as the bulk of practice; ask that they communicate to their patients indications, risks, benefits, alternatives and duration of certification; recommend that they warn patients not to operate heavy machinery while under the influence; encourage consideration of baseline and/or periodic drug testing and, in the case of patients with addiction history, psychiatric consultation prior to certifying; and emphasize the need for caution if the patient has a history of psychosis. Finally, the guidelines outline that hospitals will neither dispense nor provide funds for medical marijuana and prohibit marijuana in any form on hospital premises. **Conclusion:** Registered marijuana dispensaries offer only nonpharmaceutical-grade cannabis, with fewer quality controls than pharmaceutical-grade cannabinoids. The scientific evidence base for medical marijuana is immature. While there is some exciting research supporting its utility for neuropathic pain, other purported indications for nonpharmaceutical cannabis are based on anecdotal evidence or extrapolation from research on

synthetics or pharmaceutical-grade herbal preparations.

NO. 3

LONG-TERM OUTCOMES FROM THE NATIONAL DRUG ABUSE TREATMENT CLINICAL TRIALS NETWORK PRESCRIPTION OPIOID ADDICTION TREATMENT STUDY

Speaker: Roger D. Weiss, M.D.

Co-Author(s): J. S. Potter, M. L. Griffin, S. E. Provost, G. D. Fitzmaurice, K. A. McDermott, E. N. Srisarajivakul, D. R. Dodd, J. A. Dreifuss, R. K. McHugh, K. M. Carroll

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the scope of the problem of prescription opioid dependence; 2) Understand the role of buprenorphine and counseling in the long-term course of prescription opioid dependence; and 3) Understand the impact of any heroin use on the course of prescription opioid dependence.

SUMMARY:

Background: Despite the growing prevalence of prescription opioid dependence, no longitudinal studies to date have examined long-term response to treatment in this population. The current study thus examined outcomes over a 42-month follow-up period among participants from the Prescription Opioid Addiction Treatment Study (POATS), conducted through the NIDA Clinical Trials Network. **Methods:** POATS was a multisite randomized clinical trial of buprenorphine-naloxone and counseling for prescription opioid dependence. A subset of participants (n=375/653) enrolled in a follow-up study. Measures of opioid and other substance use and treatment utilization were administered by telephone interviews approximately 18, 30 and 42 months after enrollment in the main trial. **Results:** The majority of follow-up participants were no longer opioid-dependent at month 18; fewer than 10% met criteria for current opioid dependence at month 42. Participants who reported a lifetime history of heroin use at study entry were more likely to be opioid-dependent at month 42 (OR=4.56, 95% CI=1.29–16.04, p<0.05). Sixty-one percent reported past-month abstinence from opioids at month 42. Approximately one-third of the sample received opioid agonist treatment during follow-up; engagement in agonist treatment was associated with a greater likelihood of abstinence at month 42.

Eight percent (n=27/338) used heroin for the first time during follow-up; 10.1% reported first-time injection heroin use. **Conclusion:** Long-term outcomes for those dependent on prescription opioids demonstrated clear improvement from baseline. However, a small subgroup of participants exhibited a worsening course, characterized by the initiation of heroin use and/or injection opioid use.

FURTHER TOPICS IN SCHIZOPHRENIA

NO. 1

FLUCTUATION IN COGNITIVE FUNCTIONING IN COMMUNITY-DWELLING OLDER ADULTS WITH SCHIZOPHRENIA: IMPLICATIONS FOR TREATMENT

Speaker: Carl I. Cohen, M.D.

Co-Author(s): Tessa Murante, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the differences in cross-sectional and longitudinal data of cognition in older adults with schizophrenia; 2) Understand the clinical implications of cognitive changes in older adults with schizophrenia; and 3) Understand that schizophrenia in later life is not a quiescent or stable end-stage but one of flux and potential for change.

SUMMARY:

Background: There are limited longitudinal data concerning cognitive functioning in older adults with early-onset schizophrenia in the community. These studies have generally found stability in cognitive functioning. However, the studies did not examine “within-group” changes and thus may have provided a distorted view of cognitive stability. This study will present cross-sectional and longitudinal data concerning cognition and associated variables among community-dwelling older adults with early-onset schizophrenia in NYC. **Methods:** The initial sample consisted of 250 outpatients with schizophrenia spectrum disorders aged 55 and over who developed the disorder prior to age 45. Data on 104 follow-up interviews are presented. Mean follow-up was 54 months (range=12–116 months); mean age was 61 years, 55% were male and 55% were white. The Dementia Rating Scale (DRS) was used to assess cognition. There were no differences in the DRS and other relevant variables between the participants and dropouts. A normal community group (n=113) was used for baseline comparisons. **Results:** After controlling for education, there were significant differences between the comparison (C)

and schizophrenia (S) groups in the total DRS (C=138, S=128) and in all subscales except construction. In the S group, there were no significant changes in the mean DRS or its mean subscale scores over time; however, only 59% showed less than a 0.5 SD/year increase in their DRS scores, and 21% and 19% showed 0.5 SD/year declines and improvements, respectively. The greatest within-group fluctuations were in the memory and initiation/perseveration subscales, and the least fluctuations were in the attention and construction subscales. Twenty-three demographic, clinical and social predictor variables were initially examined; however, in nominal regression analysis, only residential status (living independently) predicted decline, and only baseline DRS predicted improvement. **Conclusion:** Although older community-dwelling persons with schizophrenia have diminished cognitive functioning versus their age peers, they do not show substantial cognitive decline in later life, with only one-fifth declining by greater than 0.5 SD/year. Importantly, cognitive functioning is not stable in later life. Although cross-sectional group means for the S group remained stable, there was considerable flux in cognitive status over time. Nearly two-fifths of the sample moved higher or lower (>0.5 SD/year change in DRS), with roughly equal proportions of persons moving in either direction. These results highlight the potential value in expanding cognitive remediation programs tailored to the needs and capabilities of aging individuals with schizophrenia. Recent pilot studies targeting cognitive functioning in this population can serve as the foundation to develop new programs.

NO. 2

MULTIPLE RETINAL PATHOLOGIES IN SCHIZOPHRENIA

Speaker: Selin Acar, B.S.

Co-Author(s): Henry A. Nasrallah, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the complexity of visualizing brain pathology; 2) Discuss the described retinal pathologies in schizophrenia; and 3) Recite the benefits of utilizing retinal pathology as a possible biomarker for schizophrenia and provide insights for future research.

SUMMARY:

Background: In addition to being a critical component of the visual system, the retina provides

the opportunity for an accessible and noninvasive probe of brain pathology in neuropsychiatric disorders. Several studies have reported various retinal abnormalities in schizophrenia, some primary and others treatment-related. There is now increasing evidence supporting the existence of retinopathy in schizophrenia across structural, neurochemical and physiological parameters. Here, we review and synthesize the types of retinal pathology in schizophrenia and discuss how these findings may provide novel insights for future research into the neurodevelopmental neurobiology of this syndrome. **Methods:** Using the keywords schizophrenia, retina and pathology on PubMed, we reviewed all studies in the English language within 30 years. We examined methods and identified common themes. **Results:** We classified the reports of retinal pathology into primary and secondary. The major secondary retinal pathology is related to the iatrogenic effects of a once widely-prescribed first-generation antipsychotic (thioridazine), which was found to be associated with retinal pigment deposits, decreased visual acuity and suppression of dark adapted electroretinogram (ERG) responses. The primary retinal findings, determined from both cross-sectional and prospective studies, were obtained primarily using ERG, optical coherence tomography and microvascular imaging. Some of the findings were replicated, but there were some inconsistencies in the literature. The most consistent findings were 1) Decreased ERG wave amplitudes; 2) Reduced macular volume; 3) Thinning of retinal nerve fiber quadrants; and 4) Widened venule caliber. **Conclusion:** The abnormal findings of the retina in schizophrenia may represent an important avenue for elucidating some of the neurodevelopmental aberrations in schizophrenia. The replicated retinal pathologies could serve as biomarkers for schizophrenia and perhaps an endophenotype that may help identify at-risk individuals. Further research in the retinal pathologies in schizophrenia and other psychotic disorders is certainly warranted.

NO. 3

THE MISSING LINK: ROLE OF HUMAN ENDOGENOUS RETROVIRUSES IN SCHIZOPHRENIA

Speaker: Awais Aftab, M.B.B.S.

Co-Author(s): Asim A. Shah, M.D., Ali Madeeh Hashmi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize that human endogenous retroviruses (HERVs) are candidates to explain the missing links between the genetic, infectious, neurodevelopmental and neuroinflammatory aspects of schizophrenia; 2) Learn about the existing evidence linking HERV-W RNA and protein expression in schizophrenia; and 3) Appreciate the hypothesized pathophysiological mechanisms leading from activation of HERV-W elements by infections to the neuroinflammation underlying development of schizophrenia.

SUMMARY:

Background: Evidence indicates that genes, environmental risk factors such as maternal infections during pregnancy, inflammatory processes and neurodevelopmental abnormalities all play a role in schizophrenia. These aspects are all likely interrelated, and human endogenous retroviruses of the W family (HERV-W) have been presented as possible candidates explaining the connections between these various threads. **Methods:** A literature search on PubMed used the search words "schizophrenia" and "HERV" or "Human Endogenous Retroviruses" or "Endogenous Retroviruses" appearing in the titles and abstracts of journal articles with no restriction on date of publication. There were 32 results, with publication dates ranging from 1999 to 2014. Eight studies investigating the role of HERV-W in schizophrenia were identified. Identified review papers were also studied. **Discussion:** HERVs are evolutionary archeological remains of retroviral infections that occurred several million years ago during the course of mammalian evolution. Most HERV elements are no longer active and have traditionally been ascribed to be a part of "junk DNA." Some HERV elements, however, retain (partial) functionality. Of particular note is an HERV-W element on chromosome 7q21 that possesses an intact env gene, encoding for the protein syncytin. HERV-W was first discovered during investigation into the role of retroviruses in multiple sclerosis. Several studies have investigated the association between HERV-W and schizophrenia. These studies have identified HERV-W RNA expression in human cortices (postmortem), CSF, plasma, mononuclear blood cells and HERV-W proteins in serum in a significantly greater number of patients with schizophrenia spectrum disorders compared to controls. These studies also suggest that HERV-W transcriptional activity may be related to severity of psychotic symptoms, that HERV-W

antigenemia is correlated with inflammatory markers and that overexpression of HERV-W env upregulates brain-derived neurotrophic factor, neurotrophic tyrosine kinase receptor type 2 and dopamine receptor D3. It has been shown that infections such as influenza, herpes simplex virus, cytomegalovirus and toxoplasma can activate HERV-W elements. They may do so directly by transactivating promoters or by demethylation of target genes, rendering them capable of responding to transactivating stimuli. Activation of HERV-W genetic elements will cause retrotransposition (accounting for various genetic modifications) and induction of neuroinflammation. This can also lead to developmental, cognitive and neurostructural deficits that have been reported in schizophrenia, even in prodromal and first-episode psychosis. It is acknowledged that the pathophysiological links between HERV elements and development of schizophrenia are highly speculative, and the need for further investigation is highlighted before any conclusions can be stated with confidence.

MAY 18, 2016

PTSD AND STRESS

NO. 1

NEURAL ALTERATIONS IN RECALLING THE PAST AND IMAGINING THE FUTURE IN PTSD

Speaker: Adam Brown, Ph.D.

Co-Author(s): Nathan Spreng, Christina Fales, Jingyun Chen, Nicole Kouri, Nadia Rahman, Donna Rose Addis, Daniel Schacter, Richard Bryant, Charles Marmar

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about how memory and future thinking are altered in PTSD; 2) Demonstrate neural alterations associated with memory and future thinking; and 3) Discuss ways that treatments for PTSD would benefit from strategies that address maladaptive future thinking.

SUMMARY:

Among the many disorders classified in the *Diagnostic and Statistical Manual of Mental Disorders*, post-traumatic stress disorder (PTSD) is distinctive in that its diagnosis is linked to a precipitating event. Since PTSD symptoms often persist long after exposure to the stressor, research and therapeutic interventions for PTSD often focus

on memory as a key factor in the pathogenesis of the disorder. In addition to those memory-related alterations identified in the diagnosis of PTSD, such as “recurrent, involuntary, and intrusive memories,” numerous studies have found that individuals with PTSD have difficulty recalling distinct personal memories (overgeneralized autobiographical memory). This phenomenon is believed to underlie the maintenance of the syndrome, as the ability to recall specific personal memories has been associated with treatment outcome. To date, however, studies have yet to examine the neural alterations associated with overgeneralized autobiographical memory in PTSD. Furthermore, a growing body of research suggests that this deficit also extends to future thinking, that is, a number of studies have reported that individuals with PTSD also have difficulty imagining distinct personal future events. This observation accords with converging work from cognitive and brain imaging studies showing that those brain regions involved in recalling one’s personal past overlap considerably with those involved in imagining one’s self in the future. The aim of this study was to elucidate the neural activation patterns associated with overgeneralized autobiographical memory and future thinking in combat veterans with PTSD. While undergoing fMRI scanning, Operation Enduring Freedom/Operation Iraqi Freedom veterans with and without PTSD were presented with 40 positive and 40 negative cue words and were asked to generate past or future personal events. The findings show that individuals with PTSD show similar neural alterations in both autobiographical memory and future thinking. In particular, individuals with PTSD exhibited less activation than those without PTSD in a number of brain regions such as the prefrontal cortex, medial temporal lobe and posterior cingulate cortex. These findings shed further light on the neural mechanisms underlying PTSD. These data also begin to reframe PTSD from a disorder of the past to one that encompasses how patients think about the future. Therefore, therapeutic strategies for PTSD might benefit from a better understanding of maladaptive future thinking, which in turn may help to promote recovery among patients not benefiting from memory-related treatments.

NO. 2

PHARMACOLOGICAL TREATMENT OF COMBAT NIGHTMARES: A VETERAN’S HOSPITAL EXPERIENCE

Speaker: Mark Budd Detweiler, M.D., M.S.

Co-Author(s): Bhuvaneshwar Pagadala, M.D., Joseph Candelario, N.P., Jennifer Boyle, M.D., Brian Lutgens, M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Assess the effectiveness of pharmacological agents prescribed to treat combat nightmares in a veteran affairs medical center; 2) Compare the results of our study to the existing literature; and 3) Offer suggestions for future research based on our study findings.

SUMMARY:

Background: Approximately 300,000 U.S. troops who have been exposed to combat in Iraq and Afghanistan can be diagnosed with depression and/or PTSD. Patients with severe, chronic, combat-related PTSD are more prone to have recurrent trauma-related nightmares. The purpose of our study is to assess the effectiveness of pharmacological agents prescribed to treat combat nightmares in a Veterans Affairs hospital and to compare these results to the existing literature. **Methods:** The electronic records of 2,131 randomly selected veterans from 2009 to 2010 were initially examined, with the last note examined in November, 2013. We only included clinic notes clearly documenting nightmares associated with PTSD, specifying use of particular pharmacological agent(s) and excluding cases where only CBT or other nonpharmacological treatments were used. **Results:** Among 327 patients with 478 separate trials involving 24 individual medications and 16 different combinations, prazosin was used most frequently (106), with a success rate of 49.1%. Among all the combinations, prazosin was used with trazodone and quetiapine equally, with success rates of 40% and 20%, respectively. Among the antipsychotics, risperidone was the most effective, with a partial or full response in 76.5% of cases. Clonidine and terazosin were similar in both frequency and success, with 17 successes for 27 uses (62.9%) and 16 successes for 25 uses (64%), respectively. **Conclusion:** It is possible that prazosin was less effective than in recent reports, as the dosing range was not sufficiently high enough for therapeutic results. Though risperidone was successful in achieving nightmare cessation or reduction in our study, it doesn't replicate the results from other studies where it was not dedicated specifically for nightmare reduction/cessation.

NO. 3

STRESS ACROSS THE LIFE COURSE AND DEPRESSION IN A RAPIDLY DEVELOPING POPULATION: THE GUANGZHOU BIOBANK COHORT STUDY

Speaker: Michael Ni, M.B.B.S., M.P.H.

Co-Author(s): Chaoqiang Jiang, M.D., Kar Keung Cheng, Ph.D., M.B.B.S., Weisen Zhang, M.D., Stephen E. Gilman, Sc.D., Tai Hing Lam, M.D., Gabriel M. Leung, M.D., C. Mary Schooling, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the impact of life course stressors on depression; 2) Demonstrate stress sensitization for depressive symptoms in a developing setting; and 3) Provide evidence that the role of childhood adversities and adulthood stressors in depression are not contextually specific.

SUMMARY:

Objective: To examine the role of stress in the development of depression among older adults in a non-Western developing setting. **Methods:** Multivariable linear and multinomial logistic regression were used in cross-sectional analyses of 9,729 Chinese participants (mean age 60.2 years) from phase 3 of the Guangzhou Biobank Cohort Study (2006–2008) to investigate the association of childhood adversities and adulthood stressors with depression. **Results:** Childhood adversities were associated with mild depression (odds ratio (OR): 1.78, 95% CI=1.58–2.02) and moderate-to-severe depression (OR: 2.30, 95% CI=1.68–3.15), adjusted for age, sex, education and childhood socioeconomic status. Past-year adulthood stressors were also associated with mild depression (OR: 1.96, 95% CI=1.54–2.02) and moderate-to-severe depression (OR: 3.55, 95% CI=2.21–5.68), adjusting additionally for occupation and income. Adulthood stressors were more strongly associated with depressive symptoms among individuals with a history of childhood adversities. **Conclusion:** Childhood adversities and adulthood stressors were independently associated with an increased risk of depression among older ambulatory adults, though adulthood stressors were more strongly associated with depression following exposure to childhood adversities. This is consistent with evidence from Western settings in which the social context of risk and protective factors for depression may differ and implies that the role of stress in the aetiology of depression is not context-specific.

CROSS-CULTURAL PSYCHIATRY

NO. 1

EVIDENCE-BASED PSYCHIATRIC REHABILITATION PRACTICES: ILLNESS MANAGEMENT AND RECOVERY, PSYCHOEDUCATION, AND CASE MANAGEMENT IN KARACHI, PAKISTAN

Speaker: Ajmal Kazmi, M.D., D.P.M.

Co-Author(s): Carlos W. Pratt, Ph.D., C.P.R.P., Russ Smith, M.Sc., C.P.R.P.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand evidence-based psychiatric rehabilitation practices for illness management and recovery, psychoeducation and case management; 2) Plan for implementations of evidence-based practices, particularly illness management and recovery, family psychoeducation, and case management training; and 3) Successfully implement evidence-based practices, particularly illness management and recovery, family psychoeducation, and case management training.

SUMMARY:

Psychiatric rehabilitation enables individuals to compensate for or eliminate the functional deficits, interpersonal barriers and environmental barriers created by disability and to restore ability for independent living, socialization and effective life management. Creating a new program or strategy is an art. Psychiatric rehabilitation is a combination of both a rehabilitation process through consumer choices (involvement) and assessment of readiness through the need for change. Core elements of psychiatric rehabilitation include commitment for change, environmental awareness, self-awareness and closeness to the practitioner. Rehabilitation diagnosis is based on overall rehabilitation goals. Functional assessment includes areas that need work and assessment of a client's strengths and weaknesses. Resource assessment includes availability of the resources. This report describes the collaboration between a comprehensive community mental health facility in Karachi, Pakistan, Karwan-e-Hayat, and the Department of Psychiatric Rehabilitation, University of Medicine and Dentistry of New Jersey (UMDNJ), U.S. This training was fostered and supported by a voluntary U.S.-based organization, Caravan of Life. In the fall of 2008, faculty from UMDNJ provided onsite consultation and training to selected Karwan-e-Hayat staff members and other invited professionals.

The 17-week process was carried out via WebCT (an Internet distance learning platform), Skype, and email. Prior to this training, Professor Smith visited Karwan-e-Hayat to meet staff, interview prospective trainees and learn about the facility. The consultation and training process continues with the eventual introduction of modified evidence-based practices into existing day programming and inpatient services. This report describes 1) The technical aspects of the process, including web-based learning and Skype; 2) The assessment of service needs through their visit and the ongoing consultation and training; 3) Differences and similarities between U.S. evidence-based practices and services at Karwan-e-Hayat; 4) The process from the perspective of Karwan-e-Hayat; 5) Plans for implementations of evidence-based practices, particularly illness management and recovery, family psychoeducation, and case management training; discussion of the Illness Management and Recovery (IMR) group includes questions of appropriate fidelity measures, facilitator training and supervision and methods of ongoing evaluation of the process; and 6) Training of the trainer program through web-based learning and Skype and development of a PsyR training center in Karachi, Pakistan.

NO. 2

A COMPARISON OF STIGMA IN DEMENTIA AND DIABETES AMONG CHINESE AMERICANS

Speaker: Benjamin Woo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the severity of stigma associated with dementia among Chinese Americans; 2) Raise public awareness about the effects of stigma associated with dementia; and 3) Help generate further discussion about stigma and its relationship to dementia among the Chinese-American general public.

SUMMARY:

Background: One of the major barriers in making a diagnosis and managing dementia in the Chinese-American population is the stigma surrounding the disease. The goal of this study is to compare levels of stigma in dementia with diabetes among Chinese Americans. **Methods:** 449 Chinese Americans answered one survey with two self-administered True/False questionnaires assessing attitudes toward dementia and diabetes. Higher scores on the surveys were associated with higher levels of stigma. The

results of the two questionnaires were compared to assess any differences in levels of stigma. **Results:** For the dementia survey, the mean of the scores was 5.58 (95% CI 5.37–5.79) with a standard deviation of 2.31. For the diabetes survey, the mean of the scores was 2.01 (95% CI 1.85–2.18) with a standard deviation of 1.76. The t-test comparing the means scores for each survey was statistically significant ($p < 0.01$). In comparison to diabetic patients, the general public believes that patients with dementia are more likely to lose their jobs, will have greater difficulty in maintaining friends, experience more difficulties in communication with others, are more of a threat to self and others, and are more likely to be institutionalized. **Conclusion:** The higher average score in the Dementia Questionnaire indicates that stigma is more severe in dementia in comparison to diabetes among Chinese Americans. Considering that stigma delays access to health care for dementia-related symptoms, efforts should be taken to minimize stigma associated with dementia.

MENTAL STATE DISORDERS

NO. 1

ANXIETY DISORDERS CO-OCCURRING WITH BINGE EATING DISORDER: SEQUENCE AND ASSOCIATIONS WITH OTHER COMORBIDITIES AND WITH EATING DISORDER PSYCHOPATHOLOGY

Speaker: Daniel F. Becker, M.D.

Co-Author(s): Carlos M. Grilo, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize that anxiety disorders commonly co-occur with binge eating disorder; 2) Identify the correlates of this co-occurrence pattern with respect to eating disorder psychopathology, psychological functioning and psychiatric comorbidity; 3) Identify the significance of onset sequence for binge eating disorder and anxiety disorder with respect to these associations; 4) Understand the potential implications of these relationships for subtyping binge eating disorder; and 5) Apply these findings to the evaluation and treatment of patients with binge eating disorder.

SUMMARY:

Objective: Binge eating disorder (BED) is associated with elevated rates of co-occurring anxiety disorders. However, the significance of this diagnostic comorbidity is ambiguous, as is the significance of the onset sequence for BED and

anxiety disorder. In this study, we compared eating disorder psychopathology, psychological functioning and overall psychiatric comorbidity in three subgroups of patients with BED: those in whom the onset of BED preceded the onset of anxiety disorder, those in whom the onset of anxiety disorder preceded the onset of BED and those without a history of anxiety disorder. **Methods:** Subjects were a consecutive series of 750 treatment-seeking patients (74% women, 26% men) who met *DSM-IV* research criteria for BED. All were assessed reliably with semi-structured interviews in order to evaluate current and lifetime *DSM-IV* psychiatric disorders (Structured Clinical Interview for *DSM-IV* Axis I Disorders–Patient Edition) and eating disorder psychopathology (Eating Disorder Examination). **Results:** In this study group, 89 (12%) subjects had onset of BED preceding anxiety disorder, 182 (24%) had onset of anxiety disorder preceding BED and 479 (64%) had never had an anxiety disorder. These groups did not differ significantly with respect to body mass index or binge eating frequency. Groups did differ with respect to eating disorder attitudes, with both of the anxiety disorder groups demonstrating higher levels of concerns about weight and shape than the group without anxiety disorder ($p < 0.001$). Both anxiety disorder groups also showed higher levels of negative affect ($p < 0.001$), and mood disorders co-occurred more frequently in these two groups ($p < 0.001$). Some differences were observed between groups with respect to age of onset for specific eating behaviors and for the disorders of interest. Compared to the other groups, onset of binge eating began later in the group for which anxiety disorder preceded BED ($p < 0.001$). Compared to the other groups, the group in which BED preceded anxiety disorder had earliest onset of BED, and the group in which anxiety disorder preceded BED had the latest ($p < 0.001$). Although anxiety disorder occurred at a much earlier average age in the group for which anxiety disorder preceded BED, there were no significant differences between groups with regard to onset age for mood or substance use disorders. **Conclusion:** Anxiety disorders occur frequently among patients with BED. We found no differences in levels of eating psychopathology associated with the relative order of onset for these two disorders and no differences in comorbidity rates. We did find that anxiety disorder in combination with BED—with either order of onset—had a clinically meaningful adverse effect on eating psychopathology, psychological functioning and psychiatric comorbidity. These

findings suggest approaches to subtyping BED patients based on psychiatric comorbidity and may also have implications for treatment.

NO. 2

DOES NEGATIVE EMOTIONAL TEMPERAMENT LINK BOTH PUFA CONCENTRATIONS AND CHILDHOOD ADVERSITY TO PERSISTENT DEPRESSIVE SYMPTOMS?

Speaker: William Coryell, M.D.

Co-Author(s): Andrew Norris, M.D., Chadi Calarge, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss relationships between PUFA concentrations, childhood adversity and enduring depressive symptoms; 2) Appreciate the likelihood that these two measures influence depressive symptoms through effects on negative emotional temperament; and 3) Understand the potentially stable relationship between PUFA synthesis and temperament.

SUMMARY:

Objective: To examine relationships between polyunsaturated fatty acid (PUFA) concentrations, childhood adversity, negative emotional temperament and prospectively observed depressive symptoms in a late adolescent/young adult sample. **Methods:** Investigators used a variety of sources to recruit individuals 15 to 20 years old who were within one month of starting a selective serotonin reuptake inhibitor (SSRI) or who were taking no psychotropic medication for a study of the effects of SSRIs on bone mass. After extensive baseline assessments, individuals underwent in-person reassessments after four, eight and 12 months. Baseline phospholipid PUFA concentrations and longitudinal evaluations for the four assessment points were available for 103 individuals. The Early Trauma Inventory Self Report-Short Form (ETISR-SF) measures four types general childhood trauma, and these analyses used the "general trauma" category. The Multidimensional Personality Questionnaire measures four broad traits, and negative emotional temperament was selected for testing here. The Inventory for Depressive Symptomatology (IDS) quantified depressive symptoms at baseline and at each follow-up interview. **Results:** The mean age at baseline assessment was 19.1 (SD=1.4) years, and 67.3% of the participants were female. The childhood trauma measure was not correlated with

omega-3 concentrations (log EPA+DHA) ($r=0.05$, $p=0.494$). With control for age and sex, partial correlations revealed significant associations between the mean IDS scores across the follow-up period and both the amount of childhood general trauma and the individual's omega-3 concentration at the beginning of follow-up. The degree of childhood trauma correlated positively with depressive symptoms ($r=-0.34$, $p=0.016$), and baseline omega-3 concentrations correlated negatively (0.34 , $p<0.001$). Neither of these associations showed any clear change over the individual baseline and follow-up evaluations. Both childhood trauma ($r=0.28$, $p=0.001$) and omega-3 concentrations ($r=-0.22$, $p=0.006$) were also significantly correlated with negative emotional temperament. However, with control for negative emotional temperament, neither the partial correlations between depressive symptoms and omega-3 concentrations ($r=-0.09$, $p=0.377$) or childhood trauma ($r=0.16$, $p=0.115$) remained significant. **Conclusion:** Both childhood trauma and omega-3 phospholipid concentrations were significantly correlated with depressive symptoms over repeated assessments during a one-year follow-up. The associations between depressive morbidity and these two risk factors were largely mediated by their correlations with negative emotional temperament.

NO. 3

POSTPARTUM DEPRESSION, MATERNAL ACCEPTANCE-REJECTION AND CHILD BEHAVIORAL PROBLEMS IN EARLY CHILDHOOD

Speaker: Miriam Schiff, Ph.D.

Co-Author(s): Naama Sulimani, Ruth Pat-Horenczyk, Yuval Ziv

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know the prevalence of postpartum depression in mothers of young children in countries outside the U.S.; 2) Understand the associations between maternal postpartum depression, current depression and child behavioral problems in early childhood; 3) Learn how mother-child relationships and social support contribute to child behavioral problems in early childhood; and 4) Explore potential explanations for ethnicity differences in maternal reports.

SUMMARY:

This study examined the associations between postpartum depression and child internalizing and externalizing behavioral problems in early childhood. The study hypotheses were based on the parental acceptance-rejection theory (PART) and the conservation of resources theory (COR), suggesting that maternal rejection and lower levels of perceived social support will moderate both the associations between postpartum depression and child behavioral problems. We recruited a representative sample of 904 Israeli, Arab and Jewish mothers and their two- to six-year-old children who lived in the sampled household (the “study child”). Maternal mean age was 33.97 (SD=5.78) Most of the mothers were married (91.0%). Child mean age was 3.90 (SD=1.21). About half (52.9%) of the children were male. Mothers reported on postpartum depression with the study child and their current depressive symptoms (CES-D), acceptance-rejection of their child (PARQ), perceived social support (MOS), child’s internalizing and externalizing behavioral problems (CBCL), and background information. The prevalence of reported postpartum depression was 24.5% and 7.4% among Jewish and Arab mothers, respectively ($\chi^2(1)=27.97, p<0.001$). Arab mothers reported higher levels of child internalizing ($F(1,869)=87.95, p<0.001$) and externalizing ($F(1,869)=116.81, p<0.001$) behavioral problems. Hierarchical regressions revealed that after controlling for background variables (ethnicity, maternal age, religiosity and educational level, child’s gender and age), postpartum depression ($\beta=0.13, p<0.001$) and current depressive symptoms ($\beta=0.21, p<0.001$) were found to be significant predictors of a child’s internalizing behavioral problems. Maternal acceptance-rejection ($\beta=0.12, p=0.001$) and perceived social support ($\beta=-0.12, p=0.003$) are significant risk factors so that greater maternal rejection and less support are associated with a higher level of internalizing behavioral problems. None of the interactions were significant. After controlling for background variables, postpartum depression ($\beta=0.10, p=0.002$) but not current depressive symptoms ($\beta=0.06, p=0.053$) were found to be significant predictors of a child’s externalizing behavioral problems. Maternal perceived social support ($\beta=-0.18, p<0.001$) was a significant predictor of a child’s externalizing behavioral problems, but maternal acceptance-rejection was not ($\beta=0.02, p=0.649$). None of the interactions were significant. **Conclusion:** Postpartum depression is associated with child maladjustment for at least the first several years of the child’s life. Although

maternal negative relationships with the child and lack of social support are important risk factors, their buffering role in the associations between postpartum depression and child behavioral problems is still not clear. Differences found by ethnicity will be discussed.

THE BROAD INTEREST OF PSYCHIATRY

NO. 1

UNDOCUMENTED IMMIGRANTS IN PSYCHIATRIC WARDS: A CASE REPORT AND CONCISE REVIEW

Speaker: Mike Wei, B.S.

Co-Author(s): Katherine Lubarsky, Bernadine Han, Janna Gordon-Elliott, Jonathan Avery

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the struggle of undocumented immigrants in America, particularly in the health care system; 2) Understand the impact of undocumented immigrants on health care costs; 3) Understand repatriation as a strategy hospitals use to curb costs when working with undocumented immigrants; and 4) Understand that there is a lack of laws governing repatriation and the dire need for them.

SUMMARY:

The United States has become home to increasing numbers of undocumented immigrants, particularly those from Latin America. While Latino immigrants are relatively healthy upon arrival, they are paradoxically more likely to have poor health and low socioeconomic status after arrival. This decline can be attributed to lack of documentation, difficulty accessing health care, language and cultural barriers, poverty, discrimination, and exploitation by employers. Overall, the U.S. health care system spends roughly \$2 billion a year caring for undocumented immigrants. Three guiding laws govern care for undocumented immigrants: the Emergency Medical Treatment and Active Labor Act (EMTALA), Medicaid and Medicare Conditions of Participation. However, these laws not only provide grossly inadequate compensation for hospitals, but no laws exist governing discharge planning or compensation for long-term care following discharge. Laws governing repatriation are sorely needed—without them, patients are vulnerable to abuse and unethical conduct. We present a case of a Honduran undocumented immigrant presenting to the emergency department following acute

psychosis. Following his stated desire to return, we assisted him with repatriation to Honduras. Given the dearth of publications regarding the intersection of undocumented immigrants in the U.S. with the psychiatric world, we provide a concise review of care of undocumented immigrants.

NO. 2

NORMALIZATION OF INCREASED BACKGROUND NOISE AFTER TREATMENT IN ADHD: A NEURONAL CORRELATE

Speaker: Emanuel Bubl, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) See the potential of the eye in developing a diagnostic marker; 2) Know how treatment acts on background noise; and 3) Understand the clinical relevance of noise as a diagnostic marker.

SUMMARY:

Background: While impulsivity and inattention are well known among the key symptoms of attention-deficit/hyperactivity disorder (ADHD), the neurobiological mechanisms of the disorder are poorly understood. Meanwhile, there is growing evidence for elevated background noise, or non-stimulus-driven neural activity, as a neuronal correlate in ADHD. In analyzing the retina, a distinct neuronal network, we demonstrated an elevated level of background noise at a very early stage in the visual system in untreated patients with ADHD. We hypothesized that this neuropathology may reflect an essential neurobiological correlate in ADHD. To test this hypothesis further, we performed a new study and compared the background noise in patients with ADHD both before and after therapy. **Methods:** Twenty patients with a diagnosis of ADHD were tested both before and after treatment with methylphenidate (MPH). The control group consisted of 20 healthy subjects. In both groups, the retinal background noise was assessed using the pattern electroretinogram (PERG), an electrophysiological measure for retinal ganglion cell function. The PERGs were recorded in a steady state mode in response to checkerboard stimuli of 12 reversals per second. ADHD severity was assessed by interview and questionnaire. **Results:** Before treatment, patients with ADHD again presented with significantly elevated background noise as compared to the control group. The elevated noise normalized after treatment in the patients and did not differ from

that of the control group. Retinal background noise correlated highly with the severity of the ADHD symptoms. **Conclusion:** These unique findings show a normalization of initially elevated retinal background noise after treatment in patients with ADHD. The data provide evidence that elevated background noise is linked to ADHD and point to a neuronal correlate for ADHD. These findings have the potential to add to the search for biological markers that mirror the stage of therapy.

NO. 3

MOTIVATIONAL INTERVIEWING EDUCATION AND PSYCHIATRY RESIDENTS' ATTITUDE TOWARD ADDICTION TRAINING AND TREATMENT

Speaker: Manish K. Jha, M.B.B.S.

Co-Author(s): Misoo Abele, M.D., Julie Brown, M.D., Sidarth Wakhlu, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the state of motivational interviewing education in psychiatry training programs; 2) Identify how motivational interviewing education is associated with attitudes toward treatment of patients with substance use disorders; and 3) Understand the importance of motivational interviewing education for general psychiatrists.

SUMMARY:

Objective: Substance use disorders (SUDs) are widely prevalent, frequently comorbid with serious mental illnesses, often undetected and rarely treated adequately. General psychiatrists have an important role in delivering care to this underserved population, and training them in motivational interviewing (MI) skills can expand and improve SUD treatment. **Methods:** In the academic year 2011–2012, training directors of general, child/adolescent and addiction psychiatry training programs and chief residents of general psychiatry programs across the U.S. were invited to participate in an anonymous online survey. In addition to descriptive analyses of responses, logistic regression analyses were conducted on responses of chief residents to evaluate the differences in attitudes associated with MI training. **Results:** We invited 333 training directors and 206 chief residents to participate in this survey. Of these, 66 of 168 (39.3%) general, 41 of 121 (33.9%) child/adolescent, 19 of 44 (43.2%) addiction psychiatry training directors and 45 of 206 (21.8%) chief residents responded. Among training

directors, 90.9% of general, 80.5% of child/adolescent and 100% of addiction psychiatry directors reported providing MI education. We found that 83.3% of general, 87.8% of child/adolescent and 94.7% of addiction psychiatry training directors reported that MI should be taught during general psychiatry residency. We also found that 77.8% chief residents reported receiving MI skills training. Chief residents who did not train in MI skills as compared to those who were trained in MI skills were 7.7 times (95% CI [1.5, 40.4], $p=0.015$) more likely to feel that their interventions were ineffective with actively substance-using patients and 8.8 times (95% CI [1.5, 52.9], $p=0.018$) more likely to report a preference that an addiction counselor or addiction specialist address substance use in their patients with comorbid SUD. **Conclusion:** Motivational interviewing skills are considered important for general psychiatrists and widely offered by training programs. Chief residents who were trained in MI skills preferred to treat ongoing SUD in their patients and had greater confidence in their treatment. These results suggest that general psychiatrists should receive training in MI skills.

SEMINARS

MAY 14, 2016

WHY SEX IS IMPORTANT: A SEMINAR ON THE IMPEDIMENTS TO ADULT LOVE

Director: Stephen B. Levine, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Clarify the utility of sex in established relationships: stabilize gender identity and sense of caring and bonding and diminish daily annoyances and extradyadic temptations; 2) Reconceptualize *DSM-5* diagnoses in terms of their negative impact on the aspiration to be loved and to love; 3) Explain the mechanisms whereby a partner's behavior becomes unlovable and explore the internal organizations of the mind that diminish investment in a partner over time; and 4) Think about the diverse motives for extradyadic sex and how to remain helpful without being morally disapproving.

SUMMARY:

This four-hour seminar has been evolving over many years at this meeting. It began with a focus on sexual

dysfunction, evolved through explorations of desire and psychological intimacy and now provides a useful vocabulary to articulate adult struggles to love and be loved. Sexual dysfunctions, including desire difficulties and psychological intimacy, will interweave with love problems as we assist psychiatrists' understanding of the pathogenesis of common psychiatric problems. This material is designed to improve the learner's capacity to function as a psychotherapist for individuals and couples. The specific topics covered will be psychiatry's avoidance of love, the reasons that sex is vital to relationships, nine meanings of love, a three-part compendium of love's impediments that specifies the barriers to relationship formation, the behaviors that challenge a partner's ability to remain loving and the internal processes that make it difficult to sustain investment in the partner. The compendium will integrate *DSM-5* diagnoses and the four major psychopathologies of love not found in our nosology: jealousy, sexual addiction, infidelity and the Madonna-whore complex (also known as the love/lust split).

TREATMENT OF SCHIZOPHRENIA

Directors: Philip G. Janicak, M.D., Stephen R. Marder, M.D.

Faculty: Rajiv Tandon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the psychopathological dimensions, recent *DSM-5* diagnostic criteria and neurobiological underpinnings of schizophrenia; 2) Appreciate the growing emphasis on early recognition and interventions to favorably alter the prognosis of high-risk individuals; 3) Describe the clinically relevant pharmacological aspects of first- and second-generation antipsychotics as well as novel therapies; 4) Better understand the efficacy, safety and tolerability of antipsychotics when used for acute and long-term management of schizophrenia; and 5) Describe recent approaches to integrating medication strategies with psychosocial and rehabilitation programs.

SUMMARY:

The treatment of schizophrenia and related psychotic disorders is rapidly evolving. There are now 10 second-generation antipsychotics available in various formulations (i.e., clozapine, risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole,

iloperidone, paliperidone, asenapine, lurasidone). Further, there is a growing focus on early identification (e.g., high-risk individuals) and appropriate interventions to favorably alter one's long-term prognosis. The relative effectiveness of antipsychotics is also an important issue (e.g., the CATIE and CUTLASS trials) and continues to be clarified. Increasingly, novel pharmacological and nonpharmacological strategies are being tested to improve cognition, mood and negative symptoms, as well as safety and tolerability. The integration of cognitive therapeutic approaches, psychosocial interventions and rehabilitation programs with medication is critical to improving long-term outcomes (i.e., recovery). As our understanding of the neurobiology and psychopathology of schizophrenia progresses, this will guide the development of future, more effective therapies for acute and maintenance strategies.

MAY 16, 2016

CPT CODING

Director: Gregory G. Harris, M.D., M.P.H.

Faculty: Jeremy S. Musher, M.D., Ronald M Burd, M.D., Junji Takeshita, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Familiarize themselves with all the CPT codes used by mental health clinicians and review issues and problems associated with payer-imposed barriers to payment for services denoted by the codes; 2) Familiarize themselves with the most up-to-date AMA/CMS guidelines for documenting the services/procedures provided to their patients.; and 3) Impart a basic understanding of appropriate use of E/M codes.

SUMMARY:

This seminar is for both clinicians (psychiatrists, psychologists, social workers) and office personnel who either provide mental health services or bill patients for such services using current procedural terminology (CPT®) codes, copyrighted by the American Medical Association. The seminar will provide an overview of the CPT® codes used most frequently by psychiatrists, with an emphasis on the use of evaluation and management (E/M) codes now required when providing evaluation and management of patients with or without psychotherapy and how to document for those codes based on the CMS E/M documentation

guidelines. It will explain the use of the add-on codes for psychotherapy and interactive psychotherapy. Seminar attendees are encouraged to obtain the most recent published CPT® manual and read the following sections: 1) The guideline section for evaluation and management codes, 2) The evaluation and management codes themselves; and 3) The section on "psychiatry." The objectives of the seminar are twofold: first, to familiarize the attendees with all the CPT® codes used by mental health clinicians and review issues and problems associated with payer-imposed barriers to payment for services denoted by the codes; second, the attendees will review the most up-to-date AMA/CMS guidelines for documenting the services/procedures provided to their patients.

PRIMARY CARE SKILLS FOR PSYCHIATRISTS

Directors: Erik Vanderlip, M.D., M.P.H., Jeffrey T. Rado, M.D., M.P.H.

Faculty: Martha C. Ward, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review the causes of excess mortality in the SMI population and discuss useful lifestyle modifications; 2) Understand the current state of the art in treating diabetes, hypertension, dyslipidemias, smoking cessation and obesity; 3) Develop skills in understanding the use of treatment algorithms for prevalent chronic illnesses in the SMI population; 4) Explore the use of a primary care consultant to assist in treatment of patients if prescribing medication; and 5) Discuss the rationale and a proposed framework for psychiatrist management of chronic physical conditions with emphasis on liability and scope of practice concerns.

SUMMARY:

Because of their unique background as physicians, psychiatrists have a particularly important role in the clinical care, advocacy and teaching related to improving the medical care of their patients. As part of the broader medical neighborhood of specialists and primary care providers, psychiatrists may have a role in the principal care management and care coordination of some of their clients because of the chronicity and severity of their illnesses, similar to other medical specialists (i.e., nephrologists caring for patients on dialysis or oncologists caring for patients with cancer). The APA recently (July, 2015) approved a formal position statement calling on psychiatrists to embrace physical health

management of chronic conditions in certain circumstances. Ensuring adequate access to training is an essential aspect of this new call to action. There is a growing need to provide educational opportunities to psychiatrists regarding the evaluation and management of the leading cardiovascular risk factors for their clients. This course provides an in-depth, clinically relevant and timely overview of all the leading cardiovascular risk factors that contribute heavily to the primary cause of death of most persons suffering with SMI and allows for the profession of psychiatry to begin to manage some of the leading determinants of mortality and morbidity in patient populations frequently encountered in psychiatric settings.

WOMEN IN PSYCHIATRY: CAREER ADVANCEMENT, ACADEMICS, ADVOCACY AND BALANCE: THE REAL WORLD

Directors: Isabel Schuermeyer, M.D., M.S., Margo Funk, M.D., M.A.

Faculty: Kathleen Franco, Karen Jacobs, D.O., Tatiana Falcone, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify challenges unique to female psychiatrists and learn ways to promote equality in their workplace; 2) Implement effective means of negotiating, networking and connecting with a mentor; and 3) Implement strategies intended to help establish and maintain a balance between career and outside pressures (such as motherhood).

SUMMARY:

Psychiatry is one of the more common specialties that women choose to enter after completing medical school. Despite this, there are still many challenges unique to women in this field. Women are under-represented in leadership positions in academic psychiatry departments. Even outside of academic departments, women are often under-represented in leadership positions within advocacy groups and professional organizations. These trends are improving, over time, but there are things that we can do to improve our degree of representation within leadership positions in our field. Psychiatrists who are also, or who become, mothers are faced with balancing two positions; each of which has high demands. Long work hours, unpredictable work schedules and limited peer support at work can significantly complicate the ever-changing difficulties

associated with raising children. The goal of this seminar is to summarize the multiple challenges that are unique to women practicing psychiatry, as well as ways to face these challenges and further their careers. Interactive exercises will be used with participants, and will address issues such as negotiating, networking strategies, setting limits, connecting with a mentor, and balancing (or juggling) demands between work and family/home. The instructors have each, in their own way, faced many of these challenges and continue to more or less thrive at work and at home. The instructors include a medical school dean, a past president of a state chapter of the APA, a residency director, a researcher and subspecialty program directors. NOTE: This is a highly interactive seminar and it is most ideal for participants to attend the entire session.

MAY 17, 2016

THE PSYCHIATRIST AS EXPERT WITNESS

Director: Phillip J. Resnick, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

Trial procedures and rules of evidence governing fact and expert witnesses will be briefly reviewed. The fallacy of the impartial expert witness will be discussed. Participants will learn that the adversary process seeks justice, sometimes at the expense of truth. The faculty will discuss pre-trial conferences and depositions. Participants will learn to cope with cross-examiners who attack credentials, witness bias, adequacy of examination and the validity of the expert's reasoning. Issues of power and control in the witness-cross-examiner relationship will be explored. Participants will learn how to answer questions about fees, pre-trial conferences and questions from textbooks. The use of jargon, humor and sarcasm will be covered. Different styles of testimony and cross-examination techniques will be illustrated by eight videotape segments from actual trials and mock trials. Participants will see examples of powerful and powerless testimony in response to

the same questions. Mistakes commonly made by witnesses will be demonstrated. Slides of proper and improper courtroom clothing will be shown. Handouts include lists of suggestions for witnesses in depositions, 15 trick questions by attorneys and over 50 suggestions for attorneys cross-examining psychiatrists.

HOW TO GIVE MORE EFFECTIVE LECTURES: PUNCH, PASSION AND POLISH

Director: Phillip J. Resnick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn teaching techniques to hold audience attention; 2) Learn how to involve the audience; and 3) Learn how to improve skills in using audio-visual aids.

SUMMARY:

This seminar will provide practical advice on how to make a psychiatric presentation with punch, passion and polish. Instruction will be given on planning a scientific paper presentation, a lecture and a half-day course. The seminar leader will cover the selection of a title through the choice of closing remarks. Teaching techniques to hold the audience's attention include the use of humor, anecdotes and vivid images. Participants will be taught to involve the audience by breaking them into pairs to solve problems with recently acquired knowledge. Participants will be told that they should never 1) Read while lecturing; 2) Display their esoteric vocabulary; or 3) Rush through their talk, no matter what the time constraints. Tips will be given for making traditional word slides and innovative picture slides. Pitfalls of PowerPoint will be illustrated. Advice will be given on the effective use of videotape vignettes. A videotape will be used to illustrate common errors made by lecturers. The seminar will also cover preparation of handouts. Finally, participants will be strongly encouraged to make a three-minute presentation with or without slides and receive feedback from workshop participants. Participants should plan to bring PowerPoint slides on a flash drive.

TRAINING PRACTITIONERS TO USE A PSYCHOPATHOLOGY CLINICAL RATING SCALE

Director: Ahmed Aboraya, M.D., D.P.H.

Faculty: Daniel Elswick, M.D., Henry A. Nasrallah, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Reliably assess the psychological symptoms and signs of the main adult psychiatric disorders-anxiety, panic, depression, bipolar, schizophrenia, alcohol, drug, attention-deficit/hyperactivity; 2) Learn about the nine principles for creating reliable psychological dimensions and how to create psychological dimensions for various disorders and diagnoses; 3) Learn about and apply the "bottom first then top (BFTT)" approach to psychiatric diagnosis; and 4) Use the Standard for Clinicians' Interview in Psychiatry (SCIP) to create a descriptive psychopathology database.

SUMMARY:

Background: Measurement-based psychiatric assessment is routinely used in research and clinical trials but is rarely used by mental health practitioners, including psychiatrists. Psychiatry residents and mental health professionals lack training on descriptive psychopathology and clinical scales in the U.S. and worldwide. One of the impediments to teaching clinical scales is the lack of a practical diagnostic interview designed for clinicians to use in clinical settings. This impediment was addressed by the development of the Standard for Clinicians' Interview in Psychiatry (SCIP) as a clinician-administered diagnostic interview. **Results:** The SCIP reliably measures 150 symptoms and signs of adult psychiatric disorders. The absence of reliable measurement of symptoms was the main limiting factor in creating reliable dimensions in the past. The SCIP's reliable symptoms and signs result in 14 reliable SCIP dimensions (anxiety, post-traumatic stress, depression, mania, hallucinations, Schneiderian first-rank symptoms, delusions, disorganized thoughts, disorganized behavior, negative symptoms, alcohol addiction, drug addiction, attention problems and hyperactivity). The SCIP's symptoms, signs and dimensions are the teaching materials for this course. The SCIP instruction manual (36 pages) and the five SCIP modules (Module A: Anxiety, Panic and Post-traumatic Stress Disorders; Module B: Mood Disorders; Module C: Psychotic Disorders; Module D: Alcohol and Substance Use Disorders; and Module G: Attention-Deficit/Hyperactivity Disorders) will be distributed to participants. **Discussion:** Participants will use the SCIP database to create a descriptive psychopathology code (DPC) for patients with mental illness and learn how this is related to the

research domain criteria (RDoC) and personalized psychiatry.

SYMPOSIA

MAY 14, 2016

IMPROVING THE EFFECTIVENESS OF CBT ACROSS CULTURES

Chair: Muhammad Irfan, M.B.B.S., M.S.

Discussant: Farooq Naeem, Ph.D., M.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize social origins of psychiatric illnesses and their relevance in developing psychological interventions; 2) Recognize and understand themes related to CBT and the need to culturally adapt CBT, especially in ethnic minority communities; 3) Identify necessary steps to culturally adapt CBT; and 4) Identify cultural assumptions underlying CBT and ACT and their implications on clinical adaptation and application in diverse populations.

SUMMARY:

CBT has a strong evidence base and is recommended by the National Institute of Health and Clinical Excellence (NICE) in the U.K. and by the American Psychiatric Association (APA) in the U.S. for a variety of emotional and mental health problems. However, it has been suggested that CBT is underpinned by specific cultural values, and for it to be effective for clients from diverse backgrounds, it should be culturally adapted. It has been suggested that cultures differ in core values, for example, individualism-communalism, cognitivism-emotionalism, free will-determinism and materialism-spiritualism. Therapists working with ethnic minority clients in the U.S. have developed guidelines for adaptation of therapy. Most of these guidelines are based on theoretical grounds or personal experiences. These guidelines were not the direct outcome of research to address cultural issues. The literature describing guidance for cognitive therapists is limited. Recently, our international group has used various methods to adapt CBT for clients from various backgrounds, including African, Caribbean, Chinese, Bangladeshi and Pakistani. In this symposium, we will describe our experience of adaptation of CBT and the

outcome of randomized controlled trials to evaluate these culturally adapted therapies.

NO. 1

DEVELOPING A MODEL FOR CULTURAL ADAPTATION OF CBT FOR AN ENGLISH-SPEAKING CARIBBEAN ORIGIN GROUP

Speaker: Kwame McKenzie, M.D.

SUMMARY:

Reports have shown that culturally adapting CBT can make it more accessible and acceptable to specific diverse populations. Our study aimed to develop a model for cultural adaptation that could be used for Canadian racialized populations and specifically to adapt CBT for an English-speaking Caribbean origin group in Toronto. A literature review was used to identify areas of a standard CBT manual that may need cultural adaptation. This was used to develop the questions for community focus groups. Feedback from the focus groups was used to adapt the manual, and a further focus group of practitioners checked that the changes that were made were practical with regard to delivering CBT. Changes in the level of personal disclosure, homework, timing of sessions and content of the examples were suggested. The therapists found the culturally adapted CBT easy to use and felt it offered them license to be more flexible in their practices. They believed it to be an improvement over existing manuals for this group. Feedback from the patients was similarly positive. Culturally adapted CBT was found to be an acceptable alternative to standard manuals in this qualitative study, and no problems were found in implementation.

NO. 2

CULTURAL ISSUES ON THE USE OF CBT AND ACT

Speaker: Kenneth P. Fung, M.D.

SUMMARY:

There is increasing recognition that cultural issues need to be addressed in order to enhance the effectiveness of psychotherapy for diverse populations. Evidence-based therapies, such as CBT, need to be culturally adapted for different populations while maintaining their core therapeutic aims. At the same time, there has also been an expansion and incorporation of other cultural practices, such as mindfulness, into the family of CBT, such as third-wave interventions like acceptance and commitment therapy (ACT). ACT is based philosophically on functional contextualism

and is the clinical application of relational frame theory. Its core therapeutic processes include acceptance, defusion, present moment, self-as-context, values and committed action. In addition to the obvious incorporation of the concept of mindfulness, its principles are culturally consistent with Asian philosophies and thought, such as Buddhism. This presentation will examine 1) The philosophical and cultural differences between the two psychological interventions—traditional CBT and ACT; 2) The cultural considerations of each in adapting them for diverse groups; and 3) The experience of integrating the use of CBT and ACT together for diverse groups, including in the Chinese and Portuguese clinical populations.

NO. 3

CULTURAL ADAPTATION OF CBT: PROCESS, METHODS AND FINDINGS

Speaker: Farooq Naeem, Ph.D., M.Sc.

SUMMARY:

We adapted CBT for Pakistani clients in Manchester, Southampton and Pakistan. A mixed methods approach was used. A series of qualitative studies were conducted, which involved interviews and focus groups with clients, their carers, mental health professionals and managers. The results of these studies were used to develop guidelines that were used to culturally adapt CBT. We found that in order to effectively work with clients from South Asian Muslim (SAM) backgrounds, therapists need to consider and develop three fundamental areas of cultural competence: 1) Awareness of relevant cultural issues and preparation for therapy; 2) Assessment and engagement; and 3) Adjustments in therapy techniques. Awareness of cultural issues, in turn, includes awareness of cultural and religious issues, capacity and circumstances of both the individual and the system, and cognitions and beliefs. Overall, findings from developing a culturally sensitive CBT project suggest that minor adjustments in therapy are required in order to work with clients from this group. So far, eight randomized controlled trials of culturally adapted CBT have been conducted in Pakistan and the U.K.. This presentation will focus on the methodology, process of adaptation and outcome of the qualitative studies that guided adaptation of CBT.

NO. 4

CULTURAL ADAPTATION OF CBT FOR PSYCHOTIC DISORDERS

Speaker: Shanaya Rathod, M.D.

SUMMARY:

CBT is the most widely recommended psychological therapy for psychotic disorders (e.g., NICE 2014). However, explanations used in CBT are based on Western concepts and illness models. There has been little attention to modifying the therapeutic framework and practice of therapy to incorporate an understanding of diverse ethnic, cultural and religious contexts. Theory, interpretation and practice of CBT in multiethnic client groups needs to be adapted to the growing literature on cross-cultural counseling and the ethical and practical concerns surrounding competency and training of psychotherapists working with these clients. Dissemination of cognitive therapy across widely diverse cultures is increasingly occurring. The evidence to support this is explored, as are problems associated with using therapy that is not culturally adapted.

NO. 5

A DEPRESSED BRITISH SOUTH ASIAN MOTHER'S "VOICES WITHIN THE FOUR WALLS": A MIXED METHODS STUDY

Speaker: Nusrat Husain, M.D.

SUMMARY:

British South Asians are one of the largest ethnic minority groups living in the U.K. High rates of depression have been reported in these women. Previous literature has neglected British South Asian women's experiences of postnatal depression. Current guidelines suggest a need for tailored maternity services to improve access to care for women from ethnic minorities. This mixed methods study looks at British South Asian women's explanatory models to explain postnatal depression, their preferred treatment, and the development and pilot testing of a culturally adapted group psychological intervention. The most commonly reported factors contributing to the persistence of depression were marital disharmony, lack of support and financial difficulties. Past interventions primarily involved antidepressants, which were not welcomed. Several other factors that often led to difficulties in engagement were identified, including stigma of mental illness, different cultural beliefs, lack of trust in mental health services and a lack of awareness of services available. The mothers found the culturally adapted group CBT intervention to be acceptable, and many reported benefits such as

higher overall well-being. The participants expressed their satisfaction with the culturally adapted intervention and felt an overall positive change in their attitude, behavior and confidence level.

**NO. 6
EVALUATION OF CULTURALLY ADAPTED CBT (CACBT) THROUGH RANDOMIZED CONTROLLED TRIALS (RCTS) IN LOW- AND MIDDLE-INCOME (LAMI) COUNTRIES: DEVELOPING THE EVIDENCE BASE**

Speaker: Muhammad Irfan, M.B.B.S., M.S.

SUMMARY:

The cultural adaptation of CBT involved a series of qualitative studies in Pakistan (a typical LAMI country), and the results were utilized in the selection of culturally equivalent terminology. We conducted randomized controlled trials (RCTs) to evaluate culturally adapted CBT, and this presentation will focus on these RCTs. In the first RCT, CaCBT was evaluated in primary care for patients with depression. This culturally adapted CBT was then used to develop a self-help manual. A multicenter RCT was conducted to test the effectiveness of this self-help manual. We also conducted RCTs for CaCBT in psychosis. Recently, an RCT of brief CaCBT was conducted in patients attending secondary care. The publication of these results will pave the path for wider acceptance of psychological therapies in general, and CBT in particular, in LAMI countries.

COMORBID PSYCHIATRIC AND SUBSTANCE USE DISORDERS: RECENT RESEARCH TO IMPROVE DIAGNOSIS AND TREATMENT

Chairs: Susan F. Volman, Ph.D., Carlos Blanco, M.D.

Discussant: Carlos Blanco, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Have a deeper understanding of the etiological complexity of comorbid psychiatric disorders and substance abuse; 2) Appreciate how research on the biological basis for comorbidity can inform and clarify diagnostic categories; 3) Understand how the choice of treatment options may depend on the source of the comorbidity in individual patients; and 4) Understand how exclusion criteria in clinical trials can compromise their generalizability for treating the larger population, which includes many individuals with comorbid conditions.

SUMMARY:

Comorbidity between psychiatric and substance use disorders is extremely prevalent, but the underlying reasons are only partially understood. Hypotheses to explain this prevalence include 1) Comorbid disorders may share common genetic, neurobiological and environmental factors that alter the neural circuits that regulate impulsivity, motivation and reward; 2) Substances of abuse may be used to self-medicate to relieve psychological suffering; and 3) Substance use may precipitate other psychiatric disorders in vulnerable individuals. These hypotheses are by no means mutually exclusive. In fact, it is quite likely that each hypothesis explains some combination of psychiatric diagnosis with the co-occurrence or history and specificity of substance use. While the etiology of comorbidity or dual diagnosis disorders is likely to be very complex, research on this question is critical for understanding pathophysiologic mechanisms, for refining diagnostic categories and for designing treatment programs that may differ for individuals with divergent paths to their comorbid disorders. This symposium will address these questions with recent research findings from epidemiological analysis, neurobiological investigations using advanced imaging approaches, the testing of hypotheses in animal models and research on the efficacy of integrated treatment approaches. The symposium will emphasize the comorbidity of depression and substance abuse. It will include discussion of the dilemmas of diagnosing and treating major depressive disorder versus substance-induced mood disorder and how these can be informed by neurobiological investigations. Although the specific focus is on depression comorbidity, the speakers will also address how the principles and strategies of their research findings have been, or can be, adapted to other psychiatric disorders that are also commonly comorbid with substance abuse. The final discussion will also address how the complexity of comorbidity limits the generalizability of clinical trials when stringent exclusionary criteria are applied.

**NO. 1
DIAGNOSTIC DILEMMAS IN CO-OCCURRING MENTAL AND SUBSTANCE USE DISORDERS**

Speaker: Edward V. Nunes, M.D.

SUMMARY:

The diagnosis of mental disorders such as depression in the setting of an ongoing substance use disorder has been a longstanding source of controversy. Substances have direct effects—intoxication, withdrawal, substance-related disturbances in mood and vegetative functioning—that can mimic mood or anxiety disorders but will resolve with abstinence. *DSM-IV* and *DSM-5* call these substance-induced disorders. However, other patients who present with similar disturbances in mood and vegetative functioning will have true mood or anxiety disorders, which will not resolve with abstinence and require specific treatment—independent disorders in the DSM terminology. This presentation will review the evidence on distinguishing independent from substance-induced disorders and present practical recommendations for how to make this differential diagnosis. The talk will also discuss theoretical implications for how to understand co-occurring mood and substance use disorders.

**NO. 2
NEUROIMAGING CORRELATES OF
PSYCHOPATHOLOGY AND SUBSTANCE ABUSE**

Speaker: Deborah Yurgelen-Todd, Ph.D.

SUMMARY:

The prevalence of comorbid substance abuse and psychiatric disorders is well-documented, although there is ongoing debate as to their potential role as shared etiologic factors. From a neurobiological perspective, it has been proposed that core symptoms observed in both substance abuse and psychopathology are associated with alterations in circuits underlying inhibitory function, motivation and reward behavior. Studies examining the neurobiology of substance abuse in both animals and humans have demonstrated consistent alterations in regions associated with the dopaminergic mesocorticolimbic pathway such as the ventral tegmental area, nucleus accumbens, amygdala, orbitofrontal cortex and anterior cingulate cortex. Such widespread brain changes may also reflect alterations in cerebral bioenergetics. For example, methamphetamine users and refractory depressed individuals share reductions in levels of phosphocreatine (PCr) in the brain, which serves as a primary short term buffer for adenosine triphosphate (ATP) levels. Multimodal neuroimaging data (structural MRI, diffusion tensor MRI, resting state functional MRI and magnetic resonance spectroscopy) acquired in both adolescent and adult cohorts of marijuana and methamphetamine users

with and without psychiatric comorbidity will be presented. Findings from these studies will be discussed in light of network dysfunctions that may be associated with risk for comorbid conditions.

**NO. 3
COMORBIDITY IN SUBSTANCE ABUSE AND
DEPRESSION: COMMON SUBSTRATES LINKED
THROUGH AMYGDALA-DEPENDENT DOPAMINE
SYSTEM DOWN-REGULATION**

Speaker: Anthony A. Grace, Ph.D.

SUMMARY:

Major depressive disorder is associated with anhedonia and amotivation, characteristics typically associated with dopamine system disruption. Such properties have also been observed individuals who have withdrawn from psychostimulant abuse. In two rat models of depression, we observed a decrease in the proportion of mesolimbic dopamine neurons firing spontaneously. This down-regulation is proposed to decrease the responsivity of the dopamine system to reward-associated stimuli. This decreased activity was dependent on the amygdala and could be rapidly reversed by the rapid-acting novel antidepressant drug ketamine. Similarly, withdrawing rats from a single dose of amphetamine also caused a dramatic down-regulation in dopamine neuron activity 24 hours following administration. As with the depression models, this dopamine system down-regulation was also amygdala-dependent and reversed by ketamine. We propose that both models arise due to a long-term compensatory change that occurs in response to stress- or amphetamine-induced dopamine system activation, which George Koob has referred to as the opponent process model. Thus, disruption in afferent regulation of the dopamine system as overcompensation to its activation appears to be the basis of anhedonia in both depression and stimulant withdrawal, in both cases, potentially driving additional drug abuse as a means to reinstate balance in the systems.

**NO. 4
TREATMENT OF CO-OCCURRING MENTAL AND
SUBSTANCE USE DISORDERS: FOCUS ON
DEPRESSION**

Speaker: Kathleen Brady, M.D., Ph.D.

SUMMARY:

Psychiatric and substance use disorders commonly co-occur, and comorbidity often has a negative impact on course of illness, prognosis and outcomes.

In spite of this fact, there are relatively few well-controlled studies addressing optimal treatment of individuals with co-occurring psychiatric and substance use disorders, and controversy concerning the best treatment options exists. In this presentation, general principles in the management of co-occurring disorders, including psychotherapeutic and pharmacotherapeutic options, will be reviewed. Depression is among the most prevalent and costly comorbid disorders, and a number of pharmacological treatment studies in the last 10 years have suggested promising intervention strategies. In this presentation, an overview of controlled trials investigating the treatment of co-occurring depression and substance use disorders will be presented. Promising new strategies based on overlapping neurobiology will be discussed.

SMOKING CESSATION: WHAT PSYCHIATRISTS NEED TO KNOW TO HELP BRING ABOUT CHANGE

Chairs: Stephan M. Carlson, M.D., Jose Vito, M.D.

Discussant: Aniyizhai Annamalaj, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the history of smoking cessation in psychiatry and the current importance of this intervention for those with comorbid mental illness; 2) Describe how quality improvement projects in inpatient psychiatry can lead to improvements in nicotine dependence; 3) Summarize the newest findings in the pharmacological management of nicotine dependence; 4) Be able to identify evidence-based psychosocial interventions for smoking cessation that show promise in psychiatry; and 5) Describe the most recent research findings in smoking cessation for schizophrenia, major depression and comorbid substance use disorders.

SUMMARY:

With an eye toward integrated care, psychiatrists need to know how to help patients with mental illness and substance use disorders quit smoking. Nicotine dependence is in itself a recognized psychiatric illness, also referred to as tobacco use disorder. Many studies have shown that smoking is the most prevalent, most deadly and most costly psychiatric disorder. Smoking's prevalence has decreased among those without mental illness; however, those with mental illness and substance use disorders continue to smoke at high rates, leading to reduced quality of life, worse mental

health outcomes, increased suicide rates and premature death secondary to smoking-related illnesses. This is a mental and public health crisis that every psychiatrist must be aware of and do their part to help address. This symposium addresses this topic in four presentations.

NO. 1

THE HISTORY OF SMOKING CESSATION IN PSYCHIATRY AND THE CURRENT EPIDEMIOLOGY IN PATIENTS WITH MENTAL ILLNESS

Speaker: Hugh Cummings, M.D.

SUMMARY:

The first presentation examines the history of smoking cessation in psychiatry, the prevalence and patterns of tobacco use in individuals with mental illness and substance use disorders, and the importance of addressing tobacco use in these smokers.

NO. 2

SMOKING CESSATION THROUGH QUALITY IMPROVEMENT AND SYSTEM CHANGE IN INPATIENT PSYCHIATRY

Speaker: Stephan M. Carlson, M.D.

SUMMARY:

A psychiatric hospital admission provides a good opportunity to help people with mental illness stop smoking because hospitals require temporary tobacco abstinence. Psychiatrists can use this as a "teachable moment" for change. This presentation will pick up on this clarion call by addressing quality improvement strategies in behavioral health systems to reduce this inequality. By utilizing the Joint Commission's inpatient tobacco performance measure set (TOB-1, TOB-2 and TOB-3), endorsed by the National Quality Forum in March, and leveraging the electronic medical record, psychiatrists with brief education in smoking cessation can help patients quit smoking.

NO. 3

AN UPDATE ON SMOKING CESSATION PHARMACOLOGY FOR PSYCHIATRISTS

Speaker: Jose Vito, M.D.

SUMMARY:

There is a myth that pharmacological options don't work or make mental illness worse. This presentation will dispel these myths with the most recent evidence-based pharmacological

interventions for smoking cessation in patients with mental illness and substance use disorders. Cochrane reviews of pharmacological interventions will be summarized with focus on varenicline in combination with nicotine replacement therapies.

NO. 4

EVIDENCE-BASED PSYCHOSOCIAL TREATMENTS FOR SMOKING CESSATION IN PATIENTS WITH MENTAL ILLNESS

Speaker: Anil A. Thomas, M.D.

SUMMARY:

There is a myth that patients with mental illness and substance use disorders do not want to quit or that quitting will worsen their condition. This presentation will review the most recent evidence-based psychosocial interventions for smoking cessation.

ESTABLISHED CURRICULA ON RELIGION, SPIRITUALITY AND PSYCHIATRY IN PSYCHIATRIC RESIDENCY PROGRAMS: A LONGITUDINAL PERSPECTIVE

Chairs: Francis Lu, M.D., John Peteet, M.D.

Discussant: Steven Scoggin, Psy.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the current rationale for psychiatric residency training program curricula on religion, spirituality and psychiatry that includes ACGME competencies/milestones in professionalism and patient care and CANMEDS standards; 2) Understand the development and evolution of model curricula on religion, spirituality and psychiatry over a longitudinal duration of a maximum of 18 years (Harvard Longwood and Baylor); and 3) Apply lessons learned about the process of developing and maintaining curricula on religion, spirituality and psychiatry, as well as the evolution of content and teaching methods.

SUMMARY:

This symposium will discuss model psychiatry residency training program curricula on religion, spirituality and psychiatry in the United States and Canada that were awarded some of the 32 John Templeton Awards for outstanding curricula on this topic between 1998 and 2007 (presented annually at the APA Annual Meeting). This symposium will present a longitudinal perspective concerning the process of development and maintenance of

psychiatric residency training program curricula on religion, spirituality and psychiatry, as well as the evolution of content and teaching methods to meet current ACGME competencies/milestones and CANMEDS standards. The curricula from adult psychiatric training programs that will be discussed include Harvard Longwood, Baylor, George Washington University, the University of British Columbia and the University of Saskatchewan. The curricula from child and adolescent psychiatry training programs that will be discussed include Wayne State and Emory, among others. Three of the presenters (Peteet, Lomax and Griffith) were original authors of their curricula and have remained at their institutions to teach (Harvard Longwood, Baylor and George Washington, respectively). The discussion will focus on how to apply the lessons learned to develop curricula on religion, spirituality and psychiatry in the participants' own institutions.

NO. 1

RELIGION, SPIRITUALITY AND PSYCHIATRY: THE HARVARD LONGWOOD COURSE 20 YEARS LATER

Speaker: John Peteet, M.D.

SUMMARY:

Training in religion/spirituality in the Harvard Longwood Psychiatry Residency Training Program began 20 years ago after a resident discussed with his class having prayed with a patient. Enough questions arose about dealing with this dimension of patients' lives that sessions devoted to exploring the area grew, and with the support of a 1998 Templeton Curriculum Award, these sessions became a full semester, required course now called "Religion, Spirituality and Psychiatry." Over the years, the course has taken a fairly consistent shape, including an overview of the spirituality/psychiatry interface and the role of the clinician in the patient's spiritual life, followed by a few standard sessions and several others selected by residents to involve outside presenters on topics such as cults, Haitian spirituality and spiritual care at the end of life and discussions focused on transference, countertransference and boundary considerations. This presentation will focus on lessons we continue to learn from the course.

NO. 2

PERSONAL AND INSTITUTIONAL CONSEQUENCES OF EDUCATIONAL EFFORTS TO INTEGRATE RELIGIOUS AND SPIRITUAL RESOURCES INTO THE CARE OF PSYCHIATRIC PATIENTS: A 17-YEAR "PERSPECTIVE"

Speaker: James W. Lomax, M.D.

SUMMARY:

This presentation will specify how one of the original Templeton-awarded curricula on religion and spirituality in psychiatry has evolved over time and the consequences of that for both the educators and learners in the program. It will also document how institutional changes have developed in both the department and the original and subsequently affiliated institutions of the residency.

NO. 3

A 25-YEAR EVOLUTION FROM TEACHING CULTURAL SENSITIVITY TO TEACHING THE SOCIAL NEUROSCIENCE OF SPIRITUALITY IN PSYCHIATRIC CARE

Speaker: James Griffith, M.D.

SUMMARY:

A “first generation” of psychiatric residency curricula in spirituality and psychiatry was represented by our 2003 John Templeton Spirituality and Medicine Award. Such curricula focused on cultural sensitivity toward patients with religious identities. A dominant aim was to foster curiosity about and respect for patients’ religious lives and to learn about their different spiritual traditions. More recently, our residency has sought a more extensive integration of spirituality into psychiatric care through additional teaching on the social psychology and social neuroscience of religious life in relation to processes of resilience and vulnerability. This approach enables a mapping of specific elements of both personal spirituality and group-based/collective religious life onto demonstrated pathways for resilience or vulnerability to illness. For example, spirituality can be shown to serve as a “delivery vehicle” for evidence-based practices that mobilize hope. Sociobiology shows how religious groups utilize social identity, hierarchy, kin recognition and reciprocal altruism to produce potent effects upon the health of their members. This approach brings clarity to distinctions between personal spirituality and group-based/collective religious life in their different salutatory effects upon physical and mental health. It also provides a conceptual framework for assessing, formulating and intervening when religious beliefs and practices exacerbate suffering or harm health.

NO. 4

RELIGION AND SPIRITUALITY IN CHILD AND ADOLESCENT PSYCHIATRY TRAINING

Speaker: Mary Lynn Dell, M.D., D.Min.

SUMMARY:

Religion and spirituality are important elements of child and adolescent development and have critical roles in family life, child rearing, education and other spheres crucial to emotional, moral, social and cognitive development. Though the importance of religion and spirituality in child and adolescent psychiatry has long been recognized by clinicians and psychiatric educators in this subspecialty, until approximately 20 years ago, scant formal discussion or literature on essential or desirable content and pedagogical methods existed. In addition, the great majority of the information published and available in this area pertained to adults only and did not begin to approach the degree of religious and cultural diversity required for training child and adolescent psychiatrists for the 21st century. This presentation will review the evolution of curricula on religion/spirituality in child and adolescent psychiatry training programs, the consensus on core content, and curricular adaptations to best meet the needs of trainees according to geographic location, relative program strengths, and existing didactic curricula and clinical rotations. Finally, examples of curricula from several training programs will be discussed, including adaptations implemented over the years to accommodate changes in training mandates, patient populations, faculty resources, and existing and complementary components of training.

NO. 5

RESIDENCY EDUCATION ON SPIRITUALITY/RELIGION AND PSYCHIATRY: A CANADIAN PERSPECTIVE

Speaker: Wai Lun Alan Fung, M.D., Sc.D.

SUMMARY:

Among the 32 recipients of the Award for Spirituality/Religion Curriculum Development for Psychiatry Residency Training Programs funded by The John Templeton Foundation, two were Canadian programs (the University of Saskatchewan and the University of British Columbia). This presentation provides an update on their current curricula and an overview of the coverage of spirituality/religion (S/R) in Canadian psychiatric residency programs, compares and contrasts such curricula with those of their American counterparts, and discusses the

opportunities and challenges of such curricula in the context of the Canadian society.

MARIJUANA: A CLINICAL UPDATE ON THE THERAPEUTIC AND RECREATIONAL USES OF CANNABIS FOR GENERAL PSYCHIATRISTS AND RESEARCHERS

Chair: Godfrey D. Pearlson, M.D.

Discussant: Deepak Cyril D'Souza, M.D., M.B.B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Provide clinical examples illustrating the importance of identifying, assessing and understanding potential benefits and hazards associated with cannabis use in both medical and recreational settings; 2) Describe hazardous effects of cannabis use on both motor vehicle driving and the developing adolescent brain; 3) Understand recent advances in the development of therapeutic cannabinoid medications; and 4) Appreciate issues made by clinicians and policymakers in formulating decisions relevant to the provision of medical marijuana.

SUMMARY:

Cannabis (CNB) is the most widely used recreational drug, with >17 million Americans admitting current use in 2010. As cannabis is decriminalized, medical use for a wide variety of conditions is allowed in multiple U.S. states and perception of harmfulness among the general public falls, cannabis use is predicted to rise, and it will become increasingly common for psychiatric clinicians to encounter cannabis users in their practice. Herbal cannabis contains approximately 100 active compounds that in some cases may have opposing effects. Some of these compounds may be medically beneficial in terms of chronic neuropathic pain relief, reducing seizure frequency, or treating psychosis or cancer-associated cachexia. In contradistinction, other cannabinoids may have adverse effects on cognition, brain maturation, motivation, and educational and social spheres and can increase psychosis risk. Thus, dissecting benefits from risks and identifying specific cannabinoid compounds responsible for these effects warrants increasing attention. This symposium brings together researchers and clinicians who either participate in physician boards advising states on which conditions medical cannabis may be appropriate for treating, are involved in large-scale youth epidemiologic studies examining risks for and consequences of adolescent CNB use,

study acute marijuana effects on cognitive function in research settings, or are researching novel cannabinoid compounds with potential therapeutic uses.

**NO. 1
THERAPEUTIC POTENTIAL OF CANNABINOIDS**

Speaker: Donald C. Goff, M.D.

SUMMARY:

The endocannabinoid system is involved in psychological and immune responses to stress. Whereas cannabinoid CB1 receptor agonists, e.g., THC and synthetic cannabinoids, can produce psychosis, another cannabis constituent, cannabidiol (CBD), may attenuate psychosis. In animal models, CBD has been found to have antioxidant, anti-inflammatory and neuroprotective activity. CBD shows promise as a treatment for psychosis, seizures, anxiety disorders, PTSD and Parkinson's disease. CBD acts in part by inhibiting the metabolism of anandamide, a partial CB1 receptor agonist. Cerebrospinal fluid (CSF) studies in first-episode psychosis suggest that anandamide is an "endogenous antipsychotic." Results of clinical trials with CBD and related compounds show CSF anandamide concentrations were elevated 10-fold in individuals with first-episode psychosis and correlated inversely with psychosis severity, consistent with the above hypothesis. These data and recent clinical trials will be reviewed.

**NO. 2
PREDICTORS AND CONSEQUENCES OF ADOLESCENT CANNABIS ABUSE**

Speaker: Hugh Garavan, Ph.D.

SUMMARY:

I will present data from the IMAGEN study, a longitudinal study of 2,000 teens assessed at ages 14, 16 and 19. All participants completed extensive phenotypic batteries, including structural and functional neuroimaging assessing inhibitory control, reward and face processing and provided blood samples for genetic analyses. Machine learning approaches identified the variables from this multimodal dataset that predict future cannabis use, and we quantified the predictive accuracy using internal cross-validation. As a counterpoint to these descriptors of drug use risk factors, I will also describe the neurobiological characteristics of resilient teens who, despite lifetime adversity, have good academic, mental health and behavioral

outcomes. Finally, I will describe changes to grey volume matter that our ongoing analyses suggest arise as a consequence of very low levels of exposure to cannabis. These results may be of importance given the ongoing decriminalization in cannabis in the U.S. and, arising from this, the probable increase in availability of cannabis to youth.

NO. 3

DRIVING WHILE STONED: HOW DANGEROUS?

Speaker: Godfrey D. Pearlson, M.D.

SUMMARY:

An area of concern is that ever greater numbers of recreational cannabis users plus cannabis legalization will increase the risk of driving while intoxicated from recent use, thereby raising the risks to public safety. Motor vehicle safety is already a significant concern in the U.S.; in 2010, approximately 11 million persons reported driving under the influence of an illicit drug in the prior year. Currently, approximately three million persons in the U.S. are reported injured, and more than 40,000 die in motor vehicle accidents annually. We assessed 20 cannabis-using subjects (9 occasional, 11 regular) at two different doses of smoked (vaporizer) cannabis and placebo in three functional MRI-simulated driving sessions. Using independent component analysis, we demonstrated that in cerebellar, motor, visual and ACC/orbitofrontal networks, cannabis dose modulated regional brain recruitment during the task. Our prior fMRI driving work has linked these networks to action planning, avoiding collisions and monitoring traffic. Brain activity was modulated by frequency of cannabis use. Regular users generally showed less activation. We also report significant cannabis effects on brain function during two other fMRI tasks measuring set shifting/attentional focus and time estimation respectively.

NO. 4

MEDICAL CANNABIS: FOR WHICH CONDITIONS AND UNDER WHAT CIRCUMSTANCES?

Speaker: Deepak Cyril D'Souza, M.D., M.B.B.S.

SUMMARY:

Medical cannabis has been approved for a number of medical conditions in many states in the U.S. Psychiatric conditions for which medical marijuana has been approved in some U.S. states include PTSD, agitation in Alzheimer's disease and Tourette's

syndrome. The strength of evidence for the efficacy of medical cannabis for these psychiatric indications will be systematically reviewed. The strength of evidence for the efficacy of medical marijuana for treating PTSD, Alzheimer's disease and Tourette's syndrome is low. Furthermore, cannabis is not without side effects, acute, residual and persistent. The possibility of tolerance, dependence and the emergence of a withdrawal syndrome should be kept in mind. Early and persistent cannabis use, especially with onset in adolescence, is associated with psychosis risk. Mental health providers need to carefully consider benefits versus risks of cannabis when certifying their patients for medical marijuana for psychiatric indications.

NO. 5

NEUROCOGNITIVE IMPLICATIONS OF HEAVY MARIJUANA USE IN ADOLESCENCE: INSIGHTS FROM NEUROIMAGING

Speaker: Alecia D. Dager, Ph.D.

SUMMARY:

The highest rates of marijuana use are observed in adolescence; this period also encompasses the final stages of brain development, the completion of formal education and the transition into adult roles. Adolescent and young adulthood cannabis use has been linked to decrements in subsequent academic, occupational and social function. Moreover, heavy use during adolescence and emerging adulthood is associated with abnormal neuromaturation and poorer neurocognitive function. This presentation will provide an overview of neuroimaging evidence characterizing the neural sequelae of heavy marijuana use in youth using data gathered from studies at both UC San Diego and in Connecticut.

INTERVENTIONS FOR EARLY PSYCHOSIS IN CHILDREN AND ADOLESCENTS: NEW ADVANCES IN COMMUNITY AND POLICY APPROACHES

Chairs: Stephanie H. Chan, M.D., Ken Duckworth, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how community-based interventions for early psychosis in children and adolescents became the focus of attention for reducing disease burden and promoting recovery; 2) Identify and describe different levels of care in the community that are key players in early psychosis intervention; 3) Know the different community

resources for referral and importance of multi-disciplinary collaboration in the success of early intervention; and 4) Describe past and current public policy efforts in promoting funding and research in early psychosis management.

SUMMARY:

Schizophrenia and other psychotic disorders are among the most severe and debilitating mental illnesses. Psychotic illnesses may be presenting earlier than before, affecting more children and teenagers, due to more awareness in the community, the increasing prevalence of substance abuse and other factors. Efforts for earlier identification and intervention target the community, physicians and other interdisciplinary mental health providers. This may improve outcomes if effective interventions are made more available and patients have better access. This symposium will provide an overview of the history behind community psychiatry in early psychosis to the current efforts in expanding services in the community for children, teenagers and families to supplement psychopharmacology. First, we discuss how obstacles like stigma and lack of understanding in early psychosis were overcome by active collaboration of the community and psychiatry. Second, tips for enhancing disease outcomes like quality of life, day-to-day functioning and assimilation into society will be covered. Third, health service innovations (e.g., levels of care) for this population will also be explored, including school-based interventions and community team-based approaches. Finally, we examine this process of care at a global level—the development of a national network of early psychosis programs; shared approaches and, at times, data sets; and recent advancements in the public policy.

NO. 1

OFFERING HOPE AND REVOLUTIONARY CARE: CHANGING APPROACHES TO EARLY ONSET PSYCHOSIS

Speaker: Jacqueline M. Feldman, M.D.

SUMMARY:

For too long, the accepted trajectory of psychosis was one of decline in cognitive, social and vocational skills; care reflected a disbelief in the concept of recovery. This culture of low expectations was clouded by the stigma attached to serious mental illness for patients, families and providers, resulting in systems of care that failed to advocate for those

with psychosis, provide for workforce development, or develop innovative supports and treatment that could facilitate recovery. This presentation offers a historical perspective of inadequate understanding of early psychosis, the consequences of these limited treatment approaches, and the potential for revolutionary changes in diagnosis and treatment of individuals with psychosis.

NO. 2

EARLY DETECTION AND INTERVENTION FOR ADOLESCENTS WITH EARLY PSYCHOSIS: PROMISING NEW APPROACHES

Speaker: Steven Adelsheim, M.D.

SUMMARY:

Both international and U.S. programs expanding early intervention for young people with early psychosis show great promise and the potential for improved long-term outcomes. At the same time, the average duration of untreated psychosis continues to be between one and two years in the U.S. In addition, most of the early intervention programs in the U.S. are based on models developed initially to support adults with chronic mental illness. This presentation will focus on some of the critical components necessary to build on the existing models of early psychosis to specifically support adolescents. Expansion of partnerships with secondary schools, school health programs and supported education at the high school level are all important in bringing adolescents to early intervention and treatment. Outreach to schools and families are both critical to the early success of these programs. Ensuring youth mental health providers are a partner in early psychosis programs is also critical. With the rapid expansion of these U.S. programs, there is an urgent need to coordinate and facilitate early psychosis program rollout with fidelity and an effort toward tracking shared outcomes. Current efforts to build the national early psychosis network will also be highlighted.

NO. 3

THE PROMISE OF TEAM-BASED COMPREHENSIVE EARLY INTERVENTIONS SERVICES: FROM RAISE CONNECTION TO ONTRACKNY

Speaker: Lisa B. Dixon, M.D., M.P.H.

SUMMARY:

Research has suggested that providing specialized early intervention services that include team-based care, phase-specific treatment, medication, family

support and education, cognitive behavioral therapy and supported education and employment may improve outcomes for people experiencing the onset of schizophrenia. Research has also suggested that longer duration of untreated psychosis (DUP) is associated with poorer outcomes, underlining the potential benefits of reducing the DUP, which may contribute to producing better outcomes. The RAISE Connection program provided such a team-based model in New York and Maryland and delivered promising outcomes with respect to symptom reduction and improved social and occupational functioning. The RAISE Connection model was further refined and modified with input from experts in the field and evolved into OnTrackNY. This presentation will discuss the challenges and strategies encountered in the expansion of OnTrackNY throughout different regions of New York State. The presentation will also discuss outcomes of the program and strategies being used to maintain and expand the program.

NO. 4

EARLY PSYCHOSIS INTERVENTION MOMENTUM IN ADVOCACY AND POLICY

Speaker: Ken Duckworth, M.D.

SUMMARY:

Early psychosis intervention as a construct has been gaining momentum in advocacy and policy spheres. For example, The National Alliance on Mental Illness (NAMI) recently added support of early intervention in psychosis to its strategic plan. This is a recent public health vision that seeks to use NAMI resources to improve long-term outcomes by developing earlier and better interventions. NAMI helped to advocate for the additional five percent in SAMSHA block grant money in early psychosis that has helped to develop more of these programs. This evolution is also happening at multiple state leadership offices and at academic centers. This presentation provides an overview of the recent efforts in policy and advocacy for early psychosis interventions.

PSYCHIATRY IN THE ARAB WORLD: A DECADE OF PROGRESS AND A FUTURE OF EXPECTATIONS

Chairs: Ossama Tawakol Osman, M.D., Abdel F. Amin, M.D., M.P.H.

Discussant: David V. Sheehan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the progress made over the past decade to the field of psychiatry in the Arab World; 2) Highlight developments in clinical psychiatric services, education, policy and research in representative Arab Countries; and 3) Identify current challenges, expectations and future opportunities for the advancement of Arab psychiatry.

SUMMARY:

Over the past decade, there were number of significant developments to the field of psychiatry in Arab countries. The degree of progress, however, varied according to the socioeconomic and geopolitical characteristics of each country. This significant progress is commensurate with increased need for more efficient mental health systems capable of meeting the ever increasing challenges to Arab communities in the Middle East. These challenges, posed by a turbulent region, are demanding new responsibilities from educational institutions, clinical service delivery health systems, psychiatric practitioners and researchers. One common theme that emerges from the progress made over the past decade in different Arab countries is the essential role of international collaborations. Many Arab communities have benefited from international experience in developing their own mental health systems of clinical services, education policy or research. For example, an integrated approach to mental health policy development was founded in Egypt by a Finnish aid project with sustained technical support from the WHO. The newly developed psychiatric training programs in the United Arab Emirates (UAE) have attended both to combined local culture priorities and global progressive demands. It was, therefore, successful in obtaining accreditation by the American Council for Graduate Medical Education – international (ACGME-i), which testifies to the quality of its training schemes. The use of international diagnostic research instruments allowed researchers in Morocco to obtain comparable epidemiologic data on the prevalence of psychiatric disorders among its population, which produced data that spearheaded a progressive move toward a change. The speakers in this symposium represent three major geographic component regions of the Arab World, i.e., the eastern (Gulf) region represented by the UAE, the western (Atlantic) region represented by Morocco and the middle (Mediterranean) Arab region represented by

Egypt. Each of the speakers will summarize progress made in their respective countries in the context of the four dimensions of clinical psychiatric service, education, research and policy. They will also outline their views on future challenges and new emerging responsibilities for psychiatrists and advocates for mental health in this ancient region of the world.

NO. 1

HIGHLIGHTS OF ARAB PSYCHIATRY OVER THE PAST DECADE: ELEMENTS OF PROGRESS AND DEMANDS FOR THE FUTURE

Speaker: Ossama Tawakol Osman, M.D.

SUMMARY:

The past decade has witnessed significant progress in Arab psychiatry commensurate with increased needs for more efficient mental health systems in Arab countries. The challenges posed by the turbulent geopolitical and cultural elements in this unstable Middle Eastern region are demanding new responsibilities from educational institutions, clinical service delivery systems, psychiatric practitioners and researchers. This involves preparing a generation of trainee psychiatrists who are cognizant of their new roles and responsibilities and are well-trained to meet the new challenges. Clinical services need to cater for an ever increasing number of mental health conditions as a result of stress, trauma and displacement. Psychiatric research needs to focus on applied components of practical value to the current and future needs of society. Psychiatrists also need to be more active and responsible for designing, advocating and lobbying for mental health policies conducive to building a resilient society in face of abrupt, and frequently chaotic, circumstances in the Middle East. This presentation will detail an overview of changes in Arab psychiatry over the past decade and will highlight expectations for the next future era.

NO. 2

MENTAL HEALTH AND PSYCHIATRY IN EGYPT: A DECADE OF PROGRESS

Speaker: Afaf Hamed Khalil, M.D., Ph.D.

SUMMARY:

The substantial improvements in mental health services require an integrated policy and strategy, educational interventions to equip service providers, public education to raise awareness, and organizational reforms to enable interventions to be embedded in the health system. To meet these

challenges, an integrated approach to mental health policy development was founded in Egypt by a Finnish aid project with sustained technical support from the WHO. This presentation will highlight the multifaceted comprehensive program to promote sustainable system change in the field of mental health policy and service in Egypt. Despite the rapid population growth in Egypt, the number of psychiatric beds didn't show much increase, owing to the new policy of deinstitutionalization, which may reduce the need for psychiatric beds. Although after care service and community care show dramatic improvement, yet are still very limited, children and adolescent mental health were not sufficient and were not given high priority. Research and publication in the field of psychiatry in Egypt have been increased about eightfold with the development of two peer-reviewed journals. Further needed improvements will be discussed.

NO. 3

A DECISIVE DECADE FOR PSYCHIATRY AND MENTAL HEALTH IN MOROCCO: 2006–2015

Speaker: Driss Moussaoui, M.D.

SUMMARY:

The last decade has been decisive to psychiatry in Morocco. The turning point was a publication in 2007 of the results of the National Epidemiological Survey on Prevalence of Mental Disorders in the general population. The high rates of mental disorders found in this study prompted the highest authorities to make mental health a priority. A major operation was conducted a few months ago called Karama ("dignity" in Arabic) to free hundreds of chained patients in a traditional practice place, Bouya Omar. The year 2007 also saw the creation of a number of associations of families and the creation of the Moroccan Association of Psychiatry Users. This had a positive impact, increasing the mental health budget for psychiatric medications and for more residents in the five departments of psychiatry in Morocco. As for child and adolescent psychiatry, several new university diploma programs were launched for mental health workers on CBT, psychogeriatrics, clinical sexology and addiction medicine. There are a few hundred psychiatric beds currently under construction, and two other departments of psychiatry (Oujda and Agadir) are being created. Also, the old Mental Health Law of 1959 is currently under revision, and a new law was passed for regulating clinical research trials. An

optimistic perspective for the coming years will be presented.

NO. 4

PSYCHIATRY IN THE UNITED ARAB EMIRATES: A DECADE OF TRANSFORMATIVE PROGRESS

Speaker: Ghanem Al-Hassani, M.D.

SUMMARY:

The United Arab Emirates (UAE) was established on December second, 1971 as a federation of seven states, called emirates. Even though it is a young country, the UAE has one of the oldest mental health laws among Arab countries in the region. Accelerated socioeconomic progress has transformed psychiatry as well in this young country. A number of progressive outcomes have been achieved in education, research, clinical services and policy making. Training programs have been created and successfully accredited by international accreditations bodies. Increasing numbers of local Emirati physicians have now graduated from such programs, contributing to a progressive building of local internal capacity for the country. Favorable economic, cultural and social lifestyles have attracted highly qualified clinical and academic psychiatrists to the country. Active epidemiological and biological research studies are increasingly filling a gap by adding much-needed literature on this region. The above accomplishments will be discussed in detail along with strategies to meet challenges for the future.

NEW NEURAL TREATMENT TARGETS IN COMPULSIVE DISORDERS

Chair: Stefano Pallanti, M.D., Ph.D.

Discussant: Martijn Figeer, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the new insights on compulsivity neurobiology and cognitive domains across different disorders; 2) Understand the role of the presupplementary motor area (pre-SMA) networks in compulsivity networks; and 3) Demonstrate how neuromodulation techniques, such as repetitive transcranial magnetic stimulation and deep brain stimulation, could be used to modulate these brain networks.

SUMMARY:

Compulsivity is a behavioral construct hypothetically underlying a range of impulsive-compulsive

disorders, including OCD, autism spectrum disorders (ASD), addiction and ADHD. According to a neurobiological approach, such as the research domain criteria (RDoC) approach, compulsivity represents a cross-disorder trait implicating a number of overlapping neural networks, which are components of the broader frontostriatal circuitry. Increasing evidence suggests that different subtypes of compulsive behavior depend on dissociable neuroanatomical substrates underlying stereotypes, perseveration, switching, reversal learning, set shifting, goal-directed habit formation and exploration-exploitation. This presentation will explore new insights regarding compulsivity neurobiology across phenotypically distinct disorders characterized by underlying common compulsive traits, such as OCD and ASD, and will focus on the presupplementary motor area (pre-SMA) as a distinct node of the frontostriatal compulsivity network, examining its role as a potential neuromodulation target in the treatment of these disorders. We will first discuss the neural networks subserving the neurocognitive mechanisms of behavioral inhibition (vmPFC, caudate) and habit learning (pre-SMA, putamen) in OCD. Afterward, the role and significance of pre-SMA as a key node of compulsivity networks will be discussed, merging contributions from neuroimaging functional studies and neuromodulation investigational and treatment studies. These latter studies will also provide a framework for the identification of appropriate neuromodulation targets in the treatment of compulsive disorders, examining the results of both invasive (DBS) and noninvasive (rTMS, TBS) techniques in phenotypically distinct disorders characterized by underlying common compulsive traits.

NO. 1

COMPULSIVITY IN THE OCD SPECTRUM: COGNITIVE DOMAINS AND NEURAL CIRCUITRY

Speaker: Naomi A. Fineberg, M.B.B.S.

SUMMARY:

Obsessive-compulsive-related disorder (OCRD) patients exhibit significant impairments in a range of cognitive tasks. Growing evidence suggests the neurocognitive mechanisms mediating behavioral inhibition and habit learning contribute toward vulnerability to compulsive activity in a broad range of disorders characterized by compulsivity. In OCD, distributed network perturbation appears focused around the prefrontal cortex (PFC), caudate,

putamen and associated neurocircuitry. In a recent fMRI study, impaired set-shifting in OCD patients was associated with reduced functional connectivity between different sectors of the caudate, frontal cortex and associated regions, along the dorsal corticostriatal axis. This reduction may account for the deficits in shifting attentional focus away from inappropriate intrusive thoughts and rituals, resulting in the clinically observed perseverative behaviors and providing a valuable biomarker for OCD. Another recent fMRI study investigating the neural correlates of OCD symptom provocation showed a functional imbalance in habitual versus goal-directed neural systems, with reduced activation in regions implicated in goal-directed behavioral control (vmPFC, caudate) and increased activation in those implicated in habit learning (pre-SMA, putamen). Promising results from treatment studies using neuromodulation to target nodes within this frontostriatal circuitry indicate new treatment possibilities for refractory OCDs.

**NO. 2
EXPLORING TRANSCRANIAL MAGNETIC
STIMULATION (TMS) AS A TREATMENT AND AN
INVESTIGATIONAL TOOL TARGETING THE
SUPPLEMENTARY MOTOR AREA (SMA) IN OCD**

Speaker: Giacomo Grassi, M.D.

SUMMARY:

Neuromodulation represents a network pathway-oriented treatment and investigational tool that could be considered a promising tool in the achievement of “precision medicine” and as a research domain criteria-based approach to several psychiatric disorders, including OCD and related disorders. Recent meta-analyses show that repetitive TMS (rTMS) targeting the pre-SMA seems to be a promising treatment for resistant OCD. The pre-SMA plays a central role in response inhibition and performance monitoring networks. Dysfunctional inhibitory control during response inhibition and increased error monitoring and sensitivity represent two core endophenotypes of OCD extensively replicated in recent years. Thus, the mechanism of action of rTMS over the pre-SMA in OCD could be linked to the modulation of inhibitory response and error sensitivity. Moreover, other magnetic stimulation techniques, such as theta burst stimulation, could be useful as investigational tools in order to further clarify the role of the pre-SMA during several cognitive tasks in OCD patients.

**NO. 3
TRANSCRANIAL MAGNETIC STIMULATION (TMS)
TARGETS (INCLUDING THE SUPPLEMENTARY
MOTOR AREA [SMA]) FOR THE REPETITIVE
BEHAVIOR DOMAIN IN AUTISM SPECTRUM
DISORDERS (ASD)**

Speaker: Eric Hollander, M.D.

SUMMARY:

Repetitive behaviors are a core symptom domain in ASD as well as other compulsive disorders. ASD may share, along with other compulsive disorders, dysfunction of cognitive flexibility and functional imbalance in habitual versus goal-directed neural systems, with reduced activation in goal-directed behavior regions and increased activation in habit-learning regions (i.e., pre-SMA). TMS paradigms in ASD have demonstrated altered cortical excitability consistent with imbalance in the excitation/inhibition ratio. Abnormalities in SMA connectivity may underlie motor control and sensorimotor integration features of ASD, including the inability to suppress repetitive movements, complex acts and intrusive thoughts. Some of these symptoms may be the result of hyperexcitability of the motor cortex and the reduction of corticocortical inhibitory phenomena, which themselves are partly a consequence of deficient inhibitory control of motor output from hyperfunctioning subcortical and habit structures, such as basal ganglia and SMA. Neuromodulation to target nodes within this circuitry may target repetitive behaviors, such that low-frequency repetitive TMS (rTMS) of bilateral SMA resulted in reductions in severity of repetitive behaviors, as well as in secondary measures of anxiety/agitation. Other studies have utilized stimulation of dorsolateral prefrontal cortex, deep-brain TMS (dTMS) of medial frontal regions and theta-burst studies of the motor cortex to target other domains in ASD.

**NO. 4
NETWORK CHANGES OF DEEP BRAIN STIMULATION
FOR COMPULSIVE DISORDERS**

Speaker: Martijn Figee, M.D., Ph.D.

SUMMARY:

Deep brain stimulation (DBS) involves modulation of brain networks via implanted electrodes for treatment of neuropsychiatric disorders such as OCD. DBS targeted at the nucleus accumbens (NAc DBS) improves obsessive-compulsive symptoms, but also induces fast and prominent changes in anxiety,

mood and motivation. These heterogeneous effects suggest that NAc DBS modulates neural pathways underlying compulsivity, as well as affective and motivational brain networks. We examined brain network changes of NAc DBS in OCD patients using functional magnetic resonance imaging (fMRI), single-photon emission computed tomography (SPECT) and electroencephalography (EEG). DBS normalized local NAc activity during anticipation of reward and frontostriatal network activity during response inhibition. Moreover, DBS reduced excessive frontostriatal connectivity and induced local dopamine release, which correlated with OCD symptom improvement. These results demonstrate that NAc DBS may be effective for OCD, and potentially also for other compulsive disorders, by restoring frontostriatal network function.

MARIJUANA: ASSESSING ITS RISKS IN A CHANGING ENVIRONMENT

Chairs: Nora Volkow, M.D., Susan R. B. Weiss, Ph.D.

Discussant: Mark Kleiman, Ph.D., M.P.P.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Be informed regarding the latest research on the impact of marijuana use on the brain and cognition; 2) Be informed regarding the role of marijuana and related compounds in triggering psychosis; and 3) Be informed about the incidence and prevalence of cannabis use, cannabis use disorder, and psychotherapeutic and pharmacological treatments.

SUMMARY:

Cannabis policy in the U.S. and globally is changing rapidly: 23 states plus the District of Columbia (DC) have passed laws legalizing marijuana, and 15 additional states have legalized a component of marijuana, cannabidiol, for medicinal use. Four states plus DC have legalized its recreational use for individuals over age 21, and while there are some areas of general agreement (cannabis use is risky for children and adolescents, and its criminalization has had a disproportionate adverse impact on minority populations), there remain many areas of growing contention. Anecdotal and preliminary reports of myriad health benefits have led states to legalize, or consider legalizing, its use for cancer, pain, epilepsy, multiple sclerosis, PTSD, Alzheimer's disease, insomnia and more, without sufficient (or any) data. At the same time, the perception of risk associated with marijuana use, even frequent use, is declining

among young people—often a harbinger of increasing use. In this symposium, we will discuss some of the major areas of current research on the adverse effects of marijuana on the brain and its relevance to psychiatry. These include long-term (permanent?) cognitive decrements, psychotogenic effects and addiction (how do we treat it? who is at risk?). Finally, scientists can't wait until all the answers are in to provide input on rational policy making. Thus, we ask the question of how we balance our current knowledge of marijuana's effects (what we know, what we suspect and what we don't know) with useful policy recommendations that minimize harm to those most at risk.

NO. 1

EFFECTS OF MARIJUANA ON THE BRAIN AND COGNITION

Speaker: Deborah Yurgelen-Todd, Ph.D.

SUMMARY:

The effects of regular marijuana use on brain integrity and cognition have important implications for policy makers considering medical and recreational marijuana laws. Nevertheless, the impact of marijuana on the brain remains a point of debate. While frequency and duration of use, duration of abstinence, and cannabinoid content influence the impact of marijuana on the human brain, it has been reported that age of initiation and high levels of consumption may be especially significant factors associated with brain alterations related to marijuana use. Multimodal magnetic resonance imaging data (structural MRI, diffusion tensor MRI, functional MRI and magnetic resonance spectroscopy), as well as clinical and neuropsychological results acquired in adolescent and young adult marijuana users, will be presented. The relationship between age of first marijuana use and total lifetime marijuana use will be discussed to demonstrate that different patterns of functional connectivity, morphometric measures and metabolite levels are associated with risk and exposure. These findings suggest that age of first use of marijuana may be associated with altered prefrontal cortical development in adolescents and may lead to disruptions in normal developmental trajectories of cortical circuits. Taken together, these results underscore the importance of preventing marijuana use in children and adolescents.

NO. 2

TRADITIONAL MARIJUANA, HIGH-POTENCY CANNABIS AND SYNTHETIC CANNABINOIDS: INCREASING RISK OF PSYCHOSIS?

Speaker: Robin M. Murray, M.D.

SUMMARY:

Some people with schizophrenia have had cognitive and behavioral problems starting early in life; this route into psychosis is secondary to neurodevelopmental abnormality. An alternative route is drug-induced psychosis. Amphetamines can induce paranoid psychosis, and abuse of phencyclidine can mimic negative symptoms of schizophrenia. Nine prospective studies have shown that use of cannabis increases risk of later psychosis; confounders such as use of other drugs, personality problems and self-medication for psychotic symptoms do not explain away this association. In a comparison of 410 people with first-episode of psychosis and 370 controls, we found no effect of traditional resin (hashish) on psychosis risk, but high-potency cannabis (high THC/low CBD) significantly increased risk. The risk was greater in those who started using cannabis early and in those who carried variants in DRD2 and AKT1 genes. The population fraction attributed to high-potency cannabis was 24%. Experimental studies show that IV injection of THC to normal volunteers induces transient psychotic symptoms, but this effect is diminished if the THC is preceded by CBD. This fits with the clinical evidence showing that CBD has antipsychotic properties and that high THC/low CBD varieties of cannabis carry a greater risk of psychosis than traditional marijuana (low THC/substantial CBD). The use of highly potent synthetic cannabinoids is associated with an even greater risk of acute psychosis.

NO. 3

CANNABIS USE DISORDER: DIAGNOSIS AND TREATMENT

Speaker: Frances R. Levin, M.D.

SUMMARY:

Marijuana is the most widely used illicit drug in the U.S. Cannabis use disorders (CUD) tend to begin in late adolescence and early adulthood, with approximately 22.2 million current users among individuals ages 12 or older. Unlike *DSM-IV*, *DSM-5* acknowledges that CUD is associated with a characteristic withdrawal syndrome that may impede cessation of use. Other notable changes in making the diagnosis of CUD will be discussed, as

well as potential diagnostic challenges. To date, psychotherapeutic approaches have been most commonly implemented. Although these approaches are efficacious, for many individuals, there remain difficulties reducing or ceasing their use. While pharmacotherapies might enhance treatment outcome, there are no FDA-approved pharmacotherapies for CUD. Several medications have shown promise in reducing withdrawal symptoms or self-administration in the human laboratory. Similarly, there are agents that have been shown to reduce marijuana use in clinical treatment settings and are worthy of further investigation. Future treatment directions will be discussed.

NO. 4

CANNABIS: PATTERNS OF USE AND RISK

Speaker: James C. Anthony, Ph.D., M.Sc.

SUMMARY:

During this presentation, in addition to coverage of some surprising epidemiological trends and estimates of disability-adjusted life years attributed to cannabis smoking, I will present and discuss three “lessons learned” from epidemiology and prevention research on cannabis use and its hazards. One lesson is about the “risk perception” evidence. If we think of each school’s level of perceived harmfulness of cannabis use as a facet of that school’s ecology in a given year, can we use it to predict the future occurrence and clustering of newly incident cannabis smoking, school by school? Another lesson is about our frequently cited estimate that, for every 9–11 newly incident cannabis smokers, we see one of the newly incident users with development of a cannabis dependence syndrome. I will present some new epidemiological evidence on transition probabilities of this type and the circumstances governing observed variations in individual risks. The third lesson is about a research question for which we do not yet have good answers: If all states were to relax their cannabis smoking penalties, would all cannabis hazards get worse or would there be health and social benefits as well? To answer this type of question, scientists must move beyond science into the realm of values, where we must view politics clearly as “the art of the possible” versus science as “the art of the soluble.”

EMERGENCY PSYCHIATRY: CHANGING ISSUES FOR TRAINING AND SUPERVISION IN PSYCHIATRIC EMERGENCY SERVICES (PES)

Chair: Michelle B. Riba, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand major clinical presentations in emergency psychiatry; 2) Explore opportunities to strengthen training and supervision in psychiatric emergency settings; and 3) Discuss specific clinical syndromes such as agitation and effective treatment strategies.

SUMMARY:

One of the most challenging and high-stakes clinical settings for patients and for psychiatric trainees is the psychiatric emergency department. It is an important gateway for many patients and their families to get clinical support in times of crisis, as well as to initiate assessment and clinical care for acute as well as chronic conditions. Taking care of patients who are acutely ill in a timely manner takes incredible skill and ability. Asking the right questions, making the right assessment and obtaining sound advice from a supervisor are all so important for trainees and can have life and death implications for patients. This symposium will present major clinical topics in emergency psychiatry as well as training and supervisory issues that are important to discuss and explore. A discussion will review these topics and encourage audience participation.

NO. 1

LEGAL ISSUES IN THE EMERGENCY ROOM

Speaker: Debra Pinals, M.D.

SUMMARY:

Psychiatrists working in emergency room settings across the country must be able to process clinical case material and render clinical decisions at a fairly rapid pace. Because of the varied nature of emergency room work, it is important to be knowledgeable about legal issues as they arise. Matters such as emergency involuntary detention and civil commitment laws, confidentiality, duty to third parties that may be at risk of being harmed by a patient, and legal and regulatory issues pertaining to physical and medication restraint practices are important to understand. Despite frequent confrontation with legal matters, psychiatrists are often uncertain about how to proceed. This presentation will review broad principles related to the legal regulation of psychiatric practice as it pertains to the emergency room setting. Participants

will be able to share their clinical vignettes and ask questions as they arise.

NO. 2

EVALUATING AND MANAGING AGITATED PATIENTS

Speaker: Rachel Glick, M.D.

SUMMARY:

The agitated patient is frightening and challenging not only to psychiatric residents and other trainees, but also to seasoned emergency department and psychiatric emergency services staff. This presentation will review how the approach to agitated patients has evolved over time and offer suggestions to help trainees and all psychiatric emergency services staff manage this difficult patient population.

NO. 3

SUICIDE RISK ASSESSMENT AND MANAGEMENT

Speaker: Jose R. Maldonado, M.D.

SUMMARY:

Suicide assessment and management is one of the most important and difficult tasks in emergency psychiatry. Global suicide rates have increased 60% over the past 45 years. Suicide is the 10th leading cause of death globally. Each year, over 30,000 people have died by suicide in the U.S. (about 105 suicides/day), and one million worldwide. It is estimated that there are 10–40 nonfatal suicide attempts for every completed adult suicide, about 100–200 among adolescents. Suicide rates vary based on factors such as race, ethnicity, gender and age. Suicide is typically impulsive in nature. As such, many patients remain uncertain to the last moment, with little premeditation, and are often ambivalent about dying. No short-term risk factor(s) have been identified to determine when, or even if, a patient will attempt or complete suicide. In fact, commonly used criteria for approving hospitalization for potentially suicidal patients have not been proven predictive of future attempts. This presentation will review the psychobiological factors associated with suicide; review suicide warning signs; and assist clinicians in conducting an adequate, individualized suicide assessment so that providers are able to identify, treat and manage acute, patient-specific suicide risk factors, including specific interventions.

NO. 4

SUBSTANCE-RELATED PSYCHIATRIC EMERGENCIES

Speaker: Adam Miller, M.D.

SUMMARY:

A high proportion of psychiatric presentations in the emergency room are related to substance use. These individuals create unique challenges that often complicate the course of treatment provided. Increased safety risk, medical comorbidities and stigma all play a role in the increased complexity of decisions that have to be made while managing these cases. Due to this, it is important for clinicians to be familiar with common concerns related to substance use disorders as well as resources available to both them and the patient. Screening, assessment and intervention are all key aspects of providing timely appropriate care for substance using populations in an emergency room setting. Throughout this presentation we will explore important aspects of each of these three topics.

NO. 5**CLINICAL MANUAL OF EMERGENCY PSYCHIATRY**

Speaker: Katherine Maloy, M.D.

SUMMARY:

Psychiatric presentations to emergency departments continue to increase. In many systems, the emergency department is the “front door” to accessing care and is an opportunity to intervene or provide resources to patients who would not otherwise seek treatment. Psychiatric emergency care can take many forms, and the evaluation of behavioral and psychiatric emergencies requires a broad range of knowledge as well the flexibility to adapt to a variety of patients and clinical scenarios. Systems of care, local mental health law and ability to access care all play a role in emergency evaluations. This presentation will discuss a basic approach to evaluating the psychiatric patient in crisis, including issues of safety, interviewing techniques, and common social situations that impact disposition and treatment. Systems of care and how they affect the management and evaluation of psychiatric emergencies will also be reviewed, along with issues in supervision and working with non-MD clinicians.

NO. 6**DEPRESSION, EUPHORIA AND ANGER IN THE EMERGENCY DEPARTMENT**

Speaker: Philippe-Edouard Boursiquot, M.D., B.Sc.

SUMMARY:

Mood disturbance is one of the more common presentations in the Psychiatric Emergency Service (PES), with substance-related disorders and psychosis. Whether the patient is depressed, euphoric, or irritable, the clinician should ensure his/her safety, assess the patient’s risk of harm to self or others, and explore the indication of admission to hospital, involuntarily if applicable. If outpatient follow up is possible, it is important to seek an available setting and aim for timely access. The diagnostic assessment is often enhanced by collateral information. The documentation of the PES visit should outline the grounds for the disposition decision, and offer supports such as crisis lines or centers in the interim period leading to involvement with outpatient services. Caution is needed when introducing an antidepressant, as patients with a diathesis for Bipolar Disorder, or the disorder itself, may become more unwell with such a medication. Patients with mood disturbances may have an underlying medical condition, and the vigilance of clinicians regarding this possibility is paramount.

NO. 7**THE PSYCHOTIC PATIENT**

Speaker: Patricia Schwartz, M.D.

SUMMARY:

Psychosis (including symptoms of delusions, hallucinations, and disorganization of speech and behavior) is a common trigger for presentation to the emergency room for psychiatric evaluation. The psychotic patient may self-present because of the distress caused by his or her symptoms, but often is referred to the emergency department by others who have concerns about the patient’s behavior. Although primary psychotic disorders such as schizophrenia are the most obvious cause, patients presenting with psychosis need to be carefully evaluated for the presence of medical conditions, substance use and other psychiatric conditions that could be causing their symptoms. This presentation will inform participants how to safely obtain the history from the patient and collateral sources, how to perform a tailored medical workup to narrow this differential diagnosis, and how to weigh the risk factors for violence and self-harm that will inform the clinician’s decision regarding the need for hospitalization and further treatment. Interventions that can be initiated in the emergency setting, both pharmacological and nonpharmacological, will also be addressed. Attention will be given to how the

emergency psychiatric evaluation of the psychotic patient (particularly in new-onset psychosis) can be used as an opportunity to build an alliance in which the patient and family are active participants in the treatment plan.

ADVANCING BIOLOGICAL MARKERS FOR PTSD

Chairs: Marti Jett, Ph.D., Charles R. Marmar, M.D.

Discussant: Eric Vermetten, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Obtain an increased understanding of large-scale genetic approaches to understanding psychiatric disorders and PTSD; 2) Understand multi-omics associated with computational biology approaches to characterize blood biomarkers and pathways, networks and mechanisms involved in the development of PTSD; 3) List metabolism, inflammation and cell aging markers for PTSD; 4) Understand the link between neuroendocrine and epigenetic markers in PTSD; and 5) Learn how the diagnosis and symptom dimensions of PTSD relate to major corticolimbic white matter tract fractional anisotropy.

SUMMARY:

This symposium will present findings from a multi-site study on biological markers of PTSD, which accounts for about half of the mental health burden in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans. Discovering biomarkers for PTSD would assist in objective diagnosis, as well as advance the recognition of PTSD along biological homogeneous dimensions. This symposium will discuss findings from the DoD-funded systems biology biomarkers study of warzone-deployed Iraq and Afghanistan male veterans, including a training sample of 52 PTSD-positive and 52 PTSD-negative (healthy control) subjects and a comparable test sample of 31 PTSD-positive and 31 PTSD-negative subjects. Both samples were matched by age, gender and ethnicity. Participation in this study involved structural and functional brain imaging, fasting state blood draw (pre- and post-dexamethasone), 24-hour urine collection, neurocognitive test and self-report questionnaires. In addition, we will present progress on an additional DoD-funded validation study involving repeat assessments after one to two years of biomarkers in 35 PTSD cases and 35 PTSD controls from the discovery phase and 35 newly recruited PTSD cases and 50 new controls for the purpose of

examining stability of markers over time. Markers ascertained on all participants in the training and test samples include neurogenetic markers; multi-omic markers; metabolism, inflammation and cell aging markers; neuroendocrine markers; and neurocognitive and imaging markers. Candidate PTSD biomarkers in the training sample of 52 cases and 52 controls and from the test sample of 31 cases and 31 controls include the following: 1) Neurogenetics findings revealed a genome-wide significant single nucleotide polymorphism (SNP), rs717947, at chromosome 4p15 ($N=147$, $\beta=31.3$, $p=1.28 \times 10^{-8}$) found to associate with PTSD; 2) Multi-omic findings included a panel of 13 mRNAs and 10 brain-specific proteins that discriminate cases from controls; 3) Metabolic and immune system findings revealed two panels that indicate an alteration in cardiometabolic syndrome and mitochondrial dysfunction in PTSD cases; 4) Neuroendocrine findings suggests promising markers: cortisol, IC(50-DEX), BMI, GR sensitivity and glucocorticoid receptor (GR) gene methylation in PTSD cases; 5) White matter abnormalities: increased white matter in fractional anisotropy (FA) in the anterior corona radiata (ACR) and superior fronto-occipital fasciculus (SFOF), tracts involved in conflict processing and spatial attention. The AUC for the training sample ranged from 0.577 – 0.916 and 0.592 – 0.783 for the test sample.

NO. 1

GWAS APPROACHES TO UNDERSTANDING THE GENOMIC ARCHITECTURE OF PTSD

Speaker: Kerry Ressler, M.D., Ph.D.

SUMMARY:

We will first review the status of genome-wide association study (GWAS) approaches to PTSD and then present specific findings from the systems biology biomarker cohort. In this study with an extreme phenotype design, we found a genome-wide significant SNP, rs717947, at chromosome 4p15 ($N=147$ [combined training and testing], $\beta=31.3$, $p=1.28 \times 10^{-8}$) to associate with the Clinician-Administered PTSD Scale. We conducted replication and follow-up studies in an external sample, a larger urban community cohort, to determine the robustness and putative functionality of this risk variant. These data identify a genome-wide significant polymorphism conferring risk for PTSD, which associated with differential epigenetic regulation and differential cortical responses to fear, thus providing new insight into understanding

genetic and epigenetic regulation of PTSD and its intermediate phenotypes.

NO. 2

PANOMIC MARKERS OF PTSD

Speaker: Rasha Hammamieh, Ph.D., Pharm.D.

SUMMARY:

Molecular elucidation of PTSD is still elusive and frequently challenged by the overlapping symptoms of its comorbidities. We selected 52 PTSD male veterans (CAPS>40) and 52 age/race matched controls (CAPS<20) from approximately 1,700 Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans via stringent screening. We detected approximately 5,600 differentially methylated CpG islands assessed in whole blood of PTSD veterans. PTSD-relevant neuroendocrine and neurogenic networks and their consequences were differentially methylated. The severity of some current PTSD symptoms was correlated with an increased risk of physiological ailments, which were captured in epigenetically perturbed insulin resistance, circadian rhythm, innate immunity and telomere management. Epigenetic changes in addiction- and fear sensitization-related genes, in concert with neurotransmissions, were synergistically connected with the lasting impacts of PTSD on brain health and performance, effectively enriching the networks of long-term potentiation, depression and fear memory consolidation. Finally, we curated a set of dimethylglycines (DMGs) that potentially drive many PTSD-relevant networks in parallel; we speculate that these genes are putative PTSD signatures. Verifications of these hypotheses are underway by probing independent validation and prospective human cohorts.

NO. 3

METABOLISM, INFLAMMATION AND CELL AGING MARKERS FOR PTSD

Speaker: Synthia H. Mellon, Ph.D.

SUMMARY:

We sought to characterize potential biomarkers of PTSD and to investigate possible accelerated biological aging in this condition. In an initial “training” sample, we compared metabolism, inflammation and cell aging markers in 52 Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans with PTSD and 52 matched controls. PTSD was associated with cardiometabolic syndrome with increased fasting glucose, HOMA,

BMI and weight. Proinflammatory cytokines were elevated in PTSD, including IFN gamma, TNF alpha and CRP. PTSD was also associated with natural killer cell senescence, and serum BDNF levels were significantly elevated. We also found reduced citrate and increased pyruvate and lactate in PTSD, signatures of mitochondrial dysfunction that reflect inefficient intracellular energy generation, as well as indirect measures of deficient nitric oxide synthesis. Each of the aforementioned findings was validated in a separate, hypothesis-driven “test” sample of 31 veterans with PTSD and 31 without, although cytokine validation data are pending. These markers may help track and stage underlying physical pathology in PTSD and suggest novel prevention and treatment interventions.

NO. 4

NEUROENDOCRINE AND MOLECULAR MARKERS AND PTSD

Speaker: Rachel Yehuda, Ph.D.

SUMMARY:

We compared neuroendocrine markers in 78 OEF/OIF veterans with PTSD (PTSD+) and 79 matched combat-exposed controls without PTSD (PTSD-). The PTSD+ group showed greater evidence of glucocorticoid receptor (GR) sensitivity in PBMCs as reflected by the lysozyme stimulation test compared to the PTSD- group, controlling for the ratio of lymphocytes to monocytes. Evidence of greater GR sensitivity was also reflected in the results of the dexamethasone suppression test (DST), as the veterans with PTSD in the full sample showed a greater decline in cortisol in response to 0.50mg DEX. Results of 24-hour urinary cortisol excretion showed that the PTSD+ veterans in the total sample tended to have lower urinary cortisol excretion. Neuroendocrine outcomes are sensitive to body weight and body composition (e.g., BMI and waist circumference). Results will be discussed in consideration of these influences. Additionally, we examined cytosine methylation of the 1F promoter of the GR gene, a molecular epigenetic marker. Results showed that a significantly lower percentage of methylated clones were observed in the NR3C1-1F promoter across the 39 CpG sites in the PTSD+ group compared to the PTSD- group. Percent methylated clones and sum percent methylation were inversely correlated with cortisol decline in response to DEX. There is a neuroendocrine signature associated with combat PTSD that is fairly

reliable in discriminating groups of persons with and without PTSD.

NO. 5

PTSD AND WHITE MATTER ABNORMALITIES

Speaker: Kirstin Aschbacher, Ph.D.

SUMMARY:

PTSD is associated with abnormalities in functional connectivity of a specific corticolimbic network; however, less is known about white matter abnormalities providing structural connections for this network. This study investigated whether the diagnosis and symptoms of PTSD are associated with alterations in fractional anisotropy (FA), an index reflecting white matter organization in a set of six a priori-defined tracts. PTSD-positive veterans had significantly higher FA than combat-exposed controls without PTSD in the anterior corona radiata (ACR) and superior fronto-occipital fasciculus (SFOF). Among PTSD-positive veterans, lower FA of the uncinate fasciculus (UF) was associated with greater mood disturbance symptoms, while higher SFOF-FA was associated with greater mood and dissociative symptoms. Higher ACR-FA was significantly associated with greater hostility. Compared to combat-exposed controls without PTSD, veterans with PTSD exhibited increased white matter FA in the ACR and SFOF, tracts involved in conflict processing and spatial attention. Exploratory symptom-tract relationships suggest the possibility that white matter might help identify phenotypes of over- versus under-affect regulation, previously shown in functional connectivity studies.

IMPACT OF MENTAL ILLNESS IN AN ARMY BASIC TRAINING ENVIRONMENT: FROM THE RECRUITS WHO JOIN THE MILITARY TO THE INDIVIDUALS WHO RECRUIT AND TRAIN THEM

Chairs: Melinda A. Thiam, M.D., Keith Penska, M.D.

Discussant: Sonda Thompson, M.S.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the behavioral health screening process for entry into the Army, including specific behavioral health requirements for assignment job positions, such as recruiter or drill sergeant; 2) Define the most common stressors experienced by recruits in basic combat training (BCT), identify how basic combat training may exacerbate prior mental illness and/or cause new mental illness, and understand the impact mental

illness has on attrition from the military; 3) Understand the most common stressors and job challenges associated with drill sergeant and recruiter duty and identify strategies/programs the Army has implemented to help mitigate such stressors; 4) Identify the purpose of mental health screening, evaluation, treatment and potential separation options for soldiers discovered to have mental health issues in basic combat training; and 5) Understand the impact of mental illness on unit mission and the behavioral health management challenges once a recruit begins basic combat training.

SUMMARY:

Mental illness is increasingly being recognized for its impact on high-quality recruitment, retention and advancement of men and women who serve in the United States military. Public attention has been focused on rising Army suicide rates. Initially, it was assumed that the increased suicide rate was due to the psychological ramifications of deployment. However, recent research has found that the majority of individuals who attempted suicide or died by suicide had never deployed. Instead, these studies found that the majority of risk factors were associated with the existence of mental illness prior to enlistment. There is little information available on the occurrence and impact of mental illness in the military initial training environment. Recruits join the military for various reasons. When recruits experience difficulty in initial training, it is important to identify why. Many recruits who struggle have pre-existing mental illness of variable severity, or they have poor stress tolerance and poor resiliency. There are two additional military roles that have a tremendous influence on the training environment: the recruiters and drill sergeants. Recruiting duty and drill sergeant duty both require specialized mental health screening before a soldier can be eligible for such duty assignment. Recruiters have significant influence on who is recruited and enlisted into the military. Drill sergeants have the arduous task of teaching civilians how to become soldiers who can survive in combat. The roles of recruit, recruiter and drill sergeant are intricately interdependent on one another. Recruiters and drill sergeants have already survived rigors of initial entry training, and frequently combat, but have very challenging jobs that require a special level of mental resiliency.

NO. 1

**“GHOSTS” THAT JOIN THE MILITARY:
PSYCHOLOGICAL CHALLENGES OF RECRUITS WHO
SEEK TO JOIN THE MILITARY**

Speaker: Melinda A. Thiam, M.D.

SUMMARY:

Army basic training is meant to prepare a recruit physically, mentally and emotionally for the rigors of military service. Although the public may assume that individuals join military for patriotic reasons, this is seldom the primary cause. Recruits join the military for a variety of reasons, both conscious and unconscious. Some recruits enter the military accompanied by the “ghosts” that are present due to troubled upbringing, past trauma or traumatic interpersonal relationships. This presentation will discuss the psychological predisposing and precipitating factors that contribute to psychological distress in basic training. The presentation will then explore specific psychological stressors due to life transition/interpersonal dynamics and conclude by discussing how the recruits’ psychological resiliency affects their ability to successfully complete military training versus consequences to recruit, basic training unit and behavioral health provider when a recruit is not mentally fit for duty.

NO. 2

**FOR THOSE WHO SNEAK THROUGH: CHALLENGES
OF SEPARATING INDIVIDUALS WHO ARE MENTALLY
UNFIT FOR DUTY**

Speaker: Keith Penska, M.D.

SUMMARY:

Behavioral health providers who work with initial entry recruits are often faced with the challenging role of determining when a soldier is mentally unfit, versus recruits who are simply struggling to adjust with the rigors of training. During initial phases of the training cycle, there is significant mental health attrition; either endorse mental health conditions that they did not disclose during recruitment and entrance processing or develop acute depression, anxiety or, in some cases, suicidal ideation. This presentation will discuss the concept of dual agency for military behavioral health providers as they are called to evaluate and recommend treatment and return to duty versus administrative separation of mentally unfit recruits based on the needs of the Army.

NO. 3

**“HOW DID THIS PERSON GET INTO THE MILITARY?”
THE CHALLENGES OF SEVERE MENTAL ILLNESS IN
ARMY RECRUITS AND THE IMPACT ON BASIC
TRAINING MISSIONS**

Speaker: David S Hodson, Ed.D., Sonda Thompson, M.S.N.

SUMMARY:

With the release of the Army STARRS study, there has been increasing public awareness of the problem of pre-existing mental health conditions in military soldiers. Furthermore, the Army STARRS study identified that over one-third of soldiers with suicidal behavior had never deployed, and over 60% of these individuals had pre-existing behavioral health concerns. Individuals with mild behavioral health problems may be able to adapt, but some individuals somehow intentionally or inadvertently circumvent the screening process and manage to enlist when they obviously are not qualified. It is not uncommon for a recruit to arrive at training reception and relapse into mania or psychosis due to discontinuing antimanic or antipsychotic medications within the past few months. This presentation will discuss the challenges of suicidal, psychotic, manic or emotionally volatile trainees and how severe mental illness creates management challenges to commanders and behavioral health providers. It is in this setting that behavioral health providers work closely with training command to create a reasonable and effective safety plan that is safe for the soldier and creates the least restrictive environment, as well as the least amount of burden to command.

NO. 4

**ARMY AMBASSADOR TO THE PUBLIC: THE
PSYCHOLOGICAL REQUIREMENTS AS WELL AS
CHALLENGES OF BECOMING AN ARMY RECRUITER**

Speaker: Chaska Gomez, Psy.D.

SUMMARY:

Recruiters are the military professionals who establish and maintain enduring relationships with future soldiers, families and the American public. Recruiters must be independent and adaptive thinkers who can thrive in a relatively isolated environment that is frequently isolated from traditional military support services, military community and command. Recruiting duty requires rigorous work schedules, usually with nontraditional hours as well as strong interpersonal skills to develop rapport with potential recruits as well as

recruits' families. Due to the psychological demands of recruiting duty, the Army has identified specific psychological requirements needed for one to be suitable for recruiting duty. Behavioral health professionals across the Army are responsible for determining behavioral health suitability for recruiting duty. Recruiters must be able to cope with the stress of recruiting duty and be able to seek out treatment when needed. This presentation will address the behavioral health requirements, discuss the processes for selecting and assigning individuals to recruiting duty, and identify common psychological and emotional stressors innate to recruiting duty. This presentation will conclude with how the psychological health of the recruiter, or lack thereof, can affect the quality, quantity and appropriateness of potential recruits who seek to enter the military.

NO. 5

THE CHALLENGE OF WEARING THE HAT: STRESSORS AND MENTAL HEALTH CHALLENGES OF DRILL SERGEANT DUTY

Speaker: Wesley N. Stokes, Psy.D., Kimberly D. Goode, A.A.S.

SUMMARY:

Drill sergeants have the arduous task of taking untrained civilians and training them to become soldiers who can survive in combat. Drill sergeant duty has a significant number of interpersonal and emotional challenges, including long hours, little time with family, political pressures, and mentoring/training young men and women who may have never been away from home or were subject to discipline. This presentation will discuss the behavioral health requirement to be eligible for drill sergeant duty, the process of becoming a drill sergeant, and the psychological and emotional challenges that are common when a drill sergeant is "on the trail," as well as potential consequences of undiagnosed behavioral health conditions. The final section will review how Drill Sergeants' psychological health can affect the quality of the training unit as a whole, individual interactions with recruits and individual interactions with other cadre members involved in training.

DEFINING THE SYNDROME OF THE ACUTE SUICIDAL CRISIS

Chairs: Igor Galynker, M.D., Ph.D., Thomas Joiner, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the concept of the syndrome of acute suicidal crisis (ASC) as a diagnostic entity and its relationship to suicide risk factors and near-term suicide risk; 2) Describe different approaches to assessing the ASC, including evaluation of the acute suicidal affective disturbance (ASAD), the ASCIS, the SSF, assessments of arousal and the TAT; and 3) Understand factors contributing to our inability to predict near-term suicidal behavior.

SUMMARY:

In the last month of their lives, half of suicide decedents will see a clinician who fails to intervene, likely because the chronic risk factors useful in predicting eventual suicide cannot identify those at risk for imminent suicide. An alternative approach, assessing the intensity of the acute suicidal crisis (ASC) syndrome, has received relatively little attention. Meanwhile, pioneering research findings suggest that patients' transitions from suicidal ideation (SI) to suicide attempt (SA) may be marked by an ASC, which is characterized as a negative affective state of increased anxiety and agitation, or "psychic pain." Subsequent studies have expanded the scope of the ASC to an acute, transdiagnostic syndrome of affective dyscontrol, cognitive dyscontrol and hyperarousal, which may serve as a trigger for SA. The purpose of this symposium is to assess the current state of knowledge of the ASC as a syndrome and to help define future research directions needed to establish its validity for the assessment of imminent suicide risk. The first speaker (Thomas Joiner) will introduce the topic of the ASC by discussing a new diagnostic entity, the acute suicidal affective disturbance (ASAD). The second speaker (Arne E. Vaaler) will bring into focus the hyperarousal component of the ASC and will present data on agitation as a predictor of near-term suicide. The third speaker (Keith W. Jennings) will examine how an excessive internal focus may contribute to the ASC and suicidal crises in general. The fourth speaker (Lisa J. Cohen) will discuss the suicidal patient's cognitive awareness of their ASC and the novel use of the Thematic Apperception Test (TAT) as an implicit suicide risk assessment tool. The final speaker (Igor Galynker) will present a conceptual overview of the ASC and the current state of knowledge of its composition and boundaries, with the emphasis on emotional dysregulation. Together, this panel will provide a

well-rounded, evidence-based description of how different symptoms experienced by acutely suicidal individuals may form the syndrome of the ASC. Understanding the syndrome of the ASC, as well as defining and assessing its contribution to suicide risk, is critical for preventing suicide.

NO. 1

THE EXISTENCE, NECESSITY, VALIDITY AND CLINICAL UTILITY OF A NEW DIAGNOSTIC ENTITY: ACUTE SUICIDAL AFFECTIVE DISTURBANCE (ASAD)

Speaker: Thomas Joiner, Ph.D.

SUMMARY:

Suicidal behavior in patients can occur when suicide risk evaluation would assess them as being at low risk for suicide. This suggests that there must exist a syndrome linked to the catastrophic outcome of suicide, which signifies high imminent suicide risk. In this presentation, we'll discuss the research data concerning the existence, necessity, validity and clinical utility of a new diagnostic entity, the acute suicidal affective disturbance (ASAD). Suicide risk and mood symptoms were assessed across several studies and samples using an array of research methods (e.g., structured clinical interviews, self-report measures). The participants included inpatients (N>8,000), outpatients (N=179), undergraduates (N=195) and active duty military (N>3,000). Evidence suggests that the ASAD is distinct from known and accepted clinical entities of MDD, SI and SA. ASAD measures moderately correlate with those for MDD and for the DSM-5's suicidal behavior disorder (r 's range from 0.20 to 0.37, p 's<0.05). ASAD possesses incremental predictive validity over these constructs as well (e.g., $\beta=0.42$, $SE=0.001$, $t=180$). Our data indicate that ASAD exists as a non-redundant syndrome. Continued work on ASAD is needed, including efforts informed by Robins and Guze's (1970) classic approach to the validation of psychopathological entities and studies investigating ASAD's association with multiple indicators across different units of analysis and incorporating RDoC constructs.

NO. 2

AGITATION AT PSYCHIATRIC INPATIENT ADMISSION: SIGN OF ACUTE SUICIDAL CRISIS AND PREDICTOR OF SUICIDE AFTER DISCHARGE?

Speaker: Arne E. Vaaler, M.D., Ph.D.

SUMMARY:

At present, 60% of those who go on to die by suicide following their discharge from inpatient psychiatric units are classified as low risk at discharge. One reason for this failure to diagnose imminent suicidal risk is our inability to correctly identify an acute suicidal crisis. Agitation is a state of hyperarousal characterized by rapidly changing behavior, excessive motor and verbal activity, vegetative symptoms and impulsivity, which has been repeatedly linked to suicidal behavior. Furthermore, agitation is a predictor of imminent suicidal acts in the inpatient setting and may be a core component of the syndrome of the acute suicidal crisis. Little is known about how agitation affects suicide rates after discharge, but such knowledge could be essential for assessing risk when discharging high-risk inpatients. In a large ongoing study of the predictive factors of post-discharge suicide, a group of high-risk inpatients (n=420) admitted to an inpatient psychiatric unit for acute suicidality were assessed for agitation using several agitation scales and an autograph. Approximately 7% of this cohort (age<40) died within two years after discharge. In this presentation, we'll discuss the relationship between agitation intensity and postdischarge suicidal behavior, suicide methods, time course, demographics, diagnosis and medications, and we'll assess if acute agitation is a predictor for suicide during the first two years after discharge.

NO. 3

UNDERSTANDING SUICIDE RISK THROUGH THE PATIENT'S EYES

Speaker: Keith W. Jennings, Ph.D.

SUMMARY:

The Suicide Status Form (SSF) is a unique, suicide-specific risk assessment, treatment planning and tracking tool central to the collaborative assessment and management of suicidality (CAMS) approach to treating suicide. It consists of quantitative and qualitative items that provide a window into the mind of a suicidal patient, exploring his/her ambivalence toward suicide, which can lead to an effective course of care. We analyzed a sample of 120 suicide attempters' qualitative SSF responses and reliably identified self- versus relationally oriented patient typologies. We then examined differences between these groups on multiple standardized suicide risk assessment measures. Results found that self-oriented patients are at higher risk of suicide than relationally oriented patients (rate ratio=1.62, $p=0.04$). These results

suggest that an excessive internal focus may contribute to suicidal crises. Instilling hope, plans and goals and increasing social connectedness appear to be crucial to effectively managing suicide risk. Increasing a patient's focus on external, relational factors may also be central to reducing overall risk of suicide. These findings are consistent with existing research supporting the use of the SSF as an effective suicide risk assessment measure that inherently facilitates potentially lifesaving treatment.

NO. 4 DEVELOPMENT OF AN IMPLICIT MEASURE OF SUICIDAL RISK

Speaker: Lisa J. Cohen, Ph.D.

SUMMARY:

In recent years, there has been increasing interest in the notion of an acute suicidal state that might precipitate transition from suicidal ideation to behavior, or even to abrupt onset of impulsive suicidal behavior. Assessment of this state has relied primarily on self-report instruments, which pose problems of self-report bias. We therefore present a novel, implicit means of assessing acute suicidal risk utilizing a scale for rating responses to projective testing, allowing us to reduce self-report bias. Psychiatric inpatients (n=103) were administered the Columbia Suicide Severity Rating Scale (CSSRS), the Beck Depression Inventory (BDI) and the Thematic Apperception Test (TAT), a classic projective test that requires subjects to produce stories in response to evocative and ambiguous pictures. Stories for cards 3BM and 3GF were rated for depression and for suicidality. High-scoring narratives reflected bleak, hopeless and acutely dysphoric representations. In a preliminary analysis, the TAT score was substantively correlated with both BDI and past-month suicidal ideation ($r=0.279$ and 0.458 , respectively). However, the TAT was not significantly associated with the lifetime CSSRS suicidal ideation severity, whereas the BDI was associated with both lifetime and acute ideation. In conclusion, the TAT score appears to differentiate between lifetime and acute suicidal risk and may have potential as an implicit measure of the latter.

NO. 5 UNDERSTANDING THE ACUTE SUICIDAL CRISIS

Speaker: Igor Galynker, M.D., Ph.D.

SUMMARY:

Suicide may be preceded by a syndrome of intolerable emotional distress, the acute suicidal crisis (ASC), which may be related to the syndromes of entrapment and ruminative flooding. To this end, we present data from our investigation of the relationship between these three constructs and the ASC and their relevance to imminent suicide risk. The Acute Suicidal Crisis Intensity Scale (ASCIS) was administered together with a psychometric battery to 135 high-risk patients upon their admission to and prior to their discharge from an inpatient unit. The internal structure of the ASCIS and its prediction of suicidal behavior following discharge from inpatient hospitalization were assessed. ASCIS showed excellent reliability, with Cronbach's $\alpha=0.971$, a five-factor structure dominated by a single primary factor with loadings from almost all items. The five intercorrelated subscales were entrapment, ruminative flooding, emotional pain, fear of dying and dissociation. In prospective assessments (n=80, 10 SA; 59% f/u rate), ASCIS scores on day of discharge from the hospital were the only significant and also robust predictor of suicidal behavior in the following two months (ROC analysis AUC 0.813, $p=0.002$; 80.0% sensitivity and 72.9% specificity at cut score ≥ 74 [OR=11, $p=0.004$]). ASCIS measures a distinct syndromic entity, and its prediction of near-term suicidal behavior suggests that this syndrome describes the cognitive/affective symptoms of the acute suicidal crisis.

MAY 15, 2016

DECONSTRUCTING THE NEUROBIOLOGY OF DEPRESSION

Chairs: Amresh Shrivastava, M.D., Charles B. Nemeroff, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Examine neurochemical and endocrinal changes; 2) Understand genetic markers and the HPA axis; and 3) Examine current evidence of the neurobiology of suicide behavior.

SUMMARY:

In the last four decades, we have seen the rise of neurobiological concepts as a core feature of the psychopathology of mental disorders. In this journey of exploring biological theories, we have passed through three different phases. The first was when clear evidence of biological changes was found, which demonstrated that brain changes are

responsible for symptoms; in the second phase, we observed that biological changes, not alone but together with psychosocial and environmental factors, are correlated with psychopathology. The third phase belongs to current times and suggests that neurobiological changes occur due to environmental and adverse events, particularly during the early days of life and individual vulnerability. The new findings have raised the bar of expectation for millions of patients suffering from depression and other mental disorders and their relatives. Frontiers of the neurobiology of depression are challenging. With new advances, newer avenues for treatment, biological markers both prognostic and diagnostic, and preventive factors are likely to be a reality in the near future. In this symposium, presenters will discuss some of the important issues regarding genetic, environmental, neurochemical and epigenetic factors and discuss their intricacies and implications.

NO. 1

CENTRAL AND PERIPHERAL IMMUNE MARKERS IN DEPRESSION AND SUICIDE

Speaker: Ghanshyam N. Pandey, Ph.D.

SUMMARY:

Background: Abnormalities of cytokines have been implicated in depression, but it is not clear if similar abnormalities exist in the brains of depressed subjects. **Methods:** We determined the protein and mRNA expression of proinflammatory cytokines in the postmortem brain of depressed suicide victims and normal control subjects, as well as the mRNA of proinflammatory cytokines and their membrane-bound receptors in lymphocytes of depressed patients and control subjects. **Results:** The protein and mRNA expression of IL-1 β , IL-6 and TNF- α were increased, and IL-10 decreased in the PFC of depressed suicide victims compared to controls. Also, the mRNA expression of IL-1 β ; IL-6; TNF- α ; and the membrane-bound receptors IL1R1, TNFR1 and R2 and IL1R-Antagonist (IL1RA), but not ILR2, IL-6R or Gp130, were significantly increased in the lymphocytes of depressed patients compared to controls. **Conclusion:** These studies indicate that the suggested immune function abnormalities in depression may be related to abnormal expression of proinflammatory cytokines and their specific receptors in the brains of depressed suicide victims or the lymphocytes of depressed patients. This research was supported by NIMH RO1 MH 048153 and NIMH RO1 MH098554.

NO. 2

PERSONALIZED MEDICINE: DEPRESSION

Speaker: Charles B. Nemeroff, M.D., Ph.D.

SUMMARY:

In spite of the repeated demonstrations of a large genetic component to vulnerability for mood disorders including bipolar disorder and major depression, genome-wide association studies (GWAS) have not revealed any single gene that mediates this risk. In contrast, a number of genetic polymorphisms, all conferring small effects, have now been demonstrated to act in concert to underlie, at least in part, this heritable component of diathesis for mood disorders. This presentation will review work from our group and others on the identification of vulnerability genes for major depression with a focus on their interaction with a well-documented environmental cause of increased risk: child abuse and neglect. Data demonstrating the importance of the following genes will be described, including studies of gene-gene interactions: CRF1 receptor, serotonin transporter, BDNF, HTR3A and the CRFB binding protein. In addition to the burgeoning "omics" arena, which includes proteomics, transcriptomics, metabolomics and epigenetics, is the area of functional and structural brain imaging. Positron emission tomography (PET) and fMRI are being utilized both to study neurobiological vulnerability to depression as well as response to individually effective treatments.

NO. 3

PSYCHONEUROBIOLOGY OF RESILIENCE

Speaker: Gustavo E. Tafet, M.D., Ph.D.

SUMMARY:

The adaptive response to stress may be successful in the short term only if it is followed by the necessary homeostatic changes aimed at fulfilling an adaptive response restricted to acute and specific demands; otherwise, the negative consequences of excessive and uncontrolled responses may result in deleterious effects such as those produced by allostatic load. This process may diverge in different individuals, therefore developing more resilient strategies or more vulnerable reactions in response to similar stressors. The possibility to identify a psychoneurobiological profile of the resilient response may provide novel strategies aimed at

more effective therapeutic approaches in the treatment of chronic stress disorders.

NO. 4

RESILIENCE: A PSYCHOBIOLOGICAL CONSTRUCT FOR SUICIDALITY

Speaker: Amresh Shrivastava, M.D.

SUMMARY:

Though risk and protective factors play an important role in determining risk of suicide, a clear psychopathological trajectory is not clearly known. It is likely that resilience, a neurobehavioral construct, plays a pivotal role in defining the “final common pathway” for suicidality. The objective of the present study is to examine the association of resilience and suicidality in individuals with psychiatric disorders. In a prospective cross-sectional study, we examined the level of resilience by the Connor-Davidson scale (CD-RISC) and suicidality by the Scale for Impact of Suicidality Management, Assessment and Planning of Care (SIS-MAP). Brief screener and psychopathology were measured by clinical parameters, psychosis, depression and level of stress. In a cohort of 78 patients, 34 had low suicidality and 44 had high suicidality. Significantly, fewer patients who scored more than 60 on resiliency (suggesting high resiliency on CD-RISC) were having severe suicidality as measured by SIS-MAP ($p=0.006$). Resilience had consistent negative correlation with severity of suicidality ($r=-0.424$, $p=0.012$, CD-RISC <60 vs. >60 , SIS-MAP 35.1 vs. 22.8 $p=0.004$). **Conclusion:** This study shows that high resilience is associated with low suicidality. Resilience may, therefore, be a one of the factors determining the severity of suicidality. The study suggests the need for exploring the role of resilience in the psychopathological construct of suicidality.

NO. 5

HPA AXIS GENETIC VARIATION, PSYCHOSIS AND COGNITION IN DEPRESSION

Speaker: Alan F. Schatzberg, M.D.

SUMMARY:

Psychotic major depression (PMD) has been reported to occur at a point prevalence of 0.3 to 0.4%. In comparison with healthy controls and nonpsychotic major depressives (NPMDs), patients with the disorder demonstrate elevated cortisol activity as evidenced by high rates of nonsuppression and very high levels of cortisol on the dexamethasone suppression test (DST), elevated

24 urinary-free cortisol levels, and high serum cortisol and plasma adrenocorticotrophic hormone (ACTH) levels. These patients also demonstrate marked neuropsychological impairments. In this presentation, we initially discuss recent findings on the relationship of cortisol levels to cognitive deficits in a cohort of approximately 140 subjects—PMD, NPMD and healthy controls. The physiology and components of the closed feedback hypothalamic-pituitary-adrenal (HPA) axis have been well characterized, as have the genes that control the production of its key components. We report genetic variation of HPA axis genes as it relates to cortisol levels, measures of depression and psychosis, and neuropsychological test results. These data indicate that allelic variation for glucocorticoid receptor (GR) single nucleotide polymorphisms (SNPs) significantly predict cortisol levels, measures of psychosis and performance on attention and working memory. CRH-R1 variants relate significantly to depression, psychosis and memory.

THE ATHLETE: HOMOSEXUALITY AND TRANSGENDERISM

Chair: Antonia L. Baum, M.D.

Discussant: David O. Conant-Norville, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the unique pressures for gay and lesbian athletes in the athletic arena with an enhanced understanding of what it means to “come out” in the sporting world; 2) Understand what it means to be a transgender athlete and the stressors related to this; 3) Have an awareness of the team dynamics when a coach is gay, lesbian or transgender; and 4) Understand the scope of complications in leveling the playing field when the competition includes a transgender athlete.

SUMMARY:

An area of potential difficulty and/or conflict in the athletic arena arises when the athlete—or coach—is either homosexual or transgender. The first presentation will focus on sports culture and homosexuality, highlighting the dissonance—or, on occasion, adaptiveness—in particular sporting cultures of being homosexual and the consequences to the athlete. The unique dynamics that may ensue on a team when the coach is homosexual—how that can affect the homosexual and heterosexual members of a team—will also be discussed. As transgenderism has become more of a household

term, there has inevitably been more visibility in sports. The controversies surrounding the psychopathology will be touched upon, followed by a more in-depth discussion of the intersection between the sporting world and being transgender and the implications for competition and a level playing field. Specifically, the performances of athletes who have chosen to take hormonal treatments have been subject to scrutiny and created controversy. The facts as we know them—along with anecdotal cases—will be presented.

**NO. 1
THE DILEMMA OF COMING OUT AS A GAY OR LESBIAN ATHLETE**

Speaker: Daniel Begel, M.D.

SUMMARY:

Establishing a comfortable identity depends upon the fit between how one is perceived and how one is. The common cultural association of athleticism with heterosexual prowess can make identity formation difficult for the gay or lesbian athlete, who must decide whether, and how, to “come out.” Three basic options include keeping one’s sexual orientation secret, declaring one’s sexual orientation publicly, and living openly as a gay or lesbian person without saying much about it. Whatever option is chosen will have consequences for an athlete’s career and peace of mind. In this presentation, the process of deciding how to express one’s sexual orientation is described for several athletes. Although fully declaring one’s sexual orientation brings personal relief, it may also invite controversy, if not stigma, within segments of the athletic community. The role of the family as a source of support is crucial to any gay or lesbian athlete deciding how to manage their sexual orientation. The sport psychiatrist must appreciate the pain and complexity of the athlete’s feelings, the athlete’s developmental history and the impact of the athletic setting. As in any therapy, the sport psychiatrist must be aware of his or her own biases and resist any temptation to arrive at a premature solution.

**NO. 2
TEAM DYNAMICS WHEN THE COACH IS GAY OR TRANSGENDER**

Speaker: Antonia L. Baum, M.D.

SUMMARY:

An athletic team is an intimate group that faces challenges to its cohesiveness and optimal function.

An analogy between team and family dynamics can be drawn. The impact on the team of a coach who is openly (or remains closeted) gay or transgender can manifest on and off the field. There are some sports cultures in which homosexuality may be more accepted and may therefore have less of an impact. However, where stigma remains for the gay or transgender coach, interventions may be helpful to the team dynamic. A clinical example of a team intervention will be presented.

**AUTISM SPECTRUM DISORDERS (ASD):
EPIDEMIOLOGY, GENETICS, REVISITING
RISPERIDONE, PARENT TRAINING AND EARLY
DETECTION**

Chairs: Lan Chi Krysti L. Vo, M.D., Lawrence Scahill, Ph.D., M.S.N.

Discussant: Paul Wang, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the best estimate of prevalence for children with autism spectrum disorder; 2) Recognize the genetic heterogeneity of autism spectrum disorder and relevance to clinical practice; 3) Identify recent findings showing a low risk of cardiac conduction problems with risperidone compared to an elevated risk for weight gain and abnormal biochemical indices; 4) Identify the essential features and supporting evidence of parent training for young children with ASD and disruptive behavioral problems; and 5) Identify the value of and new approaches to early detection and intervention of autism spectrum disorder.

SUMMARY:

Autism spectrum disorder (ASD) in *DSM-5* is characterized by impaired social communication, repetitive behavior and restricted interests. In addition to core symptoms, children with ASD may also have behavioral problems such as tantrums, aggression and self-injury. Over the past decade, there have been great strides in many areas in ASD, including epidemiology, genetics, treatment and early detection. This symposium will present recent findings and provide useful information for the practicing general psychiatrist. We begin with a review of prevalence, followed by genetics, new findings on the safety of risperidone, application of parent training in children with ASD and techniques of early detection. There is wide variability in the estimated prevalence of ASD between countries and within the same country. This symposium will review

the epidemiological literature on ASD and will provide a perspective on the role and challenges of epidemiological studies. It will also reveal genetic discoveries and discuss their importance in current clinical practice as well as their potential role in developing new insights and treatments. Risperidone was the first FDA-approved medication for serious behavioral problems in children with ASD. Since then, the second-generation antipsychotics are now among the most widely used medications in children with ASD. We present new findings on the safety of risperidone with respect to cardiac conduction and the risk of adverse cardiometabolic effects. The symposium will also review findings from a recent large-scale randomized trial of parent training in preschool-age children with ASD. Finally, the symposium will discuss the value and techniques of early detection of ASD.

NO. 1
EPIDEMIOLOGY OF AUTISM SPECTRUM DISORDERS (ASD): TO KNOW WHAT WE SEE RATHER THAN TO SEE WHAT WE KNOW

Speaker: Young Shin Kim, M.D., Ph.D.

SUMMARY:

The current estimate for the prevalence of autism spectrum disorders (ASD) ranges from 1–2.6% in school-age children. This wide variability, which has been reported between countries and within the same country, reflects differences in diagnostic definitions, sample size and case ascertainment. The *DSM-5* definition is associated with a small decrease in overall prevalence in two major population surveys. An examination of time trends in prevalence rates confirms that the prevalence of ASD has increased. However, upward trends in prevalence cannot be directly attributed to an increase in the incidence of the disorder due to multiple confounding factors affecting trends in rates. These factors include broadening of the diagnostic definition over time, changes in referral patterns, increased availability of services, heightened public awareness of ASD and decreasing age at diagnosis due to more precise measuring tools. Nevertheless, the possibility of a true increase in incidence should not be ruled out. This presentation will review the epidemiological literature on ASD and discuss methodological issues that are relevant to this important public health issue. We will also present best practices of recent epidemiological studies and will provide a

perspective on the role and challenges of epidemiological studies.

NO. 2
ADVANCES IN MOLECULAR GENETICS OF AUTISM SPECTRUM DISORDERS (ASD): APPLICATIONS IN THE CLINIC, NEW PERSPECTIVES IN CLINICAL NEUROSCIENCE

Speaker: Joseph F. Cubells, M.D., Ph.D.

SUMMARY:

Autism spectrum disorders (ASD) are among the most heritable classes of neurodevelopmental behavioral disorders. In contrast to other psychiatric disorders, such as schizophrenia, ASD by definition manifests clinically in early childhood. These features of ASD have led to rapid advances in understanding specific genetic etiologies of ASD, in which specific rare genomic differences affect risk with effect sizes large enough to be relevant to some individual patients. Indeed, searching for such rare variations has been proposed as a standard of care in the evaluation of ASD. In addition, large-scale studies of association of common genetic variation (e.g., genome-wide association studies, GWAS) with ASD have identified variants of small effect size, implicating a host of specific loci that might contribute to risk for ASD. Although clinically irrelevant with regard to evaluation and management of individual patients, our understanding of common variants in ASD supports an emerging conceptualization of ASD as a group of syndromes reflecting heritable (and environmentally influenced, and therefore potentially treatable) disruptions of synaptic structure and connectivity. This presentation will review these complimentary sets of discoveries and discuss their importance in current clinical practice as well as their potential role in developing new insights and treatments.

NO. 3
REVISITING RISPERIDONE

Speaker: Lan Chi Krysti L. Vo, M.D.

SUMMARY:

Risperidone was the first FDA-approved medication for the treatment of serious behavioral problems in children with autism spectrum disorders (ASD). The Research Units on Pediatric Psychopharmacology (RUPP) Autism Network has completed two multisite trials that demonstrate efficacy. New analyses of the first RUPP study (N=101) show that, compared to placebo, risperidone has low probability of altering

cardiac conduction parameters such as the QT interval. The study findings also raise concerns about reliance on automated ECG readings. New analyses of the second RUPP study (N=124) show that children with a mean 22.9 + 2.8 weeks' exposure to risperidone gain 5.4 + 3.4kg on average. At baseline, 60.8% of subjects were classified as normal weight. By week 24, only 29.4% remained in the normal weight group. Children with reported increased appetite showed greater weight gain than children without reported appetite increase. There were also significant increases in plasma glucose ($p=0.02$), hemoglobin A1c ($p=0.01$), insulin ($p<0.0001$), HOMA-IR ($p<0.001$), alanine aminotransferase ($p=0.01$) and leptin ($p <0.0001$). The level of adiponectin declined ($p=0.003$). From baseline to week 16, there were 11 new cases of children meeting the conventional threshold for metabolic syndrome.

NO. 4
PARENT TRAINING IN CHILDREN WITH AUTISM SPECTRUM DISORDERS (ASD): RESULTS OF A RANDOMIZED CLINICAL TRIAL

Speaker: Lawrence Scahill, Ph.D., M.S.N.

SUMMARY:

Disruptive behavior is common in children with autism spectrum disorders (ASD). Behavioral interventions are used to treat disruptive behavior, but have not been evaluated in large-scale randomized trials. We conducted a 24-week, multisite, randomized trial to compare parent training to parent education. The sample included 180 children (three to seven years) with ASD and disruptive behaviors. Parents rated disruptive behavior and noncompliance on coprimary outcomes: the Aberrant Behavior Checklist-Irritability Subscale (range 0 to 45) and the Home Situations Questionnaire-Autism Spectrum Disorder (range 0 to 9). A clinician blind to treatment assignment rated the Improvement Scale of the Clinical Global Impression. At week 24, the Aberrant Behavior Checklist-Irritability subscale declined 47.7% in parent training (23.7 to 12.4) compared to 31.8% for parent education (23.9 to 16.3) ($p<0.001$, effect size=0.62). The Home Situations Questionnaire-Autism Spectrum Disorder declined 55% (4.0 to 1.8) in parent training compared to 34.2% in parent education (3.8 to 2.5) ($p<0.001$, effect size=0.48). The proportions with a positive response on the Clinical Global Impression-Improvement Scale were 68.5% for parent training

versus 39.6% for parent education ($p<0.001$, number needed to treat=4).

NO. 5
TOWARD UNIVERSAL SCREENING AND IMPROVED ACCESS TO EARLY INTERVENTION IN AUTISM SPECTRUM DISORDERS (ASD)

Speaker: Ami Klin, Ph.D.

SUMMARY:

Given the promise of optimized outcomes as a result of early diagnosis and access to early intervention, the American Academy of Pediatrics strongly recommends universal screening via the medical home, and yet, the median age of autism spectrum disorder (ASD) diagnosis still hovers around five, and fewer than eight percent of primary care practices conduct routine screening. Challenges in the uptake of early screening include imperfect screening tools; perceived burden on primary care practices; failure, in many cases, of follow-up from a screen positive to clinical ascertainment of eligibility and access to early treatments; and regional variability in quantity and quality of early intervention services. Despite these challenges, clinical science in this field is advancing aggressively, and we are closer than ever before to having objective, quantitative and cost-effective procedures for screening young children with ASD. Moreover, the evidence base now includes a growing range of treatments that are acceptable to parents and are increasingly available. This presentation covers the imperative of early screening and early intervention. It will also consider emerging solutions that address current challenges and promise greater uptake in the community at large.

MOOD, ART AND POLITICS: ABRAHAM LINCOLN, VINCENT VAN GOGH, SYLVIA PLATH AND ROBIN WILLIAMS—RESILIENCE AND CREATIVITY IN THE FACE OF GREAT ODDS

Chair: John P. O'Reardon, M.D.

Discussant: John P. O'Reardon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the links between psychopathology and artistic achievement; 2) Identify the role that mood disorders have played in the lives of major figures in the worlds of politics, art and the movies; and 3) Appreciate that mood disorders can both be a spur to achievement as well as unleash destructive forces in the mind.

SUMMARY:

In this symposium, we will examine the lives of three great artists and one deeply beloved politician, Abraham Lincoln, to some "Father of the Nation." Through a detailed examination of their life stories, we will attempt to understand their psychology to ascertain what role psychopathology played in driving their consummate achievements. As we will discover together, such psychopathology was at times a spur to their greatness and at other times a profound obstacle to the execution of their innate gifts and creativity. All four suffered from severe mood disorders, bipolar and unipolar in type. Creativity and achievement are not restricted to artists of the word (poetry, Sylvia Plath), the canvas (Vincent Van Gogh) or celluloid (Robin Williams), but also to politicians who must become masters of both the word (oratory) and ideas (governance). Lincoln embodies the highest achievements in politics and government. He ended slavery and kept the Union intact despite the tide of secession and the horrendous losses of the Civil War. Plath put forth a tremendous creative output in a short period of time before her life was cut cruelly short by her own hand. Plath illustrates that an unchecked mood disorder may not only color a life but can also fracture it. Van Gogh, like Plath, had an enormous creative output in a compressed period of time. He struggled with his mood disorder to maintain sanity and preserve his life, which he could not achieve in the end. Finally, Robin Williams is the outstanding comedian of his era who illustrates that behind every comedic smile can lurk great tragedy. His suicide shocked many as we came to grips with the contrast between his outer persona and inner suffering.

NO. 1**MOOD, ART AND POLITICS: ABRAHAM LINCOLN, VINCENT VAN GOGH, SYLVIA PLATH AND ROBIN WILLIAMS—RESILIENCE AND CREATIVITY IN THE FACE OF GREAT ODDS**

Speaker: Thomas Newmark, M.D.

SUMMARY:

In this presentation, we will examine the lives of three great artists and one deeply beloved politician, Abraham Lincoln, to some "Father of the Nation." Through a detailed examination of their life stories, we will attempt to understand their psychology to ascertain what role psychopathology played in driving their consummate achievements. As we will

discover together, such psychopathology was at times a spur to their greatness and at other times a profound obstacle to the execution of their innate gifts and creativity. All four suffered from severe mood disorders.

NO. 2**SYLVIA PLATH AND ROBIN WILLIAMS**

Speaker: Michelle Nagurney, M.D.

SUMMARY:

This presentation will first explore the life and artistic career of one of America's greatest poets, Sylvia Plath. It will trace the onset of her severe major depression to her adolescence and her only partially successful attempt to control it in her adult life. Her relationship with Ted Hughes will be examined to cast further light on the severe downs of her depression. The downward crashing course of her mood disorder following Hughes' infidelity will be reviewed to better understand how her young life culminated in suicide. Finally, the life of Robin Williams, a modern great comedian and artist, will be examined to better understand his work and to cast light on his shocking suicide. The prevalence of mood disorders in comedians may be higher, and none was greater than Williams. However, as is now more fully appreciated, behind the happy face lurked great sadness.

NO. 3**ABRAHAM LINCOLN AND VINCENT VAN GOGH**

Speaker: John P. O'Reardon, M.D.

SUMMARY:

This presentation will review the onset and course of Abraham Lincoln's major depression. It will explore the forbidding challenges Lincoln faced in combatting his depression and at the same time rising to the summit of American politics. It will review the adaptive defenses Lincoln employed to successfully combat his moods and dysthymia. The life of Vincent Van Gogh will be reviewed in depth to trace the origins and course of his debilitating bipolar disorder. It will relate the explosion of creativity he experienced following his move to Provence to the emergence of more disturbing aspects of his bipolar disorder. Finally, the presentation will culminate in an exploration the brilliance of his art in the last months of his life, which ended in suicide.

FORGIVENESS, TRAUMA AND PSYCHIATRY: THE CLINICAL RELEVANCE FROM DIVERSE FAITH PERSPECTIVES IN THE WAKE OF THE CHARLESTON CHURCH TRAGEDY

Chairs: Chris Winfrey, M.D., Rama Rao Gogineni, M.D.

Discussant: John Peteet, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define, describe and understand forgiveness across multiple faiths, its correlates and pathological states or consequences of non-forgiveness; 2) Appreciate forgiveness as an adjunctive tool for treatment of trauma; 3) Appreciate the role of forgiveness in the recent South Carolina massacre and mass trauma; 4) Appreciate the neurobiological evidence that supports the long history of forgiveness in faith; and 5) Appreciate clinical applications to understanding forgiveness through each faith and approaches to use with patients representing that perspective faith tradition.

SUMMARY:

In the APA's spring 2015 meeting, we conducted a very well-attended and -discussed workshop aimed at understanding the role of five major spiritual and religious traditions in the facilitation of mental health. In the 2016 APA Annual Meeting, we want to expand and propose another multifaith presentation. We will discuss the role of forgiveness in trauma. PTSD is a relatively new diagnostic category. We better understand how common it may be worldwide. Although major depressive disorder is thought to represent the number one illness worldwide in the next 10 years, according to World Health Organization, PTSD is not recognized as being as prevalent as it might be. Unfortunately, PTSD is notoriously difficult to treat in psychiatry. There is not an "anti-trauma" medication, and the results of various kinds of psychotherapy are variable. PTSD is also difficult to prevent, even though we can often identify the trauma soon after it occurs and know that a significant percentage of the people traumatized will develop PTSD. Preventive measures like debriefing and propranolol have failed as a preventive measure and, in the case of debriefing, may even be counterproductive. However, forgiveness has been documented throughout history as a tool to assist in recovery from transgressions and trauma. It is now supported through empirical research to reduce the intensity of

hostile feelings, neuroticism, revenge and aggression. It also helps to promote positive psychological fruits such as hope, gratitude, kindness and love. There is now neurobiological data to support neurological and neurochemical changes of persons undergoing forgiveness. Often, the final step in psychotherapy of PTSD lies in the consideration of whether to forgive the perpetrator(s) of the trauma. The Charleston church tragedy was a rare example of a different response to trauma, that is, the unconditional, rapid forgiveness of the perpetrator by many of the survivors and their loved ones in the Christian faith. The forgiveness in Charleston had the positive psychosocial result of taking down the historical trauma trigger of the Confederate flag, and ensuing violence did not occur. Time will tell if the forgiveness will have helped prevent PTSD in the individuals traumatized, though there is some evidence of that in the Amish after such traumatic events, like the school killings of five children in 2006. Charleston challenges psychiatry as to whether we have been underappreciating the therapeutic value of forgiveness. Various religious traditions have valued forgiveness throughout history, and we can learn from their approaches to forgiveness. We have a unique group of presenters from various gender, cultural, age and religious backgrounds who have expertise in the therapeutic potential of forgiveness within psychiatry and society.

NO. 1

EMMANUEL AME MASSACRE: BAHAI FAITH PERSPECTIVE ON FORGIVENESS

Speaker: Deborah Deas, M.D., M.P.H.

SUMMARY:

Twelve parishioners of Mother Emmanuel AME Church remained after church to hold a prayer meeting and welcomed a stranger to join them. The stranger spent one hour with them while they prayed, then turned a gun on them to kill nine valiant believers. He spared one to "tell the story" as two others hid in an office nearby. News of the nine martyrs of Mother Emmanuel AME Church stunned Charleston, S.C., and the world. Within days after the martyrdom, some family members expressed their forgiveness of the person who committed the heinous act. People across the nation were in disbelief that forgiveness was rendered so soon after such a heinous act. Dr. Deborah Deas will discuss the Emmanuel AME massacre, how the Institute of Psychiatry at the Medical University of South

Carolina rose to assist, and the role of forgiveness in dealing with trauma.

**NO. 2
FORGIVENESS AND TRAUMA: CLINICAL
PERSPECTIVES FROM THE CHRISTIAN FAITH**

Speaker: Kevin Brown

SUMMARY:

In the Christian tradition, forgiveness has been revered as the cornerstone of the faith. It is considered the portal to a relationship with God. Through this relationship, one discovers how to relate to others and to self. Christianity has its roots in a Judaic context and in the Judaic laws. The inception of Christianity marks a pivotal transition from yearly forgiveness to daily forgiveness to relational forgiveness, as noted in the Beatitudes and the Lord's Prayer. These texts provide a picture of forgiveness and its role in relationships. Areas of non-forgiveness are also noted, along with problems of the soul when forgiveness is not applied. In this presentation, a brief overview of this spiritual foundation will be described to lend context to the importance of forgiveness. Forgiveness will be defined alongside pseudo-forgiveness, and problems of non-forgiveness will be described. We will also look at barriers to forgiveness. Finally, interventions and opportunities to applying forgiveness will be described, such as small groups with persons dealing with trauma. A special note will address how mental health providers and Christian leaders can partner to address care of patients.

**NO. 3
JEWISH PERSPECTIVES ON FORGIVENESS RELATED
TO PSYCHIATRY**

Speaker: H. Steven Moffic, M.D.

SUMMARY:

Forgiveness is so important in Judaism that our holiest day of the year, Yom Kippur, is dedicated to forgiveness. On Yom Kippur, one should ask and pray for forgiveness from God for sins against God. However, for whatever requires forgiveness in relationships with other people, one is supposed to ask them directly for forgiveness. Moreover, it is assumed that coming to asking for forgiveness and/or granting it is a process. Granting immediate forgiveness, as took place with some family members of those killed in the Charleston church tragedy, is such a foreign concept in Judaism that it occasionally brings forth disbelief as to the

genuineness of granting such immediate forgiveness. In many ways, the Jewish view on proper forgiveness dovetails with how forgiveness is likely to be processed in the psychotherapy of trauma in those suffering from PTSD. This presentation will not only review the Jewish perspective on forgiveness and how forgiveness is generally processed in PTSD, but will also consider the question of the appropriateness and usefulness of granting more immediate forgiveness in Judaism and in those traumatized by others. Can granting immediate forgiveness, even without a request to do so, help prevent future PTSD?

**NO. 4
FORGIVENESS, ISLAMIC RELIGION/CULTURE AND
PSYCHIATRY**

Speaker: Driss Moussaoui, M.D.

SUMMARY:

Forgiveness is not only a good step in resolving conflicts in society and paving the way for a better future, but it is a major process of maturation in the education of children. Wisdom comes to both sides when forgiveness is made and implemented between the two parties—children and parents. This is why this psychological phenomenon is important for mental health at large and for psychiatry/psychotherapy as well. In Islamic culture, not only are the words "forgive" and "forgiver" found in many surahs of the Qur'an, but two out of the 99 names of Allah mean "The Forgiver" and "The Utmost Forgiver." It is this characteristic of God that the Persian poet Omar Khayyam referred to when he said "I will drink and drink again, until I see what is the strongest: my sin or forgiveness of Allah." It is interesting to observe, from the psychopathological point of view, the parallel between the dyads guilt/persecution on the one hand and forgiveness/condemnation, accusation and blame on the other. These phenomena are used as major psychological tools in daily life and during psychopathological crises, but vary from one culture to another. Psychotherapy is a means to find the best solution for the patient dealing with these psychological components. Practical examples will be given.

**NO. 5
FORGIVENESS: HINDU AND BUDDHIST
PERSPECTIVES**

Speaker: Shridhar Sharma, M.D., D.P.M.

SUMMARY:

In Vedic literature and the Hindu epics of Mahabharata (of which Gita is a small section) and Ramayana, ksama or kshyama (Sanskrit: क्षमा), often combined with kripa (tenderness), daya (kindness) and karuna (compassion), describe the concept of forgiveness. Buddhist teachings place much emphasis on the concepts of metta (loving kindness), karuna (compassion), mudita (sympathetic joy) and uppekha (equanimity) as a means to avoiding resentments in the first place. One of the six cardinal virtues in Hinduism, forgiveness, is discussed in verses from ancient Rig Veda dedicated to deity Varuna, both in the context of the one who has done wrong and one who is wronged. The theological basis for forgiveness in Hinduism is that a person who does not forgive carries a baggage of memories of the wrong, negative feelings, anger and unresolved emotions that affect his or her present as well as future. A similar view is shared in Buddhist writings, stating "if we haven't forgiven, we keep creating an identity around pain, and that is what is reborn. That is what suffers." Therefore, in Buddhism, forgiveness is seen as a practice to prevent harmful thoughts from causing havoc on one's mental well-being. Buddhism recognizes that feelings of ill will and hatred leave lasting effects on our mind karma, and instead, cultivation of thoughts that leave a wholesome effect is suggested.

INTEGRATING SOCIOCULTURAL PERSPECTIVES OF POSTPARTUM DEPRESSION (PPD) AMONG DIVERSE WOMEN IMPROVES CARE

Chairs: Pamela C. Montano Arteaga, M.D., Maria Jose Lisotto, M.D.

Discussants: Roberto Lewis-Fernandez, M.D., Elizabeth Fitelson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the effect of sociocultural factors on minorities with postpartum depression (PPD); 2) Appreciate the interaction between emotional conflicts and sociocultural perspectives among immigrant women with PPD; 3) Realize the impact that the postpartum rituals of diverse cultures can have on the management of diverse women with PPD; 4) Understand the severity and prevalence of intimate partner violence among women suffering from PPD; and 5) Recognize the need for a culturally informed assessment and treatment model for PPD.

SUMMARY:

An integration of the complex psychological and sociocultural presentations of postpartum depression (PPD) is crucial to the development of a comprehensive assessment tool for the prevention, detection and treatment of PPD in diverse women. This symposium will expound upon these concepts through the use of both written and recorded case presentations aimed at increasing awareness and facilitating learning. Topics to be explored will include 1) The impact of migration on PPD symptomatology, 2) A comparison of PPD among different immigrant groups; 3) Examples of traditional rituals and their effect on mothers' mental health; 4) The effect of intimate partner violence on the development and persistence of PPD; 5) Using psychodynamic concepts to understand how sociocultural factors affect women psychologically during the perinatal period; and 6) The use of the *DSM-V* Outline for Cultural Formulation for the assessment and treatment of PPD among underserved women. PPD is a major public health problem, now second only to HIV/AIDS as a cause of disability in women aged 15–44 worldwide. While much focus has been placed on the biological and psychological factors of PPD, it is becoming increasingly apparent that sociocultural aspects also play a significant role. Current evidence suggests that immigrant and minority women are among the most vulnerable groups. Recent studies demonstrate a 19% prevalence rate of PPD within the general female population in the U.S., compared to a 42% prevalence rate within the refugee and immigrant subpopulations. It has been demonstrated that several cross-cultural risk factors exist among sufferers of PPD, including antenatal depression, poor marital relationship, financial hardship, unwanted pregnancy, lack of social support, unexpected birth outcomes and negative attitude toward pregnancy. However, many culturally specific factors that highlight the differential experiences of immigrant women within this general population remain. Examples include the following: 1) Child gender preferences lead to higher rates of PPD in some Asian cultures; 2) Associations exist between the traditional custom of "doing the month" and reduced PPD symptoms in various ethno kinship-based societies; and 3) The interpretation of depressive symptoms through cultural syndromes such as jinn possession among Muslims are important for accurate diagnosis of PPD. Additionally, differences in health belief models

and perceptions of mental health often lead to the stigmatization of mental illness in some cultures, creating a barrier to care that may explain the ever growing disparity seen in cross-cultural comparisons of PPD prevalence rates. More importantly, some cultural practices have been demonstrated to have either a protective or exacerbating influence on PPD, suggesting a role for the encouragement of postpartum traditions combined with education on how to ensure that these rituals provide optimum postnatal support.

NO. 1
SOCIOCULTURAL RISK FACTORS FOR POSTPARTUM DEPRESSION AMONG IMMIGRANT AND MINORITY WOMEN

Speaker: Pamela C. Montano Arteaga, M.D.

SUMMARY:

Postpartum depression (PPD) is a common complication of childbearing and has increasingly been identified as a major public health problem. Untreated maternal depression has multiple potential negative effects on maternal-infant attachment and child development. Recent research has shown that immigrant and minority women are among the most vulnerable groups. Evidence indicates that 19% of women in the U.S. suffer from PPD, compared to 42% of refugee and immigrant women (projected to contribute to 82% of the increase in population from 2005 to 2050). Recent research has resulted in earlier detection and treatment of PPD, benefiting the entire family unit. However, an inadequate focus has been placed on immigrant women, a population with unique and multilayered challenges that may compromise their mental health and prevent them from receiving adequate and equitable care. These women often face stressful pre-migration experiences, language barriers, marginalization, low socioeconomic status, lack of social support, poor physical health and difficulty adapting to host cultures.

NO. 2
OVERVIEW OF THE ASSESSMENT AND TREATMENT OF POSTPARTUM DEPRESSION

Speaker: Elizabeth Fitelson, M.D.

SUMMARY:

This presentation will explore how to use the *DSM-5* Outline for Cultural Formulation in the assessment and treatment of postpartum depression (PPD). PPD is a major concern among underserved women, and

it is important for mental health professionals to have the tools necessary to adequately treat this high-risk population.

NO. 3
POSTPARTUM RITUALS AND OTHER CULTURAL CONSIDERATIONS IN THE MANAGEMENT OF POSTPARTUM DEPRESSION (PPD)

Speaker: Kenneth P. Fung, M.D.

SUMMARY:

The postpartum period, like many other important transitional milestones in the lifecycle, is steeped in diverse cultural practices. Many perinatal traditions include specific proscribed and prohibited cultural rituals and practices before, during and after pregnancy. This commonly includes specific changes in diet, organized support and activity levels. Some of these practices are based on alternative explanatory models of health and illness, while others are based on cultural beliefs or are reflective of sociopolitical forces. In this presentation, some of these cultural practices and their potential for compounding or ameliorating postpartum depression (PPD) will be discussed. A clinical case example will be used to further illustrate the complex practical and clinical issues arising from managing PPD in the context of postpartum rituals, cultural beliefs and other sociocultural considerations.

NO. 4
INTIMATE PARTNER VIOLENCE AND POSTPARTUM DEPRESSION

Speaker: Ludmila De Faria, M.D.

SUMMARY:

Intimate partner violence (IPV) is highly prevalent worldwide and a major public health issue. Women are more likely to be victims, with serious physical and mental health consequences. The relationship between IPV and increased risk for depressive disorders during the entire perinatal period has been well established. The risk is further augmented by multiple psychosocial stressors, including poverty and immigration status. In this presentation, we will offer an overview of current data and discuss possible public health policies that can target this problem.

NO. 5

AN END TO PAINTING BY NUMBERS: A CULTURALLY INFORMED ASSESSMENT AND TREATMENT MODEL FOR POSTPARTUM DEPRESSION

Speaker: Matthew L. Dominguez, M.D., M.P.H.

SUMMARY:

Given the rich background on the unique experiences of immigrant women, a model will be proposed to improve upon the standard forms of assessment and treatment of postpartum depression. Emphasis will be placed on the correct and consistent usage of a complete biopsychosocial framework that paints a picture of the individual, not the symptoms. Reference will be made to the *DSM* cultural assessment tools already used in practice with a model of how a family mental health assessment may be utilized to engage patients who may be heavily influenced by cultural values that de-emphasize the individual. Finally, a culturally informed treatment strategy will be discussed to educate practitioners on methods of delivering psychoeducation, psychopharmacological and therapeutic interventions in a manner that is better tailored to diverse populations.

BIPOLAR DISORDER IN CHILDREN AND ADULTS IN FRANCE AND NORTH AMERICA: VIVE LA DIFFERENCE!

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know some of the features that distinguish French and American research about bipolar disorder; 2) Know some of the features that distinguish French and American practices about bipolar disorder in adults; and 3) Know some of the features that distinguish French and American research and practices about bipolar disorder in children and adolescents.

SUMMARY:

The French Psychiatric Association and the American Psychiatric Association have held joint symposia at the APA Annual Meeting for over two decades on the subject of differences in approaches to psychiatric issues. This year's symposium is titled "Bipolar Disorder in Children and Adults in France and North America: Vive La Difference!" Dr. John A. Talbott (US) will chair the symposium and introduce the session. Dr. Francois Petitjean (FR) will co-chair the session and lead the discussion. Dr. Ludovic

Samalin (FR) will open by presenting a paper on the French guidelines for bipolar disease, followed by Dr. Raymond DePaulo (US), who will talk about the role of patient and family education on bipolar disorder in America. Then Dr. Clara Brichant-Petitjean (FR) will discuss predictors of the switch to mania and, finally, Dr. Gail Robinson (CA) will discuss the North American approach to bipolar disorder during pregnancy, while Dr. Gisele Apter (FR) will present the French integrative model to bipolar disorder in the peripartum period. There will be ample time for questions and answers.

NO. 1

FRENCH GUIDELINES FOR THE TREATMENT OF BIPOLAR DISORDER: INTERESTS AND LIMITS

Speaker: Ludovic Samalin, M.D.

SUMMARY:

In the last few decades, an increasing number of drugs have been approved for the treatment of bipolar disorders. Making a relevant choice of medication represents a new challenge for clinicians. Guidelines have been developed to help them make their choice of appropriate evidence-based care in specific clinical circumstances; however, the pathway from evidence-based guidelines to evidence-based practice is not as obvious as expected. To improve clinicians' use of treatment guidelines, guidelines should be developed locally to take into account national context characteristics and feasibility. On behalf of the Association Française de Psychiatrie Biologique et Neuropsychopharmacologie (AFPBN), we developed and recently updated a consensus-based guideline for the treatment of bipolar disorders. Due to the method used, the aspects of the treatment of bipolar patients sparking debate and questions from clinicians (use of antidepressant, place of the bitherapy, interest in long-acting antipsychotics...) were covered, and we proposed graded recommendations taking into account, specifically, the risk-benefit balance of each molecule. We will present the method (based on formalized expert consensus such as American expert consensus guidelines) and the main results of this guideline and will discuss of its interests and limits in comparison with other international guidelines.

NO. 2

ANTIDEPRESSANT-EMERGENT MANIC SWITCH: IDENTIFYING AT-RISK BIPOLAR I AND II PATIENTS

Speaker: Clara Brichant-Petitjean, M.D.

SUMMARY:

Treatment of the depressive polarity of bipolar disorder is still an important challenge for clinicians, since it is the most burdensome feature of the disorder and the number of evidence-based options is very limited. The relative risks and benefits of using antidepressants for bipolar depression have been strongly debated over the past 25 years. In terms of risks, several placebo-controlled studies have shown that antidepressants could induce manic or hypomanic episodes in bipolar disorder and accelerate the rate of cycling, worsening the course of the illness by destabilizing the disorder, increasing the number of mood episodes over time. In terms of benefits, the relevance of antidepressants in the treatment of bipolar depression remains controversial. Antidepressant monotherapy is not recommended for acute or maintenance treatment of bipolar depression. Despite these concerns and despite treatment guidelines recommending against their use as monotherapy, antidepressants are still the most commonly prescribed treatment for bipolar disorder.

NO. 3**AN AMERICAN APPROACH TO BIPOLAR DISORDER: PATIENT AND FAMILY EDUCATION**

Speaker: J. Raymond DePaulo Jr., M.D.

SUMMARY:

This presentation will describe a number of programs for patient and family education in bipolar disorder from Johns Hopkins and other U.S. centers. Hopkins programs owe a great deal to two individuals who spoke and wrote about their experiences with depression and bipolar disorder. Clifford Beers' *A Mind That Found Itself* inspired the Phipps Endowment, creating the Department of Psychiatry. Kay Redfield Jamison's *An Unquiet Mind*, written shortly after she came to Hopkins, has had a global influence on how patients with bipolar disorder are perceived by themselves and others. At Hopkins, a straightforward "disease" approach to bipolar disorder was the basis for early efforts at patient education, starting with a families' organization, the Depression and Related Affective Disorders Association (DRADA, 1986 – 2006). This group was inaugurated by 16 individuals who were patients, spouses, parents or children of bipolar patients. The four other members were a Johns Hopkins nurse, two social workers in private practice and myself. This group grew to 1,100+ dues-paying

families and worked together for 20 years. The board and membership spawned educational activities.

NO. 4**THE NORTH AMERICAN APPROACH TO BIPOLAR DISORDER DURING PREGNANCY**

Speaker: Gail Erlick Robinson, M.D.

SUMMARY:

The management of bipolar disorder during pregnancy starts prior to the woman trying to conceive. Patients should be dissuaded from making decisions about conceiving during episodes of depression or mania. The psychiatrist should discuss the risks of decompensation if medication is discontinued during pregnancy. Keeping that in mind, it is important to find medications that are safe for use during pregnancy. Valproic acid, for example, has a very high risk of causing serious fetal deformities. During pregnancy, medication doses may have to increase to compensate for physiological changes. Postpartum women with bipolar disorder have a high risk of developing a depression or manic episode. They can benefit from close follow-up and support. Unfortunately, in North America, community support may be minimal due to limited funding.

NO. 5**BIPOLAR DISORDER DURING THE PERIPARTUM PERIOD: A FRENCH INTEGRATIVE MODEL**

Speaker: Gisele Apter, M.D., Ph.D.

SUMMARY:

Managing bipolar disorder during pregnancy and the immediate postpartum period is still a challenge. Adaptation of psychotropic medication during pregnancy and lactation is possible but often not well-known. Psychotherapeutic support and patient education still need to be implemented at a time when the birth of a new baby can be disruptive and stressful. In the context of the French health system, a program in perinatal psychiatry was developed to reach out and address these perinatal issues. Adaptation and monitoring of medication during pregnancy and the postpartum period and prolonged inpatient stay in the OB are offered immediately after delivery to all women with a past history of bipolar illness, with perinatal and infant psychiatry daily monitoring for 10 days and weekly, then monthly, outpatient follow-up during the first months after delivery. When initiated prenatally,

episodes are followed by mother-baby unit hospitalization. This program is implemented as part of a general psychiatric liaison emergency and follow-up program in perinatal psychiatry. Mother and infant clinical qualitative outcomes will be presented.

YOU'RE TAKING WHAT? UNDERSTANDING NEW COMMONLY USED MEDICINES FOR MEDICAL DISORDERS: A CASE-BASED APPROACH FOR THE GENERAL PSYCHIATRIST

Chairs: Jeffrey T. Rado, M.D., M.P.H., Robert M. McCarron, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand where newer medical therapies fit into the treatment paradigms for common medical conditions that have a high psychiatric comorbidity, including diabetes mellitus, cancer and hepatitis C; 2) Be aware of potential drug interactions between newer medical therapies and psychotropic medications; and 3) Appreciate how the psychiatrist can play a significant role in screening, coordinating and supporting their patients' general medical care.

SUMMARY:

In recent years, there has been an explosion of new medications used to treat general medical conditions. Recently approved agents include several novel anticoagulants, life-changing antiviral medications and groundbreaking cancer treatments. This symposium will focus on new medications that are used to treat a variety of disorders including, atrial fibrillation, pulmonary embolism, hepatitis C, diabetes mellitus and cancer. A case-based approach will be used to illustrate when these newer agents are typically used, how they differ from older treatments and common side effects that might present in a psychiatrists' office. Special attention will be paid to issues related to their use in psychiatric patients, including potential drug interactions. With psychiatrists increasingly becoming more involved in the screening and initiation of treatment for medical disorders, it is important that they have a basic understanding of newer medical therapies for disorders including Hepatitis C and diabetes, both of which have high psychiatric comorbidity. This is particularly true in seriously mentally ill populations who may have a limited understanding of their nonpsychiatric illnesses and the medications used to treat them.

NO. 1

CANCER AND PSYCHIATRIC MEDICATIONS

Speaker: Virginia O'Brien, M.D.

SUMMARY:

Newer treatments for cancer are rapidly being developed and employed in patients. It is well known that cancer patients with comorbid mental illness often face unique challenges. In this context, our presentation will highlight recently approved chemotherapeutic agents and their use in patients being prescribed psychotropic medications and the challenges that arise, which may differ from typical psychiatric practice. Through the use of illustrative clinical cases, focus will be on how these newer cancer-fighting agents are employed in the context of concomitant psychotropic use. An additional focus will be on which psychiatric drugs have evidence for use in the cancer patient and which don't and how to allay fears about prescribing stimulants, benzodiazepines, hypnotics and other psychotropic medications.

NO. 2

BEYOND METFORMIN: NEW MEDICATIONS FOR DIABETES MELLITUS AND REVIEW OF NOVEL ANTICOAGULANTS

Speaker: Sarah Rivelli, M.D.

SUMMARY:

Recent years have seen the introduction of multiple new classes of medications for diabetes mellitus. Diabetes is common in patients with a variety of psychiatric disorders, including schizophrenia and depression. Psychiatrists are increasingly being called upon to take a more active role in their patients' physical health. This is particularly true regarding screening for common disorders, initiating treatments and helping to coordinate appropriate medical follow-up. In this context, a case-based approach will be used to illustrate when these newer antidiabetic agents are typically used, how they differ from older treatments and common side effects that might present in a psychiatrist's office. Special attention will be paid to issues related to their use in psychiatric patients, including potential drug interactions. Several novel anticoagulants are now being used more frequently in atrial fibrillation and thrombotic disorders such as pulmonary embolism. A case will illustrate issues that may arise in the use of these medications in psychiatric patients.

NO. 3

NEW MEDICATIONS FOR HEPATITIS C

Speaker: Jeffrey T. Rado, M.D., M.P.H.

SUMMARY:

Novel treatments for hepatitis C have changed the way this infection is treated. Historically, the use of medications to treat hepatitis C in patients with psychiatric illness has been a challenge given the potential psychiatric side effects of these agents. Now, with revolutionary new antiviral treatments on the market, patients with comorbid hepatitis C and psychiatric illness have a wider range of options. A case-based approach will be used to illustrate when these newer agents are typically used; how they differ from older treatments; and how this impacts the treatment of hepatitis C in patients with schizophrenia, bipolar disorder and major depression. Potential drug interactions will also be reviewed.

“FRESH OFF THE BOAT”: LEARNING FROM A TV SITCOM ABOUT ACCULTURATION, FAMILY DYNAMICS AND MENTAL HEALTH IN ASIAN-AMERICAN IMMIGRANT FAMILIES

Chairs: Dana Wang, M.D., Justin Chen, M.D., M.P.H.

Discussant: Edmond Hsin T. Pi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand mental health disparities affecting Asian-American immigrant populations and describe methods of improving effectiveness of services; 2) Describe cross-cultural and intergenerational challenges faced by Asian immigrant families as depicted in a recent sitcom about a Taiwanese immigrant family; 3) Identify specific emotional stressors affecting Asian-American immigrants, including racial identity, communication inhibition and family expectations; and 4) Promote emotional resilience and provide culturally sensitive support for Asian Americans suffering from psychological distress.

SUMMARY:

Asian Americans recently surpassed Hispanics as the fastest-growing racial/ethnic group in the United States, and this growth has been primarily fueled by immigration rather than childbirth. Unfortunately, Asian Americans also have among the lowest rates of utilization of mental health services among all racial/ethnic groups in the U.S., and this pattern of

underutilization has not changed in over a decade. Even when Asian immigrants do utilize psychiatric services, they are more likely than other racial/ethnic groups to rate them as unhelpful. As a consequence, Asian Americans are vulnerable to the sequela of untreated mental illness and, for instance, have the highest rates of suicide among women aged 15 to 24. In this symposium, we will use the recent 2015 ABC sitcom “Fresh off the Boat,” about a Taiwanese-American immigrant family, to highlight unique difficulties that can cause emotional turmoil in this vulnerable population, including racial discrimination, acculturative stress and intergenerational and cross-cultural conflict. Through the humorous lens of one Chinese immigrant family’s adaptation to American culture, the speakers and the audience will collectively reflect on the struggles that this population faces on a daily basis. The symposium will begin by focusing on the main character, Eddie Huang, a second-generation Taiwanese American, and the ensuing evolution in individual identity and beliefs that he undergoes. The next presentation will address parental expectations that create conflicts for 1.5- and second-generation Asian Americans caught between conflicting family and societal values. Finally, typical communication styles between family members will be showcased to explore and reveal internal and external conflicts. Clips from the series (with permission from the producers), along with other relevant publicly available media examples, will be utilized to illustrate the presentations and discussions. The discussant will synthesize the three different presentations and comment on their relevance to patients based on extensive clinical experience treating Asian-American immigrants. Audience participation will be encouraged throughout the symposium, including a 30-minute question and answer session at the end. The symposium will promote a deeper understanding among mental health professionals of a particular example of the Asian-American immigrant struggle as a step toward addressing mental health disparities, especially among young adults, in a humorous and accessible way. The goal of the presentation is to help equip culturally sensitive providers with practical tools for addressing immigrants’ defenses, resistance and conflicts as part of more effective treatment supporting those suffering from psychological distress.

NO. 1

STRUGGLES OF AN ABC (AMERICAN-BORN CHINESE)

Speaker: Justin Chen, M.D., M.P.H.

SUMMARY:

In this presentation, Dr. Chen will first provide an overview of the 2015 ABC sitcom “Fresh off the Boat,” including an explanation of its title, and describe its reception by the general American public, as well as by Asian Americans in particular. Lack of representation of Asian-American families in the mainstream American media (other than Margaret Cho’s “All-American Girl” in 1994) will be discussed. He will then describe the challenges faced by the sitcom’s main character, Eddie Huang, regarding identity formation, racism and navigating cross-cultural dynamics and how this fits within a larger complex narrative of self-hatred, angst and alienation shared by many 1.5- and second-generation Asian Americans. He will use Gene Luen Yang’s graphic novel “American Born Chinese” to illustrate some of these themes—in particular, the tension between assimilation and retaining one’s culture of origin. While the specific examples used are Chinese American due to the sitcom’s content, themes are likely also applicable to other immigrant groups, and audience participation will be encouraged to reflect on similarities and differences. The presentation will then go on specifically to consider the main character through a psychotherapeutic lens, identifying strengths, vulnerabilities, defenses and relational style with his American classmates as well as with the remainder of his family.

**NO. 2
THE DOUBLE-EDGED SWORD OF PARENTAL EXPECTATIONS**

Speaker: Lusha Liu, M.D.

SUMMARY:

Asian parents’ expectations for their children are a double-edged sword that can promote academic excellence and success, but can also push children into deep emotional turmoil. This presentation focuses on parenting style and expectations on the development of second-generation Asian Americans. Chinese parents often feel ownership of their children rather than acknowledge their individualism. Contrary to the idea of leading by example, Chinese parents are more likely to sacrifice themselves to support their children’s efforts through admirable commitment for the opportunities they did not have, rather than pursuing personal achievements themselves.

However, their definition of success can sometimes become overly narrow and/or may not take into account the children’s own needs or desires. Education is frequently viewed primarily as a means of accessing higher income brackets rather than for the fulfillment of personal development or intellectual curiosity. These values are passed down through generations, but as immigrants are exposed to Western ways of thinking, children face conflicting expectations between societal values versus family values. While these conflicts may manifest in immigrant communities of many different ethnicities, the focus of this presentation will be on Chinese immigrants as one particular cultural example highlighted in the TV series.

**NO. 3
“I LOVE YOU, I’M SORRY”: COMMUNICATION CHALLENGES IN IMMIGRANT FAMILIES**

Speaker: Dana Wang, M.D.

SUMMARY:

The phrases “I love you” and “I am sorry” are not commonly uttered in many Chinese families. This presentation will open by counting the handful of times “I love you” and “I am sorry” are spoken within the TV series “Fresh off the Boat” between the family members, and will continue by examining their hidden meanings. The speaker will help the audience take a closer look at each of the circumstances when these words are uttered to reveal how family members communicate. Through this and other examples, the speaker will demonstrate that subjective expressions of emotions are rarely expressed in a direct fashion; rather, talking around the emotion through actions is more culturally acceptable. This can create misunderstanding and confusion, especially when families are facing stress. The internal conflict of each character in the show will be examined through their communication styles. The significance of what each character chooses to say or not say will be explored.

READJUSTMENT OF COMBAT VETERANS IN VET CENTERS AND PSYCHIATRIC CLINICS: COMPETITION OR COLLABORATION

Chair: Thomas B. Horvath, M.D.

Discussant: Charles Hoge, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the two different ways

combat veterans can enter the VA system and gain counseling or other forms of interventions to help them readjust to peace time realities; 2) Describe the unique ideology, structures and processes of Vet Centers: community-based, nonmedical, veteran-staffed outreach and counseling centers; 3) Compare and contrast the similarities and differences between traditional mental health or psychiatric clinics and Vet Centers; and 4) Review the strains and collaborations between mental health clinics and Vet Centers and their VA Central Office drivers: The Office of Mental Health and the Readjustment Counseling Service.

SUMMARY:

The Institute of Medicine's 2008 – 2012 review of the readjustment needs of Iraq/Afghanistan veterans, soldiers and families found many positive efforts and programs in the VA and DOD, but noted poor coordination between them and failed to find systematic efforts to determine their effectiveness. The writers of the report did not notice that the VA had multiple structures and processes available for help-seeking veterans and in particular ignored the "vet centers." The IOM Report was based on an extensive scientific literature and practice guideline review and did not search out the opinions of therapists, program leaders or veteran patients. It contained only a limited community opinion survey of people largely unfamiliar with the VA system. To compensate for this oversight, this symposium will hear from past and present leaders of the mental health and readjustment counseling programs of the VA and from veterans deployed to war zones in West and Southeast Asia, with a focus on real world experiences. We will allude to the reasons why the academic literature needs corrective lenses and a broader focus on clinical realities, not just experimental and efficacy studies. It was in the aftermath of Vietnam that veteran advocates and members of Congress developed an alternate to the system of large, country neuropsychiatric hospitals and urban general hospital-based psychiatric clinics. These small, community-based "vet centers" had different ideologies; different staffing patterns; different funding streams; and different command, control and communication structures. They were more home-like and more accessible in their storefront or suburban house locations; they focused on war zone deployed veterans, while the traditional clinics were swamped by the chronic mentally ill, substance abusers and the homeless, whose connection to military service was often

tenuous in those times. Over the decades, the two streams have solidified their practical and theoretical differences, even as the "main" mental health system largely gave up the NP hospitals, developed general hospital psychiatric units and established its own community-based outpatient clinics in conjunction with primary care. The vet centers expanded their community outreach to over 300 sites and deployed more than 50 well-equipped mobile vans to go deeper into communities and disaster sites. Staffing in vet centers is mostly fulfilled by veterans or family members as administrators and qualified mental health professionals, but currently, no psychiatrists are directly employed. Mental health clinics look like academic health care clinics staffed by civilians. Comparisons and contrasts will be made between clinics and vet centers, and their strains and collaborations will be explored.

NO. 1

ORIGINS OF VA READJUSTMENT COUNSELING: THE RISE AND FALL AND RISE OF UNDERSTANDING THE PSYCHOLOGICAL EFFECTS OF WAR

Speaker: Arthur S. Blank Jr., M.D.

SUMMARY:

The psychological aftereffects of war have been noted since the beginning of history, as in the legend of Gilgamesh and in Herodotus, Hippocrates. During WWI, many of the founders of modern psychoanalysis and psychiatry served in the military and clearly described, treated and recorded what today we formulate as post-traumatic stress disorder (PTSD). In World War II, American psychiatrists learned from those earlier experiences and applied their learning in battlefield and postwar treatment. But when it came to the Vietnam War, the documentation by European and American psychiatry was ignored. By 1969, large numbers of veterans had already returned from Vietnam with expectable emotional difficulties and found very little diagnosis or helpful treatment in civilian, military or VA clinics. No help was available. The tide turned in that year, when three notable observers in psychoanalysis, psychiatry and government—Chaim Shatan, Robert J. Lifton and Senator Alan Cranston—changed the course of events. The first two set in motion multiple professional changes in theory and practice. Senator Cranston began a ten-year legislative struggle to define a new category of VA services: readjustment counseling. Not until 1979 did Congress and President Carter establish a new

kind of service to veterans with several features hammered out in the ten-year legislative history: the Readjustment Counseling Service.

**NO. 2
PERSPECTIVES ON THE VET CENTER SERVICE MISSION**

Speaker: Charles M. Flora, L.C.S.W.

SUMMARY:

Readjustment counseling is now codified in 38 U.S.C. 1712A. It is a unique VA service that requires a psychosocial assessment in lieu of a medical diagnosis for its provision. This psychosocial assessment takes into consideration the entire range of psychological, social, economic and family adjustment problems reported by combat veterans transitioning to civilian life. The Congressional intent was to provide a consumer-friendly entry into the VA that would overcome barriers to care. Some combat veterans do not want to see themselves as disabled or not up to the rigors of military service, and for them, readjustment counseling is nonmedical intervention and not a health care program. Vet center counselors continue to adhere with fidelity to this perspective of seeing a diagnosis, such as PTSD, as a tool to sharpen the focus of their interventions and not necessarily as a term for public application that may be damaging to the identity of the veteran. The key to therapeutic recovery with combat veterans is establishing the alliance that will sustain the Veteran. Psychological trauma and psychosocial readjustment are interactive, often resulting in a nonlinear pattern of post-combat readjustment. Accordingly, eruptions are to be expected at various points throughout the veteran's lifecycle. No arbitrary endpoints are set for recovery or readjustment.

**NO. 3
GOOD FENCES AND BETTER NEIGHBORS: A VETERAN-CENTERED COMMUNITY APPROACH**

Speaker: Harold Kudler, M.D.

SUMMARY:

Congress wisely established the vet centers as a nonmedical counseling program rather than a health care program. That decision was instrumental in the vet centers becoming one of the most accessible, highly utilized services available to veterans. Nonetheless, many veterans enrolled at vet centers may also benefit through collaborative care with VA or community psychiatrists. This presentation will

focus on the value and challenge of coordinating care across a continuum that includes vet centers, VA psychiatrists, VA mental health clinics and community psychiatrists. Vet centers are well-positioned to manage that care to the veterans' best advantage and to ensure that VA and community psychiatrists have the military-cultural competence and ability to take and build upon a military history necessary to ensure the highest level of veteran-centered care. The Office of Mental Health provides policy guidance to the hospital- and clinic-based mental health system, and the Office of Mental Health Performance monitors compliance and the observation of the standards of care set down by the Uniform Mental Health Services Handbook and its subsequent modifications. The scientific foundations of this care are further developed and disseminated by entities like the National Center for PTSD and the MIRECC system.

**NO. 4
THE COMBAT VETERANS' PERSPECTIVE: REDUCING BARRIERS TO ACCESSING CARE AND ESTABLISHING A THERAPEUTIC ALLIANCE**

Speaker: Cathleen A. Lewandowski, Ph.D., M.S.W.

SUMMARY:

It is perhaps a given that combat veterans can confront difficulties in readjusting to civilian life. Veterans of all eras often must overcome a myriad of barriers in order to receive adjustment counseling and engage in the process of developing a therapeutic relationship. While all combat veterans have common and, one might argue, universal experiences in the readjustment process, the veteran population is becoming increasingly and more openly diverse, posing challenges to providers when seeking to establish the therapeutic alliance. Finally, researchers and policy makers have developed a range of strategies and interventions to facilitate access to care and to enhance providers' capacity to establish an effective therapeutic alliance with combat veterans. Nonetheless, more needs to be done to improve upon existing strategies and expedite the translation of knowledge of best practices among providers of readjustment counseling veterans. There are psychological, social, physical and economic barriers veterans experience when accessing care. These may differ for veterans from different eras, and with the diversity of today's veteran population, including gender, social orientation, racial and ethnic diversity, age, and economic and religious diversity, there are evolving

possible strategies for increasing veterans' access to readjustment counseling and recovery.

OPIOIDS: CRISIS AND SOLUTIONS

Chairs: Phil Skolnick, Ph.D., Ivan D. Montoya, M.D., M.P.H.

Discussant: Ivan D. Montoya, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Provide basic information/background about the scope of the "opioid epidemic" that by any metric has reached crisis proportions in the United States; 2) Provide information about the use and effectiveness of intranasal naloxone as an antidote to reverse opioid overdose; 3) Provide information about novel analgesics acting at opiate receptor variants. While analgesic, these molecules appear to lack some of the side effects associated with opioids; 4) Provide information about the latest advances in the development of vaccines to treat and prevent opioid addiction; and 5) Provide information about novel approaches to creating opioid analgesics that have a much-reduced potential for abuse and diversion.

SUMMARY:

An increase in both licit and illicit opioid use during the past decade has resulted in a dramatic rise in both the morbidity and mortality associated with opioid overdose, which now surpasses motor vehicle crashes as the leading cause of death in the United States. In 2013, The Centers for Disease Control and Prevention reported that there were more than 24,000 deaths in the United States attributable to opioid overdose. Among these deaths, about two-thirds were associated with prescription opioids (e.g., oxycodone, methadone) and one-third with heroin. Moreover, there are additional medical and social consequences of this opioid epidemic, such as a rising incidence of newborns with neonatal abstinence syndrome and an increased spread of infectious diseases, including HIV and hepatitis C (HCV), due to sharing of needles for injection drug use. This symposium will describe facets of a multidisciplinary approach that is required to effectively combat this opioid epidemic. Dr. Phillip Coffin (San Francisco Department of Public Health) will discuss the use and effectiveness of intranasal naloxone as an antidote to reverse opioid overdose. Salient issues in this presentation include who should receive this opiate antagonist and when it should be prescribed/distributed. Dr. Gavril

Pasternak (Memorial Sloan Kettering) will discuss the discovery of novel splice variants of the μ opioid receptor. This discovery has enabled the development of analgesics that interact with these splice variants, resulting in a lower risk of tolerance and abuse liability than traditional opioid analgesics. Dr. Kim Janda (Scripps Research Institute) will describe the feasibility of developing vaccines directed at heroin and other synthetic opioids. Dr. Thomas Jenkins (Elysium Therapeutics) will describe the development of novel, abuse-deterrent opioids that are intended to prevent intentional "dose dumping" and technologies that truncate the useful life of opioids, thereby reducing the potential for abuse and diversion.

NO. 1

ABUSE-DETERRENT OPIOIDS: ADVANCING BEYOND TAMPER RESISTANCE

Speaker: Thomas Jenkins, Ph.D.

SUMMARY:

The most prevalent route of abuse for both short- and long-acting opioid analgesics is the oral route (e.g., the coingestion of multiple pills). Current formulation-based "tamper-resistant" technologies are designed to resist abuse only via less common, nonoral routes (e.g., inhalation and injection). Elysium's novel O2P™ approach, applicable to all opioids, is designed to provide effective first-in-class oral overdose protection. Additionally, an immense, growing and dangerous supply of unused opioid medications are currently stockpiled in America's medicine cabinets. This pool of easily accessed opioid analgesics is subject to widespread diversion and misuse, especially among fledgling abusers. Elysium's XpiRx™ technology is designed to dramatically truncate the shelf life of prescription opioid analgesics, thereby substantially decreasing the immense pool of unused opioid drugs that enables abusers, while simultaneously reducing the risks of addiction and potentially lethal overdose. Through a partnership with NIDA, Elysium is developing the next generation of abuse-resistant opioids. The presentation will introduce our strategies aimed at reducing abuse and saving lives.

NO. 2

LAY NALOXONE FOR OPIOID SAFETY

Speaker: Phillip O. Coffin, M.D., M.A.

SUMMARY:

Provision of naloxone to lay persons has been associated with reduced opioid overdose mortality, and efforts to expand access to naloxone have rapidly proliferated in recent years. This presentation will review the evidence for naloxone provision, with an emphasis on the role of naloxone in different venues and targeting distinct populations. We will discuss the barriers and facilitators to naloxone delivery in multiple settings and consider situations in which practice has preceded data.

NO. 3

OPIATE ANALGESICS: SEPARATING THE GOOD, THE BAD AND THE UGLY

Speaker: Gavril Pasternak, M.D., Ph.D.

SUMMARY:

Opiates remain invaluable in the management of moderate to severe pain, but they come at a price. With regard to pain control, their primary advantage is the ability to suppress the subjective component of pain (the “hurt”) without interfering with more objective sensations (e.g., touch, position, temperature). While quite effective against somatic pain, their utility is limited in neuropathic and inflammatory pain states. In addition, they have well-described side effects such as respiratory depression, constipation and sedation. Repeated usage leads to tolerance and physical dependence in all patients and, in some, the potential of addiction. Clinically, pain management is an art, due in large part to the wide variability in responses among patients to various opioids. Genetic studies have now identified dozens of receptors within the μ opioid receptor family. One subset has provided potential targets for novel opioids lacking respiratory depression, physical dependence and reward behavior. Understanding these molecular mechanisms of opioid action helps explain some of the differences among opioid drugs and offers insights into the potential future analgesics.

NO. 4

VACCINATION AS A MEANS TO MITIGATE OPIOID ADDICTION

Speaker: Kim D. Janda, Ph.D.

SUMMARY:

Our laboratory at The Scripps Research Institute (TSRI) in La Jolla, CA, has been working on developing vaccines for opioid abuse. We will provide convincing evidence that the concept of

vaccination against drugs of abuse can be made to work in a clinical setting and, in the cases of treatment of heroin or synthetic opioid addiction, can be used both as a cessation aid for those who wish to quit and as a measure for preventing death from accidental overdose.

BREAKING THE CYCLE OF SERIOUS MENTAL ILLNESS

Chairs: John M. Oldham, M.D., M.S., B. Christopher Frueh, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Introduce recent findings from the MIND-MB study to improve understanding of recent advances in treatment for serious mental illnesses (SMI); 2) Improve understanding of the importance of length of stay in psychiatric hospitalization for patients with SMI; and 3) Improve understanding of biologically-based measures that may be developed further for personalized care in psychiatry.

SUMMARY:

Effective treatments and policies are lacking for adults with serious mental illness (SMI; i.e., treatment-refractory neuropsychiatric disorders). Because tightly controlled efficacy studies restrict the capacity to provide personalized care, they may also restrict treatment response. Moreover, health insurance and public sector mental health care systems rarely allow for more than very brief psychiatric hospitalizations to focus primarily on stabilization. Thus, the majority of people with SMI are not afforded the time in treatment necessary to understand and treat their complex clinical symptoms and functional impairments. Offering personalized care means recognizing that, for reasons of genetic makeup and personal history, people respond differentially to specific treatments, and poor response to one treatment does not necessarily imply poor response to another or deny the possibility of potentiation through combinations of multimodal treatments over time. This symposium presents findings from the MIND-MB study, a large-scale, naturalistic effectiveness study (N=1,500) of psychiatric inpatients, to improve understanding of care for patients with SMI. Patients averaged a hospital length of stay of five weeks and included adults and adolescents as well as a wide range of psychiatric disorders. The typical patient had three Axis I diagnoses (e.g., mood, anxiety, substance use disorders), an Axis II diagnosis (e.g.,

borderline personality disorder), multiple prior hospitalizations and episodes of outpatient care, and intensive multimodal inpatient treatment. All patients were well-characterized at admission by structured diagnostic interviews (SCID I and II) and a comprehensive battery of self-report measures of symptoms and functioning. Patients completed measures at two-week intervals while in the hospital and every three months after discharge, out to 12 months. They also completed a functional magnetic resonance imaging (fMRI) protocol shortly after admission, and a subset completed a second fMRI protocol four weeks later. Results indicate clinically meaningful symptom reduction and functional improvement across a broad range of relevant domains for adults and adolescents with SMI. For example, latent growth curve analyses modeled psychiatric symptom trajectories (e.g., depression, anxiety, disability, somatization). Patients evidenced substantial reduction in symptoms from admission to discharge, with large effects. Results also support the potential of biologically based measures to improve personalized care for this population. For example, resting-state functional connectivity (RSFC) variables in adolescents were associated with admission levels of internalizing symptoms and also predicted symptom reduction at discharge. Among adults, lower habenula-putamen RSFC was associated with increased suicide ideation and attempt at admission. Decreases in habenular fractional anisotropy were associated with suicide ideation improvement.

**NO. 1
CLINICAL COURSE AND SIX-MONTH OUTCOMES
FOR HOSPITALIZED ADULTS WITH SERIOUS MENTAL
ILLNESS**

Speaker: J. Christopher Fowler, Ph.D.

SUMMARY:

Effective treatments are lacking for adults with serious mental illness (SMI). The expected clinical course and outcome are bleak for those with co-occurring disorders, multiple medications/adjunctive psychotherapy trials and repeated psychiatric hospitalizations. With the exception of studies such as STAR*D, effectiveness trials examine single treatments for brief intervals and rarely combine treatments. By contrast, patients in clinical settings receive treatment for as long as necessary with whatever treatment modalities are required to bring about symptom relief. Studies that restrict the capacity to provide personalized care may artificially

restrict treatment response, especially for those with SMI. Results from a MIND-MB large-scale study (n=1,500) indicate that an intensive multimodal treatment model with adequate follow-up care brings about clinically meaningful functional improvement and symptom reduction for adults with SMI.

**NO. 2
THE ROLE OF EMOTION REGULATION AND
FUNCTIONAL CONNECTIVITY IN PREDICTING
INTERNALIZING SYMPTOM RECOVERY DURING
ADOLESCENTS' INPATIENT HOSPITALIZATION**

Speaker: Carla Sharp, Ph.D.

SUMMARY:

Understanding the trajectory of symptom change among adolescent psychiatric inpatients has important implications for numerous public health issues. This study had two aims: 1) To examine internalizing symptom change during the first month of inpatient care for adolescents and 2) To examine the role of emotion regulation to predict internalizing symptom recovery, measured through self-report and resting-state functional connectivity (RSFC) between the amygdala and other brain regions. 196 adolescents (61% female; age 15.19 years; SD=1.480) completed the Achenbach Brief Problem Monitor (BPM) during their inpatient stay. RSFC (n=50) and self-report data of emotion regulation (n=196) were collected at baseline. Results showed that the average internalizing symptom score at admission was high ($\alpha=66.524$), exceeding the BPM's clinical cut off score. Internalizing symptom scores declined, and this decrease was significant. While self-reported emotion regulation associated with admission levels of internalizing problems, it did not predict change in internalizing symptoms. However, RSFC variables associated with admission levels of internalizing symptoms and also predicted change. Results indicate the potential of biologically based measures that can be developed further for personalized care in adolescent psychiatry.

**NO. 3
IMPROVEMENTS IN SOMATIC COMPLAINTS
AMONG INDIVIDUALS WITH SERIOUS MENTAL
ILLNESS RECEIVING TREATMENT IN A PSYCHIATRIC
HOSPITAL**

Speaker: Alok Madan, Ph.D., M.P.H.

SUMMARY:

Individuals with serious mental illness (SMI) experience significant comorbid somatic complaints; their physical health tends to be poor. Little is known about response to integrated inpatient care that addresses psychiatric and general medical needs among individuals with SMI. Latent growth curve (LGC) analyses were employed to model somatic symptom trajectories, allowing for analysis of expected recovery based on individual patterns observed across a large sample of adult inpatients with SMI (n=989). The Patient Health Questionnaire–15 was administered at admission, every 14 days and at discharge. Background characteristics, psychiatric diagnoses and health-related variables were included as patient-specific moderators of improvement. Patients evidenced substantial reduction in somatization from admission to discharge, with large effects. Results indicate nonlinear improvement in somatic symptoms over eight weeks of treatment, with greatest symptom reduction occurring during the first weeks of treatment with continued, albeit slowed, improvement until discharge. Somatic complaints, including chronic pain, can be managed in the context of inpatient psychiatric care integrated with 24-hour nursing, internal medicine specialists and health psychologists. This model of care may be indicated for appropriately selected individuals who have failed to respond sufficiently to prior care.

NO. 4

INTENSIVE INPATIENT TREATMENT OF BORDERLINE PERSONALITY DISORDER (BPD)

Speaker: John M. Oldham, M.D., M.S.

SUMMARY:

It is widely reported in the literature that inpatient hospitalization for patients with borderline personality disorder (BPD) should be avoided if possible, but if hospitalization is essential, it should be brief (less than a week). Concerns persist from the days of inappropriately long hospital stays that patients with BPD will regress and become “institutionalized” if not discharged quickly from inpatient care. In the APA’s Practice Guideline for BPD, however, general indications for longer-stay hospital care are listed, including persistent suicidality, extensive comorbidity and refractory co-occurring mood disorder. Data will be presented from the Menninger Clinic, where patients with complex conditions that often include BPD, refractory mood disorder and substance use disorders are treated and where the average length

of stay is about 45 days. Patients with BPD improve dramatically from intensive treatment for this intermediate length of stay, comparable to or even greater than the incremental improvement of a large comparison sample of inpatients without BPD.

NO. 5

IDENTIFICATION OF HABENULA RESTING-STATE AND WHITE MATTER PATTERNS ASSOCIATED WITH SUICIDE IN A LARGE INPATIENT PSYCHIATRIC SAMPLE

Speaker: Michelle Patriquin, Ph.D.

SUMMARY:

Risk factors for suicide include major depression, substance abuse and pain, all associated with the habenula. This small brain area controls neurotransmitters that regulate reward, mood and anxiety. In 316 psychiatric inpatients, lower habenula-putamen resting-state functional connectivity at admission was associated with increased suicide ideation and attempt at admission. Decreases in habenular fractional anisotropy were associated with suicide ideation improvement. Thus, the habenula is a potential target for antisuicide therapies.

BLACK LIVES AND RACIAL DISPARITIES IN THE JUVENILE JUSTICE SYSTEM: IMPLICATIONS FOR POLICY, PSYCHIATRIC PRACTICE AND ADVOCACY

Chair: Sarah Y. Vinson, M.D.

Discussant: Ezra Griffith, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify systematic racial disparities in the juvenile justice system and associated public mental health implications; 2) Identify typical patterns of violence in U.S. adolescent males across races; 3) Identify psychological factors at play in disparate treatment of black males in the juvenile justice system; and 4) Identify the ways in which psychiatrists can inform the public discourse regarding these issues and engage in advocacy around them.

SUMMARY:

While the deaths of Black male youth at the hands of law enforcement officers has received a great amount of media attention, there are less dramatic institutional biases within the juvenile justice system with a much broader impact. This impact is of importance not only to the at-risk youth directly

involved, but also to the broader society given the trajectories of many youth involved in the juvenile justice system involved. This issue is of relevance to the field of psychiatry given that psychiatrists may serve as clinicians in areas with high proportions of at-risk youth affected by these biases, in consult to attorneys and courts as forensic efforts, or in a position to advocate for mental health care and juvenile justice policies that address these disparities and minimize their detrimental impact on children, adolescents and communities. This symposium will include discussion of these issues from three different perspectives, including that of child and adolescent forensic psychiatrist Dr. Peter Ash, former president of the American Academy of Psychiatry and Law, Director of the Emory School of Medicine Psychiatry and Law Service, who is a national expert on youth violence; attorney and professor Randee J. Waldman, J.D., the director of the Emory Law School's Barton Juvenile Defender Clinic, who engages in policy work related to juvenile justice issues and has expertise both in representing disadvantaged youth and in teaching about disparities in the juvenile justice system; and psychologist Dr. LeRoy Reese, an associate professor at Morehouse School of Medicine in the Department of Community Health and Preventive Medicine, who conducts research on the reduction of risk behavior among youth and their families and serves as a consultant to the Annie E. Casey Foundation in their efforts to reform juvenile justice policy and practice in Georgia and nationally. By the conclusion of these lectures, attendees will have an appreciation for the developmental trajectory of youth violence across races in the U.S., an awareness of institutional racism in the juvenile justice system, and basic familiarity with psychological studies that have quantified racial biases in society and within juvenile justice. Esteemed forensic psychiatrist Dr. Ezra Griffith, Professor Emeritus of and Senior Research Scientist in Psychiatry and Deputy Chair for Diversity and Organizational Ethics in the Department of Psychiatry at Yale University will serve as the discussant.

NO. 1
YOUTH VIOLENCE

Speaker: Peter Ash, M.D.

SUMMARY:

Dr. Peter Ash, former president of the American Academy of Psychiatry and Law and the Director of the Emory School of Medicine Psychiatry and Law

Service, is a national expert on youth violence. He will speak about youth violence, its prevalence across races, the trajectory of the behaviors and the limitations of mental health in predicting persistence of these behaviors into adulthood.

NO. 2
RACIAL DISPARITIES IN JUVENILE JUSTICE

Speaker: Randee Waldman, Esq.

SUMMARY:

Attorney and professor Randee J. Waldman, J.D., the director of the Emory Law School's Barton Juvenile Defender Clinic, engages in policy work related to juvenile justice issues and has expertise both in representing disadvantaged youth and in teaching about disparities in the juvenile justice system. Dr. Waldman will not only discuss systemic racial disparities that permeate the juvenile justice system, but also how disparities in special education and school services feed the school-to-prison pipeline.

NO. 3
THE PSYCHOLOGY OF RACIAL INJUSTICE IN JUVENILE JUSTICE AND RESILIENCE IN BLACK YOUTH

Speaker: LeRoy Reese, Ph.D.

SUMMARY:

Psychologist Dr. LeRoy Reese, an associate professor at Morehouse School of Medicine in the Department of Community Health and Preventive Medicine, conducts research on the reduction of risk behavior among youth and their families. He serves as a consultant to the Annie E. Casey Foundation in their efforts to reform juvenile justice policy and practice in Georgia and nationally. Dr. Reese will discuss some of the psychological studies that have quantified racial bias in the juvenile justice system. He will also discuss resilience and protective factors in Black youth and how a better understanding of and emphasis on these issues is needed in mental health and the broader society.

TOP 10 GENETIC SYNDROMES THAT PSYCHIATRISTS NEED TO KNOW

Chairs: Robert J. Pary, M.D., Janice Forster, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe several genetic syndromes that could present in a general psychiatry practice; 2) List those syndromes that are least likely to be identified at the initial psychiatric assessment;

3) Describe behavioral phenotypes associated with several genetic syndromes; and 4) Provide a rationale for the importance of identifying a genetic syndrome in a person in a general psychiatric practice.

SUMMARY:

It is increasingly common for individuals with genetic syndromes to live in the community. Some psychiatrists focus on persons with intellectual disability; other psychiatrists who practice in such diverse areas as general hospitals, mental health centers, state hospitals, jails or private outpatient offices, however, may also receive referred persons who have genetic syndromes. Persons with genetic syndromes can present in several ways. Sometimes, the individual's genetic syndrome has been previously identified. This is the usual presentation of somebody with Down syndrome. Other times, another condition may overshadow the genetic syndrome. For example, as many as half of the persons with fragile X syndrome have autism. It is possible that autism is known, but fragile X is not. Still other individuals may present with schizophrenia and only later may DiGeorge syndrome be suspected because of dysmorphic features. Furthermore, it is not only child psychiatrists who should be on the alert for previously undiagnosed genetic syndromes. Although rare, conditions such as fragile X have been first identified in an older adult clinic. A related issue is when someone has been labeled with a genetic syndrome and the psychiatrist strongly questions the diagnosis. Sometimes, as in Prader-Willi syndrome, previous treatment with growth hormone and strict behavioral treatment may result in the person having a normal body shape instead of the morbid obesity that one usually associates with Prader-Willi syndrome. Other times, the presenters have evaluated an adult with an intellectual disability who was labeled as having Down syndrome but had none of the aging nor many of the physical characteristics, yet for 40 years, the family had considered that person to have Down syndrome when there was no chromosome confirmation. Such a case raises a fundamental clinical question: what if someone is labeled as having Down syndrome at 45 years, but doesn't actually have the condition? Similarly, what if a 65-year-old has fragile X syndrome but has never been previously diagnosed? The presentations will first address the general diagnostic and treatment issues in four populations: children, adolescents, adults and older adults. Next, the presentations will

cover ten of the genetic syndromes that clinical psychiatrists may see in a community clinical practice. These syndromes include 1) Angelman; 2) Cornelia de Lange; 3) DiGeorge; 4) Down; 5) Fragile X; 6) Klinefelter; 7) Phelan-McDermid; 8) Prader-Willi; 9) Smith-Magenis; and 10) Williams. Finally, the last part of the symposium will be a question and answer session. As in many top ten lists, there is bound to be some controversy. For example, some may ask, why are fetal alcohol syndrome or autistic spectrum disorders not on the list? One may ask why Noonan syndrome or tuberous sclerosis was not mentioned. We anticipate a good debate.

NO. 1

OVERVIEW OF DIGEORGE, PHELAN-MCDERMID AND KLINEFELTER SYNDROMES

Speaker: Jeffrey I. Bennett, M.D.

SUMMARY:

DiGeorge syndrome, also known as velocardiofacial syndrome or chromosome 22q11.2 deletion syndrome, is often associated with intellectual disability or borderline intellectual functioning. In previously undiagnosed individuals, an underdeveloped chin along with cleft palate and cyanotic skin due to congenital heart problems may suggest further diagnostic workup. Children with DiGeorge syndrome are at risk for autistic spectrum disorders, ADHD and anxiety disorders. Compared to the general population, schizophrenia is increased in adults. Another deletion syndrome on chromosome 22 (22q13.) is Phelan-McDermid syndrome. Phelan-McDermid syndrome results in a loss of functioning of the SHANK3 gene and is also associated with autistic spectrum disorder. Other possible presentations include hyperactivity, anxiety and atypical bipolar disorder. Klinefelter syndrome refers to a group of chromosomal disorders in males who have one or more extra X chromosomes. Some individuals show minimal, if any, behavioral or psychiatric problems. For others, however, various psychiatric disorders have been described in persons with Klinefelter syndrome, including ADHD, impulse control and psychotic disorders.

NO. 2

OVERVIEW OF FRAGILE X SYNDROME AND CORNELIA DE LANGE SYNDROME

Speaker: Stephen Ruedrich, M.D.

SUMMARY:

Fragile X syndrome (FXS) is the most common inherited etiology for intellectual disability. The syndrome results from expansion of trinucleotide repeats CGG (cytosine-glycine-glycine) on the long arm of the X chromosome. The gene, fragile X mental retardation protein (FMRP) does not appear if there is extensive expansion (greater than 200 CGG trinucleotide repeats). FMRP is extensively found in neurons and glial cells. FXS is also considered to be the most common single gene-based etiology of autism. An emerging behavioral phenotype for FXS may include ADHD, anxiety and mood disorders, and social aversion. The observation that silencing FMRP may enhance glutaminergic signaling has led to speculation that glutaminergic antagonists may have a role in addressing FXS. This presentation will focus on clinical features of FXS and the behavioral phenotype that psychiatrists may encounter in a community or hospital practice. Cornelia de Lange syndrome is much less common than fragile X syndrome. Most individuals have significant intellectual disability, although a few persons in the borderline intellectual range have been reported. The syndrome also manifests in short stature, characteristic facial features and developmental limb issues. Persons with Cornelia de Lange syndrome also commonly demonstrate features of autism spectrum disorder, social anxiety and impulsivity. This presentation will discuss a developing behavioral phenotype.

NO. 3 OVERVIEW OF PRADER WILLI AND ANGELMAN SYNDROMES

Speaker: Janice Forster, M.D.

SUMMARY:

Prader Willi (PWS) and Angelman (AS) syndromes are disorders of genomic imprinting on chromosome 15q11-13. PWS results from the deletion of contiguous genes on the paternal chromosome or a maternal uniparental disomy (UPD)—a double copy due to a random defect during meiosis. In contrast, AS results from the deletion of two maternal genes, UBE3A and AT10, or a paternal UPD. PWS is a hypothalamic obesity syndrome with hypotonia, hypogonadism, tantrums, skin picking and abnormalities in serotonin 2C and GABAA receptors. Many infants don't thrive initially, but by four years become obese. Early correction of growth hormone deficiency improves syndromal characteristics, and along with parental education, children can appear lean. Adaptive function is rarely commensurate with

IQ. SSRIs and aripiprazole can activate mood. Mood disorders and psychosis are common in young adulthood, with 85% of individuals with UPD having bipolar disorder. Individuals with PWS deletion subtype are more likely to experience depression and anxiety. AS is correlated with the failed expression of UBE3A from the maternal chromosome. Individuals with AS deletion subtype have autistic-like features, except they seek social proximity and frequently smile and laugh. They have severe intellectual disability, minimal speech, spasticity, ataxia, sleep difficulties and seizures. Individuals with the paternal UPD are less impaired. Sleep difficulties are often a focus of treatment.

NO. 4 OVERVIEW OF DOWN AND SMITH-MAGENIS SYNDROMES

Speaker: Robert J. Pary, M.D.

SUMMARY:

This presentation will provide a brief review of not only well-studied psychiatric disorders (e.g., dementia), but also understudied ones (e.g., depressive disorders in young adults) in Down syndrome or trisomy 21. Other disorders in persons with Down syndrome that may generate discussion and debate include autistic spectrum, psychotic and bipolar disorders. Smith-Magenis syndrome is most commonly caused by a deletion in chromosome 17.p11.2. The behavioral phenotype can include varying degrees of intellectual disability, severe sleep disturbance, hyperactivity, insensitivity to pain as manifested by head-banging, insertion of foreign bodies into orifices, and removal of fingernails or toenails. Failure to recognize the syndrome has led to blaming some parents/caregivers for the injurious behaviors.

MAY 16, 2016

SENIOR PSYCHIATRISTS AND POSITIVE AGING

Chairs: Dilip V. Jeste, M.D., Glen O. Gabbard, M.D.

Discussant: Michelle Conroy

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the concepts of well-being, resilience and positive psychiatry; 2) Use the strategies for successful aging; and 3) Identify cultural diversity among senior physicians and their patients.

SUMMARY:

Today, 20% of all American physicians, including psychiatrists, are over age 65. Surveys show that practicing senior physicians have a high degree of satisfaction with their work. Over the next two decades, the number and proportion of senior psychiatrists will increase progressively. Senior psychiatrists will play an increasingly important role as clinicians, consultants, educators, mentors and administrators. They will be invaluable in dealing with the worsening physician shortages resulting from the growing and aging population, mainly by extending their careers in clinical practice but sometimes by reentry into practice, yet organized psychiatry has paid relatively little attention to its senior members. There is an urgent and serious need to consider and implement strategies to enhance the well-being of senior psychiatrists. This would involve understanding and addressing the challenges they face. Issues of cognitively impaired older physicians are under debate in state agencies. In the near future, professional organizations will be active in assessing, relicensing and credentialing senior physicians. These organizations need to help their senior members with training in the use of new technology and provide them with opportunities to obtain CME in a user-friendly manner. Senior psychiatrists are a heterogeneous group. Therefore, individualized strategies for helping them are necessary. Investing in senior psychiatrists will pay off handsomely because of their value for patient care as well as for mentoring younger psychiatrists. This symposium is unique in that it includes senior APA leaders in various areas, bringing in diverse perspectives. Jeste will present strategies for successful aging of psychiatrists, with examples of those who have pursued different lines of work. Gabbard will discuss the work of George Vaillant and Erik Erikson on generativity and altruism as key factors in successful aging and suggest how a balance between serving others and meeting one's own needs for enjoyment and leisure must be individually crafted. Scheiber will talk about the statistics and experience of the society of Senior Psychiatrists. Riba will present data on the number of senior psychiatrists in the U.S. and global workforces and how we might harness Victor Frankl's work on meaning and purpose of life for positive aging. Finally, Alarcon will present a descriptive analysis of acculturative experiences, cycles of professional development, learning hallmarks, level of integration and challenges facing ethnically diverse groups of senior psychiatrists in

the U.S. Notably, the discussant (Conroy) is an early career psychiatrist who will discuss the role of senior psychiatrists from the viewpoint of the younger generation. We expect the symposium to generate a lively discussion with the audience, and we have set aside over 70 minutes for QandA and general discussion.

NO. 1**SUCCESSFUL AGING OF PSYCHIATRISTS**

Speaker: Dilip V. Jeste, M.D.

SUMMARY:

Aging is a multidimensional experience involving physical, cognitive and psychosocial functioning. While aging of body tissues is inevitable, aging of the mind is not. Psychiatrists' successful aging is important not only for their own sake but also for their patients and trainees. There are a variety of role models of successfully aging physicians. Some psychiatrists continue their research or clinical work, at least part-time, while some turn to community service, and others enjoy personal/family life. There are also inspiring examples of physicians who fought physical and mental illnesses and became creative artists and writers in later life. Taking care of one's health, a positive attitude, realistic optimism, resilience, engagement in stimulating physical and cognitive activities, and having a good time with friends and family—that is the prescription for successful aging. This presentation will also discuss organizations' responsibilities for enhancing their senior members' wellness.

NO. 2**IDENTITY ISSUES IN THE SENIOR PSYCHIATRIST**

Speaker: Glen O. Gabbard, M.D.

SUMMARY:

More than many other professions, medicine and psychiatry are callings rather than "jobs." In addition, physicians and psychiatrists are more likely to feel that their identities and careers are inextricably woven together. The aging psychiatrist must come to terms with loss and mourning as he or she contemplates slowing down and retirement. Successful aging involves some compromise between letting go and holding on to one's identity. The work of both George Vaillant and Erik Erikson suggests that generativity and altruism are key factors in successful aging. For senior psychiatrists, some combination of taking time for oneself and serving others through teaching, mentoring and/or

some form of clinical work may serve to maintain the psychiatric identity while also giving the psychiatrists some freedom from responsibility to pursue long postponed pleasures of travel, grandchildren and leisure time pursuits. This balance must be individually crafted to fit the psychological needs of the senior psychiatrist.

NO. 3
POSITIVE AGING: THE ROLE OF MEANING

Speaker: Michelle B. Riba, M.D.

SUMMARY:

As physicians and psychiatrists, we know it is important to not only care for our patients and their families, our trainees and staff, and our own families and friends, but also to help and attend to ourselves and each other. A particularly crucial and vulnerable period occurs as we age and think about our life's work and what might lie ahead. There are many complex concepts to address: how can we stay resilient? what ways might we adapt? what could provide joy and happiness? An important concept for us to consider is "meaning." As outlined by Viktor Frankl in his influential and poignant *Man's Search for Meaning*, a key tenet is to have purpose and meaning in life. This presentation will review some of Frankl's work on meaning and why this might be particularly important for positive aging. Data will be provided regarding the number of psychiatrists in the workforce (United States and global) and how we might harness this information toward the topic of positive aging and meaning.

NO. 4
LIFERS AND SENIOR PSYCHIATRISTS: IDENTIFYING PROBLEMS AND SOLUTIONS

Speaker: Stephen C. Scheiber, M.D.

SUMMARY:

"Lifers of the APA" began as an organization when the APA developed the categories of Life Members, Life Fellows and Distinguished Life Fellows. It was subsequently renamed "Senior Psychiatrists." The organization sponsors workshops and symposia, publishes an online magazine, and presents the Berson Award annually to a senior psychiatrist who has made significant contributions to the area. The organization focuses on issues relevant to seniors in the field, including retirement, closing one's practice, continuing practice with age-related impairments, sharing of lifetime experiences, staying relevant and giving back to the profession. Promoting collegiality,

camaraderie, scholarship, teaching and support of the APA are some of the goals. Hopes and plans for the future will be shared.

NO. 5
SOCIOCULTURAL ISSUES IN THE AGING OF ETHNICALLY DIVERSE SENIOR PSYCHIATRISTS

Speaker: Renato D. Alarcon, M.D., M.P.H.

SUMMARY:

The growing number of ethnically diverse senior psychiatrists in the U.S. reflects the realities of the psychiatric workforce in the country. Considering those international medical graduates who remained after their postgraduate training, data about demographic characteristics, type of practice, geographic location and subspecialties will be presented. A descriptive analysis of acculturative experiences, cycles of professional development, learning hallmarks, level of integration and challenges will culminate with focus on members of these subgroups playing important roles in the APA's leadership, committees and caucuses. The perspectives of decades substantiate reports of successful aging and the role and value of positive experiences throughout the process. Cultural characteristics such as relationship styles with patients, strength of personal identity, nature of contacts with their home country or region, and levels of integration will also be analyzed.

STREET PSYCHIATRY: INTEGRATED CARE FOR ATLANTA'S UNSHELTERED HOMELESS

Chair: Elizabeth A. Frye, M.D., M.P.H.

Discussant: Anitra Walker, L.C.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the importance of providing integrated psychiatric and primary care on the streets for homeless individuals sleeping outdoors; 2) Describe the role of the peer specialist as a street guide and the importance of shared experiences in building trust with the unsheltered homeless; 3) Describe student educational activities on the streets and the impact of participation on students; 4) Describe the role of telemedicine as a part of street-based care; and 5) Describe methods for evaluating patient satisfaction and improving quality of care on the streets.

SUMMARY:

Street Medicine is an emerging concept in homeless health care, focused on providing medical and psychiatric care where homeless individuals live. Because of the high lifetime prevalence of mental illness among the homeless, street psychiatric care can be pivotal for homeless individuals in improving their overall health and getting off the streets. Weaving psychiatric care, primary care, nurse care coordination, student education, peer support and technology into a holistic model of health care is a complicated yet rewarding process. This unique method of health care delivery breaks down barriers commonly experienced by our homeless patients and serves as a model of excellence both inside and outside of the clinic environment. This symposium will offer participants with a new toolbox for approaching a difficult-to-treat population through perspectives from a multidisciplinary team. Each presenter—peer specialist, student, nurse and physician—will provide participants with insight and practical methods for engaging and treating street-bound homeless individuals.

NO. 1

CARE INTEGRATION ON THE STREETS: PRIMARY CARE AND WOUND CARE AS METHODS OF ENGAGING MENTALLY ILL HOMELESS PEOPLE

Speaker: Sapna B. Morris, M.D., M.B.A., Tim Porter-O'Grady, Ed.D., R.N.

SUMMARY:

Integrated mental and physical health care, although rare among street medicine programs, is important in reducing morbidity and mortality among the homeless. Because so many of our street-bound patients have experienced discrimination in the health care setting, they are often reticent to accept any kind of health services. Providing convenient and seamless collaborative care when and where the person is willing to accept it can significantly impact the well-being of unsheltered individuals. The presenters will highlight their experiences as a part of an integrated care team and the use of physical care as "outreach" to engage homeless individuals in psychiatric treatment.

NO. 2

TECHNOLOGY ON THE STREETS: TELEMEDICINE AS A TOOL TO EXPAND PSYCHIATRIC CARE FOR ROUGH SLEEPERS

Speaker: Kathy Schaaf, B.Sc., R.N.

SUMMARY:

Telemedicine is emerging as a tool for providing medical care to difficult-to-reach populations, including the homeless. The Mercy Care street medicine team launched a unique tele-street medicine program to expand psychiatric and primary care services to Atlanta's unsheltered homeless. Through the use of telemedicine, unsheltered individuals see their psychiatrist via telemedicine in a public library, a soup kitchen, and on the streets. Additionally, the team has been able to provide more consistent access to primary care on street rounds through the use of telemedicine. During this presentation, members of the team will discuss the nuts and bolts of telemedicine implementation on street rounds, the successes and challenges of the program, and data on consumer satisfaction with the telemedicine experience.

NO. 3

PEER SPECIALISTS AND THEIR UNIQUE ROLE IN STREET MEDICINE TEAMS

Speaker: Ricky Alexander

SUMMARY:

Peer specialists often guide street medicine teams and may be the first people unsheltered homeless persons meet during street outreach. Research indicates that mental health clients "served by teams with peer specialists demonstrated greater gains in several areas of quality of life and overall reduction in the number of major life problems." This presenter will describe how he uses his past experiences to motivate rough sleepers with mental and addictive disorders to take steps to improve their own health. Peer specialists' expertise in the engagement of unsheltered individuals is unique and of vital importance to consumers and clinicians alike.

NO. 4

STUDENT PERSPECTIVES AND EDUCATION WITH HOMELESS POPULATIONS/PATIENT SATISFACTION AND QUALITY IMPROVEMENT ON THE STREETS

Speaker: Aleta Christensen, M.P.H.

SUMMARY:

Teaching allied health students how to provide quality integrated care for homeless individuals is a core component of the Mercy Care Street Medicine Program. Allied health students working with the team enjoy a unique experience while learning to provide medical and psychiatric care for unsheltered homeless people on the street. Research has demonstrated that students who have more

extensive experience with the homeless show more positive attitudes toward the homeless and may increase their likelihood to work with the homeless when they graduate. This presentation will discuss the student role and their educational experience on street medicine. Information gathered from patient satisfaction surveys can be used to drive positive change and growth, as well as monitor performance among facilities and providers. Patient satisfaction should be applied to the street medicine model to shape a program that will best serve the unsheltered homeless. The speaker will discuss the results of mixed methods evaluation of an Atlanta-based street medicine program and how to improve quality of care while working on the streets.

CONTEMPORARY ISSUES IN JUVENILE JUSTICE

Chairs: William Arroyo, M.D., Jorien Gemma Breur, M.D.

Discussant: Louis Kraus, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the key concepts relevant to the assessment of adolescent culpability, especially from a developmental perspective, in the sentencing of juvenile offenders; 2) Identify the main differences between the determination of competency to stand trial in adolescents and adults and how the legal system addresses them; 3) Describe the characteristics of youthful offenders who engage in the rare event of the homicide of a parent or close relative (parricide) based on preliminary research; and 4) Identify key aspects of the mandatory federal law that provides for the education of youthful offenders who have “emotional” and other disabilities and relevant parental rights.

SUMMARY:

The juvenile justice system was formally launched in the State of Illinois in 1899. It was given the charge to operate as benevolent parents who would provide structure to youth who were not abiding by societal norms. It would “educate” and “rehabilitate” youth as opposed to punish them. It has become evident that, despite this original intent, the balancing act of protecting society and supporting the development of youth who have had brushes with the law is quite evident. Psychiatrists who work in this area must be skillful at working with systems that generally operate in silos of human services. At times, psychiatrists may work

almost exclusively with youth and the juvenile court. Others may work with an array of systems, including law enforcement, the juvenile court, education, health and mental health. Psychiatrists who frequently work with the juvenile court must be able to address an array of legal questions that have dire implications for a youth’s future. Approximately ten years ago, the U.S. Supreme Court determined that the death penalty for minors was unconstitutional, therefore restructuring the landscape of culpability among minors as opposed to adults. Psychiatrists are now faced with a new framework for assessing mitigating factors and how such factors are presented in court; furthermore, this framework has implications for those young adults, ages 18 – 21, who may still be developing. Conducting an adequate assessment of youth as it relates to incompetency to stand trial (IST) has assumed greater importance in recent years as states have implemented the parameters for such and as some have begun to revise them as a result of new brain research and conclusions from the initial foray into the distinction between IST in youth and adults. In regard to the factors related to IST in youth, developmental immaturity has been added to the traditional factors of mental illness and intellectual disability. The killing of a parent is a rather uncommon event among youth. Approximately two percent of all homicides in the U.S. are parricides. Youth’s developmental history is quite different than that of their adult counterparts. There is an increasing data base regarding the circumstances related to such events. Sentencing outcomes vary widely and are rather unique relative to sentencing for other homicides. Education for every youth is obviously essential in mastering an array of basic skills for socialization, development and future employment. Psychiatrists who work with the juvenile court in correctional settings or in the community with youth in the juvenile justice system should be aware of the basic laws governing education, especially special education (Individuals with Disability Education Act), because of the much higher prevalence of disabilities, including those classified as “emotional” and “learning” in nature, as compared to the non-juvenile justice population.

NO. 1

THE IMPACT OF CHANGING VIEWS OF ADOLESCENT CULPABILITY

Speaker: Peter Ash, M.D.

SUMMARY:

Three U.S. Supreme Court cases, beginning with the 2005 *Roper v. Simmons* case in which the Court ruled the death penalty for minors unconstitutional, have clarified the legal landscape regarding how courts consider adolescent culpability to be reduced from that of an adult who has committed a similar crime. This in turn has changed how psychiatrists both assess mitigating factors in sentencing and present their findings to the courts. In addition, these concepts have had significant impact in sentencing 18 – 21 year olds, including those for whom prosecutors seek the death penalty, if a reasonable argument can be made that they exhibit characteristics that the Court has identified as reducing culpability in adolescents under the age of 18.

**NO. 2
CURRENT ISSUES AND FUTURE DIRECTIONS IN THE
ASSESSMENT OF JUVENILE COMPETENCY TO STAND
TRIAL**

Speaker: Caitlin Costello, M.D.

SUMMARY:

The issue of juveniles' competency to stand trial (CST) has received increasing attention. The importance of the careful assessment of juveniles' ability to understand courtroom proceedings and assist their attorneys has also been heightened with more frequent transfer of juveniles to adult criminal court and increasing severity of criminal penalties, as well as by the significant overlap between risk factors for incompetency to stand trial (IST) and involvement in the juvenile justice system. In addition to the factors of mental illness and intellectual disability that can impair adults' CST, juveniles can also be found to be IST based on developmental immaturity. However, state laws vary significantly in how they address juvenile CST and whether they provide for developmental immaturity as a basis for IST. Further complicating the assessment of adolescent adjudicative competency are the different rates at which different decision making skills mature. Developmental neuroscience has an important ongoing role to play in increasing our understanding and assessment of the various issues affecting juvenile CST.

**NO. 3
ADOLESCENT PARRICIDE: PERSONALITY, CRIME
CHARACTERISTICS AND SENTENCING**

Speaker: Wade C. Myers, M.D.

SUMMARY:

Parricides comprise two percent of all U.S. homicides. Nearly one-third of these parent victims are killed by offspring age 19 or younger. In contrast to adult parricide offenders, adolescent offenders are generally the victims of severe, chronic child abuse and rarely have psychotic disorders. There is limited research available on youthful parricide perpetrators, and little is known about the relationship between psychopathology, personality and crime scene findings in them. This presentation will cover advances in our knowledge about these young offenders and will also provide recent findings on the relationship between psychopathy and crime scene behaviors in this population. Additionally, the disparate, at times even whimsical, sentencing outcomes for these offenders will be discussed. Clinical cases will be interspersed during the presentation to highlight key points.

**NO. 4
EDUCATION OF YOUTH IN JUVENILE JUSTICE
SYSTEMS**

Speaker: William Arroyo, M.D.

SUMMARY:

On any given day, approximately 60,000 youth are housed in correctional facilities across the country. Many such youth have been victimized by child abuse and neglect, have been raised in unsafe neighborhoods, and/or have been homeless at times. Many have one or more mental disorders. These youth have three to four times the rate of disabilities that require special education and related services, such as "emotional disturbance" and specific learning disabilities, as does the non-adjudicated school population. Most of these young people will return to their communities. High-quality education in correctional facilities should prepare them to resume their lives and education in their communities and encourage their future success. In addition, these youth should be accommodated in appropriate school settings in the community upon release. Furthermore, there are multiple evidence-based interventions available in local communities. Ultimately, the goal is to decrease contact with the juvenile justice system among such youth. Although the census among juvenile correctional facilities has decreased in the recent past, the rate at which Latino, Black and Native American youth interact with the juvenile justice system is disproportionately higher than their White youth counterparts.

BRIEF THERAPY WITH “DIFFICULT” PATIENTS

Chair: Mantosh Dewan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know some factors that make a patient “difficult to treat”; 2) Use some motivational techniques with a wide range of patients; 3) Use basic prolonged exposure techniques in brief treatment with traumatized victims; and 4) Use cognitive techniques in brief treatment with patients with personality disorders.

SUMMARY:

Many-if not a majority of-psychiatric patients are considered “difficult to treat.” This population is even more challenging when brief treatments are considered. However, recent advances allow for a better understanding as well as a more focused approach with more specific, evidence-based techniques. These are proven to effectively treat “difficult” patients in a time-limited framework. This symposium will consider some general factors that make patients difficult to treat. The presentation on motivational interviewing emphasizes how to engage a range of “difficult” patients in their own care. Prolonged exposure for traumatized patients will be illustrated by the treatment of a rape victim. Another presentation specifies the most important cognitive therapy techniques that are effective in working with “difficult” patients, including those with personality disorders. The presentations are rich in clinical material, practical tips and video, with protected time for interaction with the audience.

NO. 1

THE “DIFFICULT” PATIENT AND POOR OUTCOMES

Speaker: Mantosh Dewan, M.D.

SUMMARY:

“Difficult” patients are usually associated with poor outcomes. To improve results, one or more key factors will need to be addressed. Chronicity, severity and readiness for change are important patient factors. The ability to reach “difficult” patients and establish a therapeutic alliance so that sophisticated and targeted therapeutic strategies can be employed is a key therapist factor.

NO. 2

A MOTIVATIONAL INTERVIEWING PERSPECTIVE ON THE “DIFFICULT” PATIENT

Speaker: Steve Martino, Ph.D.

SUMMARY:

Motivational interviewing (MI) is a well-established, empirically supported treatment for a range of psychiatric and medical conditions. Decades of research have demonstrated its efficacy, effectiveness and mechanisms of action. However, as with any clinical approach, practitioners encounter patients who they deem “difficult to treat.” This presentation will examine the perspective taken within motivational interviewing when working with these patients. The presentation will provide clinical vignettes that illustrate challenges when helping patients enhance their motivation for change. Focus areas of discussion will include 1) Understanding the “difficult” patient; 2) Distinguishing patient arguments against change from discord in the patient-practitioner relationship; 3) Identifying critical motivational rubs; and 4) Specific components within MI that might facilitate the motivational enhancement process.

NO. 3

EXPOSURE THERAPY FOR TRAUMA SURVIVORS WITH SEVERE PTSD

Speaker: Seth J. Gillihan, Ph.D.

SUMMARY:

This presentation will describe how the therapeutic techniques in exposure therapy for PTSD address the processes that maintain the disorder and will summarize the evidence base supporting this treatment. It will also include brief video clips of Dr. Edna B. Foa, a pioneer in trauma treatment and the developer of prolonged exposure therapy, demonstrating the key techniques of the treatment.

NO. 4

CBT FOR CHALLENGING PROBLEMS

Speaker: Judith S. Beck, Ph.D.

SUMMARY:

Patients may present difficulties in treatment because of their highly negative beliefs and dysfunctional coping strategies, but before assuming that problems are due to intrapsychic features within the patient, it is important to rule out other factors. For example, patients may struggle in therapy because they are not receiving the right “dose” of treatment or the appropriate format of treatment. They may pose a challenge because the clinician has incorrectly conceptualized their case, failed to develop a strong therapeutic relationship or

provided ineffective treatment. After a brief review of these factors, we will focus on the CBT conceptualization and treatment of patients whose treatment is challenging due to the presence of personality disorders.

PSYCHODYNAMIC PSYCHOTHERAPY ACROSS PERSONALITY DISORDERS: TRANSFERENCE-FOCUSED PSYCHOTHERAPY

Chairs: Frank E. Yeomans, M.D., Otto F. Kernberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the relation between an individual's psychological structure and symptoms such as anxiety and depression; 2) Establish an appropriate treatment frame to both contain acting out and facilitate the exploratory work of therapy; and 3) Diagnose the presence of the "pathological grandiose self" structure in patients with narcissistic personality disorder.

SUMMARY:

Even as psychiatry has adopted an increasingly biological focus, clinical experience reminds us that many patients' complaints of symptoms such as depression and anxiety are strongly related to internal psychological conflict and to maladaptive mental representations of self and others. It is important to have a conceptual system to both frame our understanding of internal conflicts and structure and guide our therapeutic interventions. Object relations theory provides a clear means of understanding internal conflict that leads to effective interpretation insofar as the interventions are made in language that captures the internal representations of self and other at the heart of the conflicts. After a brief review of the central concepts of object relations theory, this panel will 1) Offer a description of the four basic techniques used across all psychodynamic therapies: interpretation, transference analysis, maintaining a stance of technical neutrality and use of countertransference reactions; 2) Discuss the essential role of framing psychotherapy to reap the most benefit both in terms of limiting pathological behaviors and also in terms of facilitating the exploration of internal conflicts; 3) Review the particular structure underlying narcissistic pathology and its many derivatives and discuss how to work effectively with this structure with focus on adaptations of the four basic techniques for NPD; and 4) Delineate specific

exploratory interventions that are effective in resolving internal conflicts and their related symptoms.

NO. 1

THE FOUR FUNDAMENTAL TECHNIQUES OF PSYCHODYNAMIC PSYCHOTHERAPY

Speaker: Otto F. Kernberg, M.D.

SUMMARY:

The basic techniques of psychodynamic psychotherapy are interpretation, transference analysis, maintaining a stance of technical neutrality and utilization of countertransference material. These techniques assist the physician in gaining insight into the internal conflicts that underlie patients' symptoms and difficulties in relations and functioning. It is important for the therapist to grasp the way in which these four techniques are interrelated and to understand how they can be modulated and used in different proportions according to the level of the individual patient's pathology and the goals of the treatment.

NO. 2

THE ESSENTIAL AND MULTIPLE ROLES OF THE TREATMENT FRAME

Speaker: Frank E. Yeomans, M.D.

SUMMARY:

Psychodynamic psychotherapy has traditionally given perfunctory attention to the frame of treatment. However, clinical experience has shown that 1) The treatment frame is an invaluable tool in helping gain access to the patient's internal dynamics and 2) The level of emphasis that must be given to the frame is related to the level of the individual patient's pathology. This presentation will focus on the essential role of framing psychotherapy to reap the most benefit in terms of limiting pathological behaviors and also in terms of facilitating the exploration of internal conflicts.

NO. 3

RECONSIDERING EXPLORATORY INTERVENTIONS IN DYNAMIC THERAPY: BEYOND INSIGHT

Speaker: Eve Caligor, M.D.

SUMMARY:

This presentation will review the various functions that exploratory interventions may play in the psychodynamic treatment of patients with personality disorders. Dynamic therapists have

traditionally viewed exploration primarily as a road to self-understanding or insight. More contemporary approaches have broadened and deepened our understanding of the impact of exploratory interventions, especially in the treatment of patients with personality disorders falling in the moderate to severe range of severity. In this setting, in addition to promoting self-understanding, exploratory interventions function to support and stabilize central psychological capacities that are often inadequately developed in patients with personality disorders. In this presentation, we will focus, in particular, on the role of exploratory interventions in promoting affect containment, self-observation, reflection on internal states and the capacity to contextualize moment-to-moment experience within a continuous sense of self across time in the treatment of patients with personality disorders.

**NO. 4
ADDRESSING THE CHALLENGES OF NARCISSISTIC
PERSONALITY DISORDER**

Speaker: Diana Diamond, Ph.D.

SUMMARY:

Individuals with narcissistic psychopathology are recognized as a clinical challenge. They possess a heightened vulnerability in the sense of self, for which the typical grandiose narcissistic presentation compensates. The grandiose self may be expressed overtly in self-aggrandizing behavior that hides vulnerability and shame or covertly in self-effacing behavior that covers hidden grandiose fantasies. In either case, the patient's difficulties allowing for a healthy dependency on and attachment to the therapist, along with difficulties tolerating interpretive work, challenge the therapist's skills. This presentation will focus on techniques to successfully engage and treat these patients. A group of clinicians and researchers at the Personality Disorders Institute at the Weill Cornell Medical Center has developed a therapy for the spectrum of personality disorders. Working on the two fronts of case studies and empirical research, we have identified techniques for patients with narcissistic disorders, helping us understand patterns of defense and affect regulation for NPD patients and to illuminate how to work with narcissistic resistance.

**CURRENT CHALLENGES AND OPPORTUNITIES IN
PSYCHIATRIC ADMINISTRATION AND LEADERSHIP**

Chairs: Victor J. A. Buwalda, M.D., Ph.D., Sy A. Saeed, M.D., M.S.

Discussants: Steven S. Sharfstein, M.D., M.P.A., Saul Levin, M.D., M.P.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Gain knowledge of the current challenges and opportunities in psychiatric administration and leadership; 2) Gain a sharper understanding of the necessity to prevent the further decline of psychiatrists in administrative and leadership positions; 3) Gain knowledge on leadership issues to improve treatment outcomes at the systems level; and 4) Gain knowledge on lean management, career paths and trends in residency training, cultural diversity issues, and ethical issues in psychiatric administration and leadership.

SUMMARY:

While psychiatrists, whether in a hospital, in private practice or in a group organization, are routinely involved in some administrative work, it is not always recognized that we all have administrative roles and responsibilities. Clinical psychiatrists generally feel that administration is unrelated to their key role—the care and treatment of patients. Institutional administration, especially in hospitals, is often considered a matter of budgets, red tape, politics and compromises, a job done by non-clinicians. It also appears that there is little training regarding administration and management for physicians, and especially psychiatrists, during their training. Research by McKinsey in collaboration with the London School of Economics shows that hospitals perform 50% better when physicians are involved in management positions. Also, hospitals where physicians are closely involved in decision making and implementing changes perform better. Also, on a lower level, their presence is advocated, especially because of their knowledge and experience of the clinical care process. Literature also suggests that those who manage mental health services increasingly regard clinician leadership as an essential administrative element in the effective introduction of innovation and quality improvement of clinical care. The Group for the Advancement of Psychiatry (GAP, founded in 1946) Committee on Psychiatric Administration and Leadership (CPAL, founded in 2011) recently worked on areas that present both as challenges and opportunities for psychiatrists involved in the field of psychiatric administration and management. This work resulted in a series of papers that were published as a special section on Administration and Leadership in

Psychiatric Quarterly (2015). This symposium is comprised of this work that focused on the expanding horizons for psychiatric administrators and leaders. The authors will present their work on the topics the GAP members wrote about.

NO. 1

LEAN MANAGEMENT IN MENTAL HEALTH CARE

Speaker: Joseph P. Merlino, M.D., M.P.A.

SUMMARY:

business and industry have utilized various quality management methodologies for many years. Recently, the concept of lean management has been applied to the health care sector. This presentation will outline the application of lean management and continuous quality improvement at one of New York's largest behavioral health care organizations and how it assisted in the transformation of efficiency, effectiveness and improved patient care.

NO. 2

ROLE OF LEADERSHIP IN NARROWING THE GAP BETWEEN SCIENCE AND PRACTICE: IMPROVING TREATMENT OUTCOMES AT THE SYSTEMS LEVEL

Speaker: Sy A. Saeed, M.D., M.S.

SUMMARY:

It has been well-documented that health care does not reliably transfer what we know from science into clinical practice. As a result, Americans do not always receive the care suggested by the scientific evidence. Despite the best intentions of a dedicated and skilled health care workforce, this can often lead to poor clinical outcomes. As research and technology rapidly advance, this gap between science and practice appears to be widening. There is increasing public concern about a lack of access to appropriate treatment, pervasiveness of unsafe practices and wasteful uses of precious health care resources leading to suboptimum treatment outcomes. Leadership has a critical role in creating and sustaining the environment that supports health services for individuals and populations that increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Leadership has some responsibility to improve outcomes by ensuring effective use of evidence-based treatment guidelines, measurement-based care, knowledge and skills management, care coordination, and information technologies. This presentation will address leadership issues in these

components of a system's ability to improve treatment outcomes.

NO. 3

TRAINING FUTURE LEADERS: CHALLENGES AND OPPORTUNITIES

Speaker: Farooq Mohyuddin, M.D., M.B.B.S.

SUMMARY:

Well-trained psychiatric leaders are essential to lead our field into the future, yet lack of leadership training in psychiatric residency training is one factor cited as an impediment to recruiting psychiatrists to leadership positions. This presentation will focus on the current status of leadership training and curricula used for residents' training in the U.S. and compare this with training in Canada and Europe. The presentation will also address the challenges and opportunities for leadership training.

NO. 4

CULTURAL ISSUES IN PSYCHIATRIC ADMINISTRATION

Speaker: Neil K. Aggarwal, M.D., M.B.A.

SUMMARY:

This presentation will address cultural issues in psychiatric administration and leadership through two issues: 1) The changing culture of psychiatric practice based on new clinician performance metrics and 2) The culture of psychiatric administration and leadership in light of organizational cultural competence. Regarding the first issue, some observers have discussed the challenges of creating novel practice environments that balance business values with the future of psychiatric training. Regarding the second issue, studies of psychiatric administration and leadership reveal a disproportionate influence of older men in positions of power despite efforts to recruit women, minorities and immigrants who increasingly constitute the psychiatric workforce.

NO. 5

ETHICAL LEADERSHIP IN PSYCHIATRY

Speaker: H. Steven Moffic, M.D.

SUMMARY:

As the nature of mental health care has changed so much over the last generation, so have the ethical challenges for the leadership and administration of our evolving systems of care. These changes include the destruction and fragmentation of our federally

funded community mental health system, the rising dominance of for-profit managed care, the need for more integrated care, and the increasing leadership of non-psychiatrists. Having had the experience of leadership roles in all of our major mental health care systems during this time period and written extensively on the ethical challenges involved, I will present some possible solutions as our new accountable health care systems roll out.

DISENTANGLING GUNS AND MENTAL ILLNESS: THE SANDY HOOK EFFECT

Chair: Tobias Wasser, M.D.

Discussant: Ezra Griffith, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the relationships between mental illness, violence and media portrayals of those with mental illness as violent; 2) Identify several types of legislation related to mental health and gun regulation; and 3) Appreciate the potential impact of legislation related to mental health and gun regulation on those with mental illness.

SUMMARY:

Research has consistently shown that the vast majority of people who are mentally ill are not violent, that only a small proportion of violence in the community can be attributed to persons with mental illness and that individuals with psychiatric disabilities are far more likely to be victims of violent crime than perpetrators of it. However, the misperception that those with a mental illness are more likely to engage in violence, specifically gun violence, persists and is often amplified by the media. This misconception is detrimental and stigmatizing to our patients, as media portrayals of persons with mental illness as violent lead to increased public fear and avoidance of these individuals and a tendency to overestimate their dangerousness. Each time mental illness is implicated at the epicenter of a mass shooting, this stigma intensifies. In this presentation, we use Connecticut, the home of the tragic events at Sandy Hook Elementary School, as a case example of the types of complications that can arise from these misperceptions in the form of legislative regulation related to guns, mental illness and their intersection. We begin by describing the unique legislative backdrop in Connecticut, which preceded Sandy Hook regarding mental health and gun regulations,

in particular prohibitions to firearm ownership, temporary firearm seizure by law enforcement and related reporting requirements. We will then discuss legislative changes enacted following Sandy Hook and subsequent complications for both those with mental illness and practitioners regarding firearm prohibition and access to care. Finally, we will hear from one of the 16 members of the Governor's Sandy Hook Advisory Commission, created to make specific recommendations related to public safety, regarding the Commission's process and recommendations regarding school safety, gun violence and mental health treatment.

NO. 1

GUN CONTROL LEGISLATION AND REPORTING REQUIREMENTS

Speaker: Michael Norko, M.D., M.A.

SUMMARY:

The earliest gun control measures in the state of Connecticut began in 1923. Subsequent changes to gun control measures have been significantly influenced by tragic events and federal and state legislation. Congress first prohibited possession of firearms by those "adjudicated as mental defective or committed to any mental institution" in 1968. The Brady Handgun Violence Prevention Act was introduced to Congress in 1987 and enacted in 1993, initially requiring a five-day waiting period for gun purchases and ultimately establishing the National Instant Criminal Background Check System (NICS). In 2005, the Connecticut General Assembly (CGA) enacted legislation requiring that the state comply with NICS reporting, resulting in a set of state policies and procedures to comply with the laws while attempting to protect patient confidentiality to the extent possible. After the Connecticut lottery shootings in 1998, the CGA instituted legislation in 1999 that allows law enforcement, after obtaining a warrant, to seize firearms from any person who is deemed to pose a risk to self or others. This was the first legislation of its kind in the country and was influenced by the mental health community, which had advocated to base seizures on dangerousness, rather than on mental illness per se. In this presentation, we review the history that led to Connecticut's present system of gun regulation and permit prohibition, with a focus on its impact on those with mental illness.

NO. 2

PERMIT PROHIBITION AND GUN SEIZURE STATUTES

Speaker: Madelon Baranoski, Ph.D.

SUMMARY:

The firearm seizure legislation passed in Connecticut in 1999 required notice by the court to the state Department of Mental Health and Addiction Services, “which may take such action ... as it deems appropriate” in response to the court’s finding of “risk of imminent personal injury” to self or others. Thus, data were available to mental health officials about the firearm seizures. In this presentation, we review data from more than 1,100 seizure incidents from October 1999 through September 2015, including demographics of gun owners, geographical distribution of seizures, how the calls to police were initiated, what types of risk were observed, situation factors at play at time of seizure, history of mental health treatment of the gun owners, number and type of firearms seized, the outcomes of the hearings, and the clinical outcomes of a subgroup of cases where the police brought the individual to the emergency department for evaluation. We will discuss conclusions and questions derived from the data as well as the implications for future research and policy development.

NO. 3

PSYCHIATRIC ADMISSIONS AND GUN OWNERSHIP FOLLOWING SANDY HOOK

Speaker: Tobias Wasser, M.D.

SUMMARY:

In April 2013, the Connecticut senate and house of representatives passed legislation (Public Act [PA] 13-3) entitled “An Act Concerning Gun Violence Prevention and Children’s Safety,” which implemented new laws related to school safety, gun violence and mental health. Of particular significance for psychiatrists, PA 13-3 broadened the mental health provisions that disqualify a person for a gun permit. Under the Act, any person who voluntarily admitted himself or herself to a psychiatric hospital during the preceding six months would be ineligible for gun ownership. Also, the Act required that psychiatric hospitals inform the Department of Mental Health and Addiction Services, which was to maintain a list of such voluntarily admitted patients (requiring the creation of the Voluntary Admission Tracking System, or VATS). Noticeably absent was any provision for individuals who were involuntarily admitted to a psychiatric hospital on an emergency basis. Here we describe the implementation of this Act, data from the VATS reflecting voluntary

admissions in the state since its implementation and the unintended consequences for those with mental illness.

NO. 4

THE SANDY HOOK ADVISORY COMMISSION: LESSONS LEARNED

Speaker: Ezra Griffith, M.D.

SUMMARY:

Shortly after the tragedy at Sandy Hook Elementary School in December 2012, Connecticut Governor Dannel P. Malloy established the Sandy Hook Advisory Commission. Comprised of 16 subject matter experts in the fields of mental health and mental wellness, secure facility design and operations, law enforcement training and response, and public policy implementation, the Commission was not intended to be an investigatory body. It was not intended to tell the story of what happened on December 14, 2012 with academic rigor and forensic precision. It was endowed only with moral authority as representatives of a state so shaken by this tragedy. Over a two-year period, the panel reviewed laws, policies and practices in place on December 14, 2012 in order to make recommendations intended to reduce the probability of another tragedy on the scale of what occurred at Sandy Hook Elementary School. In this presentation, we discuss the process the Commission employed, its recommendations and the personal reflections of one of the mental health experts appointed to the Commission who also serves as the Medical Director for the Connecticut Department of Mental Health and Addiction Services.

BREAKTHROUGHS IN THE UNDERSTANDING AND TREATMENT OF PERSONALITY PATHOLOGY

Chair: James H. Reich, M.D., M.P.H.

Discussants: Erin Hazlett, Ph.D., Alan F. Schatzberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how neuroimaging indicates the pathology of borderline personality disorder may involve cognitive reappraisal and habituation; 2) Understand how oxytocin affects the pathology and functioning in borderline and schizotypal personalities; 3) Understand ways that the office clinician can utilize findings from personality treatment studies in the office setting; 4) Understand how neurobiology can contribute to the

understanding of impulsive aggressive behavior; and
5) Understand the relationship of borderline personality disorder to alexithymia.

SUMMARY:

This symposium is focused on delineating some of the recent advances in research and treatment in patients with personality pathology. It will include a discussion of social cognition with associated genes and biochemical intermediaries (oxytocin) on borderline (BPD) and schizotypal (SPD) personality disorders. There will be a discussion of impulsive aggression and the how that is modified by serotonin, other biochemical pathways and cognition. Emotional dysregulation will also be examined from a neuroimaging perspective where it is hypothesized that emotional dysregulation in BPD may derive from a failure to adequately engage two typically adaptive mechanisms of emotion regulation: cognitive reappraisal and habituation. The aspect of emotional regulation in relation to startle response in BPD patients will also be presented, with the ultimate hypothesis that in BPD there is impaired “emotional interoception,” which can be viewed as an important aspect of mentalization. Finally, there will be a review of some of the different validated therapies for treating personality pathology and what they may mean to the clinician in office practice.

NO. 1

SOCIAL COGNITION AS A NEW THERAPEUTIC TARGET IN PERSONALITY DISORDERS

Speaker: M. Mercedes Perez-Rodriguez, M.D., Ph.D.

SUMMARY:

Background: Interpersonal dysfunction is a core feature of personality disorders. Abnormalities in social cognition are recognized in patients with personality disorders. **Methods:** We examined social cognition abnormalities in borderline (BPD) and schizotypal (SPD) personality disorders using behavioral, functional imaging genetics and structural neuroimaging. We tested an association between oxytocin genes and haplotypes and social cognitive traits (empathy, attachment style and aggression). We tested the effect of intranasal oxytocin on social cognition. **Results:** Social cognitive accuracy is impaired in BPD and SPD and improved in SPD patients after social cognitive remediation. SPD patients have decreased empathic accuracy for negative emotions associated with lower social functioning. Neuroimaging suggests abnormalities in

social cognition/emotion processing brain networks in BPD. BPD patients have decreased FA in white matter tracts involved in emotion recognition. BPD patients have abnormal amygdala reactivity and a habituation deficit to emotional social stimuli, modulated by BDNF genotypes. Genetic data support the modulation of social cognitive traits by oxytocin genotype. We identified a risk haplotype significantly associated with higher aggression and anxious attachment. **Conclusion:** Converging evidence suggest that social-cognitive impairment is a core feature of BPD and SPD and that oxytocin and BDNF modulators hold promise for development of novel therapeutics.

NO. 2

NEUROBIOLOGY AND TREATMENT OF IMPULSIVE AGGRESSION IN HUMAN SUBJECTS

Speaker: Emil Coccaro, M.D.

SUMMARY:

Objective: While “aggression” comes in many forms, one of the most important is impulsive aggression. This presentation will review studies examining the biology and treatment of impulsive aggression and offer an overarching view of the problem. **Methods:** A number of complementary methods were used, including neurochemistry, psychopharmacological challenge, neuroimaging and randomized clinical trial. **Results:** Aggression is most consistently associated with a functional deficit in brain serotonin (5-HT), and agents that increase brain 5-HT can reduce aggressive behavior. This view is complicated by the fact that several other neurotransmitter systems work to stimulate aggression and, thus, a balance of inhibitory and facilitatory neurotransmitters likely “set the threshold” for aggressive response in humans. In addition, social and emotional information processing factors likely affect how individuals respond to threat and/or frustration, and this must be considered as well. Trials of SSRIs, which increase brain 5-HT, reduce aggression, as does cognitive behavioral intervention, which involves cognitive restructuring/coping skills training. **Conclusion:** Impulsive aggressive behavior likely affects three percent of the general population. Factors associated with it are complex, but we are coming to understand the various components and are testing empirically based strategies to reduce the impact of these behaviors on people affected by this externalizing behavior.

**NO. 3
THERAPEUTIC IMPLICATIONS OF RECENT
NEUROIMAGING FINDINGS ON EMOTION
DYSREGULATION IN PERSONALITY DISORDERS**

Speaker: Harold W. Koenigsberg, M.D.

SUMMARY:

Emotional dysregulation contributes to severe disturbances including extreme anger, intense emotionality, sudden mood shifts, excessive situational reactivity, unstable interpersonal relationships and self-destructive, even suicidal behavior. While it is present in a range of disorders, borderline personality disorder (BPD) is most prototypical. Informed by neuroimaging findings that will be presented, we posit that emotional dysregulation in BPD may derive from a failure to adequately engage two typically adaptive mechanisms of emotion regulation: cognitive reappraisal and habituation. We present imaging data suggesting that BPD patients can be trained to enhance the effectiveness of their use of cognitive reappraisal to regulate emotion, a novel approach to treatment that may have a role in psychotherapy. We will also discuss the psychotherapeutic implications of the impairment in habituation present in patients with BPD.

**NO. 4
NEUROBIOLOGICAL EVIDENCE FOR IMPAIRED
MENTALIZATION IN BORDERLINE PERSONALITY
DISORDER**

Speaker: Antonia S. New, M.D.

SUMMARY:

In our early work using affective startle to measure affect responsiveness to emotional probes, we hypothesized that individuals with BPD would have an enhanced response to negative emotional stimuli. We imagined that patients with BPD, who seemed to have heightened emotional responsiveness, would indeed show a heightened amplification of their startle response to negative emotional stimuli compared to healthy individuals. Our study confirmed this hypothesis, but found, unexpectedly, that BPD patients rated their own emotional responses to the negative stimuli as more neutral than did the healthy controls. We replicated this blunted subjective rating of emotional responses paired with an exaggerated physiological measure of emotional response with fMRI BOLD response in the amygdala bilaterally, finding that BPD patients rated their responses to both positive *and* negative stimuli

as more neutral than did healthy controls. This dichotomy was initially puzzling, but led us to measure a construct called “alexithymia” in these patients. We found BPD patients to be highly alexithymic, with particular difficulty identifying and describing their own emotions. In this presentation, I will present these data and more that show impaired “emotional interoception” in BPD, which we view as an important aspect of mentalization.

**NO. 5
MOVING FROM TREATMENT AS USUAL TO GOOD
CLINICAL CARE FOR PERSONALITY DISORDER:
TRAITS FOR THE OFFICE-BASED CLINICIAN**

Speaker: James H. Reich, M.D., M.P.H.

SUMMARY:

There is now a body of treatment research on personality disorder traits. These studies usually take place in a university or specialized treatment setting far different from the setting where the office-based clinician practices. Many of the techniques used in these studies require extensive training that most office-based psychiatrists often have not completed. However, many psychotherapy research studies have used a control arm of manual codified “good clinical care” as a control group. In these studies good clinical care is a highly effective treatment. This presentation will examine commonalities of this research-defined good clinical care and how they might be translated to office-based care. This presentation will also review other key treatment studies using various modalities of treatment and examine how these findings might translate to approaches to care for office-based psychiatrists. Not all of the techniques will transfer, of course. On the other hand, the office-based clinician may have more flexibility to focus on an individual’s specific needs with techniques drawn from a variety of modalities, and this flexibility may be highly beneficial to an individual patient.

**NEW ISSUES IN UNDERSTANDING AND
ADDRESSING TOBACCO USE AND MENTAL ILLNESS**

Chair: Wilson M. Compton, M.D.

Discussant: Tony P. George, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the shifting use of tobacco products by persons with mental illness and addiction, where cigarettes are just one of many products used; 2) Understand the role of genetics in

influencing the risk for tobacco addiction and the responses to treatment; 3) Understand ways to increase tobacco cessation services for psychiatric patients; 4) Understand potential causes of the high prevalence of smoking in persons with schizophrenia and how current data helps to clarify which processes are likely to be most important; and 5) Be familiar with current knowledge about safety, design and performance, abuse liability, and efficacy of electronic cigarettes.

SUMMARY:

One of the most positive public health advances of recent decades in the U.S., the marked reduction in tobacco use, has not been shared by persons with mental illnesses. At present, it is estimated that nearly half of the 448,000 annual deaths each year from tobacco are in persons with mental illness. Especially for persons with serious mental illness, many years of life are lost due to tobacco use. A further issue is the development and widespread distribution of electronic nicotine delivery products (“e-cigarettes”), which offer the potential for a new route to abstinence but may also be a pathway to continued or new-onset addiction. How these new products are used by persons with mental illness and their impact on health outcomes is an essential question. Further, a key underlying issue is how to understand the relationship between tobacco use and mental illness. Studies suggest strong genetic pathways to tobacco addiction, and multiple studies suggest shared neurobiological substrates for tobacco addiction and mental illnesses. While most have thought tobacco to be a marker for the risk of mental illness without direct causal implications, recent evidence suggests that tobacco use may play a causal role in the development of schizophrenia. Finally, many persons with mental illness are interested in quitting tobacco use, respond to treatments (when offered), and can benefit from outreach and care. How to structure such treatment so that it will reach these vulnerable populations is a key question. In this symposium, Dr. Conway will discuss emerging data on the co-occurrence of substance use, substance use problems and symptoms of mental health problems across 12 tobacco product-specific user groups, using data from the Population Assessment of Tobacco and Health (PATH) study of over 45,000 persons ages 12 and older. Dr. Goniewicz will describe current data about how e-cigarettes vary in design, performance, nicotine delivery, prevalence and patterns of use and the potential application of e-cigarettes in harm

reduction and smoking cessation. Drs. Kendler and Bierut will explore new data that suggest potentially causal pathways from smoking to schizophrenia (and similar nonaffective psychoses) using national registry, twin and family-study design data as well as genetic data. Dr. Saxon will discuss how integrated treatment can be more effective than separate treatments for tobacco addiction and psychiatric illness, with data from his research on manualized integrated treatment for co-occurring tobacco use and PTSD. Dr. George will then serve as the discussant to highlight the clinical and research implications of this panel. The overall goal is to point the way forward for reducing tobacco use and improving the health outcomes for persons with mental illness who use tobacco products.

NO. 1

IT’S NOT JUST CIGARETTES: THE EVOLVING EPIDEMIOLOGY OF TOBACCO PRODUCT USE, SUBSTANCE USE AND SYMPTOMS OF MENTAL ILLNESS IN THE U.S.

Speaker: Kevin P. Conway, Ph.D.

SUMMARY:

While cigarette use has declined in the U.S., those who continue to smoke are more likely to exhibit substance use problems and symptoms of mental illness. However, it is not clear if these associations exist for non-cigarette tobacco products. This study examined the co-occurrence of tobacco product use (cigarettes, e-cigarettes, traditional cigars, cigarillos, filtered cigars, pipe, hookah, snus pouches, other smokeless tobacco, dissolvable tobacco, bidis and kreteks) with substance use and symptoms of mental illness among adult and youth participants from wave 1 of the Population Assessment of Tobacco and Health (PATH) study, a nationally representative longitudinal cohort study of tobacco use and health in the U.S. Across tobacco products, tobacco users were not only more likely to report alcohol or drug use compared to nonusers, but use of each tobacco product was associated with higher severity levels of substance use problems, as well as internalizing and externalizing problem symptoms.

NO. 2

TOBACCO USE AS A RISK FOR PSYCHOSIS?

Speaker: Kenneth Kendler, M.D.

SUMMARY:

In national Swedish registry data, smoking prospectively predicts risk for schizophrenia in both

men and women. This association does not arise from smoking onset during a schizophrenic prodrome and demonstrates a dose-response relationship. Little of this association is explained by social class or drug abuse, and in a correlative design, the risk for nonaffective psychosis was appreciably higher in the smoking member of siblings and twins discordant for smoking. These results help to evaluate the plausibility of various etiologic hypotheses for the association between smoking and schizophrenia.

NO. 3
SHARED GENETIC RISK FACTORS BETWEEN SCHIZOPHRENIA AND NICOTINE DEPENDENCE

Speaker: Laura J. Bierut, M.D.

SUMMARY:

Schizophrenia is frequently complicated by comorbid smoking behaviors. Historically, this increased comorbidity has been explained by individuals with schizophrenia “treating” symptoms of their illness. Newer evidence now points to smoking as a predisposing (and potentially causative) factor in the development of this severe mental illness. In addition, underlying schizophrenic and smoking behaviors are some shared genetic factors, specifically genetic variation in cholinergic nicotinic receptor subunit genes. This shared genetic predisposition provides new knowledge about the underlying neurophysiology that contributes to comorbid severe mental illness and substance use disorder.

NO. 4
E-CIGARETTES: PROMISE AND PERIL

Speaker: Maciej L. Goniewicz, Ph.D., Pharm.D.

SUMMARY:

Electronic nicotine delivery devices, also known as e-cigarettes, are devices designed to imitate regular cigarettes and deliver addictive nicotine via inhalation without combusting tobacco. Recent data indicate that use of e-cigarettes is rapidly increasing, especially among youth and smokers with mental conditions. Although it cannot be said that currently marketed e-cigarettes are safe, they likely pose less direct hazard to the individual smoker than tobacco cigarettes and might help smokers quit smoking. The use of e-cigarettes as a harm reduction strategy among cigarette smokers who are unable to quit warrants further study. Further research is needed to evaluate long-term effects of switching, including

the mental health effects of continued use of e-cigarettes.

NO. 5
INTEGRATION OF TOBACCO CESSATION AND MENTAL HEALTH CARE FOR VETERANS WITH PTSD

Speaker: Andrew J. Saxon, M.D.

SUMMARY:

We developed a manualized intervention that integrates tobacco treatment with mental health care for veterans with PTSD and demonstrated its efficacy in a multisite, randomized controlled trial. We then used a learning collaborative model to implement this novel intervention in 12 veterans affairs multidisciplinary PTSD programs comprising 70 staff members. All participants who planned to deliver integrated tobacco treatment did so (n=52). Within 12 months of initial training, an additional 46 locally trained providers delivered integrated tobacco treatment, and 395 veterans received it. Barriers and facilitators to implementing integrated tobacco use treatment into general mental health care will be discussed.

THE SURGEON GENERAL’S REPORT ON MENTAL HEALTH, PARITY AND INTEGRATED CARE

Chairs: Eliot Sorel, M.D., Constance E. Dunlap, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Give examples of how the 1999 Surgeon General’s Report on Mental Health, the 2008 Domenici-Wellstone Parity Law and the 2009 Affordable Care Act enhance access and quality of mental health care; 2) Describe the economic and social consequences of not attending to mental health care; 3) Identify new models of care integration as well as new clinical roles and leadership opportunities for psychiatric physicians in collaborative/integrated care teams; and 4) Demonstrate the ability to apply principles of integrated care in clinical practice.

SUMMARY:

Non-communicable diseases, inclusive of mental disorders, lead in the global burden of disease and disability. The Surgeon General’s Report on Mental Health, the Domenici-Wellstone Parity Law and the Affordable Care Act are distinct and complementary American research and policy initiatives that together provide enhanced access, quality and sustainability of care for millions of Americans and

have diminished shame, stigma and discrimination against mental disorders. Current international scientific evidence indicates that not attending to the care of people who suffer from mental disorders and their comorbid conditions such as cardiovascular disorders, diabetes and others has a significant impact on individuals' and populations' health as well as economic consequences for all, low-, middle- and high-income countries. The direct and indirect costs of mental illness are very high and can amount to over 4% of the gross domestic product. Patients with behavioral health and comorbid conditions can present in any primary care and specialty components of existing health care systems. Therefore, the development and implementation of collaborative/integrated models of care that include close collaboration between primary care and psychiatry is essential. After presenting the Surgeon General's Report findings and recommendations, the relevant Parity Law and Affordable Care Act aspects and the health economic dimensions, the basic principles of collaborative/integrated models of care will be reviewed: team-driven, population-focused, measurement-guided, evidence-based, accountability and quality improvement-minded. New emerging clinical models, team membership and systems leadership opportunities will be examined. There will be ample opportunities for dialogue between the presenters and the participants.

NO. 1
MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL

Speaker: David Satcher, M.D., Ph.D.

SUMMARY:

Mental Health: A Report of the Surgeon General was released in 1999 and was the first report on this topic to come from the office of the surgeon general. This report made several key points: 1) Mental health is vital to overall health and well-being; 2) We cannot take our mental health for granted. Just as things go wrong with the heart, the lungs, the liver and the kidneys, things go wrong with the brain. There should be no shame in that. Our challenge is to respond with the best available care based on the best available science; and 3) The stigma or negative attitudes toward mental illness and drug addiction often present barriers to access to care. Successful interventions help to reduce stigma. The good news is that we are able to diagnose and treat mental disorders successfully in 85 – 90% of cases. The bad

news is that so few persons seek and access mental health care. That is what must change, and that is what the Affordable Care Act should allow to happen. When it comes to mental health, it is important to remember that culture counts, and so we released the supplement *Mental Health: Culture, Race and Ethnicity* (2001). While we found no evidence of major differences in the prevalence of mental disorders, there were differences in the burden of mental disorders. This disparity is one of our major research areas.

NO. 2
MENTAL HEALTH PARITY, THE DOMENICI-WELLSTONE LAW AND THE AFFORDABLE CARE ACT

Speaker: Patrick Kennedy

SUMMARY:

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) set the stage for full inclusion of mental health and addiction services in the Affordable Care Act of 2009 (ACA). Together, these two laws promised to reconfigure access to and payment for care related to mental health and substance use disorders in the United States. In opening doors for treatment of mental health and addiction disorders, enactment of the Affordable Care Act was analogous to the Civil Rights Act or the Voting Rights Act of the mid-1960s in providing legal protection to a sizeable segment of the population that had been systematically ignored up to that point. As with the civil rights laws of the 1960s, however, the protections promised by MHPAEA and ACA will take some time to be realized by their intended recipients. Entrenched interests and, particularly, payers' resistance to change continue to place barriers in the way of equitable coverage for behavioral health disorders, and the prospect is that it will take years of regulatory refinement and costly litigation to secure the rights specified in the law.

NO. 3
MAKING MENTAL HEALTH COUNT

Speaker: Francesca Colombo

SUMMARY:

Despite the vast burden that mental ill health imposes on people and economies, many countries continue to neglect mental health care, and the unmet need for effective treatment remains high. Mental disorders account for one of the largest and fastest-growing categories of disease with which health systems must cope and lead to significant

personal, social and economic costs. People with severe mental disorders die up to 20 years earlier than the general population, as well as being six to seven times more likely to be unemployed. One in two people are estimated to experience mental illness at some point in their life, affecting their job prospects, wages and productivity. The direct and indirect costs of mental illness can exceed four percent of gross domestic product (GDP) in many of the Organization for Economic Cooperation and Development (OECD) countries. The OECD report *Making Mental Health Count* demonstrates that making mental health a policy priority would enhance people's lives and have significant social and economic benefits.

NO. 4

INTEGRATED CARE IN CLINICAL PRACTICE

Speaker: Eliot Sorel, M.D.

SUMMARY:

Non-communicable diseases (NCDs) lead in the global burden of disease in low-, middle- and high-income countries. Mental disorders lead among NCDs, representing 14% of the global burden of disease and 30 – 45 % of the global burden of disability. Epidemiologic evidence indicates that 50% of mental disorders exist by age 14 and 75% by age 24. Early onset, late detection and intervention, comorbidity, and health systems' fragmentation augment the severity of illness and increase the global burdens of disease, disability, longevity and health care costs. Significant degrees of comorbidity exist between mental disorders and other non-communicable diseases such as cardiovascular disorders, diabetes, cancer and others. Most of the clinical care for these conditions is delivered in primary care settings with variable degrees of success. Developing collaborative, integrated models of care would enhance care quality, access and outcomes. This presentation will 1) Describe core principles of integrated care—team-driven, population-focused, measurement-guided, evidence-based, accountable and quality improvement; 2) Indicate how to best support their implementation in clinical practice; 3) Highlight the emerging new opportunities for psychiatric physicians in collaborative and integrated teams and systems of care; and 4) Illustrate the potential for innovating new models of education and training in collaborative and integrated care.

NEW PERSPECTIVES ON TREATMENT OF BORDERLINE PERSONALITY DISORDER (BPD)

Chairs: John Gunderson, M.D., Victor Hong, M.D.

Discussant: Joan Anzia, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know the advantages and disadvantages of being available between sessions for BPD; 2) See the value and feasibility of training residents in a non-intensive management model for treating BPD; 3) Improve the quality of ER interventions for BPD; 4) Integrate rejection sensitivity into understanding and treatment of BPD; and 5) Understand how good self-knowledge and -awareness are essential for therapists with BPD patients.

SUMMARY:

This symposium will feature new perspectives on the treatment of patients with borderline personality disorder, sometimes through the lens of familiar concepts like countertransference (Dr. Gabbard) or familiar problems, e.g., inter-session contacts (Dr. Jacob), or sometimes through examination of new settings, e.g., emergency rooms (Dr. Hong) or the emergence of a generalist model (Dr. Gunderson). Dr. Choi-Kain will introduce new clinical applications of the rejection sensitivity concept. All presentations will provide practical how-to lessons in the clinical care of borderline patients.

NO. 1

PROS AND CONS OF INTER-SESSION CONTACT WITH BORDERLINE PERSONALITY DISORDER (BPD) PATIENTS

Speaker: Karen L. Jacob, Ph.D.

SUMMARY:

BPD has a reputation for being a challenging disorder to treat due to the nature of the illness. Most people with a diagnosis of BPD struggle with emotion dysregulation, behavioral reactivity and cognitive distortions, and their relationships are wrought with interpersonal challenges. With emerging empirically supported treatments (EST) for BPD, therapists are becoming more skilled at successfully helping this cohort of patients. A common factor associated with many of these ESTs for BPD includes therapists' active involvement in the process of treatment. In some treatments, such as dialectical behavior therapy (DBT), therapists' accessibility between sessions is an integral and emphasized aspect of the

therapeutic process. There are costs and benefits of being so accessible to patients, which can affect the process and outcome of treatment. Assessing the function for patient contact between sessions is one way to determine whether such contact is a productive part of treatment, as contact has the potential to enhance aspects of the therapeutic process. However, if challenges arise due to inter-session contact, the contact itself can prove destructive to treatment. Recommendations are provided to avoid detrimental outcomes for the therapist (therapist burnout), as well as the overall viability of the patient's treatment. This presentation addresses inter-session contact from a DBT perspective.

NO. 2
REJECTION SENSITIVITY AS A PARADIGM FOR UNDERSTANDING BORDERLINE PERSONALITY DISORDER (BPD) AND ITS COMORBIDITIES

Speaker: Lois W. Choi-Kain, M.D., M.Ed.

SUMMARY:

Rejection sensitivity is characterized by anxious anticipation of and angry reactivity to real or perceived rejection. Individuals with higher rejection sensitivity are at greater risk to develop a number of psychiatric disorders, including mood disorders, anxiety disorders and personality disorders. This presentation will review empirical findings on the relationship between BPD and its comorbidities and propose clinical interventions using a rejection sensitivity framework that can be integrated into any general mental health care setting.

NO. 3
A GENERALIST MODEL IS "GOOD ENOUGH" FOR TREATING MOST BORDERLINE PERSONALITY DISORDER (BPD) PATIENTS

Speaker: John Gunderson, M.D.

SUMMARY:

The availability of effective treatment for BPD patients is a major public health problem. The major evidence-based treatments (DBT, MBT, TFP) are too intensive and require too much training to adequately address this problem. A series of recent studies have shown that less-intensive treatments can effect nearly the same benefits. This "generalist" model emphasizes psychoeducation and case management and integrates medications and family intervention in ways that are pragmatic, commonsensical and eclectic. This presentation will

describe this approach and discuss how it can be introduced into residency training programs.

NO. 4
GUIDELINES FOR EMERGENCY ROOM MANAGEMENT OF BORDERLINE PERSONALITY DISORDER (BPD) PATIENTS

Speaker: Victor Hong, M.D.

SUMMARY:

The prevalence of patients with BPD in the psychiatric emergency room is high. There are unique challenges in the management of these patients in that setting, including disruptive behavior, repeated visits, concerns about safety and liability, and disposition issues. In the absence of guidelines for how to approach these issues, patients are often not treated optimally, and what occurs in the emergency room can be harmful. Iatrogenic problems are common and often arise from negative staff attitudes as well as lack of adequate training in the treatment of BPD. Psychoeducation for patients and their families; the reinforcement of connections between interpersonal stressors, symptoms and behaviors; the employment of an active, authentic therapeutic stance; and rational management of suicidality and self-harm are all crucial to an adequate assessment and disposition. Training for emergency room staff regarding these interventions could lead to improved attitudinal changes as well as better patient outcomes. This presentation proposes helpful guidelines in how to best manage BPD in the emergency room while avoiding common pitfalls.

NO. 5
A 40-YEAR RETROSPECTIVE ON BORDERLINE PERSONALITY DISORDER (BPD) AND COUNTERTRANSFERENCE

Speaker: Glen O. Gabbard, M.D.

SUMMARY:

In this presentation, I will discuss how the research on BPD over the last 40 years has changed our view of countertransference. In the mid-1970s, the patient with BPD was seen as a chronic patient who was not likely to get much better. The etiology was mainly focused on bad or abusive parenting. The countertransference was regarded as generated by the patient and having little to do with the therapist. Today, we are aware of genetically-based hyperreactivity to interpersonal interaction, opioid deficits and attachment problems as central to the etiology. In addition, we now see BPD patients as

making accurate perceptions of facial expressions while in some cases misinterpreting what they see. These factors make therapist self-knowledge even more important in treating BPD patients.

THE EVOLVING ROLE OF PSYCHIATRISTS IN MEDICINE: FROM EAST TO WEST

Chairs: Saul Levin, M.D., M.P.A., Michelle B. Riba, M.D.

Discussant: Edmond Hsin T. Pi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate an understanding of the evolving role of psychiatrists in medicine in the Pacific Rim and North America from the perspectives of Japan and the United States; 2) Provide mental health awareness strategies that incorporate cultural factors that lead to screening and prevention; and 3) Provide mental health screening strategies for preventing mental health disorders that incorporate cultural factors.

SUMMARY:

The role of psychiatrists in medicine is constantly evolving with new movements and findings in the social, political, economic, scientific and technological landscapes. These changes require that psychiatrists transform and adapt to their environment through the regular review and evaluation of their experiences and body of knowledge in order to maintain an integral and impactful role in medicine. Around the world, the intersection of social issues in mental health impacts the role of the psychiatrist in society. This symposium represents the interconnectivity of the global community of psychiatrists to exchange experiences and knowledge in order to identify the commonalities in evolving national landscapes in order to gain a better understanding of the evolving role of psychiatrists. The involvement of psychiatrists in the development of mental health and health care policies opens the door to the incorporation of prevention interventions and strategies that can lead to the early assessment and treatment of mental health disorders. Prevention in mental health is essential to reducing the increasing burden of mental disorders. Greater attention to awareness and prevention in mental health at the level of policy formulation, legislation, decision making, resource allocation and the overall health care system is essential and a common goal for psychiatrists around the world.

NO. 1

THE EVOLVING ROLE OF PSYCHIATRISTS IN MEDICINE: JAPAN

Speaker: Tsyuyoshi Akiyama, M.D., D.Phil.

SUMMARY:

According to the 2013 *Psychiatric Services* article "Mental Health Care Reforms in Asia: The Regional Health Care Strategic Plan: The Growing Impact of Mental Disorders in Japan," Japan designated mental disorders as the fifth "priority disease" for national medical services after cancer, stroke, acute myocardial infarction and diabetes. This coincides with the 2010 findings of the Global Burden of Disease study, which identified the burden of mental health and substance use disorders as accounting for 7.4% of total disease burden, making it the fifth leading disorder category in the number of years of life lost to disability, illness or early death. At the time, all prefectures in Japan were required to review and assess their local mental health needs and identify and develop necessary service components. This movement to prioritize mental health disorders in Japan brought the role of the psychiatrist to the forefront of medicine in Japan.

NO. 2

THE EVOLVING ROLE OF PSYCHIATRISTS IN MEDICINE: THE UNITED STATES

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

SUMMARY:

Psychiatrists are evolving by incorporating primary care skills, practicing population-based medicine, using data to drive care, honing leadership skills and connecting with the community. The evolving role of the psychiatrist in the United States also involves attaining a deeper understanding of and involvement in the health care system. With psychiatrists in the United States working in a variety of settings, including general and psychiatric hospitals, university medical centers, community agencies, courts and prisons, nursing homes, industry, government, military settings, schools and universities, rehabilitation programs, emergency rooms, hospices, and private practices, their scope of influence is vast. The role of psychiatrists in the United States includes leading and working together with other medical specialties to address comprehensive mental health care reform, physician payment reform and the incorporation of the Affordable Care Act. These serve as examples of the

influence of organized psychiatry on policy making at the highest levels of government to effectively spread the reach of psychiatry and the effective treatment of patients with mental health needs.

NO. 3

THE ROLE OF PSYCHIATRISTS IN MENTAL HEALTH DISORDER AWARENESS AND PREVENTION: SUICIDE IN JAPAN

Speaker: Shigenobu Kanba, M.D., Ph.D.

SUMMARY:

In 2013, Japan's national rate of suicide stood at 21.4 deaths per 100,000 people, well above that of other high income countries. An assessment of local mental health needs by prefecture led to the development of service components that strike a balance between institutional- and community-based care for patients, a shift from care and treatment provided in hospitals to care and treatment provided in communities. Under a 2012 initiative of the National Center of Neurology and Psychiatry in Japan, national specialized care and research centers launched collaborative care programs focused on depression diagnosis and treatment to integrate mental health care with general medical care. Understanding the impact of suicide on communities in Japan and the United States serves as a model for understanding the global impact of a serious issue affecting a nation's populous. It also highlights the impact of such issues on the evolving role of the psychiatrist at both at the national and community levels.

NO. 4

GLOBAL MENTAL HEALTH: THE ROAD FORWARD

Speaker: Maria Oquendo, M.D.

SUMMARY:

Globally, mental disorders remain three of the top 10 contributors to years lived with disability. This is even more so in low- and middle-income countries (LMICs)—over 75% of those with mental disorders in LMICs receive no care despite substantial disability. When treatment is provided, it is rarely based on evidence-based practices, and human rights violations occur frequently. Critically, there is a dearth of human resources. Thus, strategies need to include training of people who are not mental health professionals, using task-shifting or task-sharing, who can provide services under supervision. Moreover, given scant monies available to fund mental health care in LMICs, implementation

research must be conducted as new programs are deployed. This will ensure that limited resources are used efficiently. The research can ensure that adaptations of evidence-based interventions are both culturally acceptable and practical in the local setting without losing their essential active ingredients. Additionally, examining outcomes of newly developed programs using novel randomization strategies can document the utility of a given investment. A key aspect of this work involves partnering with local universities and health ministries to develop programs. Only then can we ensure that the investment will continue to bear fruit over the long term.

ARE INVOLUNTARY OUTPATIENT COMMITMENT LAWS A GOOD THING? ETHICS CONSIDERATIONS AND ANALYSIS

Chair: Robert Weinstock, M.D.

Discussant: Steven Hoge, M.D., M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the arguments for and against involuntary outpatient commitment and the degree to which the data does or does not support the efficacy of such laws; 2) Identify the relevant ethical considerations related to involuntary outpatient commitment and how to balance them in a manner to determine their own ethics judgments about such laws; 3) Appreciate the ways in which involuntary outpatient commitment can help patient welfare despite depriving them of some autonomy; 4) Appreciate the ethical concern that such laws may be used disproportionately to deprive some minority groups of their freedom; and 5) Have a balanced view of this complex area including related ethical concerns and the latest APA position on the advisability of such laws and ethical challenges they present in psychiatric practice.

SUMMARY:

Involuntary outpatient commitment (IOC) can help patients who lack insight into their mental illness, which prevents them from appreciating the need for psychiatric treatment, including psychotropic medication. As a result, a "revolving door" phenomenon develops in which such patients become stabilized in the hospital only to stop medication upon discharge despite evidence that medication is needed. They subsequently decompensate and soon require readmission. Although intruding on patient autonomy, IOC can

help patients who lack the ability to weigh the risks and benefits of treatment themselves. However, such laws can present ethical problems. An alternative name for IOC used by some, “assisted outpatient treatment,” is a euphemism that belies the involuntary and mandatory nature of these laws. Although many psychiatrists may view these laws as assisting treatment, many patients are likely to perceive them as forcing treatments upon them that they do not need or want. Additionally, such involuntary procedures may disproportionately be used against some minority groups to civilly commit them as outpatients, like what often happens now as inpatients. For example, African-American males may be seen as dangerous because of cultural stereotypes in ways White Americans are not. There are contrary ethics arguments. African-American males subject to outpatient commitment might be spared jail time, which would be the likely alternative police would employ. Because of a shortage of public treatment options, minorities may suffer restriction of liberties without clear benefit. These laws might primarily help relatively wealthy White Americans who have adequate resources to cover treatment. In this symposium, Marvin S. Swartz, M.D., chair of the APA Committee on Judicial Action, who developed an IOC position statement and resource document for the Council of Psychiatry and Law, will present the relevant data and resultant arguments related to such laws. Ezra Griffith, M.D., chair of the APA ethics committee, will present some of the ethical concerns these laws can raise. Robert Weinstock, M.D., a member of the APA Committee on Judicial Action and consultant to the APA ethics committee, will describe a method called dialectical principlism, initially introduced in his Presidential Address at the American Academy of Psychiatry and the Law. This method facilitates identifying ethical concerns and prioritizing them according to the obligations consistent with specific roles. These duties are then weighed to arrive at the most ethical course of action. William Connor Darby, M.D., a resident who has been working on dialectical principlism with Dr. Weinstock, will utilize and demonstrate this method to arrive at a balanced view of these ethical considerations. Stephen Ken Hoge, M.D., chair of the APA Council on Psychiatry and the Law, will be the discussant and will summarize as well as provide his viewpoints on the issues presented.

NO. 1

FOR WHOM AND UNDER WHAT CONDITIONS CAN INVOLUNTARY OUTPATIENT COMMITMENT BE EFFECTIVE?

Speaker: Marvin S. Swartz, M.D.

SUMMARY:

Involuntary outpatient commitment (IOC) is a civil court procedure whereby a judge can order a noncompliant person with mental illness to comply with needed treatment. Evidence of IOC’s effectiveness is somewhat mixed. In the first experimental study of IOC, conducted in North Carolina, patients ordered to IOC had fewer readmissions to the hospital, spent fewer days in the hospital and had a number of other improved outcomes if they received IOC for six months or more. However, a similar study of a pilot statute at New York City’s Bellevue Hospital found such no benefit. In 1999, the New York State legislature enacted Kendra’s Law, establishing a provision for IOC for persons with mental illness at risk of relapse. This program includes a wide array of court-ordered enhanced outpatient services, including intensive case management. In support of the program, a legislatively mandated evaluation of New York’s program in 2009 found that it reduced psychiatric hospitalizations, shortened hospital lengths of stay, and improved receipt of intensive case management services and medication adherence—among a number of other positive outcomes. However, a recent randomized controlled trial in the United Kingdom found no benefit to a similar program when compared to conditional release. This presentation will critically review findings from existing studies.

NO. 2

AN ETHICS-BASED VIEW OF INVOLUNTARY OUTPATIENT COMMITMENT

Speaker: Ezra Griffith, M.D.

SUMMARY:

Involuntary outpatient commitment (IOC) is an intervention that has prompted considerable debate in the lay and academic literature. Despite the ongoing discussion, over 40 states have reportedly adopted this form of involuntary treatment. However, there has been no wholesale consensus about the activity, as many of the states have actually implemented IOC in different ways. In this presentation, I will examine IOC from an ethical perspective. I will review it in terms of certain basic ethical principles such as truth-telling, respect for persons, autonomous decision making, honesty in

professional interactions and commitment to the broader society. The ensuing discussion should be helpful in fostering a thoughtful and balanced appraisal of IOC and catalyzing serious reflection on the ethical basis of IOC. Dialectical principlism will be utilized in this analysis.

NO. 3

DIALECTICAL PRINCIPLISM: AN APPROACH TO ANALYZING AND RESOLVING ETHICAL DILEMMAS

Speaker: Robert Weinstock, M.D.

SUMMARY:

Dialectical principlism was first introduced in my Presidential Address at the American Academy of Psychiatry and the Law's annual meeting in 2014 and continues to be developed with Dr. Darby. The method has similarities to the "reflective equilibrium" of the renowned ethical and political philosopher John Rawls. It facilitates clarity in understanding and resolving complex ethical dilemmas; competing ethical factors and duties are identified and laid out, prioritized consistent with the specific context and role, and then balanced. Involuntary outpatient commitment often creates conflict between the bioethical duty of beneficence and autonomy. Ordinarily competent patients have an ethical right to make autonomous decisions, but when mental illness severely impedes a patient's ability to weigh the risks and benefits of psychiatric treatment—especially psychotropic medication—there may be a need to override wishes expressed by the patient to refuse treatment and engage in substitute decision making. Beneficence in these limited situations may need to override autonomy as a last resort. Following the expressed wishes of a patient lacking the capacity to weigh the risks and benefits of psychiatric treatment can be harmful to such patients and violate the bioethical duty of nonmaleficence. This presentation will also address the APA annotations to the AMA Principles of Medical Ethics in the various contexts in which involuntary outpatient commitment might be utilized.

NO. 4

BALANCING CONFLICTING ETHICAL CONSIDERATIONS IN INVOLUNTARY OUTPATIENT COMMITMENT

Speaker: William C. Darby, M.D.

SUMMARY:

Involuntary outpatient commitment (IOC) can be an incredibly effective treatment approach for select patients—those with serious mental illness who lack insight or have other problems that impede their ability to obtain adequate care voluntarily. In these special patient populations and under the right circumstances, it will be argued that the bioethical duty of beneficence outweighs other ethical considerations, thus making it most ethical to treat these patients involuntarily. Laws are necessary to facilitate IOC but can be fraught with serious ethical risks. Autonomy will be sacrificed in favor of beneficence in these situations, yet it should not be done lightly, rather only as a last resort when more cooperative efforts with the patient fail. The intent of the intervention must be to target the reduction of the patient's symptom burden and severity, not merely a means of monitoring or policing patients. Such legislation has the potential for abuse to discriminate against minority groups, and measures need to counteract conscious and unconscious racial bias. The competing ethical considerations will be laid out, prioritized and balanced using dialectical principlism. The conclusion will be that such laws can be helpful, but safeguards are needed to protect patients and prevent misuse.

THE FACE OF RESILIENCE: WORKING WITH SURVIVORS OF INTIMATE PARTNER VIOLENCE (IPV)—A HOLISTIC MODEL TO CARE

Chairs: Mayumi Okuda, M.D., Obianuju "Uju" Obi Berry, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe existing collaborations that integrate advocacy services and mental health services for IPV survivors; 2) Identify the barriers and advantages of interdisciplinary teamwork (i.e., law enforcement, social work, criminal justice, immigration, psychiatric services) in providing care to IPV survivors; 3) Critique the experience implementing psychopharmacological treatments and evidence-based psychotherapies in non-specialty settings serving IPV survivors; and 4) Formulate future directions for the expansion of an integrated model of care that addresses advocacy and mental health needs of IPV survivors in settings like the family justice center.

SUMMARY:

Intimate partner violence (IPV), which affects at least 20 – 25% of women, can result in injuries, homicide,

legal proceedings, the involvement of child welfare, and the need for emergency shelter for survivors and their families. IPV is also associated with an increased risk for mental health problems including depression, PTSD and suicide. For mental health providers, addressing the multiple complex needs of IPV survivors while caring for their mental health problems can be daunting. Remarkably, there are few service models that address the many needs of IPV survivors in conjunction with psychiatric and psychological services. This symposium will explore the current state of collaborations between domestic violence service agencies and mental health treatment settings and describe the presenters' experiences working in a novel collaborative initiative between Columbia's psychiatry department and the New York City Family Justice Centers (FJCs), an initiative of the Mayor's Office to Combat Domestic Violence. The symposium will highlight the complexities regarding legal issues, immigration and housing needs and describe an innovative method for integrating advocacy services while providing psychiatric/psychological treatment for IPV survivors and their families.

NO. 1
CULTURAL BARRIERS AND NOVEL STRATEGIES IN WORKING WITHIN THE IPV COMMUNITY

Speaker: Obianuju "Uju" Obi Berry, M.D., M.P.H.

SUMMARY:

Individuals who experience intimate partner violence (IPV) are more likely to suffer from mental health problems compared to those who do not experience IPV. Given the high comorbidity between IPV and mental health problems and the health care system's efforts to integrate care, collaborations between IPV agencies and psychiatric services is essential. To achieve this integration, we must overcome the cultural barriers between these systems of care. This presentation will explore some of the barriers and identify novel strategies for partnerships between IPV and mental health care.

NO. 2
A MODEL OF COLLABORATIVE CARE BETWEEN MENTAL HEALTH AND IPV SERVICES

Speaker: Elizabeth Fitelson, M.D.

SUMMARY:

Full recognition of the scope of intimate partner violence (IPV) is just one step. Our society has relegated IPV to the socio-criminal-legal sphere,

where survivors of violence receive social services and violent individuals are punished. Psychiatrists are surprisingly absent from this landscape, but should engage more by integrating their clinical skills into treatment settings. The newly formed partnership between the psychiatry department at Columbia University and the city-run Bronx Family Justice Center (BXFJC) is accomplishing this. This presentation will discuss the origins of the collaboration and address issues of cross-collaborative models of integration.

NO. 3
NEW YORK CITY FAMILY JUSTICE CENTERS OF THE MAYOR'S OFFICE TO COMBAT DOMESTIC VIOLENCE

Speaker: Margarita Guzman, J.D., M.B.

SUMMARY:

The Mayor's Office to Combat Domestic Violence (OCDV), established in 2001, oversees the citywide delivery of domestic violence services, develops policies and programs, and works with diverse communities to increase awareness of intimate partner violence (IPV). Among several initiatives, OCDV operates the New York City Family Justice Centers (FJCs), which provide comprehensive civil legal, counseling and supportive services for victims of domestic violence, elder abuse and sex trafficking. Located in the Bronx, Brooklyn, Queens and Manhattan, the FJCs are supportive, nonjudgmental environments that provide holistic services to victims of all ages, genders and sexual orientations, regardless of their immigration status. Key city agencies; community, social and civil legal service providers; and district attorney's offices are located on-site at the Centers to make it easier for victims to get help. This presentation will describe the range of services provided by the FJCs and a new initiative to provide psychiatric services on-site. The presentation will also highlight the challenges of legal and mental health system interactions in diverse scenarios frequently encountered by IPV survivors.

NO. 4
EVIDENCE-BASED PSYCHOTHERAPIES FOR INTIMATE PARTNER VIOLENCE (IPV) VICTIMS

Speaker: Rosa Regincos, L.C.S.W.

SUMMARY:

IPV is widespread, with at least 20 – 25% women reporting IPV at some point in their lives. IPV is associated with an increased risk for medical and

psychosocial comorbidity. There are many risk factors that will increase the occurrence of IPV and the likelihood for revictimization. Risk factors for IPV include witnessing IPV and other types of violence during childhood, childhood physical and sexual abuse, socioeconomic and legal status, race, cultural rigid gender roles, and lack of social and emotional supports. These complex backgrounds present roadblocks for treatment and recovery. This presentation will describe two clinical vignettes drawn from the clinical experience at the Bronx Family Justice Center (BXFJC), illustrating techniques for the diagnosis and management of trauma-related psychiatric disorders. Case discussion will focus on assessing past and current risk factors and joining efforts to address the multiple needs of patients while tailoring and implementing psychological treatments. Evidence-based psychological interventions, including exposure and nonexposure treatment to address trauma-related psychiatric disorders, will be discussed: trauma focus treatment, behavioral activation treatment (BAT), interpersonal therapy (IPT), seeking safety and skill-based group treatment for chronic stress.

**NO. 5
IMPLEMENTING PSYCHIATRIC TREATMENTS IN A
NONSPECIALTY SETTING**

Speaker: Mayumi Okuda, M.D.

SUMMARY:

Community-based holistic service models such as the family justice center (FJC) effectively assist intimate partner violence (IPV) survivors with their multiple complex needs, having the potential to serve as a gateway to the acceptance of other services such as psychiatric services. Available research focusing on IPV survivors' processes to seek help indicate that individuals who seek help from one source are significantly more likely to seek help from other sources over time; in other words, one form of help seeking may enable acceptance of other forms of help. Given the multiple barriers to the detection of IPV in health care and mental health settings, and the fact that IPV survivors, particularly ethnic minorities, are more likely to present for services in nontraditional settings, this collaboration offers a venue to deliver culturally acceptable mental health services for IPV survivors. This presentation will illustrate the advantages and challenges of the model, explore insights from different professionals working at advocacy agencies that refer IPV survivors to mental health services, and describe the

experience working as a psychiatrist providing psychopharmacological treatments in a non-specialty setting.

**EVIL, PSYCHOPATHY AND TERROR: LESSONS
PSYCHIATRY LEARNED FROM NAZI GERMANY**

Chair: Joel E. Dimsdale, M.D.

Discussant: Paul Summergrad, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss psychiatric approaches used to understand psychopathology in the Nuremberg war criminals; 2) Understand how biomedical research was distorted to foster pseudoscientific theories and murderous behavior; and 3) Discuss the nature of evil utilizing fiction and a specific example involving psychiatrists in Nazi Germany and the T4 project.

SUMMARY:

Nazi Germany fell 70 years ago. In the debris of the country, observers encountered appalling evidence of atrocities. Much of this evidence was detailed in a series of war crimes trials at Nuremberg. Psychiatrists had two roles at Nuremberg. Some were there to help determine if there were psychopathological roots in the war criminals. Others were there as defendants themselves for having participated in the killing activities. This symposium focuses on how contemporary psychiatry struggles to understand such massive evil. The presenters will discuss this topic using different approaches—from archival historical investigation to historical novels.

NO. 1

**ANATOMY OF MALICE: USING RESEARCH ARCHIVES
TO STUDY PSYCHOPATHOLOGY IN NAZI WAR
CRIMINALS**

Speaker: Joel E. Dimsdale, M.D.

SUMMARY:

When the ashes settled after World War II and the Allies convened an international war crimes trial in Nuremberg, psychiatrists and psychologists tried to fathom the psychology of the Nazi leaders. They used extensive psychiatric interviews, IQ tests and Rorschach inkblot tests. Never before (nor since) has there been such a detailed study of governmental leaders who orchestrated mass killings. This is a forgotten story to many psychiatrists, and yet the sharply differing explanatory models developed at

Nuremberg will be readily recognizable 70 years later. Tracking down unpublished material in unlikely archival locations was one of the challenges of doing this research, which is described in my book *Anatomy of Malice* (Yale University Press, 2016). War crimes are not going away and it is likely that psychiatrists will be called upon to evaluate such individuals in the future. One of our challenges will be to build upon the knowledge base from Nuremberg but have that knowledge reflect contemporary clinical and research understanding.

NO. 2

EVIL IN WARTIME AND IN PEACETIME

Speaker: Michael H. Stone, M.D.

SUMMARY:

Evil in wartime equates with actions inflicting suffering well beyond the violence necessary to defeat the enemy. Examples include use of extreme torture and genocide accompanied by torture. The perpetrators are often ordinary citizens operating in groups fired up by a sadistic charismatic leader. Evil in peacetime equates with actions by psychopaths, sadists and (sometimes) mentally ill persons, as in the case of mass murderers and serial killers.

NO. 3

USING FICTION TO TELL THE STORY OF AKTION T4

Speaker: Stephen M. Stahl, M.D., Ph.D.

SUMMARY:

The T4 Project, named after the address of its ministry in Berlin at number 4 Tiergartenstrasse, was the program of forced euthanasia for disabled children and adults with psychiatric disorders in wartime Nazi Germany. Psychiatrists assessed whether patients were incurable and then forced the victims to undergo a “mercy death” by lethal drug overdose, gassing or starvation. Over 70,000 were killed in the first phase of the project, and hundreds of thousands by the end of the war. This is a story unknown to many modern psychiatrists, particularly in the US. The complicity of psychiatrists was also not widely known until recently—and until leaders of psychiatry in modern Germany widely publicized this secret that was hiding in plain sight for 70 years. This is a very difficult story to tell, so using fiction to convey it as mostly true historical fiction in a thriller genre with interesting characters and a fast pace was the challenge of my novel *The T4 Project* (Harley House Press, 2016). The freedom that fiction allows is to explore the concept of evil, whether it can be a

psychiatric disorder and how modern-day examples of evil show that this is a fundamental issue of human nature to be understood if it is to be avoided in the future.

BIOLOGICS (VACCINES, MONOCLONAL ANTIBODIES AND ENZYMES) TO TREAT SUBSTANCE USE DISORDERS

Chairs: Ivan D. Montoya, M.D., M.P.H., Phil Skolnick, Ph.D.

Discussant: Phil Skolnick, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know the biologics (vaccines, monoclonal antibodies and enzymes) that are being investigated for the treatment of cocaine use disorders; 2) Learn about the monoclonal antibodies that are being investigated for the treatment of drug overdose; 3) Understand the mechanism of action of immunotherapies to treat drug use disorders and overdose; and 4) Gain knowledge about the current research and future directions of biologics to treat drug use disorders and overdose.

SUMMARY:

Small molecule (i.e., medication) approaches have been ineffective or marginally effective in treating drug use disorders. Multiple medications have been investigated to treat stimulant use disorders, but none has been approved by the FDA, and it is unlikely that any medication will be ready for approval in the next few years. There are medications approved by the FDA for nicotine and opioid use disorders, but the long-term efficacy is less than optimal. Therefore, there is a public health need for safe and effective or more effective treatments for drug use disorders. Biologics, such as vaccines, monoclonal antibodies and enzymes, are opening a new window of possibilities to treat these disorders. The mechanism of action of biologics is to prevent or retard the access of the abused drug to the central nervous system. Thus, biologics produce a pharmacokinetic antagonism and appear to prevent the neurotoxic effects, including effects on the central reward system, of the drugs of abuse. Antidrug vaccines can stimulate the immune system to produce antibodies specifically against the drug of abuse. The antidrug monoclonal antibodies are obtained by different methods that do not require the immune system of the host. Enzymes are being developed to catalyze the degradation of an abused drug (e.g., cocaine) orders of magnitude more

rapidly than the wild-type enzyme. Several biologics have been investigated, and some of them have been evaluated in phase III clinical trials. Although they have been safe to administer to humans, they have not shown sufficient efficacy. New methods of production of biologics and new biologics that appear more effective are being investigated. The purpose of this symposium is to provide an overview of this rapidly emerging area and inform the audience about the current research status of biologics to treat drug use disorders and overdose.

**NO. 1
ENZYME THERAPIES FOR COCAINE ADDICTION AND OVERDOSE**

Speaker: Chang-Guo Zhan, Ph.D., M.Sc.

SUMMARY:

Cocaine is a widely abused drug that can produce effects on the brain, liver, heart and other organs. Currently, there are no FDA-approved medications to treat cocaine use disorder and overdose. Generally speaking, it is essential for a truly effective addiction medication to effectively block the drug's physiological effects without affecting the normal functions of the brain, while preventing relapse during abstinence. Most pharmacological approaches to treat addictions either affect the functions of brain receptors/transporters or are often unable to prevent relapse. Our recently developed, highly efficient cocaine-metabolizing enzymes have been proven effective in blocking cocaine's physiological effects without affecting normal functions of the brain and appear to prevent drug use relapse. In this presentation, I will first give a general overview of cocaine-metabolizing enzymes and then present results from preclinical and clinical studies evaluating the safety and efficacy of enzymes for the treatment of cocaine use disorders and overdose. The presentation will include the latest development of a long-acting enzyme therapy and what may be expected in the near future concerning enzyme therapies for these conditions.

**NO. 2
MONOCLONAL ANTIBODIES TO TREAT SUBSTANCE USE DISORDERS AND OVERDOSE**

Speaker: Samuel M. Owens, Ph.D.

SUMMARY:

This presentation will address the current status of human trials of an anti-methamphetamine monoclonal antibody (mAb) and the preclinical

testing of anti-methamphetamine, anti-phencyclidine and anti-cathinone mAbs for detoxification and overdose. Between the first report of the preclinical treatment of a phencyclidine overdose using a mAb in 1996 and the FDA clinical trial of a mAb for the treatment of methamphetamine addiction in 2014, the development of mAb medications for substance use disorders has advanced significantly. These novel, protein-based medications could save lives and play a critical role in helping patients achieve sustainable abstinence from drug abuse by serving as an in vivo guard against vulnerability to relapse. We hypothesize that treatment with an anti-drug of abuse mAb, along with behavioral modification therapy, could assist a drug user in adopting the lifestyle changes needed to control drug-taking behavior.

**NO. 3
PHARMACOKINETIC STRATEGIES TO MITIGATE NICOTINE'S PSYCHOACTIVE EFFECTS**

Speaker: Matthew W. Kalnik, Ph.D.

SUMMARY:

In order to overcome the limitations of nicotine vaccines, two complementary biological approaches employing a pharmacokinetic mechanism are being actively evaluated preclinically as potential new treatments for nicotine addiction: 1) Nicotine-specific monoclonal antibodies binding the circulating nicotine and 2) Enzymatically degrading the nicotine in circulation. Nicotine-specific monoclonal antibodies (Nic-mAbs) can be directly dosed to achieve uniformly high levels across all individuals, thereby overcoming the highly variable responses seen with nicotine vaccines. Nic-mAbs have demonstrated preclinical proof of concept in rodent models of nicotine addiction. A first-in-class nicotine degrading enzyme has recently been characterized and shown to have an attractive therapeutic profile, as it is able to degrade nicotine at the nanomolar plasma concentrations of nicotine found in smokers. Antidote Therapeutics is leading a strategic alliance of university and biotechnology companies to progress fully human Nic-mAbs and nicotine degrading enzymes toward the clinic in collaboration with the National Institute on Drug Abuse, whose progress shall be presented.

**NO. 4
VACCINES FOR COCAINE AND METHAMPHETAMINE ADDICTIONS**

Speaker: Thomas Kosten, M.D.

SUMMARY:

Antidrug antibodies reduce drug levels in the brain by binding a drug before it enters the brain. Because antibodies are much larger than drugs, neither the antibody nor the bound drug can get into the brain. Thus, any drug that is bound to an antibody cannot cross the blood-brain barrier and cannot enter the brain. Active antidrug vaccines stimulate the body to make its own antibodies by chemically linking these abused drugs to toxins such as cholera toxin. Alternatively, passive immunotherapy uses monoclonal antibodies that are generated in a laboratory and then administered via intravenous injection. Rapid advances are being made with immunotherapies for nicotine, cocaine, methamphetamines, opiates, phencyclidine and potentially other drugs of abuse. The cocaine vaccine has been tested in humans with excellent success. Antibodies can treat drug overdose, reduce drug use relapse or protect certain at-risk populations who have not yet become drug dependent. Immunotherapies have technological limitations that our laboratories are addressing in rodent studies. Technological challenges for vaccines include inadequate antibody responses in 25 – 30% of individuals and retention in drug abuse treatment during vaccination, which can take two to three months for adequate antibody levels to develop. Predicting who will develop adequate antibody responses will be improved as we understand its genetic determinants.

EFFECTIVE RESPONSES TO JUSTICE-INVOLVED PERSONS WITH MENTAL ILLNESSES

Chairs: Robert L. Trestman, M.D., Ph.D., Fred C. Osher, M.D.

Discussant: Debra Pinals, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the scope of the problem of justice involvement and incarceration of individuals with mental illness; 2) Identify best practices for diversion from incarceration, such as mental health courts; 3) Understand the nature of adequate correctional mental health treatment and current best practices; 4) Identify the characteristics of the Stepping Up Initiative; and 5) Recognize the systemic changes needed to reduce incarceration of those with mental illness.

SUMMARY:

Justice involvement of individuals with mental illness has reached critical levels. Hundreds of thousands of people with serious mental illness are incarcerated in America's jails and prisons. Hundreds of thousands more are under community correctional supervision. Two APA publications—one from a Group for the Advancement of Psychiatry (GAP) committee on psychiatry and the community and one from the APA Council on Psychiatry and the Law—serve as the foundation for this symposium. In this symposium, we begin with a brief context of the problems and concerns of justice involvement for individuals with mental illness. We then turn to opportunities for prevention: what can be (and is being) done to prevent incarceration of individuals with mental illness, efforts such as specialized police responses and community corrections teams. Once someone does become justice-involved, there is a growing range of options to connect them to treatment rather than to incarcerate. Such programs as mental health courts and assisted outpatient treatment will be discussed. Despite these growing efforts, many individuals still become incarcerated. What happens—and what should happen—next? We review concepts of adequate care, best practices at multiple levels of intervention and care, and populations that require special attention. A specific topic of growing national attention is the use of restrictive housing—"solitary confinement"—notably with persons with mental illness. Here, we present current approaches to managing this issue in correctional settings. We finish the presentations with a focus on opportunities and challenges of reentry into the community—how best to support community transition to maximize opportunities for success. We conclude with a discussion of the nationwide collaboration to address justice involvement of those with mental illness, the Stepping Up Initiative. Our discussant will raise questions and set the stage for active audience engagement on this clinically, politically and ethically challenging topic.

NO. 1

EFFECTIVE RESPONSES TO JUSTICE-INVOLVED PERSONS WITH MENTAL ILLNESSES

Speaker: Robert L. Trestman, M.D., Ph.D.

SUMMARY:

Justice involvement of individuals with mental illness has reached critical levels. Hundreds of thousands of people with serious mental illness are incarcerated

in America's jails and prisons. Hundreds of thousands more are under community correctional supervision. In this presentation, we begin with a brief context of the problems and concerns. We then turn to opportunities for prevention: What can be done to prevent incarceration of individuals with mental illness? Once someone does become justice involved, there is a growing range of options to connect them to treatment rather than to incarcerate. Despite these growing efforts, many individuals still become incarcerated. What happens—and what should happen—next? We review concepts of adequate care, best practices at multiple levels of intervention and care and populations that require special attention. We finish the presentation with a focus on reentry into the community. We conclude with a discussion of the nationwide collaboration to address justice involvement of those with mental illness—The Stepping Up Initiative. Our discussant will raise questions and set the stage for active audience engagement on this clinically, politically and ethically challenging topic.

NO. 2

WHAT CAN WE DO TO PREVENT INCARCERATION?

Speaker: Fred C. Osher, M.D.

SUMMARY:

What can be (and is being) done to prevent incarceration of individuals with mental illness? Efforts such as specialized police responses and community corrections teams will be discussed.

NO. 3

TREATMENT OPTIONS FOR INCARCERATION

Speaker: Merrill Rotter, M.D.

SUMMARY:

Once someone becomes justice-involved, there is a growing range of options to connect them to treatment rather than to incarcerate. Such programs as mental health courts will be discussed.

NO. 4

CORRECTIONAL MENTAL HEALTH TREATMENT: WHAT IS ADEQUATE?

Speaker: Elizabeth Ford, M.D.

SUMMARY:

We review concepts of adequate correctional mental health care. A specific topic of growing national attention is the use of restrictive housing—"solitary

confinement"—notably with persons with mental illness. Here, we present current approaches to managing this issue in correctional settings.

GLOBAL MENTAL HEALTH: CURRENT CLINICAL AND CULTURAL PERSPECTIVES AND INNOVATIONS

Chair: Renato D. Alarcon, M.D., M.P.H.

Discussant: Renato D. Alarcon, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the most important global events with resulting clinical conditions and difficulties in the provision of services; 2) Recognize the sociocultural factors that are contributing negatively to the current situation across the world; 3) Delineate specific public and mental health actions aimed at the alleviation or solution of global problems; and 4) Promote the effective application of technological resources such as telepsychiatry in the management of specific clinical problems.

SUMMARY:

Background: Global mental health (GMH) has become a fashionable concept that encompasses different aspects of psychiatry's activities, from clinical to preventive actions, research and its impact on diverse populations, elaboration of public policies and diagnostic or therapeutic modalities, and pronouncements about the future of our discipline in the world. In turn, cultural perspectives further broaden the scope of GMH and open the door to the application of technology-inspired innovations, such as telepsychiatry. **Methods:** Literature reviews, personal experience, current history, international perspectives and pioneering efforts in psychiatric applications of telepsychiatry are the basis of different presentations that provide a concrete update of GMH's substantial contributions to the study and management of complex sociopolitical and -cultural situations in countries like Pakistan, regions like the Middle East or Latin America, and tragic realities like the Syrian conflict. Telepsychiatric innovations as specific means of collective relief and methodology of clinical management in these circumstances is analyzed and strongly advocated. **Results:** Stigma; discrimination; scarcity of human, material and administrative resources; social impact of exclusionary policies; religious dogmatism; underdiagnoses; and pervasive inequities in the provision of mental health services are duly documented for all the countries and regions examined. In the countries evaluated, psychiatry is

considered an almost undesirable specialty and mental illness a contagious condition. Similarities in spite of geopolitical, historical and cultural diversity are emphasized as possible avenues of common management strategies. Telepsychiatry emerges as a feasible, flexible, pragmatic, effective and adaptable resource for diagnoses such as PTSD in the Syrian conflict, but also as a resource to deal with different clinical and cultural settings across the world.

Conclusion: Joint international efforts; constitution of specialized advisory teams; a determined set of educational, training and funding policies; and a fair assignment of resources, improved communication and coordinated management programs, with the inclusion of telepsychiatry, are suggested. A continuous, practical research program must support the viability of many of these measures.

NO. 1

REALITIES OF PSYCHIATRIC PRACTICE IN PAKISTAN: A BRIEF OVERVIEW

Speaker: Filza C. Hussain, M.D.

SUMMARY:

According to a report from the World Health Organization, Pakistan, with a population of 180 million, only has 0.31 psychiatrists per 100,000 inhabitants. This reality may reflect a variety of factors whose implications for the overall mental health situation in the country are the subject of this presentation. The stigma against mental illness is a complex and multifactorial phenomenon with roots in religious, social, cultural and legal constructs. This manifests itself by underreporting of mental conditions and undesired outcomes such as suicide, a thriving business for faith healers, and a general hesitance to talk about these issues in order to avoid harassment from the police and/or being labeled a social outcast. Consequently, the fear of public shaming keeps patients from seeking specialized help. Psychiatry is a less desirable practice, a fact reinforced by the forceful and shameful questioning to which a young physician who declares his/her intention to pursue psychiatry as a specialty is subjected. Furthermore, training programs and experience, even in the country's premier medical schools, leave much to be desired. This may also explain why countries such as the U.S., the U.K., Australia, New Zealand and some in the Middle East accept, train and retain a high number of psychiatric international medical graduates (IMGs) from Pakistan. Many of these IMGs do not return to their

home country, leading to a vicious cycle of poor psychiatric care back home.

NO. 2

WHEN DOCTORS STIGMATIZE AND DISCRIMINATE: THE CULTURE OF MEDICAL PRACTICE ABOUT MENTAL HEALTH IN THE MIDDLE EAST

Speaker: Ahmad Adi, M.B.B.S., M.P.H.

SUMMARY:

Contrary to the concept of healing as an effort to protect the sick from injustice, a growing body of literature documents the active display of inequities, discrimination and stigmatization of mental illness and its sufferers by doctors and psychiatrists themselves. This discrimination against psychiatric patients in the Middle East, for instance, starts with the fact that mental health services suffer from a severe shortage of psychiatrists. As reviewed in 2012, the number of psychiatrists can be as low as 0.31 psychiatrists for 100,000 people in Middle Eastern countries. The inequities persist because fewer medical students choose to pursue psychiatry as a specialty because it is viewed as an "inferior field" compared to others in medicine. This perceived "inferiority" stems from underlying cultural misconceptions that classify psychiatry as a nonmedical field or consider mental illnesses as "contagious," a condition that can be transmitted to health care workers and their families. The isolation of mentally ill persons is seen as "necessary," thus the abandonment and neglect of systematic treatment. Examples of these situations will be discussed in the presentation. Stigma is one of the root causes of the shortage of mental health services; therefore, an indispensable action in Middle Eastern countries to deal with this issue should be to have the medical community, as well as the community at large, as main targets of awareness "campaigns of truth" about mental health.

NO. 3

MENTAL HEALTH OUTCOMES OF THE SYRIAN CONFLICT: AN EMPHASIS ON PTSD

Speaker: Malik Nassan, M.B.B.S.

SUMMARY:

A brief description of the sociocultural background of the Syrian population in the context of the ongoing conflict and its impact on the mental health and support resources of the population is presented. Furthermore, the emerging humanitarian

and psychosocial crises are discussed with emphasis on several neglected aspects of PTSD. Since March 2011, an estimated 65% of the three million Syrian refugees in neighboring countries have clinical manifestations of psychological trauma. An early cross-sectional study among Syrian refugees in Turkey estimated a point prevalence rate of 33.5% for PTSD. In addition to an estimated high prevalence of PTSD, there seems to be evidence of a strikingly limited capability of the Syrian health system to effectively provide mental health care to those affected. Telepsychiatry is proposed as an effective strategy, emphasizing its advantages in the minimization of stigma and its potential successful implementation. The benefits and limitations of this process in the targeted population will be discussed.

NO. 4

TELEPSYCHIATRY: IT IS EFFECTIVE, VERSATILE AND KNOCKS DOWN BARRIERS RELATED TO GEOGRAPHY, CULTURE AND LANGUAGE ACROSS THE GLOBE

Speaker: Donald M. Hilty, M.D.

SUMMARY:

Telepsychiatry (TP) is effective, well-received and a standard way to practice. Outcomes are as good as or better than in-person care; it is feasible and adds tremendous value at little cost. It is effective for diagnosis and assessment across many populations (adult, child/adolescent, geriatric and ethnic) and for disorders in many settings (consultation to primary care, psychiatric outpatient, skilled nursing). Preliminary studies suggest it is also effective across cultures and languages (e.g., ethnic groups, refugees), preferred in some populations (e.g., veterans) and now feasibly applied to new settings (e.g., emergency, home health, inpatient). In a world with many potential obstacles to care, TP appears preferred due to privacy/confidentiality (e.g., Indian health), trust (e.g., an impartial doctor from another country for refugees) and facility in accessing interpreters (or using a common third language when the doctor and patient have different primary ones). Newly published TP competencies based on ACGME and CanMEDs frameworks include cultural issues as part of good patient care, communication and systems-based practice.

AN UPDATE ON DIAGNOSTIC AND ASSESSMENT CONSIDERATIONS FOR THE TREATMENT OF COMORBID OPIOID ADDICTION AND CHRONIC PAIN

Chair: Will M. Aklin, Ph.D.

Discussant: Wilson M. Compton, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Better understand the literature on fMRI-based biomarkers for pain and emotion; 2) Make informed clinical decisions on how best to treat acute and chronic pain in patients with a history of addiction based on case presentations; 3) Better understand mechanisms on the transition of acute to chronic pain and identify any of these mechanisms while treating patients; 4) Discuss how best to use buprenorphine to treat both pain and addiction to opioid analgesics; and 5) Recognize and treat opioid tolerance and addiction potential in chronic pain patients with a possible diagnosis of hyperesthesia.

SUMMARY:

This symposium will provide an update on research findings that underscore pathways of care that both reduce addiction and improve the treatment of pain. Specifically, diagnostic and assessment considerations will be discussed in the context of specific management concerns of different types of pain, including patients who present with a wide variety of addiction histories. Additionally, how each of these addiction histories should be considered by the clinician in order to establish specific treatment plans will be explored. The workshop will cover five areas: 1) Recent changes in the objective diagnosis of pain conditions via fMRIs and other imaging techniques; 2) How to treat acute and chronic pain in patients with a history of addiction; 3) Mechanisms on the transition of acute to chronic pain and the identification of any of these mechanisms while treating patients; 4) How to use buprenorphine to treat both pain and addiction to opioid analgesics; and 5) Recognizing and treating opioid tolerance and addiction potential in chronic pain patients with a possible diagnosis of hyperesthesia.

NO. 1

NEUROIMAGING OF PAIN AND DISTRESS: FROM BIOMARKERS TO BRAIN REPRESENTATION

Speaker: Tor Wager, Ph.D.

SUMMARY:

Pain and emotional distress are realities that affect us all, but their measurement is complex. Many factors contribute to self-reported pain, including

nociception, thoughts about the future, and social decision making and communication, among others. Deconstructing pain by analyzing its component brain processes could transform how we understand and treat it. This deconstruction is a current frontier in affective neuroimaging. In this presentation, I describe a series of studies aimed at beginning to address these questions, working from the hypothesis that specific brain systems underlie specific aspects of overall pain experience, and dysregulated responses in these systems are treatable in specific ways. Combining functional neuroimaging with machine learning techniques, we have developed brain markers that can indicate intensity of pain and negative emotion in individual participants with >90% accuracy, with no prior knowledge of an individual's experience. This work provides a pain-specific brain target, allowing us to begin to 1) identify the similarity of pain-related and other affective brain processes and 2) understand the specific functions of components of this "pain system." Our findings suggest that specific types of aversive experiences are encoded in separable, though co-localized, systems. In addition, specific parts of the "pain system" are responsible for avoidance learning, which may contribute to the development of chronic neuropathic pain.

**NO. 2
PRESCRIPTION OPIOID USE AND THE TRANSITION
OF ACUTE TO CHRONIC PAIN: PREVENTING
PROBLEMATIC OPIOID USE AND PERSISTENT PAIN
AFTER SURGERY**

Speaker: Jennifer Hah, M.D., M.S.

SUMMARY:

Prescription opioids are the leading cause of overdose deaths in the U.S., and overdose death rates, prescription opioid sales and substance abuse treatment admissions have climbed in parallel over the past decade. Millions of Americans go through surgery every year, which results in acute pain and obligatory prescription opioid use. Exposure to prescription opioids in the perioperative environment is a potential pathway to prolonged opioid use, misuse and addiction. Data will be presented on the association between long-term prescription opioid use, affective disorders and substance abuse. Increased rates of substance abuse and depression exist in long-term prescription opioid users compared to nonusers with chronic pain, and pain intensity does not predict treatment with opioids vs. non-opioid analgesics. A summary of the

current approach to postoperative pain management will be provided. A disconnect exists between opioids prescribed and opioids used after surgery. The amount of prescribed opioids often does not influence patients' decisions to continue or discontinue opioid use, and patients exhibit wide variability in opioid needs after similar procedures. Research examining the risk factors for delayed opioid cessation will be discussed. In addition, interventions to promote opioid cessation in the perioperative environment will be presented. Also, research examining risk factors for persistent pain after surgery will be discussed.

**NO. 3
TREATMENT OF CO-OCCURRING CHRONIC PAIN
AND OPIOID USE DISORDER**

Speaker: Declan Barry, Ph.D.

SUMMARY:

Chronic pain (i.e., non-cancer pain lasting at least three months) is highly prevalent in patients entering opioid agonist maintenance treatment (OMT) and is associated with deleterious treatment outcomes. Among patients with opioid use disorder, OMT has demonstrated efficacy in attenuating nonmedical opioid use; however, the presence of untreated chronic pain may be associated with illicit drug use and elevated psychiatric distress. To date, strategies for managing chronic pain during OMT have not been systematically evaluated. This presentation will describe studies regarding 1) The treatment needs of OMT patients with chronic pain; 2) Providers' experiences treating these patients; 3) The development of integrated counseling approaches for treating the interrelated problems of chronic pain and opioid dependence during OMT with methadone or buprenorphine; and 4) Findings from pilot studies and randomized clinical trials that have examined the feasibility, acceptability and initial efficacy of psychosocial interventions in opioid treatment programs in office-based settings.

**NO. 4
UPDATE ON THE TREATMENT OF ACUTE AND
CHRONIC PAIN IN THE PATIENT WITH A HISTORY OF
SUBSTANCE ABUSE**

Speaker: Sean Mackey, M.D., Ph.D.

SUMMARY:

Patients with a history of addiction experience trauma and acute painful medical illnesses, may have to undergo surgery, and suffer chronic pain,

much like patients who are not addicted. These patients require treatment for pain. Undertreatment of these patients is a particular problem in patients with opioid dependency and/or methadone maintenance. This presentation will update the audience on the strategies for management of acute and chronic pain in the addicted patient, focusing on patients with opioid addiction. We will discuss the importance of maintaining the patient on their baseline opioids, the methods of assessing a patient's pain, use of non-opioid adjuvants for pain management and the importance of nonpharmacological pain management therapies.

NO. 5

LONG-TERM OUTCOMES FROM THE PRESCRIPTION OPIOID ADDICTION TREATMENT STUDY

Speaker: Roger D. Weiss, M.D.

SUMMARY:

The Prescription Opioid Addiction Treatment Study (POATS), conducted via the NIDA Clinical Trials Network, was the largest study yet conducted of treatment for those dependent on prescription opioids. The study compared different lengths of buprenorphine-naloxone (bup-nx) and different intensities of counseling in 653 participants at 10 U.S. sites. POATS then engaged in a 42-month follow-up study, in which 375 main-study participants took part. This presentation will focus on results of the long-term follow-up study, with particular emphasis on the impact of bup-nx treatment in the longer term, as well as discussing issues related to the 42% of the POATS population who reported current chronic pain upon entering the study. Participants improved over time in both their opioid use and their pain. While those who took bup-nx continued to have better outcomes at follow-up than did those who did not take this medication, those who did not engage in agonist treatment had better outcomes over time than they had during the main trial.

TREATMENT OF COGNITIVE IMPAIRMENT AND FUNCTIONAL DISABILITY ACROSS PSYCHIATRIC CONDITIONS: WHAT HAS BEEN ACHIEVED

Chairs: Herbert Y. Meltzer, M.D., Philip D. Harvey, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Relate good functional outcome in schizophrenia and bipolar disorder to successful

improvement in cognitive impairment; 2) Understand the greater ability of atypical vs typical antipsychotic drugs to improve cognitive impairment; 3) Critically evaluate reports of the effects of psychotropic drugs to improve cognitive impairment; 4) Evaluate cognitive rehabilitation programs and associated biomarkers to improve cognition in schizophrenia; and 5) Understand the role of neural plasticity in enabling some antipsychotic drugs and cognitive rehabilitation to improve cognitive impairment.

SUMMARY:

Cognitive impairments are now known to be a major contributor to functional outcomes across neuropsychiatric conditions, including schizophrenia, major depression and bipolar disorder. Rates of disability are generally correlated with persistent cognitive deficits, which can range as high as 90% in schizophrenia. Treatment efforts have included pharmacological and cognitive remediation interventions, and assessment strategies have expanded to include assessments of both neurocognition and functional capacity. This symposium will address the state of the art of treatment of cognitive deficits and disability reduction in schizophrenia and targets for developing more effective treatments. Dr. Philip Harvey will review the assessment of cognition and disability in schizophrenia, including regulatory perspectives and the extent of cognitive improvement needed to improve functioning. Dr. Herbert Meltzer will review the role of neurotransmitters and synaptic plasticity in learning and memory and present clinical and preclinical evidence for antipsychotic drugs and components of their pharmacology having a domain-specific benefit on cognitive impairment via enhancement of neural plasticity. Dr. Richard Keefe will discuss methodological issues in clinical trials and recent data on supplemental pharmacological treatments of cognitive deficits in schizophrenia and depression. These two presentations will consider the evidence for and against direct cognitive benefits from some antipsychotic drugs and reasons for divergent views. Dr. Sophia Vinogradov will review the evidence that various cognitive remediation interventions have a benefit on cognitive impairment in schizophrenia independent of medication effects and support by biomarker studies, which show positive effects on neural plasticity.

NO. 1

TREATMENT OF COGNITION AND DISABILITY: RATIONALE AND STRATEGIES

Speaker: Philip D. Harvey, Ph.D.

SUMMARY:

Cognitive impairments are major contributors to disability across neuropsychiatric conditions. In schizophrenia, cognitive deficits are associated with the severity of impairments in everyday activities and vocational functioning, while social cognitive deficits and negative symptoms appear to be more strongly related to social outcomes. Further, the ability to perform critical functional skills, referred to as functional capacity, including components of activities of everyday living, vocational skills and social competence, appear to mediate the relationship between cognition and social cognition and real-world functioning. Regulators in both the U.S. and the E.U. have suggested that in order to demonstrate the clinical significance of cognitive changes and receive approval for a medication or medical device to enhance cognition, there must also be a functional co-primary measure, either performance-based or with data collected by an informant. While no treatment to date has received regulatory approval, it is not clear if regulators would waive the requirement that both domains improve if there was substantial and definitive improvement in one of these two domains. This presentation will focus on the relationship between cognition, functional capacity and everyday outcomes. Results regarding the convergence of treatment-related changes in cognition and functional capacity will be reviewed.

NO. 2

ATYPICAL ANTIPSYCHOTIC DRUGS PARTIALLY CORRECT COGNITIVE DYSFUNCTION IN SOME SCHIZOPHRENIA PATIENTS: UNDERSTANDING THE EFFECT OF ANTIPSYCHOTIC DRUGS ON NEUROPLASTICITY CRITICAL FOR LEARNING AND MEMORY

Speaker: Herbert Y. Meltzer, M.D.

SUMMARY:

The relative efficacy of typical and atypical antipsychotic drugs (APDs) for treating the cognitive impairment associated with schizophrenia (CIAS) is still controversial despite all meta-analyses of head-to-head clinical trials showing advantages for atypical APDs. The reasons for this include variations in duration of trials, concomitant medications, lack of consideration of tardive dyskinesia, use of

composite cognitive scores, not recognizing differences in drug effects on specific domains and differences among the atypical APDs. There has been tremendous growth of knowledge about the neurobiology of cognition in relation to atypical APDs. These studies have overwhelmingly shown that the multireceptor-acting atypical APDs are procognitive and able to restore learning and memory in animal models of CIAS by enhancing neurotransmitter action and synaptic health, in contrast with typical APDs which may even impair the procognitive effects of atypical APDs in human and animal models. This presentation will discuss evidence supporting the greater efficacy of atypical APDs for some patients, provide guidance to clinicians as to how to optimize the effect of atypical APDs on CIAS and provide an understanding of the neurobiology of their variable efficacy on specific cognitive domains.

NO. 3

TREATMENT OF COGNITIVE DEFICITS IN PATIENTS WITH SCHIZOPHRENIA AND MAJOR DEPRESSION

Speaker: Richard Keefe, Ph.D.

SUMMARY:

There are currently no FDA-approved medicines for the treatment of cognitive impairment in schizophrenia or depression. However, many pharmacological compounds that have promise as cognitive enhancers are in various phases of development. This presentation will describe the most recent data available from these drug development programs. Almost all patients with schizophrenia have some degree of cognitive impairment compared to expectations derived from their early history and socioeconomic backgrounds. This unmet medical need is the target of clinical trials that measure cognitive impairment with performance-based measures of cognition such as the MATRICS Consensus Cognitive Battery and measures of functional capacity that include performance-based measures and interview-based rating scales. In phase 2 trials, these outcomes have demonstrated improvement with treatments such as encenicline, an alpha-7 nicotinic agonist. Cognitive impairment is also an important treatment target in patients with major depression. Many depressed patients complain of problems with attention and memory, and their performance on cognitive tests tends to be worse than age-matched healthy controls. Recent clinical trial data suggest that antidepressant medications may have variable

effects on cognitive function, with some domains improving while others worsen.

NO. 4

FMRI AND MEG STUDIES OF CORTICAL PLASTICITY INDUCED BY COGNITIVE TRAINING IN SCHIZOPHRENIA

Speaker: Sophia Vinogradov, M.D.

SUMMARY:

In this presentation, we will present imaging evidence of cortical plasticity induced by cognitive training in an RCT of individuals with schizophrenia randomly assigned to participate in either 50 hours of “neuroplasticity-based” computerized cognitive training or 50 hours of a computer games control condition. The computerized training places implicit, increasing demands on auditory perception and accurate aural speech reception, embedded within auditory and verbal working memory/verbal learning exercises. The target of this training is to improve the accuracy and efficiency of auditory encoding and working memory in order to generate improvements in verbal memory. We find that training results in significant improvement in cognitive outcome measures and also generates changes in activation patterns during untrained auditory working memory tasks as well as other higher-order cognitive operations. These changes occur in both sensory and prefrontal cortical sectors and are associated with cognitive and functional improvements. Taken together, our data indicate that participants manifest a range of improvements and that some subjects show a stronger response pattern to training than others. We will discuss some of the potential moderating and mediating variables, including medication status, that may play a role in this variable response pattern to the intervention.

THE SCIENCE OF LATE-LIFE DEPRESSION PREVENTION: UPDATES FROM THE VITAL-DEP (VITAMIN D AND OMEGA-3 TRIAL-DEPRESSION ENDPOINT PREVENTION) STUDY

Chairs: Olivia I. Okereke, M.D., S.M., Charles F. Reynolds III, M.D.

Discussant: Barry Rovner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List the three modes of prevention under the Institute of Medicine framework for prevention of mental disorders; 2) Describe the purpose, progress and major future

objectives of the VITAL-DEP study; 3) Describe the role of nutritional levels and intakes, including supplements, in late-life depression; 4) Discuss how risk and protective factors for late-life depression may differ among African Americans and other minorities and implications for prevention strategies; and 5) Summarize the state of knowledge regarding hazardous drinking in late-life and its potential relation to late-life depression risk.

SUMMARY:

Depression in late life is common and highly disabling. Frequently, depression is underrecognized and undertreated in older adults, particularly among minorities. Furthermore, residual symptoms and dysfunction from depression are major problems, even when treatment is provided. Therefore, prevention of late-life depression has emerged as a modern public health priority. In response to the imperative for effective late-life depression prevention, the VITAL-DEP (vitamin D and omega-3 trial-depression endpoint prevention) study was initiated in 2010. VITAL-DEP is a first-of-its-kind, large-scale, factorial randomized trial of two highly plausible agents—vitamin D and omega-3 fatty acids—for the prevention of depression and promotion of long-term positive mood among older adults over a treatment period of five to seven years. To date, VITAL-DEP has completed baseline and early follow-up among approximately 19,000 randomized men and women (mean age=65 years); over 70% have blood samples. In addition, deep-phenotyping assessments were completed in a subset of over 1,000 participants, who received in-person diagnostic interviews; underwent cognitive testing; and provided self-reports on dimensional measures of depression, anxiety, daily functioning, subjective memory, social support, caregiving activity and alcohol use behaviors. Finally, a critical aspect of VITAL-DEP has been attainment of high racial and ethnic diversity: 19% of VITAL-DEP participants are African American, and over 25% are from minority backgrounds. In this symposium, we will use VITAL-DEP and related projects of its co-investigative team as a platform to overview the state of the science of late-life depression prevention. We will begin by reviewing the evidence for the imperative for late-life depression prevention and introducing the design of VITAL-DEP. Then, we will provide an update on the progress of VITAL-DEP to date and major planned efforts, such as the integration of novel biomarkers and race/ethnic diversity into developing a comprehensive approach to defining

risk architecture of late-life depression and optimal prevention. This will be followed by a sophisticated view of the role of nutrient levels, intakes and supplements in late-life depression and prevention provided by a psychopharmacology and nutraceutical science expert. Next, a leader in the field of diversity in late-life mental health will present examples of how knowledge of race/ethnic differences can be integrated into studies on risk factors and prevention in late-life depression. Finally, an expert in alcohol use disorders will provide a novel perspective on the under-appreciated issue of hazardous drinking in older adults and how VITAL-DEP is poised to shed further light on this concern. Throughout the symposium, emphasis will be placed on how knowledge gained from this symposium can be applied to screening, assessment and treatment of patients in attendees' own clinical practices.

NO. 1

THE VITAL-DEP TRIAL OF LATE-LIFE DEPRESSION PREVENTION: DESIGN, OBJECTIVES, PROGRESS AND PLANS

Speaker: Olivia I. Okereke, M.D., S.M.

SUMMARY:

Prevention of late-life depression is a major public health priority. This session will introduce the VITAL-DEP (vitamin D and omega-3 trial-depression endpoint prevention), a large-scale, long-term, national randomized controlled trial for prevention of depression and maintenance of healthy mood in late life. Current progress of this ongoing trial, including description of randomized study population and observations from early follow-up, will be presented. Major objectives for planned work, such as integration of novel biomarkers to provide mechanistic insights into mediators and moderators of treatment effects, will be described. At the end of this session, participants will be able to describe the design components of a large trial that simultaneously incorporates strategies for universal, selective and indicated prevention of late-life depression.

NO. 2

ASSOCIATION BETWEEN LATE-LIFE DEPRESSION AND DIETARY VITAMIN D, OMEGA-3 FATTY ACIDS AND OTHER NUTRIENTS

Speaker: David Mischoulon, M.D., Ph.D.

SUMMARY:

Sub-optimal dietary intakes and/or biochemical levels of nutrients may play a role in depression. The balance of intakes of omega-3 fatty acids in maintenance of mood is among the better studied examples in the literature. The objective of this presentation is to provide information on the impact of baseline nutritional indicators of vitamin D and omega-3 fatty acids on late-life depressive outcomes during early follow-up waves, in the setting of the ongoing VITAL-DEP randomized trial. It is hypothesized that persons with sub-optimal intakes or levels of selected nutrients at baseline will be more likely to develop depressive symptoms. Findings will be framed in the context of existing literature of these nutrients and their role in emergence and/or recurrence of depressive disorders, including recent findings from randomized trials.

NO. 3

COMPARISON OF RISK AND PROTECTIVE FACTORS FOR DEPRESSION IN RACIALLY AND ETHNICALLY DIVERSE OLDER ADULTS

Speaker: Charles F. Reynolds III, M.D.

SUMMARY:

Older adults who are from racial/ethnic minority groups show particular vulnerability to common mental disorders, such as depression. Older Blacks, for example, bear a higher burden of risk for depression rooted in social and medical disadvantages: more disability; greater health risks, including obesity, smoking and substance use disorders; lower education attainment; and lower likelihood of marriage. Blacks also have a higher incidence of dementia, and preventing depression may delay or prevent dementia, as depression is a potential risk factor for cognitive impairment and dementia. We will describe key findings during the early follow-up in VITAL-DEP regarding differences in risk factors and depressive outcomes by race/ethnicity. These findings will be discussed in the context of recent literature, including the published study "Preemption of Depression in Older Black and White Adults" (Reynolds et al., *Psychiatric Services*, 2014), which highlighted the prominent roles of factors such as medical multimorbidity, functional disabilities and obesity in depression development and efficacy of lifestyle and problem solving interventions for reducing the burden of depressive symptoms among older African Americans. Special attention will be given to potential contributions of family support structures and the patient "lexicon"

for describing the experience of depression (“stress” vs. “depression”) among minority elders.

NO. 4

RECOGNIZING PROBLEM DRINKING IN OLDER ADULTS: IMPLICATIONS FOR LATE-LIFE DEPRESSION

Speaker: Grace Chang, M.D., M.P.H.

SUMMARY:

Hazardous, or problem, drinking has emerged as a public health concern. However, the prevalence of hazardous drinking among older adults is underappreciated. Furthermore, the potential role of hazardous drinking in the emergence and/or perpetuation of late-life depression has been understudied. Preliminary findings from the VITAL-DEP study population regarding problematic drinking and late-life depressive and anxious symptoms will be reviewed. Moreover, this presentation will provide an update on what is known regarding the prevalence of problem drinking behaviors, including binge drinking, among older adults in the U.S. Furthermore, it will highlight how the use of detailed, repeated assessments of drinking in the VITAL-DEP (using the AUDIT-C and DSM alcohol disorder diagnosis modules) is poised to expand knowledge on the role of drinking behavior on late-life depression risk.

COUNTERING VIOLENT EXTREMISM

Chairs: Stevan M. Weine, M.D., Aliya Saeed, M.D.

Discussant: Neil K. Aggarwal, M.D., M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe strategies for countering violent extremism, including integrating public mental health and health approaches; 2) Recognize the threats posed by recruitment and radicalization in the U.S.; 3) Discuss research on countering violent extremism, including a focus on prevention, intervention and psychosocial issues; and 4) Identify the missteps of counterterrorism and prevention strategies and offer alternatives.

SUMMARY:

Countering violent extremism (CVE) is an array of policies, programs and initiatives designed to both prevent violent ideologies from taking hold of people in the first place and to stop them from crossing the line toward actual violence. It is now a top U.S. governmental domestic and global strategy for addressing the evolving threat of violent

extremism. CVE is rooted in the White House Strategic Implementation Plan, with recent precedents in the U.K. Prevent program and the LAPD’s Muslim Liaison Unit. CVE requires broad-based changes in government, law enforcement and the public from an emphasis on a traditional law enforcement approach toward arresting criminals to an emphasis on having the community be as active as possible in protecting itself with the support and assistance of law enforcement and government. However, as a field of practice, CVE is still very much emerging. Domestically, CVE lacks sound theory and models, best practices, and evidence of effectiveness. Several questions are in urgent need of clarification: What is the evolving nature of the violent extremism threat? How are CVE programs being developed and adapted in diverse domestic and international settings? How can legitimacy with, trust in and cooperation from the public in law enforcement and government be enhanced through CVE? How can law enforcement and government conduct traditional policing and security operations when needed without undoing trust, legitimacy and cooperation gained by CVE and community policing approaches? What role can mental health play in CVE? If CVE is to be effective and sustainable, then these questions, among others, urgently need answers. This symposium was organized by the Committee of Terrorism and Political Violence of the Group for the Advancement of Psychiatry.

NO. 1

A COMPARATIVE ANALYSIS OF TERRORIST PROPAGANDA MAGAZINES: UNDERSTANDING THE MOTIVATIONAL DIMENSIONS

Speaker: Anthony Lemieux, Ph.D., M.A.

SUMMARY:

To effectively counter violent extremism, it is critically important to unpack and analyze its appeal. Using the information-motivation-behavioral skills (IMB) framework, which has been widely tested, validated and applied across a range of health behavior change interventions as a conceptual and analytic framework, I examine the content featured across three publications including Al Qaeda in the Arabian Peninsula’s English-language magazine *Inspire*, ISIL’s English-language magazine *Dabiq* and Al Shabaab’s magazine *Gaidi Mtaani*. This comparative analysis focuses on motivational elements including core attitudes, perceptions of social normative support, and perceived threats and vulnerabilities that are emphasized in each of the

publications. In addition, the linking of motivational elements and specific behavioral skills such as bomb making, weapons training and emphasis on a creative and do-it-yourself ethos (which have been regular features of *Inspire*) and an emphasis on identity and themes of journey (which have been regular features of *Dabiq*) will be analyzed. By emphasizing the connection of content across these publications to underlying concepts that can be mapped onto established models of intervention and health behavior change, I explore the potential to bring a more precise understanding of the mechanisms by which these magazines develop appeal to Western audiences and potentially motivate action.

NO. 2

VIOLENT EXTREMISM: CHALLENGES FACED BY MUSLIM COMMUNITIES

Speaker: Aliya Saeed, M.D.

SUMMARY:

Muslim communities in America have had to deal with unprecedented internal as well external challenges since the attacks of September 11, 2001. There is now a generation of Muslim men and women who have mostly grown up under the shadow of the "war on terror." These communities need to protect their young members from sliding into extremism while maintaining their identity in the face of xenophobia, western military interventions in Muslim countries and sometimes thorny relationships with law enforcement. This presentation will summarize the challenges faced by Muslim-American communities in the fight against violent extremism, as well as their points of strength.

NO. 3

SUFFER THE LITTLE CHILDREN: CHILD RECRUITMENT INTO VIOLENT EXTREMIST GROUPS

Speaker: Mia M. Bloom, Ph.D.

SUMMARY:

This presentation will contrast the diverse processes of recruitment of child soldiers in Africa with how youth are recruited into terrorist organizations in the Middle East and South Asia. The research draws from original data based on biographies, autobiographies, human rights reports and media accounts of the different processes involved in recruitment collected by the authors. The presentation will involve a mixed methodological approach in order to demonstrate the differences in

coercion, different types of inducements and the role of family and peers in the recruitment of youth into violent extremism. The presentation will include detailed case studies from research conducted in Pakistan at the youth deradicalization facility Sabaoon in Malakand.

NO. 4

MOVING BEYOND MOTIVE-BASED CATEGORIES OF TARGETED VIOLENCE INTERVENTIONS

Speaker: Stevan M. Weine, M.D.

SUMMARY:

Today's categories for responding to targeted violence are motive-based, and these tend to drive policy and practices. These categories are based on assumptions that there are significant differences between ideological and nonideological, and domestic and international, actors. Motive-based categories are limited by 1) Lack of robust empirical evidence of distinct individual risk factors; 2) Similar behavioral traits being found across categories, especially at early stages; 3) The different ecological niches that drive behavior becoming more similar; and 4) Unintended consequence of provoking resistance from communities who feel stigmatized. We question the use of these categories and offer an alternative way of addressing these issues. We propose adapting a multidisciplinary approach to assessing risk and to developing intervention strategies that are focused especially on the pre-criminal space. We describe four levels of capability that should be in place at the local level through multidisciplinary teams that combine community and law enforcement components.

NO. 5

EVALUATING CVE PROGRAMS: LESSONS LEARNED AND FUTURE DIRECTIONS FOR RESEARCH

Speaker: John Horgan, Ph.D.

SUMMARY:

One of many recurring criticisms of programs characterized as "countering violent extremism" is whether they are effective and, if so, how. In this presentation, John Horgan will provide an overview of results from a two-year National Institute of Justice-funded study that recently evaluated a community-based CVE program in Montgomery County, Maryland. In particular, and drawing from Williams, Horgan and Evans' (2015) paper on vicarious help seeking, this presentation will identify and explore a series of emergent gaps and lessons

learned from this case study for the future development of CVE programming in the United States.

CHANGING BEHAVIORAL HEALTH SYSTEMS TO TREAT TOBACCO THROUGH TRAINING AND POLICY INITIATIVES

Chair: Jill M. Williams, M.D.

Discussant: Andrew J. Saxon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss issues and barriers that have prevented tobacco treatment to occur in mental health and addictions treatment settings; 2) Recognize that knowledge barriers exist for behavioral health providers, including psychiatrists, and that educational initiatives are an essential part of a tobacco systems change intervention; 3) Understand how policy is an effective tobacco control strategy that increases the effectiveness of tobacco treatment initiatives; and 4) Consider how tobacco can be integrated into treatment for behavioral health conditions in a variety of treatment settings.

SUMMARY:

Smoking rates in individuals with a mental illness or addiction are at least double that of the general population, and these individuals have less access to treatment for tobacco use disorders across the health care spectrum. A 2014 survey by SAMHSA indicated that only one in four mental health treatment programs offers smoking cessation treatment. Reduced tobacco dependence services in behavioral health care settings may, at least in part, represent a knowledge deficit among providers and lax policies in terms of restricting tobacco use. Changing behavioral health care systems to address tobacco requires policy development and training for staff. In order for cessation programs to develop and be successful, staff need to become educated about evidence-based tobacco dependence treatment practices. Education can also help to improve attitudes about the hope for successful treatment and encourage providers to offer alternatives to smoking. We will describe a specialized curriculum to train psychiatrists and behavioral health professionals that includes motivational approaches and working with tobacco as a co-occurring disorder. Evaluation of the training program revealed that it increased tobacco treatment compared to baseline practices.

Psychiatric residency is also an opportune setting to provide tobacco training. We will discuss dissemination of Psychiatry Rx for Change, a four-hour curriculum for psychiatric residencies focused on identifying/treating tobacco dependence in those with mental illness. The curriculum was associated with significant improvements in knowledge/confidence for treating tobacco, regardless of program site, resident smoking status, interest level or PGY level. We will also review a manualized intervention that integrated tobacco treatment with mental health care for veterans with PTSD. This treatment demonstrated its efficacy in a multisite, randomized controlled trial and was then disseminated successfully at 12 Veterans Affairs multidisciplinary PTSD programs via a learning collaborative. A tobacco-free environment will support the cessation efforts of individuals and also effect cultural change by establishing new accepted norms. We will outline and review the policy, training and administrative work done by the UCLA Tobacco-Free Taskforce as they transitioned the UCLA Health System into a tobacco-free environment and changed the culture of how smoking cessation is addressed at the bedside or in the office. Barriers to becoming tobacco-free will also be discussed and include lack of institutional support, time constraints, resistance from staff and faculty, and patient complaints. Even if programs are not entirely tobacco-free, they can develop policies to restrict access to tobacco and shape treatment practices. New models for addressing tobacco through training and policy initiatives have emerged and will be reviewed in this symposium.

NO. 1

TRAINING PSYCHIATRISTS AND BEHAVIORAL HEALTH PROVIDERS IN TREATING TOBACCO THROUGH CONTINUING EDUCATION

Speaker: Jill M. Williams, M.D.

SUMMARY:

Few continuing education programs that train behavioral health professionals to deliver tobacco treatment services have been described and evaluated. Existing models for training health care providers primarily target primary care providers. These models may be too brief and don't address the complex needs of smokers with behavioral health comorbidity. We developed a specialized curriculum to train psychiatrists and other behavioral health professionals that includes motivational approaches and working with tobacco

as a co-occurring disorder. Continuing education credits are provided as an incentive to busy practitioners, and training is provided in a live format to allow for discussion and active learning. This two-day continuing education training conference has been held 18 times since 2006 for more than 600 psychiatrists and other behavioral health staff. Evaluation of the intensive training program revealed that it increases tobacco treatment compared to baseline practices.

**NO. 2
DISSEMINATION OF AN EVIDENCE-BASED TOBACCO
TREATMENT CURRICULUM TO PSYCHIATRIC
RESIDENCY PROGRAMS**

Speaker: Smita Das, M.D., Ph.D.

SUMMARY:

Psychiatric residency is an opportune setting to train to improve practice. The speaker will discuss dissemination of Psychiatry Rx for Change, a curriculum focused on identifying/treating tobacco dependence in those with mental illness. The four-hour curriculum (evidence-based, patient-oriented cessation treatments relevant for all tobacco users, including those not ready to quit), previously tested in a pilot study, was disseminated within eight training programs across four states. Surveys on knowledge, attitudes and practice habits were administered before, after and six months after training. One hundred nineteen valid baselines and 72 follow-up surveys were collected (44% PGY3, 56% female, 53% Caucasian and 38% never tried tobacco). The curriculum was associated with significant improvements in knowledge/confidence for treating tobacco, regardless of program site, resident smoking status, interest level or PGY level. Attitudes about barriers significantly improved. Over 90% of residents recommended the training, stating it would increase the number of patients they treat and improve the quality of tobacco counseling; 77% rated the training to be as good as or better than other didactics in their program. The online Psychiatry Rx for Change curriculum has been accessed by >3,400 registrants with >13,000 file downloads. Dissemination of the Psychiatry Rx for Change residency curriculum positively impacted knowledge/confidence across training sites and PGY level.

**NO. 3
LESSONS LEARNED FROM CREATING A TOBACCO-
FREE HEALTH SYSTEM**

Speaker: Tim Fong, M.D.

SUMMARY:

In 2012, UCLA health system administrators created a taskforce with the purpose of modernizing the culture of the health system to become tobacco-free. This presentation will outline and review the policy, training and administrative work of the UCLA Tobacco-Free Taskforce. The taskforce was charged with transitioning the entire UCLA health system into a tobacco-free environment and to change the culture of how smoking cessation is addressed at the bedside or in the office. As a first step, the taskforce created a tobacco-free policy and position that was approved by hospital leadership and then disseminated to over 10,000 UCLA health employees. Products created by the taskforce, such as the website, patient education materials, standardized patient order sets for nicotine withdrawal, staff training materials and copies of hospital policies, will be presented for attendees to understand the challenges, successes and innovations used to make a large health system tobacco-free. In addition to this taskforce, the culture of addressing smoking cessation at UCLA has also been significantly advanced by the design and implementation of an e-referral into the electronic medical record. This e-referral allows physicians and nurses to generate an automatic referral to California's smoking quitline, which then generates a phone call directly to the patient at a time of their choosing.

**NO. 4
IMPLEMENTATION OF INTEGRATED TOBACCO
TREATMENT INTO MENTAL HEALTH CARE FOR
VETERANS WITH PTSD**

Speaker: Andrew J. Saxon, M.D.

SUMMARY:

Individuals with PTSD have high rates of tobacco use compared to the general population. We developed a manualized intervention that integrates tobacco treatment with mental health care for veterans with PTSD and demonstrated its efficacy in a multisite, randomized controlled trial. We then used a learning collaborative model to implement this novel intervention in 12 Veterans Affairs multidisciplinary PTSD programs comprising 70 staff members. All participants who planned to deliver integrated tobacco treatment did so (n=52). Within 12 months of initial training, an additional 46 locally trained providers delivered integrated tobacco treatment,

and 395 veterans received it. Analysis of focus group data from six teams who participated in the learning collaborative identified key themes related to implementation of integrated care. Acceptability of integrated care was high, but teams faced common challenges related to fit between treatment delivery and clinic structure, provider time, securing buy-in from providers who weren't part of the learning collaborative team, training new staff and lack of active support from facility leadership. Flexibility in terms of the treatment itself and how teams delivered the treatment was critical in addressing challenges. Innovative adaptations of integrated care, including group delivery and integrating delivery with other evidence-based treatments helped to overcome some barriers.

MAY 17, 2016

MENTALLY ILL AND TRAUMATIZED POPULATIONS IN SOUTH SUDAN: A NOVEL MIND-BODY TREATMENT FOR HEALING A WAR-TORN COUNTRY

Chair: Patricia L. Gerbarg, M.D.

Discussant: Richard P. Brown, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the challenges faced by South Sudan in providing mental health services to individuals with mental illness and traumatized survivors of war; 2) Explain fundamental neurophysiological principles that account for the effects of voluntarily regulated breathing practices on sympatho-vagal balance and heart rate variability; 3) Describe the use of a mind-body program being used to relieve stress and symptoms of trauma in South Sudan; 4) Practice coherent breathing as a component of self-care for relief of personal and work-related stress; and 5) Utilize resources provided for further learning about the use of mind-body practices in clinical populations and following mass disasters.

SUMMARY:

South Sudan exemplifies many of the problems faced by African nations and other countries with few resources to meet the needs of war-affected populations living under extreme stress due to poverty, trauma, widespread disease and the threat of recurring violence. Since the creation of an independent Sudan in 1956, civil wars between the north and the south have repeatedly traumatized the population, prevented development of

infrastructure, and left the country with huge numbers of mentally ill people and a handful of health care professional with few resources to provide care. Since July 9, 2011, the year South Sudan became an independent country, it became necessary to create models and policies to deal with health in general and mental health in particular. Dr. Atong Ayuel, Director of Mental Health for the Ministry of Health of South Sudan and the only practicing psychiatrists in South Sudan, has been tasked by the Ministry of Health to develop a plan to address the mental health needs in her war torn, conflict-ridden country. In this symposium, Dr. Ayuel will describe the state of mental health services, the needs of the mentally ill and the factors that led her to train mental health professionals in a mind-body program called Breath-Body-Mind (BBM) as one of the mental health interventions for South Sudan. Dr. Richard P. Brown and Dr. Patricia Gerbarg have adapted BBM for use in post-disaster areas to rapidly relieve anxiety, insomnia, post-traumatic stress disorder and depression. Dr. Gerbarg will review the neurophysiology and evidence base supporting the safety, feasibility and effectiveness of this program, including its use in South Sudan over the past four years. Having demonstrated that it is not only effective, but also readily accepted by the Sudanese, BBM has now been introduced in the mental health care system. How this program is taught will be shown in video clips of Dr. Brown teaching BBM to psychologists, other health care and relief workers, psychiatric patients, and recently liberated slaves, including adults and children, in South Sudan. Dr. Brown will lead the symposium attendees through a set of practices. This will enable participants to experience the effects of the program on their own mental and physical states. Caregiver and health care professionals affected by stress can use these practices for self-care and can easily integrate them into the individual and group therapies they provide patients. Large-group interventions are also relevant in the U.S. and other countries affected by the worldwide epidemic of stress. Resources for learning further BBM practices will be provided. For those interested in a full day of Breath-Body-Mind lectures and practices, see the APA course by Dr. Brown and Dr. Gerbarg: Mind-Body Programs: Stress, Anxiety, Depression, PTSD, Military Trauma and Mass Disasters.

NO. 1

PROJECT FOR MENTALLY ILL SURVIVORS IN SOUTH SUDAN: TRANSFORMING THE PRESENT, SHAPING THE FUTURE

Speaker: Atong Ayuel, M.D.

SUMMARY:

As South Sudan emerges from 30 years of civil war, we face the current situation: 1) Infrastructure destroyed; 2) War, trauma, violence, tropical diseases, illicit drugs, alcohol abuse and poverty created huge numbers of mentally ill. South Sudan has 10 million people. Population ratings of PTSD are above 35%; 3) Most mental health care is provided by nonmedical, traditional healers; community leaders; and religious leaders based on tradition, superstition and religious beliefs; 4) A large population of homeless mentally ill wander unsupervised and are harmed. The mentally ill are kept in chains, locked compounds and jails without treatment; and 5) A paucity of trained mental health care providers—currently, South Sudan has only one practicing psychiatrist, five psychologists, and 24 mental health trainees. With so few health care professionals and such a large population in need, we need effective programs that require few providers to serve large populations, require no specialized equipment or medications, and will be accepted in communities accustomed to traditional healing practices. We need a program for which we can rapidly train providers. Breath-Body-Mind matches our situation. In July 2015, Dr. Brown trained 24 psychologists in Juba. Using the materials he provided, we will develop these psychologists as a starting point for a country-wide breathing and meditation program helping with stress management and reducing the burden of psychological distress.

NO. 2

NEUROPHYSIOLOGY, CLINICAL STUDIES AND OBSERVATIONS: WAR SURVIVORS AND MENTALLY ILL SOUTH SUDANESE

Speaker: Patricia L. Gerbarg, M.D.

SUMMARY:

Dr. Brown and Dr. Gerbarg adapted a brief mind-body intervention, Breath-Body-Mind (BBM) for use in post-disaster areas to rapidly relieve anxiety, insomnia, post-traumatic stress disorder and depression. Dr. Gerbarg will review the neurophysiology that accounts for the effects of voluntarily regulated breathing practices on sympatho-vagal balance, heart rate variability,

emotion regulation, reconnection and symptom resolution. She will present the evidence base supporting the safety, feasibility and effectiveness of BBM, including its use in South Sudan over the past four years. Having demonstrated that it is not only effective, but also readily accepted by the Sudanese, BBM has now been introduced in the mental health care system. How this program is taught will be shown in video clips of Dr. Brown teaching BBM to psychologists, other health care workers, NGO service personnel, psychiatric patients and recently liberated slaves, including adults and children, in South Sudan.

NO. 3

EXPERIENCE THE EFFECTS OF BREATH-BODY-MIND AS IT IS TAUGHT IN SUDAN

Speaker: Richard P. Brown, M.D.

SUMMARY:

Dr. Brown will lead participants through a sequence of Breath-Body-Mind (BBM) practices, gentle movements with paced breathing and guided meditation, just as they are being taught to mentally ill and traumatized populations in Sudan. Participants will be able to experience the effects of these practices on their own mental states while also observing the specific techniques that make it possible to quickly teach the practices to large numbers of people and to easily train future teachers. Health care providers and nongovernmental organization (NGO) workers are under severe stress due to their intense workload, lack of institutional support and exposure to the same dangerous, unpredictable living conditions that their patients endure. Most of the caregivers have experienced traumas of war, violence and loss themselves. Practicing BBM provides relief for caregiver stress, trauma and burnout. Large-group interventions are also relevant in the U.S. and other countries affected by the worldwide epidemic of stress. Resources will be provided for participants to access additional information and training in these mind-body techniques for self-care, disaster relief and integration into work settings (private office, clinics, hospitals and military).

BORDERLINE PERSONALITY DISORDER (BPD) ACROSS THE LIFESPAN: DEVELOPMENTAL PRECURSORS IN INFANCY THROUGH OLD AGE

Chairs: Marianne Goodman, M.D., Mary C. Zanarini, Ed.D.

Discussant: John Gunderson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize borderline personality disorder (BPD) symptomatology across the lifespan; 2) Recognize how individual diagnostic criteria present through the trajectory of the illness over time; and 3) Gain more knowledge of the limited literature of older adult and geriatric presentations of BPD.

SUMMARY:

Borderline personality disorder (BPD) is a serious mental illness characterized by pervasive instability in moods, interpersonal relationships, self-image and behavior. This symptomatology often disrupts family and work life, long-term planning, and the individual's sense of self-identity. There is growing interest in following the trajectory of BPD across the development of the disorder and understanding its changes through its lifespan. Accumulating evidence from longitudinal studies with youth and adults demonstrate that BPD symptoms typically remit within several years, although functional outcomes can remain problematic. This symposium will present recent findings on BPD phenomenology and the changing expression of symptomatology over the lifespan of the disorder. Dr. Marianne Goodman will begin the symposium presenting data on infancy and childhood precursors and their relationship to adolescent-onset BPD in males and females. Sharp and colleagues will present prospective data on two samples of adolescents: a community sample of adolescents followed up over four annual time points on a symptom-based measure of BPD and a small clinical sample of adolescents with *DSM-IV* criteria-defined BPD followed up over 18 months. The course of borderline pathology is examined as well as predictors of change in level of symptoms and diagnosis. Dr. Stephanie Stepp will also address the developmental course of BPD during the transition from adolescence to young adulthood. Her presentation will focus on the stability of BPD symptoms during this transition, and the impact of BPD during adolescence on young adult developmental milestones (e.g., high school graduation, obtaining additional education/training, obtaining employment) will be examined. Dr. Mary Zanarini will review levels of acceptance and forgiveness in a middle age cohort of patients with BPD and axis II comparison subjects over 16 years of prospective follow-up. Dr. Robert Biskin will review

the limited literature of older adult and geriatric presentations of BPD. Changes associated with diminishing social networks and changes in physical health status will also be addressed. Finally, our discussant, Dr. John Gunderson, an expert in BPD psychopathology across the ages, will discuss the clinical implications of these findings.

NO. 1

INFANCY, CHILDHOOD AND ADOLESCENT PRECURSORS TO THE DEVELOPMENT OF BORDERLINE PERSONALITY IN MALE AND FEMALE OFFSPRING

Speaker: Marianne Goodman, M.D.

SUMMARY:

To characterize precursors and trajectories in the development of borderline personality disorder (BPD), anonymous Internet surveys were administered to parents about their BPD male and female offspring and non-BPD siblings. Questions covered aspects of probands' lives from pregnancy through young adulthood. BPD offspring were identified through both lifetime clinical diagnoses and diagnostic criteria embedded within the survey. We report on 234 female offspring meeting strict criteria for BPD, 87 non-BPD female siblings, 97 male offspring meeting strict criteria for BPD and 166 non-BPD male siblings. For girls, parents of female offspring with BPD describe the presence of affective symptomatology beginning in infancy. These affective symptoms persist and are joined by interpersonal difficulties that manifest themselves in toddlerhood and childhood. By adolescence, difficulties with impulsivity, aggression, acting out and self-destructive behaviors dominate the profile. Parents with BPD sons describe the early emergence of a constellation of symptoms that include separation anxiety starting in infancy; body image concerns in childhood; and impulsivity, emptiness and odd thinking in adolescence. This trajectory differs from the developmental course found in females diagnosed with BPD.

NO. 2

THE COURSE OF BORDERLINE SYMPTOMS IN ADOLESCENTS WITH AND WITHOUT *DSM-IV* CRITERIA-DEFINED BORDERLINE PERSONALITY DISORDER (BPD)

Speaker: Carla Sharp, Ph.D.

SUMMARY:

While several studies have examined the course of borderline symptoms in adolescents, these studies have mostly made use of community samples and unvalidated measures of BPD. Moreover, limited data are available on predictors of the course of borderline symptoms as well as the stability and/or change in particular symptom clusters. In this presentation, we will present data on 100 adolescents with (n=50) and without (n=50) *DSM-IV* criteria-defined BPD who were followed up for 18 months after discharge from an inpatient psychiatric hospital. Demographic as well as sociocognitive and emotion regulation variables will be examined to identify predictors of stability, increase or decline in symptoms. Symptom clusters of affective dysregulation and interpersonal difficulties will be examined for stability and change. Together, data from this study will help clarify the specificity of borderline symptoms in those who meet criteria versus those who do not meet criteria for BPD and will provide valuable insight into the course and predictors of BPD in adolescents with severe psychopathology.

NO. 3
THE COURSE OF BORDERLINE PERSONALITY DISORDER (BPD) FROM ADOLESCENCE TO YOUNG ADULTHOOD

Speaker: Stephanie Stepp, Ph.D.

SUMMARY:

Adolescence represents a window of vulnerability, a time when recognizable signs and symptoms of borderline personality disorder (BPD) are likely to first emerge. However, the implications of adolescent symptoms for the course of BPD and success in the pursuit of developmental tasks related to education/work and intimacy remain unclear. This presentation will discuss findings regarding the developmental course of BPD symptoms and the incidence of full-blown disorder during the transition from adolescence to young adulthood in a large, urban sample of young women (N=2,450). Ages at onset of diagnosis and of individual symptoms will be used in latent growth curve models to examine the stability and persistence of BPD across the early teenage years to the early 20s. Adolescent clinical characteristics most predictive of young adult educational/occupational attainment and satisfaction with romantic partner(s)/peers will also be identified. Prognostic predictors of BPD symptom continuation, exacerbation, remission and recovery will be identified. The implication of these findings

for screening and early identification of BPD will be discussed.

NO. 4
LEVELS OF ACCEPTANCE AND FORGIVENESS REPORTED BY BORDERLINE PATIENTS AND AXIS II COMPARISON SUBJECTS OVER 16 YEARS OF PROSPECTIVE FOLLOW-UP

Speaker: Mary C. Zanarini, Ed.D.

SUMMARY:

This study has two objectives. The first is to determine the levels of acceptance and forgiveness reported by borderline patients and axis II comparison subjects over 16 years of prospective follow-up. The second is to determine the levels of acceptance and forgiveness reported by borderline patients who had and had not achieved recovery (i.e., concurrent symptomatic remission and good psychosocial functioning) over the past decade and a half. The level of acceptance and forgiveness was reassessed every two years using items from a self-report measure developed to assess the positive affective and cognitive states characteristic of borderline patients over time. Borderline patients reported approximately a third the level of these states with respect to comparison subjects. However, the level of these states increased significantly over time for those in both groups, with borderline patients reporting a steeper rate of increase than axis II comparison subjects. In contrast, recovered borderline patients reported approximately twice the level of these states as nonrecovered borderline patients. However, the level of several of these states increased significantly over time for those in both groups, with nonrecovered borderline patients reporting a somewhat steeper rate of increase than those who had recovered. Taken together, the results of this study suggest that borderline patients tend to report becoming more forgiving and accepting of others and themselves over time.

NO. 5
BORDERLINE PERSONALITY DISORDER (BPD) IN AN AGING POPULATION

Speaker: Robert Biskin, M.D., M.Sc.

SUMMARY:

Borderline personality disorder (BPD) is defined in *DSM-5* as a long-term condition. Accumulating evidence from longitudinal studies with youth and adults demonstrate that BPD symptoms typically

remit within several years, although functional outcomes can remain problematic. Unfortunately, there is little evidence regarding the course of symptoms of BPD in an older adult or geriatric population. Preliminary evidence indicates continued overall improvement in symptoms over time, although worsening of affective symptoms is a possibility, which may be associated with increased social impairment. Changes associated with diminishing social networks and changes in physical health status will also be addressed. Finally, the limited data on treatment of BPD in the geriatric population will be discussed.

SEXUALITY AND PSYCHIATRY: ETHICAL AND POLICY DILEMMAS

Chair: Kenneth J. Weiss, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand issues of human sexuality in diverse settings; 2) Know the sexual rights of persons with disabilities from a legal perspective; and 3) Understand reporting requirements and ethical concerns generated by the 2003 Prison Rape Elimination Act.

SUMMARY:

This symposium addresses issues of human sexuality in diverse settings, each with ethical concerns for mental health professionals. Ms. Lynch will address sexual rights of persons with disabilities from a legal perspective. Dr. Joy will discuss the ethical issues faced by mental health professionals treating individuals who report viewing child pornography. Dr. Watson will explore, from an institutional perspective, the reporting requirements and ethical concerns generated by the 2003 Prison Rape Elimination Act. Dr. Weiss will examine the questions of self-determination, competency and sexuality in cases of dementia.

NO. 1

SEXUAL SELF-DETERMINATION IN PERSONS WITH DEMENTIA

Speaker: Kenneth J. Weiss, M.D.

SUMMARY:

In this era of self-determination, the values and wishes of individuals are respected. This applies to medical and mental health decisions, notably in the form of the advance directive or durable power of attorney. Using these legal instruments, persons

who lose capacity to exert judgment in their affairs can make their preferences known using a substituted judgment standard. Common examples include end-of-life decisions and the need for psychiatric hospitalization. In this presentation, questions are raised about sexuality—whether a person can express a preference that would survive incapacity. We look at the example of an Iowa man criminally charged after allegedly engaging in a sexual act with his wife in the nursing home where she was treated for dementia. Is it sexual assault to engage in a sexual act with an incapacitated person, irrespective of one's intentions or apparent consensual behavior? The Iowa defendant was acquitted, but the case raises important issues. Is it possible for competent persons to express preferences and values regarding intimate behavior with named partners that will survive incapacity? If so, how would a sexual advance directive be accomplished, and how would it reconcile with criminal statutes? If not, to what degree should intimate contact be regulated in nursing homes and elsewhere?

NO. 2

BEYOND A QUESTION OF COMPETENCY: THE RIGHTS OF INDIVIDUALS WITH MENTAL ILLNESS TO ENGAGE IN VOLUNTARY SEXUAL ACTS

Speaker: Alison J. Lynch, Esq.

SUMMARY:

With the growth of mental disability law over the past 50 years, very few topics remain off limits to scholars and judges who face these issues daily. However, discussions of the right of persons with mental illness, especially those currently institutionalized in psychiatric hospitals, to voluntary sexual interaction often touch a raw nerve, even for those practicing in the field. Although this may be a difficult subject, even among legal and medical practitioners familiar with mental illness, it is one that must be raised for the sake of the client. Dignity and rights violations will occur if we do not recognize the ability of persons with mental illness to practice free sexual expression. Current literature addressing this subject often presumes that the institutionalized mentally ill are incompetent. The conversation, therefore, only addresses this issue from the perspective of an incompetent, institutionalized adult. We must broaden the scope of these examinations and rather than presume incompetency, deal directly with the situation of a competent mentally ill person wishing to engage in

sexual activity. In this presentation, I will examine legal competency as well as the difficulties encountered when one uses different measures of “competency” for different tasks or activities. Additionally, I will explore the attitudes that surround this type of discourse and their impact on advancing the rights of persons with mental illness.

**NO. 3
REPORTING CHILD PORNOGRAPHY USE:
PSYCHIATRISTS AS POLICE**

Speaker: Michelle Joy, M.D.

SUMMARY:

Mandatory reporting laws are designed to protect vulnerable populations from harm. Traditionally, these laws have legally required reporting the suspected abuse of children, the elderly and dependent adults by those who may work closely with these populations. Following a recent amendment to California’s Child Abuse and Neglect Reporting Act that mandates the reporting of viewing child pornography, new ethical questions arise for psychiatrists across the country. In this presentation, we will examine the intended protection being enacted by such reporting, considering how children are potentially being protected from harm and in what ways alongside other possible societal benefits. We will look at the breaking of confidentiality with regard to this reporting as compared with traditional exemptions to the ethical standard of confidentiality in the psychiatrist-patient relationship. Consideration will also be given to how new standards could potentially affect the therapeutic relationship, both between specific individuals and as a model of providing help. In addition, we will examine potential harms to an individual caused by reporting, including specific legal and societal repercussions of being considered a sexual offender. To this end, we will review case examples with a range of populations, relationships, viewing patterns and pornographic content to explore the ethical contours of reporting the viewing of child pornography.

**NO. 4
SEXUAL VICTIMIZATION IN CORRECTIONAL
SETTINGS**

Speaker: Clarence Watson

SUMMARY:

Navigating the issue of sexual behavior in correctional settings is complex. Sexual activity,

whether staff-inmate interactions or inmate-inmate interactions, raises questions regarding consent to engage in sexual acts and whether consent can ever truly be given in correctional environments. While all state jurisdictions, the District of Columbia and the federal government prohibit staff sexual abuse of inmates, only 25 states and the District of Columbia specifically direct that inmates are unable to consent to sex with staff. On the other hand, some states have laws that indicate that inmates can consent to sexual activity with correctional staff. Complicating these matters further, there is a broad range of sexual behaviors between inmates that may span from consensual activity to rape. Accordingly, defining, recognizing and addressing sexual victimization in correctional settings has been challenging. In 2003, Congress enacted the Prison Rape Elimination Act (PREA), which was the first federal legislation that expressly addressed sexual abuse in correctional settings. We will discuss the phenomenon of sexual victimization of persons in custody, the issues related to addressing that phenomenon and the federal legislation aimed at that subject.

FOOD AND THE BRAIN

Chairs: Emily C. Deans, M.D., Laura R. LaChance, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss up-to-date nutritional studies and their relationship with mental health; 2) Perform food assessments with their patients and recommend safe and effective dietary change; 3) Understand the impact of the microbiota on inflammation in the body and brain and how diet interacts with the microbiota; and 4) Describe the potential benefits and risks of specialty diets, such as ketogenic, low-carb, vegetarian, etc., on mental illness and health.

SUMMARY:

In this symposium geared toward clinicians, we will review the latest available research linking nutrition to mental health along with practical tips about addressing diet in your medical practice. Surprisingly, the evidence suggests that changing dietary habits may be one of the most powerful mechanisms we have to improve resiliency to stress and to mitigate or prevent the development of mental illness. However, nutrition literature is often contradictory, controversial and constantly changing

and can leave clinicians unsure what is safe and effective to recommend. We will provide an evidence-based guide to navigate these murky waters. The symposium will be divided into four sections including interactive sessions, case examples and a QandA period. Our first segment will be an interactive session talking about food as a vital sign, demonstrating and practicing a simple food assessment and how to integrate available evidence and stages of change in the process of motivating healthy dietary habits. We will then review specific vitamins, minerals and fermented foods, along with global dietary patterns and their links to mental illness based on the recent literature. We will also introduce The Brain Food Scale, a food rating instrument based on a comprehensive scientific literature review. The third segment will discuss how gut and brain health are linked and provide insight from the increasing evidence linking microbiome changes to mental illness and cognitive function. Our final segment will address specialty diets (such as vegetarian, low-carb, fasting, etc.) and their health and psychiatric implications. The symposium will conclude with an interactive “Brain Food Prescription” giving attendees an opportunity to apply the knowledge learned along with a QandA session.

NO. 1
FOOD AS A VITAL SIGN: THE SIMPLE FOOD ASSESSMENT

Speaker: Drew Ramsey, M.D.

SUMMARY:

As the evidence connecting food and mental health grows, dietary assessment and nutritional prescription are clinical tools ripe for consideration. However, psychiatrists and other mental health clinicians may feel fundamentally unprepared to give guidance to patients about diet. While in some complex cases, specialists such as nutritionists are greatly needed, for the most part, mental health providers are, in fact, both uniquely qualified and positioned to help in this area. Mental health clinicians’ skills of detailed history taking, empathy and motivating behavioral change make them well-equipped to intervene with food. In this interactive session, we will demonstrate a simple food assessment, how to elicit details about a patient’s diet and identify problem areas, and how to use motivational interviewing and behavioral activation techniques to urge healthy dietary habits.

NO. 2
ANIMALS, VEGETABLES AND MINERALS: THE FUNDAMENTALS OF NUTRITION AND PSYCHOPATHOLOGY

Speaker: Laura R. LaChance, M.D.

SUMMARY:

In this presentation, we lay out the evidence for various nutrients and dietary patterns and how they affect brain health. Good data in this area has finally become available over the past decade or so, enabling the clinician to feel confident despite the ever-changing recommendations in nutrition science. Vegetables, tubers, grains, fruit, meat, eggs, dairy and nuts contribute varying nutrition to the diet, whereas processed foods in general fall far short of what we require for a healthy brain. We have used a comprehensive literature search to develop the Brain Food Scale, which enables us to identify the best way to obtain essential nutrients for the brain in the diet.

NO. 3
YOU ARE WHAT YOU EAT: SPECIAL DIETS AND THEIR IMPLICATIONS IN MENTAL HEALTH AND GUEST OR HOST—THE MICROBIOME AND BEHAVIOR

Speaker: Emily C. Deans, M.D.

SUMMARY:

It seems like, every few years, a new dietary craze comes into vogue and others that fell out of fashion make comebacks into common practice. Using evidence and real case examples, we will discuss major diets and how they impact mental health, including nutritional or psychological problems to watch for unique to certain diets. Our discussion will include vegetarian/vegan, paleo, low-carb and ketogenic, intermittent fasting, gluten-free, and casein-free diets, as well as populations where nutrition may be an especially key issues, such as the elderly, eating disordered and post-gastric bypass patients. We are happy to field questions about various dietary trends. Humans have coevolved over the entire history of our species and beyond with our microbiome and parasitic infections. Recently, massive changes in hygiene and diet have led to remarkable changes in the population and diversity of our microbiomes. Copious animal evidence and an increasing number of human trials show us that eukaryotic and prokaryotic guests in our guts influence our mental health via immunomodulatory and neurotransmitter mechanisms. Practical

implications and low-risk ways to modulate the microbiome, including diet, will be explored.

DSM-5 AND RDOC: MOVING TOWARD A COMMON AGENDA FOR UNDERSTANDING MENTAL DISORDERS

Chairs: Philip Wang, M.D., Dr.P.H., Diana E. Clarke, Ph.D., M.Sc.

Discussant: Mario Maj, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the importance of the NIMH RDoC initiative; 2) Understand changes in *DSM-5* that are in parallel to the RDoC initiative; and 3) Understand, conceptually and operationally, how the RDoC initiative and *DSM-5* can be bridged and how this is relevant to clinical practice and care.

SUMMARY:

The aim of the field of psychiatry is to better diagnose, treat and prevent mental disorders. Toward these ends, the field is attempting to move toward a more dimensional approach to the diagnosis of mental disorders, to more accurately capture the underlying bases of mental disorders and ways patients present for care, as well as enhance the precision of treatment efforts. The *DSM-5* attempted to move diagnosis in these directions in several ways. At the organizational level, mental disorder categories were re-clustered based on known biological similarities, such as those suggested by genetic overlap. Dimensional measures to capture symptomatology, severity and functional deficits that may occur across diagnostic categories were also incorporated. These changes are consistent with the goals of the National Institutes of Health (NIMH) Research Domain Criteria (RDoC), a new research framework for classifying mental disorders. Similar to *DSM-5*, RDoC seeks to incorporate information ranging from basic neuroscience and genetics to self-reports so as to better understand the basic dimensions underlying human behavior, from normal to abnormal. While there has been some concern that the two initiatives conflict in their goals and philosophies, this symposium will cover important ways that *DSM-5* and RDoC are highly complementary and mutually necessary to the field of psychiatry and its patients. The goal of this symposium is to provide audiences with a better understanding of the parallels between revisions in *DSM-5* and the efforts of RDoC in hopes of demonstrating how the two initiatives can be

bridged and ultimately improve the future of psychiatric diagnosis and patient care. Speakers will present on the NIMH RDoC initiative with specific emphasis on the RDoC domains and their importance in improving our understanding of the bases of mental disorders. In addition, speakers will discuss mechanisms for bridging *DSM-5* and RDoC, such as implementation into clinical practice of the *DSM-5*'s cross-cutting measures as well as future RDoC dimensions once they have been validated. This discussion will be conducted at the conceptual level as well as empirically by using data from the *DSM-5* field trials and other research efforts. For example, results from the study of the associations between maladaptive personality and resting state functional magnetic resonance imaging variables will be used to demonstrate the linking of dimensional ratings of personality traits, per *DSM-5*, and biological variables with relevance to psychopathology.

NO. 1

USING THE NIMH RDOC TO HELP CLARIFY PSYCHIATRIC DISORDERS

Speaker: Charles A. Sanislow, Ph.D.

SUMMARY:

Research aimed at connecting psychiatric diagnoses with internal mechanisms has lagged behind advances in integrative neuroscience. Impediments to progress include problems with categorical diagnoses derived from clinical observation (e.g., psychiatric diagnoses are heterogeneous within and across diagnostic categories, dimensional gradients of psychopathological phenomena cut across diagnostic categories, high rates of diagnostic comorbidity are evident in clinical practice, and studies that have employed categorical diagnoses to define study groups have produced limited results). The National Institute of Mental Health (NIMH) Research Domain Criteria (RDoC) initiative was developed to provide an alternative framework to guide research aimed at identifying disruptions in neurobiological and behavioral mechanisms and to connect such disruptions to clinical symptoms. This presentation will describe the RDoC initiative, the domains and how the framework can be deployed in psychopathological research. The ways that the goals of RDoC differ from and complement those of the *DSM-5* will be addressed. Discussion will focus on ways to bridge RDoC research to clinical symptoms and disorders.

NO. 2

THE CONCEPTUAL BRIDGING OF *DSM-5* AND RDOC: MOVING THE FIELD OF PSYCHIATRY FORWARD?

Speaker: Philip Wang, M.D., Dr.P.H.

SUMMARY:

In acknowledging the limitations of a purely categorical diagnostic schema, *DSM-5* took a number of important steps toward a more dimensional approach to the diagnosis of mental disorders. At the organizational level, mental disorder categories were re-clustered based on known biological similarities, such as those suggested by genetic overlap. Dimensional measures to capture symptomatology, severity and functional deficits that may occur across diagnostic categories were also incorporated. These changes are consistent with the National Institutes of Mental Health Research Domain Criteria (RDoC) goal to move toward a classification of mental disorders based on behavioral dimensions and neurobiological measures. The ultimate goal of both systems is to more accurately capture the underlying bases of mental disorders, better reflect the ways in which patients present for care and enhance the precision of treatment efforts. This presentation will be a conceptual discussion of possible mechanisms for the bridging of *DSM-5* and RDoC, such as implementation of the *DSM-5* cross-cutting measures and future RDoC domains into clinical practice, once they are validated. More broadly, the presentation will emphasize the important ways in which *DSM-5* and RDoC are highly complementary and mutually necessary for the field of psychiatry and its patients.

NO. 3

A CROSS-WALK BETWEEN RDOC DOMAINS AND *DSM-5* CROSS-CUTTING DIMENSIONAL MEASURES: EVIDENCE FROM *DSM-5* FIELD TRIALS

Speaker: Diana E. Clarke, Ph.D., M.Sc.

SUMMARY:

In the absence of a fully dimensional diagnostic schema, *DSM-5* developed cross-cutting and dimensional measures of personality traits and functioning to help improve our understanding of disorders and address the issue of co-occurring symptoms and conditions. The cross-cutting measures were conceptualized to serve as “a review of mental systems” in patients who present for mental health care. The measures assess the presence and severity of 12–13 psychiatric symptom

domains and functioning that cut across diagnostic boundaries and impact prognosis and treatment. Scores on the measures were envisioned to help clinicians more accurately diagnose and treat their patients. Also, when used in conjunction with *DSM-5* categorical diagnoses, the information on these cross-cutting domains will allow for identification of the heterogeneity within diagnoses, which is important for improvements in our understanding of the biological basis of mental disorders. The goal of this presentation is to use data to show how the bridging of *DSM-5* and the National Institute of Mental Health (NIMH) Research Domain Criteria (RDoC) initiatives may be operationalized. Specifically, data from the *DSM-5* field trials will be used to show how the combination of *DSM-5* categorical diagnoses and its cross-cutting and dimensional measures of personality and functioning taps into the same constructs as the NIMH RDoC domains.

NO. 4

THE *DSM-5* MALADAPTIVE PERSONALITY TRAIT MODEL: PHENOTYPES FOR RDOC

Speaker: Robert Krueger, Ph.D.

SUMMARY:

The National Institute of Mental Health (NIMH) Research Domain Criteria (RDoC) initiative represents a bold effort to circumvent the limitations of psychiatric categories derived from authority. In emphasizing dimensional approaches to studying biological systems underlying human individual differences, NIMH has made a key move toward bringing science to bear on the study of mental illness. In making this move, however, it is critical to develop paradigms and approaches that can link biological systems with the signs and symptoms that directly constitute psychopathological behavior. The *DSM-5*'s new model of maladaptive personality traits represents an approach to characterizing dimensions underlying psychopathology that can serve as compelling phenotypic targets for neurobiological inquiry. In this presentation, I will describe approaches to RDoC-compliant dimensional research linking biological variables with psychopathology, with specific reference to our work on associations between maladaptive personality and resting state functional magnetic resonance imaging variables.

SOCIAL TRAUMA

Chair: Sheila Judge, M.D.

Discussant: Kenneth Thompson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize how culture shapes reactions to traumatic events and list a variety of sources of collective or social trauma; 2) Understand how the long-term effects of stress and trauma are transmitted from mother to child via molecular and genomic processes; 3) Describe AVATAR therapy to treat auditory hallucinations based on knowledge of the causal pathways of traumatic events in childhood at the onset and the course of psychosis; 4) Recognize victims and survivors of human trafficking and identify risk factors and treatment strategies for such complex trauma in children and adults; and 5) Demonstrate knowledge of the mental health needs and trauma histories of minors in institutional placement as well as needed policy and systems reform.

SUMMARY:

Social trauma can occur from a single catastrophic event, or from ongoing stressful—or even horrific—conditions, and is experienced by a defined group of any size. Its effects can be felt on identity formation of both individuals and social groups, on mental and physical health, and in complex interactions with culture and heredity. In this symposium, social trauma will be further defined and delineated. In particular, the role of culture in shaping response to catastrophe or adverse experience will be highlighted. Examples from North Africa will illustrate the ability of a society's culture to serve either as an agent of processing and healing or of constraint and additional trauma. One of the most exciting aspects of this field is research into the ways trauma is encoded. The effect of massive social trauma, such as the experiences of the Holocaust and the 9/11 attacks, on mothers can be demonstrated to have effected changes in the genes of their children via epigenetic tags in areas associated with stress regulation. How childhood adversity is linked to the onset of psychotic symptoms is also being studied and will be discussed. Clinical trials are underway in London to document reduced frequency of persistent auditory hallucinations using a computer-based interactive therapy to directly address earlier trauma. The panel will look at certain traumatized populations in the United States, exploring deficiencies in the delivery of treatment. The inability of most health care

personnel to recognize those caught in human trafficking furthers victims' existence in the shadows of medical and psychiatric care. There will be a review of the history of institutionalizing children in this country, up to and including current situations such as undocumented children seeking asylum from war and the further traumatization of youths in the residential treatment system. Finally, there will be a lively interactive discussion tying together all of these aspects of psychological trauma, especially from the perspective of social exclusion.

NO. 1

SOCIAL TRAUMA: CULTURE, PSYCHE AND SYMPTOM DEVELOPMENT

Speaker: Driss Moussaoui, M.D.

SUMMARY:

Trauma covers a wide variety of aspects for individuals and communities, and the subsequent reaction varies tremendously from the most resilient to the most catastrophic. In Morocco, the forced exile of the sultan of Morocco in 1953 by the colonial authorities came as a big shock to the whole population. As a result, what was probably the largest number of pseudohallucinations observed in the world occurred when millions of Moroccans "saw" the image of the sultan in the moon. In 1960, an earthquake hit the southern city of Agadir, killing 17,000 people; a study by Douab et al. showed that 38.8% developed PTSD after the earthquake, and four decades later, 10% were still suffering from PTSD. Another study conducted by Kadri et al. among 80 bipolar female inpatients showed that 14.3% stated that they lived out of prostitution, and 15% more had a standard of living that made probable their living from prostitution. This is culturally due to the family exclusion of female bipolar patients who show hyperactive sexual behavior during their manic episodes. These examples from Morocco are but a few in this presentation, which will illustrate how trauma, psychiatric symptoms and their treatment are bounded by cultural beliefs and circumstances.

NO. 2

SOCIAL TRAUMA RESEARCH I: EPIGENETIC INHERITANCE IN DESCENDANTS OF TRAUMA SURVIVORS

Speaker: Rachel Yehuda, Ph.D.

SUMMARY:

Recent advances in molecular biology, genomics and epigenomics have now provided paradigms for understanding the long-term effects of stress, as well as how stress effects can pass from parent to child. This presentation will focus on intergenerational transmission of trauma as a particularly enduring effect of stress. The focus will be on how maternal effects are transmitted in utero and after birth. Most of the research has been conducted on adult children of Holocaust survivors but has now generalized to include children of other trauma survivors such as children born to pregnant women who survived the World Trade Center attack on 9/11. The research has evolved to explain the contribution of early environmental experiences—including parenting—on highly conserved molecular and genomic processes. These changes in and of themselves do not signify pathology, but provide a paradigm for understanding long-term effects of profoundly important events. The work has already led to a better understanding of biological risk factors for PTSD and predictors of outcome in response to trauma.

**NO. 3
SOCIAL TRAUMA RESEARCH II: CHILDHOOD
EXPERIENCE AND THE ONSET OF PSYCHOSIS**

Speaker: Thomas K. J. Craig, Ph.D., M.B.B.S.

SUMMARY:

Early studies (notably those carried out by George Brown and Tirril Harris) demonstrated an association between common mental disorders and prior stressful events, with further research establishing lifespan correlates of these adversities in adulthood with prior neglect and maltreatment in childhood. The relevance of early adversity and how the downstream consequences relate to the onset of schizophrenia and other psychoses is now becoming clearer. In this presentation, I will provide a brief overview of recent research from our group in London elaborating the causal pathways that link childhood and adult adversity with the onset and course of psychosis and the implications this has for therapy. I will illustrate the therapeutic aspects through presentation of some recent observations from our ongoing clinical trial of AVATAR therapy—a computer-based dialogue therapy for patients suffering from persistent auditory hallucinations. These suggest that directly addressing this early traumatic experience in a brief therapy can have profound effects on the frequency of voices and their associated distress.

**NO. 4
SOCIAL TRAUMA IN U.S. POPULATIONS I: HUMAN
TRAFFICKING**

Speaker: Vivian Pender, M.D.

SUMMARY:

There are anywhere from 800,000 to 21 million human beings in the world trafficked for labor or sexual servitude. Illegal profits reach \$150 billion each year. In 2000, the U.S. and other member states adopted the UN Palermo Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children. There are now federal and state laws in the U.S. that aim to protect victims from prosecution. Increasingly, the victim is referred to a social service agency, and the buyer and trafficker are arrested. It is estimated that 50% of victims in captivity and 80% of victims and survivors seek health care but are not adequately identified, assessed or treated. Studies show that only 40% of health care professionals, house staff and faculty are aware of human trafficking, and only 5% of victims are referred to a community agency. Health care professionals can be trained to have increased awareness, identify risk factors in children and adults, refer or treat complex trauma, assist victims to exit "the life," and advocate for social change.

**NO. 5
SOCIAL TRAUMA IN U.S. POPULATIONS II:
INSTITUTIONALIZED YOUTH**

Speaker: Andres J. Pumariega, M.D.

SUMMARY:

The U.S. has a long history of institutionalization of youth with social, emotional and behavioral needs, from large orphanages in the early days of the nation to recent internment of minority youth. Much advocacy has focused on deinstitutionalization of youth, including 1) The Child Welfare League of America advocating foster care over orphanages; 2) The Native American Child Welfare Association's work to end placement of Native American youth in boarding schools; and 3) Work by many advocates to reduce institutionalization of youth in the mental health and juvenile justice systems. Still, the U.S. leads the world in incarceration of youth in juvenile justice (over 100,000, 75% from minority populations, with high mental health needs) and has over 200,000 youth in behavioral residential treatment facilities (RTFs). More recently, large

numbers of undocumented immigrant Latino youth are now placed in residential facilities. This practice continues even with a lack of evidence for benefit from RTFs, high rates of prior traumatization among youth in RTFs and recent investigations of abuses within RTFs. This presentation reviews RTF placement of youth in the U.S., evidence around mental health needs and trauma histories among youth served, and policy and system reform needed to address adverse consequences of this practice.

CHOOSING THE RIGHT TREATMENT FOR SUBSTANCE USE DISORDERS

Chairs: Herbert D. Kleber, M.D., Edward V. Nunes, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

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

lower age of onset. This symposium combines current scientific knowledge with discussion of the most efficacious treatments for all of these agents. Emphasis is on office-based approaches, and presentations include discussion of both pharmacological and psychological treatment methods. The speakers are nationally recognized experts in substance use disorders and will discuss practical and cutting-edge treatments.

NO. 1 DETECTING AND MANAGING MISUSE OF PRESCRIPTION STIMULANTS AND SEDATIVE- HYPNOTICS

Speaker: John J. Mariani, M.D.

SUMMARY:

Despite extensive clinical experience, concerns about overprescribing, abuse liability, and the behavioral safety of sedative-hypnotics and stimulants still remain, an especially concerning problem given the marked rise of stimulant use. While these medications are effective treatments for psychiatric disorders, specifically sedative-hypnotic agents for anxiety disorders and stimulants for ADHD, both classes of medication have a significant risk of abuse, and the incidence of non-prescribed use is substantial. An overview of the strategies to detect and manage abuse of these controlled substances will be provided. Special attention will be focused on the complex clinical issues that arise when prescribing these agents in the presence of co-occurring substance use disorders.

NO. 2 MANAGING OPIOID USE DISORDER USING MEDICATIONS: ROLE FOR OPIOID AGONISTS AND ANTAGONISTS

Speaker: Adam Bisaga, M.D.

SUMMARY:

Substantial increases in the abuse of prescription opioids observed recently in the U.S. have resulted in sharp rises in morbidity and mortality. While opioid dependence is among the most destructive of addictions, it also has the most powerfully effective medication treatments. Maintenance with the opioid receptor agonist methadone, the partial agonist buprenorphine or the antagonist naltrexone are each associated with substantial rates of remission. We will provide an update on the current state of medication-assisted treatments for opioid dependence, describing the strengths and

limitations of each treatment approach. We will present an approach to treatment that offers patients a range of pharmacotherapy options to match a particular medication with an individual patient. We will also discuss target treatment outcomes and response criteria, and we will discuss new approaches to medication induction and discontinuation, as well as strategies for transitioning patients between various treatments to achieve long-term recovery.

**NO. 3
CHOOSING TREATMENT FOR PROBLEMATIC NON-
PRESCRIPTION STIMULANT USE**

Speaker: Elias Dakwar, M.D.

SUMMARY:

Problematic use of cocaine and amphetamine-type stimulants remains a health concern with no effective pharmacotherapies. An emerging approach to treating stimulant use disorders is to identify synergistic combinations of medications and/or behavioral treatments. Dopaminergic medications and glutamate modulators have shown the greatest promise, both when administered together, as in the d-amphetamine and topiramate combination, and when a specific medication is paired with a behavioral treatment, as with d-amphetamine and relapse prevention therapy (RPT). Research suggests that integrated approaches may be most promising, with a combination of pharmacological and behavioral interventions such as contingency management or RPT likely to be most effective for patients to achieve and maintain abstinence. Practical and safety concerns involved in prescribing medications with abuse liability to stimulant users will also be discussed, as well as new data suggesting novel approaches to integrated medication-behavioral treatments for cocaine use disorders.

**NO. 4
CHOOSING TREATMENT FOR CANNABIS USE
DISORDERS**

Speaker: Frances R. Levin, M.D.

SUMMARY:

Cannabis is the most widely used illicit drug in the United States, with 10% of users ending up dependent. Underlying psychopathology increases this risk, and in others, marijuana use may increase risk of depression and psychosis. Heavy chronic cannabis use can lead to a characteristic withdrawal syndrome, especially with current THC levels

averaging 7 – 10%. Such symptoms may hinder a patient's ability to reduce or cease use. Various psychotherapeutic treatment approaches have been efficacious, but no one type of psychotherapy has been found to be superior, and relapse rates are high. The efficacy of pharmacological interventions has had only limited trials. In the laboratory setting, agonists (e.g., dronabinol [oral THC], nabilone) have shown some promise, as well as combined pharmacotherapies (such as dronabinol and lofexidine). There have been a limited number of outpatient clinical trials, with dronabinol and gabapentin showing some benefit. A recent adolescent study of a combination of n-acetylcysteine with contingency management showed promising results. To date, pharmacological trials in cannabis-dependent adults with concurrent psychiatric disorders have not found that the active psychiatric medication is superior to placebo in reducing cannabis use or psychiatric symptoms. An overall review, including treatment implications, will be presented.

**NO. 5
COMBINING MEDICATION AND PSYCHOSOCIAL
INTERVENTIONS IN THE TREATMENT OF
SUBSTANCE USE DISORDERS**

Speaker: Edward V. Nunes, M.D.

SUMMARY:

Several types of psychosocial-behavioral interventions, including cognitive-behavioral skill-building approaches (e.g., relapse prevention, community reinforcement approach, contingency management, motivational enhancement therapy and 12-step facilitation), have been studied for use either alone or in combination with medications for treatment of substance use disorders. Such interventions have served as a means of helping patients to achieve abstinence, encouraging lifestyle change and promoting compliance with medications. An overview of these models and a brief review of findings in treatment outcome research will be provided. Obstacles encountered in delivery of these approaches, the clinical implication of integrating such models and the efforts to generalize research findings to community settings will be addressed.

**BIOMARKERS OF TREATMENT RESPONSE AND
TOLERABILITY IN PSYCHOTIC AND MOOD
DISORDERS**

Chairs: Sophia Frangou, M.D., Ph.D., Peter Buckley, M.D.

Discussant: Godfrey D. Pearson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe biological markers of relevance to treatment response and tolerability to schizophrenia and mood disorders; 2) Better understand the specificity and sensitivity of biomarkers for treatment response and tolerability and their relationship to disease mechanisms; 3) Critically appraise the role of these biomarkers for treatment planning for psychotic and mood disorders; and 4) Reflect on their own clinical practice and how it could benefit from biological insights about the role of psychotropic agents.

SUMMARY:

A biomarker is any biological feature that has the potential to be an informative indicator of biological processes related to disease risk, occurrence, prognosis, treatment response and tolerability. Biological research in psychiatry has led to the identification of multiple genetic, molecular and imaging features that have been associated with schizophrenia and mood disorders. These advances have led to regulatory health authorities placing greater importance on the contribution of biomarkers for the development of drugs that could be safer and more efficient. However, there is ongoing debate about the validity and reproducibility of biomarkers and whether they can have a role in current clinical management. This symposium brings together four experts in the field to critically discuss the state of the art in biomarkers across the major mental disorders, from schizophrenia to major depressive disorder. Each speaker in this symposium will discuss the concept of biomarkers and their putative relationship to risk, diagnosis and treatment in schizophrenia and mood disorders. Dr. Peter Buckley will present an overview of current antipsychotic trials and new agents with antipsychotic potential. He will then discuss how the use of “peripheral” biomarkers, derived mostly from blood, that provide information on variation in genetic, genomic and metabolic processes can be usefully employed to minimize adverse reactions and predict treatment response in schizophrenia. Dr. Sophia Frangou will focus on “neuroimaging-informed” biomarkers of response and how they relate to biomarkers for disease risk and expression. She will also present data on the predictive value of anatomically informed effective connectivity parameters for acute response and sustained

remission in affective and nonaffective psychosis. Dr. Allan Young will present data on molecular and endocrine biomarkers for treatment response in bipolar disorder, taking into account the extended clinical phenotype that includes cognitive and symptom dimensions. He will also discuss the potential usefulness of these biomarkers for drug development in bipolar disorder. Dr. Sidney Kennedy will focus specifically on major depressive disorder and will cover the range of imaging and molecular markers that have been associated with symptomatic remission and treatment resistance. Dr. Godfrey Pearson will act as the discussant and will provide a critical commentary on the data presented and discuss biomarker discovery and reproducibility from the perspective of large transdiagnostic cohorts.

NO. 1

RELIABLE BIOMARKERS, PERSONALIZED MEDICINE AND THE TREATMENT OF SCHIZOPHRENIA: WILL SCIENCE (EVER?) TRUMP CLINICAL “TRIAL AND ERROR?”

Speaker: Peter Buckley, M.D.

SUMMARY:

Biomarkers are chemical/physiological parameters that can provide reliable and predictive information about the course and treatment of a given illness. Biomarkers are being increasingly sought after in other medical conditions; in some instances (e.g., breast cancer therapy), they are beginning to be incorporated into clinical decision making and, for some conditions (e.g., cystic fibrosis), have generated pharmacogenetic “designer drugs” to target core diseases. There is a confluence of research investigating potential biomarkers for schizophrenia and nascent research applications to clinical therapy of schizophrenia. This development is critical and holds future promise (at least) to offer an alternative to the current clinical “trial and error” decision making in both drug selection and treatment response in schizophrenia. This presentation will illuminate early progress and strategies for evaluating biomarkers, as well as how this approach can advance schizophrenia treatment toward personalized medicine.

NO. 2

EFFECTIVE CONNECTIVITY CHANGES IN WORKING MEMORY AND AFFECT PROCESSING NETWORKS IN AFFECTIVE/NONAFFECTIVE PSYCHOSIS: RELATION TO TREATMENT RESPONSE

Speaker: Sophia Frangou, M.D., Ph.D.

SUMMARY:

Brain imaging studies have identified robust changes in brain structure and function of patients with affective and nonaffective psychosis. Antipsychotic treatment has been shown to affect resting state and task-related connectivity. This presentation discusses findings from a cohort of 60 patients (mean age=27.1 years, SD=4.4 years) with recent onset (<5 years duration) affective and nonaffective psychosis, recruited through the Mount Sinai Hospital psychiatric services. Magnetic resonance imaging (MRI) data were obtained from the patients and 30 demographically matched controls using a 3T Skyra scanner while performing a working memory paradigm. Patients were scanned prior to treatment initiation with an antipsychotic. Dynamic causal modelling (DCM) was used to examine effective connectivity within the working memory network. Bayesian model selection was performed to evaluate alternative network architectures across groups, and Bayesian model averaging was used to compare connection strengths across groups. Effective connectivity between frontoparietal regions was reduced in all patients but improved with antipsychotic treatment. Effective visuo-frontal connectivity was reduced in patients, particularly those with nonaffective psychosis, and did not normalize with treatment and predicted reduced treatment response. Our findings suggest that functional abnormalities within the working memory network respond differently to treatment and predict the degree of response.

NO. 3

BIOMARKERS FOR TREATMENT RESPONSE AND TOLERABILITY IN BIPOLAR DISORDER

Speaker: Allan H. Young, M.D., Ph.D.

SUMMARY:

Bipolar disorder (BD) is a common, chronic, severe, complex and costly group of recurrent psychiatric illnesses that can be devastating for affected individuals and their families. Suicide is an important risk across the lifespan of bipolar patients. Mania can present with associated depressive symptoms, leading to complicated, problematic and difficult-to-treat mixed states. Psychotic symptoms may suggest schizophrenia, and a major depressive episode may appear to be unipolar depression, often over prolonged periods. Comorbid anxiety and substance/alcohol abuse often confuse the

diagnostic picture. These factors contribute to problems with the response to treatment in BD. Incorrect treatment may worsen prognosis, increasing hospital stay and the overall costs of treatment and patient management. There is a significant clinical need for more effective and better-tolerated drug treatments for BD. Although the pathophysiology and neurobiological processes responsible for BD are not fully understood, a greater understanding of the causative underlying mechanisms is gradually emerging. Identification of new drug targets driven by recent research should help define a more tailored and potentially more successful approach to the treatment of BD. Future advances are expected based on the ability to manipulate and redress the fundamental disease processes and neurobiological dysfunction that underlie BD.

NO. 4

MULTIMODAL MARKERS OF TREATMENT RESPONSE IN DEPRESSION

Speaker: Sidney H. Kennedy, M.B.B.S.

SUMMARY:

Identifying biological and clinical markers of treatment response in depression is an area of intense research that holds promise for increasing treatment efficacy for acute episodes and preventing relapse/recurrence. Additional benefits include decreased health care costs and increased workplace productivity. Research efforts to date have identified clinical characteristics and various genetic, neuroimaging and biochemical markers that are associated with treatment response. These findings have yet to be translated into clinical practice, primarily because of limitations related to reproducibility and limited predictive power. This presentation has a dual focus. It synthesizes available data on biomarker candidates across different modalities and their relevance to pharmacological and nonpharmacological (e.g., rTMS) response in depression. It also discusses ways to integrate biomarker candidates from across different modalities and highlights the need for advanced bioinformatics and statistical modelling, including multimodal pattern recognition techniques. Integrative models are more likely to capture the complexity of pathophysiological mechanisms and the diversity of phenotypic expression of depression and identify the key signatures of treatment response.

THE WAR ON WOMEN CONTINUES

Chairs: Gail Erlick Robinson, M.D., Gisele Apter, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand ongoing harassment and discrimination faced by women; 2) Challenge the idea that elective abortion has negative psychological consequences; 3) Understand the interference in women's lives, including threats to access to contraception and interfering with women's decisions regarding their pregnancies; 4) Discuss the negative consequences to mothers and children of not providing adequate maternal leave; and 5) Understand the mental health effects to women of poverty and poor access to health care.

SUMMARY:

North America is perceived to be a part of the world in which women are liberated and have equal rights and freedoms. It was expected that longstanding inequities that affect women's physical and mental health and well-being would gradually disappear. However, many places in the world show greater progress for women than we do in North America. In recent decades, we have seen the undermining of reproductive rights, the constant distortion of scientific data, and the growth of persistent sociological and cultural biases. Women still cannot get equal pay for equal work, there is an ongoing feminization of poverty, and trauma and abuse of women are common around the world. Attacks against reproductive rights have sprung up in numerous states. Access to excellent health care is vital, and yet attempts are being made to defund women's health care services. Companies will pay for erectile dysfunction medication but refuse to pay for contraceptives. If a woman has an unwanted pregnancy, laws and restrictions in many states put obstacles in the way of her seeking abortion under the false pretense that they are protecting women from developing an "abortion trauma syndrome," a syndrome that does not exist in any textbook or research. If there is a problem in the pregnancy, external forces intervene to force caesarian sections or put women in jail for not cooperating with someone else's ideas about what to do. Once a child is born, there is limited or no opportunity for maternity leave. The effects of these restrictions on women's mental health and well-being will be discussed.

NO. 1

IS THERE A WAR ON WOMEN?

Speaker: Carol C. Nadelson, M.D.

SUMMARY:

The mental health of women around the world is deeply affected by many of their life experiences. These can be related to their governments and laws, their culture, and their individual situations. They are often second-class citizens, to be used and discarded. They endure sexual violence, slavery and abuse, even as young children. They can be forced to be suicide bombers and instruments of war without any voice or recourse. They can be locked away, uneducated and without health care or any personal resources. Violations of women's rights occur even in so-called Western democracies. It is well-known that societies that respect, value and educate women fare far better than those that abuse them. The nature and implications of this war on women will be discussed.

NO. 2

BARRIERS IN ACCESS TO MENTAL HEALTH CARE FOR WOMEN

Speaker: Helen Herrman, M.D., M.B.

SUMMARY:

The services provided for women with mental ill health in primary health care, community mental health services or hospital settings do not in many places respond adequately to their needs. The inadequacies in response can reproduce or amplify the difficulties and injustices that women face in their lives, especially maltreatment as girls and intimate partner violence as adults. The 2009 International Consensus Statement on Women's Mental Health recommends that "[providers, policy makers and advocates] integrate girls' and women's mental health as a priority in policy and program development and support safe, respectful, appropriate, gender-sensitive comprehensive mental health and physical health services for girls and women across the lifecycle irrespective of their economic and social status, race, nationality, or ethnocultural background." Attention to respectful relationships, partnerships with women and their families, and the training of staff with regard to women's needs, privacy and safety are key to achieving adequate quality care for women. This presentation will discuss the need for applying these principles and practices in physical and mental

health services, whether community or hospital-based, and in communities of all income levels.

NO. 3

THE HISTORY OF CONTRACEPTION

Speaker: Malkah T. Notman, M.D.

SUMMARY:

The availability of effective methods of contraception has been taken for granted in the developed world and, aside from certain religious groups, widely used. It may be surprising to learn that, one hundred years ago in the early 20th century, one of the leaders in the birth control movement, Margaret Sanger, was repeatedly attacked and jailed for teaching and writing about contraceptives as well as promoting and selling them. In the 1950s, it was still illegal in some states to sell contraceptives. The language that characterized the birth control movement and was used by Sanger, who wrote “No woman can call herself free who doesn’t own and control her own body,” is still an important theme in the present. Currently, it reflects the position of those supporting the availability of abortion. The anti-abortion groups currently use similar language to oppose abortion as was used to oppose contraception; both have been viewed as a “violation of the laws of God” or immoral in that they oppose the natural and inherent reproductive function of women. This presentation will review the history of contraception and describe how it and the anti-abortion movement have a similar basis in the belief that women must be controlled, as control of their own bodies threatens an important aspect of the social structure.

NO. 4

THE REAL ABORTION TRAGEDIES: SILENCE AND MISINFORMATION

Speaker: Nada L. Stotland, M.D., M.P.H.

SUMMARY:

One-third of women in the United States will have an abortion during their lives. Reputable evidence repeatedly demonstrates that they overwhelmingly emerge as psychiatrically well after the procedure as before and feel that they have made the best decision under the circumstances. Nevertheless, they permit their elected representatives in many states to require that women seeking abortion be given misinformation, undergo medically unnecessary interventions and cope with highly

inconvenient waiting periods. Public insurance cannot, and private insurance generally does not, cover the cost of abortion. Most medical students and residents are not trained to perform abortions. There are fewer and fewer facilities offering abortions; large geographic areas have no provider. All these burdens weigh most heavily on women—and their families—who are poor and otherwise disadvantaged, including those with psychiatric disorders. The same psychosocial factors that led to this situation silence the very women who could speak most persuasively about the need for safe, accessible, affordable abortion.

NO. 5

THE MYTH OF THE “MATERNAL-FETAL CONFLICT”

Speaker: Gail Erlick Robinson, M.D.

SUMMARY:

The term “maternal-fetal conflict” supposedly describes a situation in which the mother’s wishes or behavior are not in the best interest of the fetus. The assumption is that outside “experts” know more about what should happen during the pregnancy based on the belief that if a woman does not agree with recommended treatment she does not care about her baby. This judgment by others has been used to force caesarian sections on women, charge them with assault for being an addict while pregnant or even keep them on life support to sustain the pregnancy. This term offers a simple explanation for a complicated set of feelings, beliefs and circumstances that are rarely indicators of the mother’s selfish disregard for the well-being of her child. The woman who refuses a recommended caesarian section may be uneducated, poorly informed about the medical reasons or simply afraid of doctors and hospitals. She may believe she is protecting her baby rather than putting it at risk. The pregnant addict may be strongly motivated to get clean but unable to find any programs that are willing to treat her. Although a mother cannot be compelled to donate a kidney to her toddler, somehow the pregnant woman loses her rights to autonomy and the freedom to make choices once she is pregnant. Ironically, getting pregnant is often the end of reproductive freedom.

NO. 6

MATERNITY LEAVE: ALL IN FAVOR?

Speaker: Gisele Apter, M.D., Ph.D.

SUMMARY:

We now know that pregnancy and the peripartum period do not miraculously protect women from mental health issues. In fact, pregnancy and the birth of a baby are stressful and potentially anxious events even when most desired. Among factors, absence of leave and employment insecurity have been linked to both anxiety and depression. Affect disorders that occur during pregnancy have a negative impact on pregnancy, birth and postpartum maternal and infant mental health. These disorders have also been shown to be correlated to prematurity and maternal negative general health outcome. Prematurity and negative maternal health are themselves positively correlated to poor outcome for the mother-infant relationship. The peripartum period is a time for access to care, for care itself and for environmental support. Bonding and attachment links are built during the first postpartum months. When will we recognize that offering women adequate conditions during pregnancy and the postpartum period is not only a right for women today but also a necessity for children tomorrow?

PATIENT SUICIDE IN RESIDENCY TRAINING: THE RIPPLE EFFECT

Chairs: Alexis A. Seegan, M.D., Sidney Zisook, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify feelings resident psychiatrists and supervising psychiatrists may have after a patient completes suicide; 2) Demonstrate understanding of a need for improvement in preparing residents for the likelihood of suicide in their careers and in supporting residents who experience patient suicide during training; 3) Demonstrate knowledge of strategies, including video training and postvention protocols, used to prepare residents and support them after a patient suicides; and 4) Make recommendations to their home training programs on how to improve support for residents who experience patient suicide.

SUMMARY:

According to the Centers for Disease Control and Prevention, in 2010, suicide was ranked the 10th leading cause of death, accounting for 38,364 deaths. Studies estimate that 20 – 68% of psychiatrists will lose a patient to suicide in their careers. A significant number of residents will experience patient suicide during residency training. Unfortunately, open discussions about the feelings

and issues raised in response to suicide are rare in training programs and in the literature. This silence may be due to the shame, guilt, fear, confusion, sadness and other emotions in residents, their colleagues and their supervisors after a patient dies by suicide. We believe this lack of discussion interferes with the use of positive coping strategies by residents and that residency training programs need improvement in supporting residents through this difficult experience and preparing them for the likelihood of losing a patient to suicide during their career. This symposium will include presentations from three psychiatric residents from different residency programs across the U.S. sharing their experiences of having a patient die by suicide. A residency training director will then discuss the challenges in educating trainees about the impact of patient suicide. She will show brief clips from a video, "Collateral Damage: The Impact of Patient Suicide on the Psychiatrist," of a psychiatrist supervisor discussing his own experience of patient suicide. This DVD was developed as a discussion stimulus for residents, faculty and private practitioners in psychiatry to help them with the experience of having a patient commit suicide. Small group sessions led by panelists will follow, allowing for sharing of experiences with patient suicide among audience participants. An attending psychiatrist will then discuss the development of a support system (including education symposia and a postvention protocol) for residents who experience patient suicide at two training programs (Columbia and UCSF). Next, a residency training director will discuss the collaborative project of making the training video "Collateral Damage." Then, an attending psychiatrist will present results from a resident education research project that tested the efficacy of a new patient suicide curriculum that included the use of this training video. There will be a second small group session led by the panelists for audience participants to discuss interventions to help residents deal with patient suicide in their own home training programs. The final presenter, a residency training director and the vice chair of education at an academic medical institution, will speak about the effect that patient suicide has on all levels of psychiatric training, from the resident to the senior psychiatric attending to the academic medical environment. The symposium will close with QandA from the audience.

NO. 1

EXPERIENCING PATIENT SUICIDE AS A PSYCHIATRIC INTERN

Speaker: Daphne Ferrer, M.D.

SUMMARY:

Patient suicide, though anticipated to occur at some point in our careers as psychiatrists, is a difficult experience. When it occurs as early as intern year of residency training, this is a unique experience in itself. My experience was with a 38-year-old male with bipolar disorder, alcohol use disorder, PTSD by history, borderline and dependent personality features, multiple prior psychiatric hospitalizations for threatening suicide in the setting of alcohol intoxication, medication noncompliance, and recent life crisis (recent breakup with girlfriend). After a few weeks' stay in the hospital, he was discharged to a former employer's home (who coincidentally was the father of another patient on the unit), with the plan to follow up at an intensive outpatient program—at the time, the patient was not interested in getting help for alcohol use. One month after hospitalization, the patient was found dead by suspected suicide by overdose in the basement of his former employer's home by the employer's wife. This presentation will illustrate the impact this experience has had on me as a mental health provider and how it will continue to shape me in my journey as a psychiatrist.

NO. 2

IMPACT OF PATIENT SUICIDE ON TRAINEES: THE ROLE OF EDUCATIONAL CURRICULA

Speaker: Deepak Prabhakar, M.D., M.P.H.

SUMMARY:

This presentation will discuss results from a resident education research project that investigated the efficacy of a new patient suicide curriculum. The curriculum educated residents about patient suicide, common reactions and steps to attenuate emotional distress while facilitating learning. Eight psychiatric residency training programs participated in the study, and 167 of a possible 240 trainees (response rate=69.58%) completed research-related evaluations. These results were compared to assess both knowledge and attitudes resulting from this educational program. Participants reported increased awareness of the common feelings physicians and trainees often experience after a patient suicide, available support systems, required documentation and the role played by risk management. This patient suicide educational

program increased awareness of issues related to patient suicide and shows promise as a useful and long-overdue educational program in residency training.

NO. 3

IMPACT OF PATIENT SUICIDE ON RESIDENTS AND HELPING RESIDENTS COPE WITH SUICIDE

Speaker: James W. Lomax, M.D.

SUMMARY:

When a patient commits suicide during a resident's training, the effects are more clinically significant compared to practicing psychiatrists, and residents often do not seek help due to feelings of shame and guilt. During this presentation, we will show video clips with residents discussing their emotional reactions to patient suicide as well as what kind of support they would have wanted from their residency program.

NO. 4

EMOTIONAL AND COGNITIVE RESPONSES OF CLINICIANS TO PATIENT SUICIDE

Speaker: Joan Anzia, M.D.

SUMMARY:

This presentation will explore both senior clinicians' and trainees' responses to a patient suicide using video interviews of people at both career stages. Two brief video interviews will be followed by a review of emotional and cognitive responses to this event and facilitated group discussion.

DUAL DISORDERS: TWO DIFFERENT DISORDERS OR ONE?

Chair: Roger D. Weiss, M.D.

Discussant: Roger D. Weiss, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define "dual disorders"; 2) Identify potential common neurobiological underpinnings of dual disorders; 3) Identify treatment approaches for individuals with dual disorders; and 4) Understand how a dysfunctional brain reward circuit may contribute to co-occurring substance use in patients with schizophrenia.

SUMMARY:

The term dual disorder (DD) is often used to describe the common situation in which a person suffers from both an addictive disorder and a psychiatric

disorder, either simultaneously or sequentially. The related term “dual diagnosis” is used the same way. But what do these terms actually describe? How can we explain the common co-occurrence of addictive and psychiatric disorders? Are they different aspects of the same complex clinical entity, or are they simply two different conditions, with separate etiologies and pathophysiologies that tend to sort together? Some have suggested that individuals with psychiatric disorders “self-medicate” with addictive substances. Does this explain the association? Does the common co-occurrence indicate a shared etiology or a shared pathophysiology? Would a better understanding of DDs drive more effective treatment? This symposium brings together international leaders in this field to discuss these questions. Dr. Shaul Lev-Ran will review the epidemiological studies that indicate and describe the nature of the common co-occurrence of these addictive and psychiatric disorders and will discuss the role of standardized definitions in planning and developing much-needed specialized services for the treatment of individuals with dual disorders. Dr. Nestor Szerman will discuss the possibility that both conditions are in some way causally linked—that dual disorders can be best understood as a single neurodevelopmental disorder that can present with addiction-related or psychiatric symptoms at different stages of life. Dr. Ruben Baler will suggest that closer attention to nonlinear dynamics and critical states in the brain could transform our fundamental understanding of co-occurring addictive and mental disorders and spur much-needed progress in our diagnostic and therapeutic approaches. Dr. Leo Sher will discuss the frequent association between dual disorders and suicide and provide insight into the psychological and neurobiological basis of this association. Finally, Dr. Alan Green will present neuroimaging data suggesting the shared disruption of the brain reward circuitry in individuals with schizophrenia and co-occurring substance use disorders. These data provide a biological explanation for the “self-medication” hypothesis and, further, suggest the implications for novel therapeutic interventions. Dr. Roger Weiss will serve as the discussant.

NO. 1
EPIDEMIOLOGY OF DUAL DISORDERS: THE CURRENT STATE OF RESEARCH AND METHODOLOGICAL CHALLENGES

Speaker: Shaul Lev-Ran, M.D.

SUMMARY:

Epidemiological research repeatedly reports a strong association between psychiatric disorders and substance use disorders, indicating that these dual disorders (DDs) are associated with increased severity and persistence of both disorders. Though cross-sectional data regarding this association are persistent across all psychiatric disorders, longitudinal research varies in terms of order of appearance of the disorders, affecting our understanding of potential causal relations between the two disorders. Several methodological issues may affect results and conclusions from epidemiological studies on DDs. Examples include variability in diagnostic tools and criteria required for particular diagnoses, the specific disorders included within the respective categories of psychiatric disorders, and whether or not studies differentiate between independent (“primary”) and substance-induced psychiatric disorders. These are all important when examining the epidemiology of DDs, as they clearly affect any understanding of this common association. In this presentation, Dr. Lev-Ran will present the current state of epidemiological research on DDs and its contribution to the understanding of the complex relationship between both disorders, as well as discuss relevant methodological challenges. Finally, the specific role of standardized definitions of DDs in planning and developing much-needed specialized services for the treatment of these disorders will be discussed.

NO. 2
DUAL DISORDERS: TWO DIFFERENT MENTAL DISORDERS?

Speaker: Nestor Szerman, M.D.

SUMMARY:

Dual disorders (DDs). This is the term commonly accepted within the mental health field to refer to those patients who suffer from an addictive disorder and other mental disorders. It can occur simultaneously or, even more importantly, sequentially throughout their life span. The vast majority of individuals exposed to substances with addictive properties do not progress to develop an addictive disorder. It is possible that a common genetic vulnerability might increase the risk of both substance use disorders (SUDs) and other mental disorders. Are we talking about two disorders? Are addiction disorders and other mental disorders different? Has our field, to date, essentially excluded biological discoveries that are involved in SUDs and

other mental illnesses? This symptomatic high concurrency strongly suggests that the co-occurrence of DDs is not due solely to random or coincidental factors. It seems reasonable to explore the assertion that both conditions are in some ways causally linked. DDs can probably be best understood as a single neurodevelopmental disorder, considering that these are disorders that begin during the individual's development and may present with different phenotypes, such as addiction-related or other psychiatric symptoms, at different stages of the lifespan.

**NO. 3
IS CRITICALITY CRITICAL TO UNDERSTAND DUAL DISORDERS?**

Speaker: Ruben Baler, Ph.D.

SUMMARY:

Progress in the study of the relationships between physiological abnormalities and mental disorders continues to be hampered by the complexity of the human brain. As a result, our ability to identify and catalogue vulnerability factors, diagnose mental illnesses, and treat them effectively has only modestly advanced in recent decades. The problem is compounded by dual disorders. Many achievements in medicine have come from applying linear theory to problems. Indeed, most current methods of data analysis use linear models, which are based on proportionality between two variables and/or relationships described by linear differential equations. However, nonlinear behavior commonly occurs within human systems due to their complex dynamic nature. This is particularly true for the brain, making it quite refractory to our attempts at describing or manipulating it via linear models. This presentation will discuss the possibility that some manifestations of nonlinear dynamics could significantly augment our understanding of the nature of complex dynamic systems in the human brain in normal and diseased states. Starting to think about complex psychiatric disorders from this perspective may be required not only to define a new framework to discuss and investigate dual disorders but also to make the next qualitative jump in our ability to alleviate their impact.

**NO. 4
SUICIDAL BEHAVIOR IN PATIENTS WITH DUAL DISORDERS**

Speaker: Leo Sher, M.D.

SUMMARY:

this presentation will discuss the frequent association between dual disorders and suicide. Dual disorders are associated with higher suicidality than non-substance use psychiatric disorders without comorbid substance use disorders or substance use disorders without comorbid non-substance use psychiatric disorders. For example, one study has shown that patients with comorbid major depressive and alcohol use disorders had higher lifetime aggression, impulsivity, and hostility scores; were younger at their first suicide attempt; and had a history of more previous suicide attempts compared to patients with major depressive disorder without comorbid alcohol use disorder. Insight into the psychological and neurobiological basis of the association between dual disorders and suicidal behavior will be provided during this presentation. The pathophysiology of suicide in military veterans with dual diagnosis will be discussed. Therapeutic interventions aimed at the prevention of suicide in individuals with dual disorders will be reviewed. In addition to obtaining a history of non-substance use psychiatric disorders and suicidal behavior, clinicians should carefully assess comorbidity with substance use disorders and personality traits such as aggression and impulsivity. This may help identify dual disorder patients at high risk for suicidal behavior.

**NO. 5
SCHIZOPHRENIA AND SUBSTANCE USE DISORDER:
IS IT ALL ABOUT REWARD?**

Speaker: Jibran Y. Khokhar, Ph.D.

SUMMARY:

Substance use disorders commonly occur in patients with schizophrenia and worsen the course of schizophrenia; the basis of this co-occurrence is not clear. Moreover, optimal treatments that improve the symptoms of schizophrenia while lessening the substance use have not been developed. We have proposed that substance use disorders that occur in patients with schizophrenia are based on a brain reward circuit deficit in such patients and, moreover, that substances themselves have the ability to lessen this deficit while they also have the potential of worsening the course of schizophrenia. We will present data from a neuroimaging study of patients with schizophrenia and co-occurring cannabis use disorder that support this notion. In this study, a measure of resting state connectivity in the brain reward circuit decreased in patients as compared to

normal control subjects, but the deficit in resting state connectivity lessened when the patients smoked a cannabis cigarette or took oral tetrahydrocannabinol (THC), the primary psychoactive ingredient in cannabis. These data will be reviewed and discussed to understand the optimal route for developing new therapeutic interventions for individuals with schizophrenia and co-occurring substance use disorder.

UNDERSTANDING BORDERLINE PERSONALITY DISORDER: 35 YEARS OF PROGRESS THROUGH EMPIRICAL RESEARCH: PART 2

Chairs: Mary C. Zanarini, Ed.D., Perry Hoffman, Ph.D.

Discussant: Mary C. Zanarini, Ed.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify what statements about BPD are rooted more in myth than in reality; 2) Discuss the advantages and disadvantages of both a dimensional approach as well as a categorical approach to the diagnosis of BPD; and 3) Appreciate the contradictions as well as the recommendations for the use of specific pharmacological classes in the treatment of BPD.

SUMMARY:

At the Annual Meeting in Toronto in 2015, we presented a symposium reviewing the progress made in understanding and treating borderline personality disorder (BPD) through 35 years of empirical research. The presentations were short, concise and tried to provide the general psychiatric clinician (distinct from the clinician who saw himself or herself as specializing in BPD) with facts and myth-busting information to assist him or her in understanding and treating BPD. In 2015, the topics covered were a general overview of BPD, a review of the different randomized controlled trial-supported effective psychosocial treatments, the identification and management of suicide risk, and a thorough discussion of the course of BPD. That symposium had over 300 attendees, and we hope to continue a review of important topics and empirically based findings with respect to BPD in Atlanta in 2016. The topics to be covered in 2016 include 1) Family-based interventions by Lois Choi-Kain, M.D.; 2) Psychopharmacology by Kenneth R. Silk, M.D., 3) Advances in understanding the neurobiology, including imaging, of BPD by Christian Schmahl, M.D.; 4) Categorical versus dimensional issues in diagnosis of BPD by John Oldham, M.D.; and 5) The

future of research and treatment in BPD as seen through the perspective of past and current research by Otto Kernberg, M.D.. The discussant will be Mary Zanarini, Ed.D. Each of these speakers, as well as the discussant, is considered among the leaders in the field of study of BPD. We hope to develop a video tape library based upon these presentations (including those presented in 2015) in conjunction with the National Education Alliance for Borderline Personality Disorder (NEABPD) that can serve as an important resource for all mental health professionals from many different disciplines. We hope that by continuing to increase the basic knowledge that clinicians have about BPD, as well as attempting to dispel the continuing myth of BPD as an untreatable disorder, we will be able to expand the pool of informed clinicians who can adequately and appropriately treat this important disorder.

NO. 1 FAMILY INTERVENTIONS FOR BORDERLINE PERSONALITY DISORDER (BPD) IN THE AGE OF EBTS

Speaker: Lois W. Choi-Kain, M.D., M.Ed.

SUMMARY:

Advances in understanding borderline personality disorder (BPD) in terms of its interpersonal disturbances and biological bases have paved the way for destigmatizing the diagnosis for patients and their families. Early research focused on family environments and failures as etiologic factors, leaving patients feeling severe mistrust and families feeling shame and guilt. More novel scientifically informed theories of BPD have reframed the interpersonal difficulties patients and families encounter in a more neutral framework, allowing both patients and family members to better understand the challenges involved on each side. This presentation will examine the evolution of our views of BPD and the role of family work in its treatment.

NO. 2 HOW NEUROBIOLOGY CAN HELP TO IMPROVE PSYCHOTHERAPY FOR BORDERLINE PERSONALITY DISORDER (BPD)

Speaker: Christian Schmahl, M.D.

SUMMARY:

Borderline personality disorder (BPD) is characterized by severe functional impairments, a high risk of suicide, extensive use of treatment, harm to others and high costs to society. Current theories

view dysfunctions in emotion processing and social interaction as core mechanisms of BPD. This often leads to prototypical behavioral patterns such as nonsuicidal self-injury, high-risk behavior and impulsive aggression. Research on psychological and neural mechanisms of BPD points toward an interplay between dysfunctional information processing, impairments of frontolimbic circuits and learned maladaptive behaviors. This presentation will provide an overview of the latest research on mechanisms of emotion dysregulation and disturbed social interaction in BPD. Further, it will delineate new avenues of treatment approaches for BPD that combine the understanding of neurobiological and psychotherapy mechanisms. Examples of this, which will be depicted in the presentation, are fMRI-based neurofeedback, effects of dialectical behavior therapy on neural mechanisms of emotion regulation and computer-based training of social interaction.

NO. 3
DIMENSIONAL VERSUS CATEGORICAL DIAGNOSIS OF BORDERLINE PERSONALITY DISORDER (BPD)

Speaker: John M. Oldham, M.D., M.S.

SUMMARY:

Since the inception of the planning process for *DSM-5*, it has been recognized that borderline personality disorder (BPD) is best characterized dimensionally as a set of pathological personality traits. Although *DSM-5* Section II sustained the categorical diagnostic criteria for BPD, unchanged, from *DSM-IV*, an alternative model for personality disorders is included in Section III, which is evidence-based and defines the essential features of any personality disorder (PD) as impairment in personality functioning and the presence of pathological personality traits. In this model, BPD is defined as the presence of moderate or greater impairment in personality functioning in two or more of four components: identity, self-direction (components of a sense of self), empathy and intimacy (components of interpersonal functioning), along with the presence of at least four pathological personality traits in the domains of negative affectivity, disinhibition and/or antagonism. This hybrid model has been shown to be more clinically useful than the traditional categorical model. The alternative model aligns well with the proposed PD system in the forthcoming ICD-11, and both the *DSM-5* and ICD-11 models will be described.

NO. 4

FUTURE DIRECTION OF RESEARCH AND CLINICAL APPROACHES TO BORDERLINE PERSONALITY DISORDER (BPD)

Speaker: Otto F. Kernberg, M.D.

SUMMARY:

This presentation will propose that the main focus of research regarding borderline personality disorder (BPD) should center on the mechanisms of change involved in each therapeutic approach. Research on specific mechanisms of change should replace global assessment of the comparative effectiveness of the various psychotherapies. Regarding theoretical approaches to the study of personality disorders, a general effort should be addressed to integrate the concepts of personality development, structure and pathology with the contribution of genetics, central nervous system structures and neurotransmitters, intrapsychic structural developments, mechanisms of psychosocial effects on personality structure, and the relations between all these determinants in the consolidation of behavior. At the clinical level, we should not try to practically integrate the different approaches, but deepen our understanding of the specific effects of each treatment in terms of bringing about therapeutic change and developing the effectiveness of these mechanisms by ongoing research on the respective psychotherapeutic techniques.

TEEN AND YOUNG ADULT MISUSE AND ABUSE OF PRESCRIPTION DRUGS: PATHWAYS TO DRUG ADDICTION?

Chairs: Cheryl A. Boyce, Ph.D., Timothy Wilens, M.D.

Discussant: Carol J. Boyd, Ph.D., R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn the trends and developmental course of nonmedical use of prescription drugs (NUPD) among U.S. adolescents; 2) Determine the clinical and neuropsychological characteristics of college students who engage in the nonmedical use of stimulants (misuse); 3) Understand factors of adolescent male and female athletes who may be at greater risk of nonmedical opioid use and misuse; and 4) Understand principles of a cost-effective, brief, universal preventive intervention conducted during middle school for long-term prescription drug misuse.

SUMMARY:

In this symposium, participants will learn about current trends in prescription drugs and their illicit use that warrant increasing attention. Prevention models beginning in middle school will be highlighted to address adolescent and young adult nonmedical use of prescription drugs. Abuse of prescription drugs is highest among young adults aged 18 to 25, with 5.9% reporting nonmedical use in the past month. Among youths ages 12 to 17, 3.0% reported past-month nonmedical use of prescription medications. Among adolescents, prescription and over-the-counter medications account for most of the illicit drugs high school seniors commonly abuse. Specifically, the abuse of opioids, sedatives, stimulants and tranquilizers is most prevalent among U.S. adolescents and young adults. While the developmental course of heavy drinking and marijuana use are well-documented, there is relatively little known about the trajectories of nonmedical use of prescription drugs (NUPD) among U.S. adolescents. Most adolescents do not continue NUPD, but there are gender and racial differences in developmental trends and course. Analyses suggest increased risk for substance abuse into adulthood for some adolescents engaging in NUPD. Among those who abuse prescription drugs, high rates of other risky behaviors, including abuse of other drugs and alcohol, have also been reported. Among young adult college populations, stimulant misuse has continued to be of great concern. While stimulants are widely used for treatment of ADHD, the misuse of stimulants among young adult populations on college campuses has been difficult to ascertain, prevent and treat. The biological and behavioral mechanisms of prescription drug use and misuse, particularly stimulants, are related to co-occurring ADHD, depression and other psychopathology. Opioid use among adolescent athletes has been another area warranting concern. Some contact sports, where injury and pain is more common, place male adolescents at higher risk for engaging in opioid abuse. There is hope with early preventive interventions for illicit use of prescription drugs, beginning in middle school. Randomized clinical trials of universal prevention strategies that involve families have demonstrated long-term effects on decreasing prescription drug misuse through young adulthood. Preventive interventions have also been shown to be cost-effective for public health. Understanding the mechanisms of illicit use of prescription drugs by youths and young adults can inform strategies to prevent future substance abuse and co-occurring psychopathology.

NO. 1

ADOLESCENT ATHLETES: EXERCISE, PERFORMANCE AND PRESCRIPTION DRUG ABUSE OF OPIOIDS

Speaker: Philip Velliz, Ph.D.

SUMMARY:

Background: Many adolescent athletes sustain sport injuries that require prescription opioid analgesics to manage pain; unfortunately, some of these youths misuse them. Indeed, these prescriptions put adolescent athletes at a greater risk of misusing opioid analgesics and other types of narcotics (e.g., heroin). **Objective:** We examined medical misuse, nonmedical opioid use and 30-day heroin use among adolescent athletes who participated in competitive sports. **Methods:** This secondary analysis uses nationally representative data from 8th, 10th and 12th grade students from the Monitoring the Future study (2006 – 2014). **Results:** Athletes had similar odds of engaging in both past-30-day heroin use and nonmedical opioid use when compared to their peers who did not participate in competitive sports. However, males who participated in high contact/high injury sports had the highest odds of engaging in past-30-day nonmedical opioid use when compared to their male peers who did not participate (AOR=1.40 95% CI=1.04, 1.84). No associations were found among female athletes competing in a variety of sports. **Conclusion:** While some adolescent athletes may be at greater risk of nonmedical opioid use, these associations were not found with other narcotics (e.g., heroin), which may signify a dependence on narcotics.

NO. 2

TRENDS AND TRAJECTORIES OF PRESCRIPTION DRUG MISUSE AMONG U.S. ADOLESCENTS

Speaker: Sean Esteban McCabe, Ph.D.

SUMMARY:

Objective: The nonmedical use of prescription opioids, sedatives, stimulants and tranquilizers is most prevalent among U.S. adolescents and young adults. While the developmental course of heavy drinking and marijuana use are well-documented, there is relatively little known about the trajectories of nonmedical use of prescription drugs (NUPD) among U.S. adolescents. **Methods:** A regional sample of middle school students was followed from early to late adolescence, and a national sample of high school seniors were followed from late adolescence to adulthood via self-administered

questionnaires. **Results:** NUPD peaked during late adolescence, and there were significant gender and racial differences in the trends and developmental course of NUPD. Among those who reported NUPD in at least one wave, the vast majority reported NUPD in one wave only. While the annual nonmedical use of stimulants declined over time following late adolescence, the same decrease was not observed for the annual nonmedical use of prescription opioids, sedatives or tranquilizers. **Conclusion:** Although most NUPD appears to be noncontinuing, a minority of adolescents report NUPD across multiple waves and have increased risk of substance abuse. There is heterogeneity in NUPD during adolescence, and the findings reinforce the importance of initiating preventive intervention efforts during early adolescence.

NO. 3 CHARACTERISTICS OF COLLEGE STUDENTS WHO MISUSE STIMULANT MEDICATIONS

Speaker: Timothy Wilens, M.D.

SUMMARY:

Objective: Stimulants are among treatments of choice for ADHD. We examined the clinical and neuropsychological characteristics of college students who engaged in the nonmedical use of stimulants (misuse). **Methods:** College students with (misusers) and without (controls) the misuse of stimulants were assessed blindly by structured psychiatric interviews (SCID), the Behavioral Inventory of Executive Functioning (BRIEF) and Substance Use Disorder Questionnaire (SUD). **Results:** One hundred stimulant misusers and 199 controls (mean age 20.6 years) were enrolled. Misusers were more likely than controls to endorse an alcohol, drug or overall substance use disorder, with 39% of misusers endorsing a (sub)threshold stimulant use disorder. Immediate-release stimulants were preferentially misused. Compared to controls, misusers had higher rates or trends of ADHD and conduct and panic disorders, as well as more clinical evidence of executive dysfunction on the BRIEF and lower global assessment of functioning. **Conclusion:** College students who misuse stimulant medications are more likely to have more SUD, ADHD, psychopathology and executive function impairment than controls. The clinical implications of these data and the literature will be discussed.

NO. 4

THREE RCTS EVALUATING UNIVERSAL PREVENTIVE INTERVENTIONS: LONGITUDINAL EFFECTS ON PRESCRIPTION DRUG MISUSE AND COST-EFFECTIVENESS

Speaker: Richard Spoth, Ph.D.

SUMMARY:

This presentation examines long-term prescription drug misuse outcomes from three RCT evaluations of brief universal preventive interventions conducted during middle school, including cost effectiveness analyses. **Objective:** Across RCTs, outcomes were measured at ages 18 – 25. Self-reported outcomes were prescription opioid misuse (POM) and lifetime prescription drug misuse overall (PDMO). The three universal interventions were 1) The Iowa Strengthening Families Program alone (ISFP); 2) A revised ISFP, renamed Strengthening Families Program: For Parents and Youth 10 – 14, or SFP 10-14, plus the school-based life skills training program (SFP 10-14 + LST); and 3) SFP 10-14 plus one of three school-based interventions selected from a menu (SFP 10-14 + SP). **Results:** ISFP showed significant effects on POM and PDMO, with relative reduction rates (RRRs) of 65% and comparable benefits for higher- and lower-risk subgroups. SFP 10-14 + LST showed significant or marginally significant effects on POM/PDMO across all ages; higher-risk participants showed stronger effects (RRRs 43 – 79%). SFP 10-14 + SP showed significant results for POM/PDMO (RRRs 20 – 21%); higher- and lower-risk participants showed comparable outcomes. **Conclusion:** Cost effectiveness was demonstrated; LST combined with SFP 10-14 was the most cost efficient. Results suggest brief universal interventions have potential for public health impact and that the delivery of SFP 10-14 + LST could be the most cost-efficient method.

PSYCHIATRISTS AS LEADERS: THE IMPORTANCE OF LEADERSHIP DEVELOPMENT IN A NEW ERA OF HEALTH CARE

Chair: William D. Rumbaugh Jr., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Provide education to civilian psychiatrists about military psychiatric training, with specific emphasis on leadership development; 2) Provide a framework for educating psychiatrists on how to motivate their colleagues, ancillary staff and employees to produce better results in their clinical work; and 3) Understand the applicability of

leadership in a broader clinical context, including quality improvement and continuing education.

SUMMARY:

Psychiatrists are often medical leaders in multiple environments and clinical contexts. However, few training programs provide any formalized education in leadership development. The past several decades of military psychiatry have provided important leadership lessons that are applicable in both uniformed and civilian clinical settings. This symposium will provide an academic discussion of leadership beginning with a summary of the history of leadership research and development, with particular emphasis on interpersonal leadership theories. Additionally, this symposium will discuss medical leadership development, drawing on experiences from the United States Military Academy, the Uniformed Services University of the Health Sciences, the Army Medical Department Center and Schools, and U.S. Army psychiatric residency programs. The audience will learn tangible lessons to consider when faced with leadership challenges and opportunities in clinical and administrative contexts. In an age of increasing financial and time constraints, psychiatrists are often faced with the challenge of motivating their subordinates to provide quality psychiatric care. The experiences of the panel, coupled with lessons learned from uniformed leadership research and theory, may help provide the audience with useful ideas and solutions when faced with leadership challenges in providing high-quality psychiatric care.

NO. 1

LEADERSHIP AS A BEHAVIORAL SCIENCE AND CLINICAL COMPETENCY: FROM ODYSSEUS TO THE PRESENT

Speaker: Matthew Moosey, M.S.

SUMMARY:

Although leadership has been the subject of much discussion and commentary for millennia, the formal study of leadership in behavioral science has been limited to the past several decades. Matt Moosey, a doctoral candidate in clinical psychology, will present a brief history of leadership theory and research, as well as more modern leadership science. He will also discuss contemporary leadership models that are especially useful to psychiatry, including relational theories, transformational leadership theory (TLT) and the FourCe model of uniformed medical leadership. The presentation will also discuss the

physician leadership development program at the Uniformed Services University of the Health Sciences School of Medicine (USUHS SOM) and suggest elements of this program that audience members may integrate into their clinical practice. Mr. Moosey will also address how the multiple psychological, social and physical environments surrounding psychiatric practice present unique challenges and opportunities for health care leaders. The discussion will conclude with a presentation of future challenges for psychiatric leaders in a world increasingly dominated by social media and other digital forms of communication.

NO. 2

MANAGING BEHAVIORAL HEALTH PROVIDERS: THE NUANCES OF LEADING THIS UNIQUE POPULATION

Speaker: Wendi Waits, M.D.

SUMMARY:

Behavioral health providers have unique traits that set them apart from most medical professionals. They tend to be highly empathic, exceptionally sensitive and impressively altruistic. They are outstanding listeners and even better observers. They prefer prose to shorthand and can provide an amazing amount of detail in their oral and written communications. They expect their managers to be fair, supportive and encouraging at all times. Business decisions that decrement certain services or resources can be perceived as personal affronts. Staff meetings can feel a bit like group therapy sessions. Often, there is a subtle expectation that leaders will always allow staff time to process strong feelings, even about issues as mundane as the cafeteria hours, a new electronic health record or ICD-10. Dr. Waits will discuss some common cultural characteristics of behavioral health organizations, the reasons she has enjoyed leading them and the adaptations she has had to make in her management style to gain providers' buy-in and achieve organizational success. She will reference population statistics and share several vignettes from her own personal experience, providing a few pearls of wisdom for the new or struggling behavioral health leader.

NO. 3

BUILDING TEAMS AND MORALE BY BRINGING FUN INTO THE WORKPLACE

Speaker: Josephine P. Horita, D.O.

SUMMARY:

In this era of fiscal austerity, leaders can often face difficulties with staff retention, compensation (vacation time, overtime, bonuses) and morale within their organization. However, there are ways in which one can successfully create staff incentives, esprit de corps and a “pride of ownership” in order to decrease staff turnover. Dr. Chatigny will review techniques to build teams and improve group cohesion in the workplace, incorporating fun activities and incentives to improve staff morale and retention. Examples include fund raising efforts, events within the clinic, yearly parties, awards, parking spot competitions, personalized business cards and annual interdepartmental competitions such as a chili cook-off. Leaders will learn how to use creative thinking, cooperation from senior management and networking to enhance their workplace.

PHYSICIAN SUICIDE: TOWARD PREVENTION

Chair: Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List the biopsychosocial determinants of medical student and physician suicide; 2) Implement a comprehensive psychopharmacological and psychotherapy treatment plan for symptomatic physicians; 3) Delineate institutional and organizational mandates to lower the risk of suicide in today’s trainees and practicing physicians; and 4) Be comfortable reaching out to grieving medical communities that are seeking psychiatric consultation after one of their own has died by suicide.

SUMMARY:

According to the American Foundation for Suicide Prevention, 300 – 400 physicians die by suicide in the United States each year. The vast majority have an underlying psychiatric illness that drives this fatal and tragic act. Sadly, many physicians who kill themselves are underdiagnosed and undertreated. Some have received no treatment at all. In this symposium, we will review the most current research available on the matter, including lifesaving intervention and prevention strategies. Dr. Myers will answer the question “Why do physicians kill themselves?” He will discuss the many biopsychosocial determinants that coalesce in a “perfect storm” that envelopes and overwhelms the suffering physician, thereby precipitating suicidal behavior. Dr. Moutier will summarize unique traits in

medical students and medical education that put them at risk. Her presentation includes both case examples of students who have taken their lives and her recommendations for institutional change. Drs. Goldman, Shah and Bernstein will describe common stressors and challenges in residents and fellows that may put this cohort at risk for suicide. They will include suggestions for change at programmatic, state and national levels that include early case finding, treatment and prevention. Dr. Gabbard will review 10 key issues when treating suicidal physicians. These range from paying close attention to blind spots when one physician treats another to aggressive treatment of sleep disturbances to vigilant monitoring for suicidal ideation and behavior. Dr. Zisook will describe a very successful suicide prevention program established in one academic medical center after the suicide death of a faculty member there. This has become a model that can be adapted nationwide. There will be more than one hour of protected time for active discussion with the audience and presenters.

NO. 1

WHY DO PHYSICIANS KILL THEMSELVES?

Speaker: Michael F. Myers, M.D.

SUMMARY:

The most common psychiatric illnesses that can lead to suicide in physicians are mood and anxiety disorders and substance-related and addictive disorders. These are largely treatable disorders with a good prognosis, but many physicians are never accurately diagnosed and given the comprehensive treatment that they need and deserve. Data from family members of physicians who have died by suicide reveal two startling phenomena: 1) Their loved one was often poorly compliant with treatment and 2) The treating psychiatrist and/or psychologist did not appreciate how dangerously ill their physician patient was. Stigma is a major culprit, as are transference and countertransference (to be discussed by Dr Gabbard). Perfectionism contributes to both depression and suicide and is common in physicians and exists on a continuum. Those at the higher end of the spectrum and physicians with narcissistic, antisocial and introversion traits are also at risk of self-harm. Joiner’s interpersonal model of suicidal behavior (thwarted belongingness, perceived burdensomeness and acquired ability to kill oneself) helps to explain why physicians kill themselves. Some physicians who kill themselves are in the 10 – 15% of decedents with no diagnosable

psychiatric illness. This cohort includes physicians with debilitating medical illnesses, physicians acutely flooded with shame and guilt after public exposure, and an unknown group who have taken the answers with them.

NO. 2

SUICIDE IN MEDICAL STUDENTS: INTERVENTIONS AND CULTURE CHANGE

Speaker: Christine Moutier, M.D.

SUMMARY:

Much is known about the prevalence rates and associated factors for medical student burnout, depressive symptoms and other mental health-related distress. While medical student suicide remains less well-studied than these upstream experiences, we can use a conceptual model, examples of programs and experience to guide next steps for medical educators, medical schools and students. Suicide risk and protective factors in three major categories, drawn from the evidence from the field of suicide research and suicide prevention, will be presented: biological, psychological and social/historical. By combining these risk and protective factors in a dynamic model with everyday life stressors and events, a conceptual model for understanding suicide risk will be elucidated. As this model is applied to medical student suicide risk, we will examine the points for greatest potential impact for prevention. Many medical school programs aim to increase student well-being through curricular changes, mental health education, mentorship, community-building, and arts and humanities, but few have been studied in terms of suicide-related outcomes. Examples of programs that have shown promising results will be reviewed.

NO. 3

SUICIDE IN RESIDENTS AND FELLOWS: ACGME INITIATIVES AND RECOMMENDATIONS

Speaker: Matthew L Goldman, M.D., M.S., Ravi N. Shah, M.D., M.B.A., Carol A. Bernstein, M.D.

SUMMARY:

Following the suicides of two medical interns in 2014, the graduate medical education community has embarked on a process to determine how best to address these issues, especially early in training. We will present the results of a national consensus conference developed by the ACGME involving stakeholders in GME, including residents and program directors. We will discuss the specific steps

that the ACGME will be taking to begin the process of changing the culture of medicine to foster resilience and well-being, to identify trainees at risk, to provide adequate access to appropriate mental health services, and to assist training programs and institutions when untoward events occur.

NO. 4

CRITICAL ISSUES IN THE TREATMENT OF SUICIDAL PHYSICIANS

Speaker: Glen O. Gabbard, M.D.

SUMMARY:

The challenges in treating suicidal physicians are formidable. Treating psychiatrists are prone to treat physicians in a way that departs from what they usually do with suicidal patients. Countertransference blind spots are common. Certain principles of good care are essential: 1) Do not readily accept denial of suicidality in the context of depression or narcissistic injury; 2) Address concerns about the impact of treatment on licensure; 3) Treat sleep problems aggressively; 4) Establish a strong therapeutic alliance that emphasizes the real relationship more than transference; 5) Differentiate between the fantasy and the act of suicide; 6) Discuss the limits of treatment; 7) Investigate precipitating events; 8) Explore fantasies of the interpersonal impact of suicide; 9) Establish level of suicide at baseline and monitor changes; and 10) Use consultation to help with blind spots.

NO. 5

SAVING LIVES: ONE MEDICAL CENTER'S RESPONSE TO A FACULTY MEMBER'S SUICIDE

Speaker: Sidney Zisook, M.D.

SUMMARY:

After a series of annual medical student, resident, fellow or faculty suicides, about one per year, the UCSD Dean's office and health science center commissioned and supported a new, multidisciplinary committee, the Healers Education, Assessment and Referral (HEAR) Committee, to alter this tragic pattern. To achieve its overriding goal of reducing medical student and physician suicide, HEAR developed a two-pronged approach: 1) Utilize an anonymous, web-based interactive screening and referral program developed by AFSP and now used at many colleges, medical centers and other institutions and 2) Provide educational outreach to all facets of the medical school and health care

community to help destigmatize mental health treatment and inform constituencies of available resources. Over a six-year period (May 2009 – August 2015), 1,134 medical and pharmacy students, 1,380 house staff (residents and fellows), and 1,922 faculty members have been invited to complete the anonymous questionnaire, and every department in the medical school, all chief residents and residency training directors, the graduate medical education leadership, and all medical students have attended at least one formal HEAR presentation. A total of 160 mental health referrals to psychiatrists or psychologists have been made, most of whom report that they would not have sought treatment at this time without this program. In five of the six years, there were no known suicides among the target populations.

INNOVATIVE PRACTICES IN COLLEGE MENTAL HEALTH

Chairs: Michelle B. Riba, M.D., Daniel Kirsch, M.D.

Discussant: Victor Schwartz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review some of the best practices for psychiatrists who are working in the field of college mental health; 2) Understand the issues of integration and collaboration, including obstacles and challenges, in providing quality mental health care to college students; 3) Determine what the ideal college mental health program might include; 4) Discuss ways that we need to improve training programs and opportunities so that we can encourage careers in college mental health; and 5) Have an opportunity to discuss case examples of issues in the delivery of services in college mental health.

SUMMARY:

A growing and critically important public health concern surrounds the rise in college students' stress levels with increased rates of anxiety, depression, alcohol and substance abuse, eating disorders, suicide, and violence on campus. Campus mental health programs are struggling to keep up with the demand. Families are asking for guidance and assistance in helping to transition their adolescents, who may be at risk, into situations where families may not be able or ready to support students with moderate to severe mental health problems. Individuals struggling with these problems run the gamut from students in small community colleges,

where access and resources may be scarce, to four-year liberal arts, high-powered universities, where the stress in various engineering and math programs may be particularly difficult, to graduate programs, where small numbers of students in each program make it difficult to help support those who might need extra assistance. Students may be from countries and families at a great distance who cannot easily provide the support the student needs, and if the student is failing, pressures mount related to mental health and other problems. Understanding how to best help students, families, faculty and staff with these problems will require innovative solutions approaching this issue from a number of perspectives. This symposium will provide some clinical examples and context for these problems, and each presenter will use their considerable experience to review the evidence-based literature. Questions and answers will stimulate audience participation.

NO. 1

CLINICAL ILLUSTRATIONS OF MANAGEMENT ISSUES IN COLLEGE MENTAL HEALTH

Speaker: Richard Balon, M.D.

SUMMARY:

This presentation will focus on major clinical issues in the college student population. Several clinical cases illustrating dilemmas in the management of depressed students, suicidal students, students using substances of abuse, students demanding performance-enhancement medications and students with comorbid personality disorder will be presented and discussed with other presenters and/or the audience. The cases will explore different student levels (college, medical students, graduate students) and their specific needs during treatment. Discussion of various levels of service and various levels of complexity (e.g., involvement of family in treatment, psychiatrist involvement in the promotion committee, and psychiatrists responding to the requests of the promotion committee) will also be included.

NO. 2

DEVELOPING AND IMPLEMENTING WELLNESS PROGRAMS FOR MEDICAL STUDENTS

Speaker: Preston Wiles, M.D.

SUMMARY:

A growing literature describes the high level of stress, burnout, depression and suicidal ideation in

undergraduate medical students. We will describe the process of developing a program of screening and assessment of both wellness and distress at various critical points throughout the medical school curriculum. This wellness program increases awareness of stress and burnout and highlight the availability of treatment, reduces stigma through openly addressing issues medical students frequently face, and allows for self-identification of at-risk students to increase access to care. Using evidence-based gatekeeper training for peer-to-peer identification of at-risk students augments these efforts. Creating programs that can be offered at scale to enhance resilience and prevent burnout—mindfulness meditation and self-compassion—has been an important complement to efforts to increase access to care.

NO. 3

IMPROVING COLLABORATIVE DEPRESSION CARE IN COLLEGE HEALTH: THE NATIONAL COLLEGE DEPRESSION PARTNERSHIP

Speaker: Carlo Ciotoli, M.D.

SUMMARY:

Numerous studies suggest suboptimal case identification and treatment engagement among college students with depression. In response, the National College Depression Partnership (NCDP) has supported college health systems and clinicians in delivering improved depression care through the use of outcomes measurement, quality improvement methodology and collaborative learning. NCDP collaboratives organized system-level changes around Ed Wagner's care model to address the factors associated with optimal depression care, including self-management support, delivery system design, decision support, clinical information systems, and community resources and policies. Forty-two diverse institutions of higher education—including two- and four-year institutions, private, public, large, and small—have participated in an NCDP collaborative.

NO. 4

INNOVATIONS IN SERVICE PROVISION FOR INTERNATIONAL STUDENTS

Speaker: Leigh White, M.D.

SUMMARY:

International students, predominately from Asian countries, are a growing demographic at U.S. institutions of higher learning. These students face

the usual college stresses as well as additional pressures that may contribute to depression, anxiety and other mental health concerns. International students tend to present at much lower rates for counseling than their American peers, present with more severe symptoms and are more likely to not return after intake. University health and counseling services are using many innovative practices to encourage earlier access to care and to provide culturally competent services that students will be more likely to return to. These practices include campus outreach, providing depression screening and behavioral health care in the primary care setting, increasing the cultural competence of all staff, actively hiring for a diverse staff with competence and interest in treating international students, increasing alternative treatment options, integrating psychiatric care into a larger treatment team, and providing support groups to spouses and families.

NO. 5

A CURRICULUM FOR COLLEGE MENTAL HEALTH AND YOUNG ADULT PSYCHIATRY

Speaker: Daniel Kirsch, M.D.

SUMMARY:

Youth between the ages of 18 and the mid-20s—youth adults (YA)—differ significantly from younger adolescents and older adults. Seventy-five percent of mental disorders appear before age 24. Mental disorders, including substance use, account for the largest portion of the medical burden in this group. Their top three causes of mortality—homicide, suicide and accidents—are linked to incomplete development and problems with impulsivity, affect regulation and cognition. Adult psychiatrists are charged with treating young adults, yet curricula, expert faculty and training opportunities are limited. Training experiences in college mental health provide all the above. A sample curriculum will be presented that underscores the developmental perspective necessary for adult psychiatrists to be prepared to treat young adults effectively.

QUEERLY INVISIBLE: LGBTQ PEOPLE OF COLOR AS PSYCHIATRISTS AND PATIENTS

Chairs: Vivek Datta, M.D., M.P.H., Dinesh Bhugra

Discussants: Debbie R. Carter, M.D., Dinesh Bhugra

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe minority stress theory,

especially in relation to the mental health of LGBTQ people of color; 2) Apply the principles of cultural formulation to problems faced by LGBTQ people of color; 3) Understand the challenges faced by LGBTQ people of color in adolescence and later life; 4) Apply the principles of trauma-informed care to the treatment of LGBTQ people of color; and 5) Understand the challenges faced by LGBTQ psychiatrists of color.

SUMMARY:

Despite increasing awareness of the importance of cultural competence as a core skill for psychiatrists, understanding how multiple minority status in general, and the intersection between racial and sexual identity in particular, affects mental health has received scant attention. LGBTQ people of color (LGBTQ-POC) are at increased risk of mental disorders, substance use disorders and suicidal behaviors that cannot be explained by considering sexual orientation and race/ethnicity in isolation. In addition to experiencing homophobia like their White counterparts and the racism experienced by ethnic minorities in general, LGBTQ-POC experience racism within LGBTQ communities and homophobia in racial/ethnic communities. The emergence of the study of microaggressions has provided us with a new discourse to understand the daily trauma that minority groups face. These traumas may be re-enacted and played out in the very systems where LGBTQ-POC turn for help. We review the contributions of minority stress theory to our understanding of the development of mental illness, health risk behaviors and health care utilization, with a focus on LGBTQ-POC as a multiply marginalized group. We then consider the challenges that LGBTQ-POC face in navigating the mental health system, including the challenges that LGBTQ psychiatrists of color encounter from the personal perspectives of the presenters, who are all LGBTQ psychiatrists of color from different ethnic minority backgrounds. Finally, we consider, through case discussion, the developmental challenges faced by LGBTQ-POC across the lifespan from adolescence to old age. Throughout, we place an emphasis on the cultural formulation of problems in LGBTQ-POC and discuss how the principles of trauma-informed care apply.

NO. 1

MULTIPLE MINORITIES AS MULTIPLY MARGINALIZED: APPLYING THE MINORITY STRESS THEORY TO LGBTQ PEOPLE OF COLOR

Speaker: Kali Cyrus, M.D., M.P.H.

SUMMARY:

The evidence is now overwhelming that discrimination negatively impacts both the physical and mental health of minority groups. Members of multiple-minority groups, such as LGBTQ people of color (LGBTQ-POC), are disproportionately at risk for negative health outcomes due to chronic stress from stigmatization, discrimination and fear of rejection. The minority stress model, which analyzes the complex relationship between external (discrimination/prejudice) and internal (self-doubt/rumination) stressors that shape the experience of multiple-minority groups, helps us understand the lived experiences of LGBTQ-POC. LGBTQ-POC are adversely affected by cumulative discrimination and social exclusion, including racism from the LGBTQ community and homophobia and heterosexism within their racial/ethnic community. In this way, they are a multiply marginalized group, which has implications not only for their risk of mental illness, but also to their access to mental health care and the quality of care they receive. Through the application of the minority stress model, we will examine how both explicit and disguised slights (microaggressions) take their toll on the mental health of LGBTQ people of color.

NO. 2

TRAUMATIC IDENTITIES: A TRAUMA-BASED APPROACH TO THE MENTAL HEALTH TREATMENT OF LGBTQ PEOPLE OF COLOR

Speaker: Matthew L. Dominguez, M.D., M.P.H.

SUMMARY:

The social isolation experienced by LGBTQ people of color (LGBTQ-POC) can be reframed as an example of complex trauma. Using a model loosely based on the self-trauma theory proposed by John Briere, the lifelong social dissonance of LGBTQ-POC can be likened to other forms of childhood abuse and neglect. Case examples will be used to discuss how repeated and prolonged negative interactions within the LGBTQ population, racial/ethnic communities and immediate/extended family unit act to alter attachment dynamics; encourage the development of maladaptive coping mechanisms; and distort cognitions of self, other and future. Unfortunately, the systems of care that LGBTQ-POC turn to for help with their mental health problems may expose them to further trauma. A treatment approach combining psychodynamic and cognitive behavioral approaches will be proposed, with the goal of guiding patients

toward an integrated sense of self and improving the capacity for the formation of secure attachments. Finally, the application of the principles of trauma-informed care to working with LGBTQ-POC will be considered.

**NO. 3
UNDERSTAND THE CHALLENGE OF LGBTQ
ADOLESCENTS OF COLOR**

Speaker: Rashad Hardaway, M.D., James Murphy, M.D.

SUMMARY:

Adolescence challenges youth with the task of forming self-identity and navigating their role among family, peers and society. Development of sexual orientation and gender identity, particularly among LGBTQ racial/ethnic minorities, often creates conflict within the individual and leads to traumatic experiences for young people both with their families and their peers. They are at high risk of experiencing bullying, homelessness and social exclusion. In turn, psychiatric illness, high-risk behaviors and suicidality may result. The lack of protective supports in their communities, as well as health care providers who lack the cultural competence to deal with this population, may further compound their isolation and aloneness. This presentation will review the developmental challenges faced by LGBTQ adolescents of color, supplemented by a case vignette highlighting the importance of provider education on LGBTQ minority health to provide key interventions for treatment. Further, we will highlight the challenges of working with families from racial/ethnic minority backgrounds with a teen identifying as LGBTQ.

**NO. 4
GRAY, GAY, BLACK AND BLUE: DEPRESSION IN
OLDER LGBTQ PEOPLE OF COLOR**

Speaker: Seon Kum, M.D.

SUMMARY:

Perceived ageism, heterosexism, homophobia and racism all adversely affect mental health. Older LGBTQ people of color (LGBTQ-POC) may not only contend with these forms of discrimination but also find themselves rootless and experience discrimination within these various communities. We explore the intersection of these factors and compare the differences in experiences of LGBTQ-POC compared to their White counterparts. We also attempt to tease out the causes of the

forementioned trials that LGBTQ-POC face in the later stages of life, ranging from the phenomenon of “going back in the closet” to coming out for the first time in old age. Finally, we will present a case of an older gay African-American patient, whom the presenter has been seeing for psychotherapy for two years, in order to examine how older LGBTQ-POC navigate life in relation to their experiences with isolation, loneliness and end-of-life issues.

**UNDOCUMENTED AND REFUGEE CHILDREN
ARRIVING AT U.S. BORDERS: MENTAL HEALTH
ISSUES AND TREATMENT INTERVENTIONS**

Chair: Eugenio M. Rothe, M.D.

Discussant: Pedro Ruiz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about the scope, demographics, and historical and sociopolitical determinants of the refugee crisis across the U.S.-Mexico border; 2) Learn about the mental health consequences of the migration process on children and families; 3) Learn about the existing and emerging legal perspectives that regulate the refugee flow and determine the legal rights and the fate of the undocumented children; 4) Learn from the response to previous U.S. child refugee crises especially what psychiatrists and U.S. psychiatry in general can do to assist in facing this crisis; and 5) Understand the negative responses by the host culture to these child refugees in the current sociocultural context and how psychiatrists and U.S. psychiatry can address them.

SUMMARY:

The surge of unaccompanied minors entering the U.S. through the U.S.-Mexico border increased dramatically from 39,000 in 2013 to 57,000 in 2014. In the past, most of the children crossing the U.S. border were teenagers, but in the last year, the percentage of children under 12 years old has increased by 117%, compared to a 12% increase for those 13 – 17 years old. On June second of 2014, President Obama declared this situation an “urgent humanitarian issue” and entrusted the Federal Emergency Management Agency (FEMA) with managing more than 60,000 detained undocumented children, mostly from Central America, in order to provide humanitarian aid, social and legal services and to determine whether they will be repatriated or if they will stay in the U.S. Also, in the first five months of 2015, the Mexican

government deported a record number of children travelling without a guardian across that country back to their Central American countries of origin. In addition, the U.S. border patrol has apprehended 12,509 unaccompanied children who were trying to cross the U.S.-Mexico border, which has dramatically reduced the flow of these children into the U.S. in the last half year. Elevated rates of PTSD, anxiety disorders and depression have been documented in all of these populations. If children who are already residing in the U.S. are taken into account, seven percent of all K-12 children in American schools have at least one undocumented parent, and 79% of these children were born in the U.S. Due to the undocumented status of their parents, many of these children have difficulties accessing medical and psychiatric care and suffer psychological trauma when their parents are deported. This symposium will outline the various aspects of the refugee crisis along our borders, examining various perspectives: the mental health and social services implications, the legal and political perspectives, the historical and generational roots of this crisis in the Central American child refugees crisis of the 1980s, the lessons learned from prior Caribbean child refugee crises into South Florida, the psychological roots of the negative response by the host culture in the U.S., and the role of psychiatrists and of U.S. psychiatry in the treatment of these populations.

**NO. 1
YOUNG NEWCOMERS' GRITTY STRUGGLE TO SAFETY**

Speaker: William Arroyo, M.D.

SUMMARY:

During the 1980s, the U.S. experienced an ongoing migration of tens of thousands of Central Americans. These families escaped rampant poverty, major civil strife in their countries, repeated violent assaults, disappearance of family members and blatant government corruption. The more recent surge of tens of thousands of new Central American emigrants comes from the countries of El Salvador, Guatemala and Honduras. This surge includes more than 62,000 unaccompanied youth who traveled to the U.S. in FY14 – 15, plus a similar number of families. Many report leaving behind violent neighborhoods that are riddled with gang violence, violent encounters between locals and local and federal law enforcement agencies, government corruption, severe poverty, and limited employment opportunities, among others. Their emigration

through Mexico had been very arduous and full of many risks. The lack of immigration reform, which Congress has recently debated without developing a solution, poses additional challenges for these young people. There is an emerging network of communities throughout the country that are beginning to offer support for these new arrivals. Clinical concerns include PTSD, adjustment to new communities and adjustment to new families.

**NO. 2
BRIEFING ON BACKGROUND AND CHALLENGES PRESENTED TO THE U.S. LEGAL SYSTEM RELATED TO THE RECENT MIGRATION OF YOUTH AND CHILDREN FROM CENTRAL AMERICA**

Speaker: Juan Carlos Gomez, Esq.

SUMMARY:

The recent waves of children and young persons from Central America present challenges to the legal, educational and social welfare systems in the United States. There are factors that have pushed these children out of their countries and pull factors that have attracted them to the United States. In many instances, parents sent or sent for these children. Many of the children are fleeing violence related to gangs and narcotics in their three main countries of origin—El Salvador, Guatemala and Honduras. Historical causes include civil wars, the transfer of the narcotics industries from other countries, and the failure of states to protect their own citizens or to provide them with any real hope out of extreme poverty. This presentation will address the limited immigration solutions available to these children and young persons and the problems that will result for most of this population. The presentation will also address the issues presented to the legal system related to education and social welfare systems.

**NO. 3
UNDOCUMENTED AND REFUGEE CHILDREN IN SOUTH FLORIDA: PAST AND PRESENT AND LESSONS LEARNED**

Speaker: Eugenio M. Rothe, M.D.

SUMMARY:

South Florida has received multiple waves of migration since the mid-20th Century, and many of these immigrants have been children. In 1960, an exodus of over 20,000 unaccompanied child refugees entered the U.S. from Cuba as a result of the communist revolution in Cuba. Even though no

statistical studies exist about the fate of these children, anecdotal accounts and participant autobiographies point to varying degrees of psychological traumatization. Due to the ongoing chaotic state of the country of Haiti, many boat people have landed in South Florida since the 1970s, and many have been children. In addition, on January 12, 2010, parts of Haiti were devastated by a massive earthquake, and many of its victims arrived in South Florida. In the summer of 1994, the economy of the island of Cuba plunged into the deepest financial crisis since the onset of the 1959 communist takeover. The Cuban government invited all of those who were discontent to leave, which culminated in a massive exodus by sea to the U.S. Many died at sea, and others were intercepted by the U.S. Coast Guard and placed in refugee camps at the U.S. Naval Base at Guantanamo Bay. Of the refugees, 2,500 were children and adolescents who remained in the camps for up to a year prior to being admitted to the U.S. The author of this presentation worked directly with this population in the camps and will discuss the lessons learned from two and a half decades of working with child refugee populations in South Florida.

**NO. 4
TREATMENT FOR UNDOCUMENTED REFUGEE AND
IMMIGRANT YOUTH: PRACTICE PARAMETER AND
EVIDENCE-BASED APPROACHES**

Speaker: Andres J. Pumariega, M.D.

SUMMARY:

The U.S. faces the task of serving increasing numbers of non-European immigrant youth, including refugee populations accepted by the U.S. government and the large exodus of unaccompanied youth from Central America. Immigrant children and their families are dealing with cultural transition and its associated significant stresses, as well as significant histories of psychological trauma with additional mental health consequences. This presentation first focuses on principles of treatment for these vulnerable populations based on the recommendations of the AACAP Practice Parameter for Culturally Competent Child Psychiatric Care, which helps to identify and address clinical and cultural needs of immigrant and refugee patients. The model proposed for mental health care for immigrant children integrates both cultural competence principles and the community-based systems of care model of child and family mental health services. The application the practice

parameter will be illustrated using brief clinical vignettes of work with immigrant and refugee children and their families. The presentation also reviews the considerable literature on evidence-based models of culturally informed treatment for refugee and immigrant populations, which serve as models for effective treatment modalities and services. Child and adolescent and general psychiatrists can be far more effective integrating cultural approaches in their interventions with immigrant and refugee youth.

UPDATES IN HIV PSYCHIATRY 2016

Chair: Lawrence McGlynn, M.D., M.S.

Discussant: Marshall Forstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Construct a biopsychosocial differential diagnosis and formulate a comprehensive treatment plan for patients with HIV and depression; 2) Determine the risks and benefits of stimulants in a patient with HIV who is experiencing fatigue, depression or cognitive dysfunction; 3) Develop a compassionate psychiatric treatment plan for transgender patients living with HIV and comorbid mental illness; and 4) Appreciate the urgency of treating tobacco use in HIV and construct an effective treatment plan.

SUMMARY:

Presenters participating in "Updates in HIV Psychiatry 2016" are active members of the APA HIV Steering Committee and have identified four areas that may challenge psychiatrists seeing patients with HIV/AIDS. These conditions are also more likely to cause infectious disease and primary care providers to make referrals to psychiatry for consultation and ongoing treatment management. Topics this year include the assessment and treatment of depression, the use of prescribed stimulants in HIV, psychiatric considerations for HIV-positive transgender patients, and the treatment options for tobacco use disorders in HIV. Presenters will also incorporate updated medical information on HIV relevant to each presentation. Cases will be used to illustrate each topic. Dr. Blanch will review the most recent evidence of the prevalence and characteristics, as well as treatment, of depression in people living with HIV/AIDS. Despite the importance of detecting and treating depression in HIV-infected patients, this syndrome frequently goes unrecognized. The ascertainment of depression in HIV-infected patients

may be expected to be difficult or biased due to the possible confounding effect of the physical symptoms of the infection. Fatigue, diminished appetite and sleep, and loss of weight may be physical symptoms of HIV infection as well as depressive symptoms. On the other hand, HIV induces activation of inflammatory mediators, mainly cytokines. These inflammatory mediators may also play a causative role for the presence of depressive symptoms. Dr. Blanch will use a case-based approach to his presentation. Dr. McGlynn will discuss the role of stimulants in patients living with HIV. Fatigue, debilitating depression and cognitive impairment may lead providers to consider the use of stimulants in patients living with HIV. Some prescribers may hesitate to consider their use for a number of reasons, including comorbid cardiovascular disease, polypharmacy, history of substance use, lack of insurance coverage and lack of familiarity with this class of medications. Dr. McGlynn will discuss the research, indications, risks and benefits of stimulants in patients living with HIV. Transgender people continue to be one of the highest risk groups for contracting HIV and ultimately becoming disengaged from HIV care. Dr. Moghimi will discuss the HIV risk factors that transgender people face and unique aspects of their psychiatric care from his experience with the largest provider of LGBT/HIV services in Washington D.C. Dr. Douaihy will discuss the devastating impact of tobacco use in HIV-positive individuals. He will examine the unique issues related to HIV-positive smokers, identify the importance of addressing co-occurring psychiatric and substance use disorders with tobacco use disorders, and review the research data on smoking cessation approaches in the HIV population and their applications in clinical settings through a case discussion.

NO. 1
DEPRESSION IN PERSONS WITH HIV

Speaker: Jordi Blanch

SUMMARY:

Despite the importance of detecting and treating depression in HIV-infected patients, this syndrome frequently goes unrecognized. The ascertainment of depression in HIV-infected patients may be expected to be difficult or biased due to the possible confounding effect of the physical symptoms of the infection. Fatigue, diminished appetite and sleep, and loss of weight may be physical symptoms of HIV infection as well as depressive symptoms. On the

other hand, HIV induces activation of inflammatory mediators, mainly cytokines. These inflammatory mediators may also play a causative role for the presence of depressive symptoms. The purpose of this presentation is to review the most recent evidence of the prevalence and characteristics of depression in people living with HIV/AIDS. Treatment choices, including biological and psychological options, will also be discussed.

NO. 2
PRESCRIBED STIMULANTS IN HIV: INDICATIONS, SAFETY AND CONTROVERSIES

Speaker: Lawrence McGlynn, M.D., M.S.

SUMMARY:

Dr. McGlynn will discuss the role of stimulants in patients living with HIV. Fatigue, debilitating depression and cognitive impairment are common complaints in HIV and may lead providers to consider the use of stimulants in these patients. Some prescribers may hesitate to recommend their use for a number of reasons, including comorbid cardiovascular disease, polypharmacy, history of methamphetamine use, lack of insurance coverage and lack of familiarity with this class of medications. Dr. McGlynn will discuss the research, indications, risks and benefits of stimulants in patients living with HIV. He will illustrate the presentation with relevant cases.

NO. 3
TOBACCO AND HIV: AN URGENT NEED TO TAKE ACTION

Speaker: Antoine Douaihy, M.D.

SUMMARY:

Tobacco use disorder among HIV-positive individuals represents a significant public health issue. Smoking is highly prevalent among persons living with HIV and is associated with a high risk for tobacco-associated morbidity and mortality. More than 50% of individuals living with HIV in the U.S. are current smokers, with estimated smoking rates ranging from 50 to 70%, compared to 20% in the general population. The high prevalence of smoking has significant health implications for HIV-infected individuals. Smoking has been linked to a myriad of health risks and increased mortality in this population. In addition, emerging data show that HIV-infected smokers experience decreased quality of life. The objectives of this presentation are to 1) Discuss the impact of tobacco use in HIV-positive

individuals; 2) Examine the unique issues related to HIV-positive smokers; 3) Identify the importance of addressing co-occurring psychiatric and substance use disorders with tobacco use disorders; and 4) Review the research data on smoking cessation approaches in the HIV population and their applications in clinical settings through a case discussion.

NO. 4

COMPASSIONATE CARE OF TRANSGENDER PEOPLE LIVING WITH HIV

Speaker: Yavar Moghimi, M.D.

SUMMARY:

Although there has been great progress in the acceptance of transgender people in society in recent times, transgender people continue to be one of the highest-risk groups for contracting HIV and ultimately disengaging from HIV care. Dr. Moghimi will discuss the HIV risk factors that transgender people face, along with unique aspects of their psychiatric care, from his experience at Whitman-Walker Health, the largest provider of LGBT/HIV services in the Washington D.C. area.

MAY 18, 2016

CONSEQUENCES OF POLYPHARMACY IN PATIENTS WITH TRAUMATIC BRAIN INJURY AND COMORBID PSYCHOLOGICAL HEALTH CONDITIONS

Chair: Geoffrey Grammer, M.D.

Discussant: Linda Fuller, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the limitations of current evidence-based medicine for treatment of mild traumatic brain injury; 2) Describe commonly prescribed medications for patients with mild traumatic brain injury and comorbid psychological health conditions; 3) Provide evidence that increased medications and their interactions may not be improving the symptoms of mild traumatic brain injury patients as currently prescribed; and 4) Identify the classification of major medication interactions associated with increased mild traumatic brain injury symptom complaints.

SUMMARY:

Over the last 15 years, more than 320,000 active duty service members (SMs) have sustained a traumatic brain injury (TBI); the majority of these

injuries were diagnosed as mild TBI (mTBI). Patients with chronic sequela of mTBI are at risk of polypharmacy. Polypharmacy generally refers to the simultaneous use of multiple medications to treat a single ailment, and for the purpose of this study, polypharmacy is considered the use of four or more medications on a regular basis (Patterson et al., 2014). Polypharmacy is common for patients with comorbid conditions and often results in unintended consequences that may include a variety of neurological and psychological sequela that can undermine both the acute and post-acute mTBI treatment phases. Research efforts describing the effects of multiple medications and medication interactions on morbidity in mTBI patients remain limited. Given the population bias inherent in increasing the number of prescribed medications, we sought to explore the role of medication interactions when controlling for the total number of medications administered. To examine those effects, we evaluated a population of active duty SMs with mTBI and comorbid conditions, comparing medication interactions to postconcussive symptomatology including somatosensory, vestibular, cognitive and affective impairment. After reviewing the association between major medication interactions and mTBI patients, we discuss clinical significance and established treatment guidance. Discussion will address discordance between real world practice and clinical guidelines.

NO. 1

CASE REPORT OF A SERVICE MEMBER WITH SEVERE POSTCONCUSSIVE SYNDROME AND POLYPHARMACY AND THEIR RECOVERY FACILITATED BY CREATIVE ART THERAPY

Speaker: Melissa Walker, M.A.

SUMMARY:

Exposure to a combat environment can have a lasting impact on a service member's emotional well-being and functional status. Polypharmacy can result from providers' altruistic and ambitious attempts to address otherwise intractable symptoms. Art therapy was used as part of an integrated model of the clinical care for active duty military service members who suffered from traumatic brain injury with comorbid psychological health conditions. The successful integration of art therapy in a multimodal clinical care setting for active duty military can be a helpful guide for art therapists working in multidisciplinary settings.

NO. 2

POLYPHARMACY PATTERNS IN ACTIVE DUTY SERVICE MEMBERS WITH TRAUMATIC BRAIN INJURY AND COMORBID PSYCHOLOGICAL HEALTH CONDITIONS

Speaker: Thomas J. DeGraba, M.D.

SUMMARY:

Currently, there is little data describing psychotropic medication use in patients with traumatic brain injury and comorbid psychological health conditions. Many of these patients have complex psychotropic profiles involving a variety of classes of agents. Forty-nine patients presenting to an intensive outpatient treatment program were examined, and trends in medication profiles are presented. Overlapping classes and combination therapies were a common observation in this study group.

NO. 3

PRACTICE GUIDELINES AND META-ANALYSES FOR MEDICATION MANAGEMENT OF TRAUMATIC BRAIN INJURY AND PTSD

Speaker: Jonathan P. Wolf, M.D.

SUMMARY:

There are limited accepted pharmacological treatment options for patients with traumatic brain injury and/or PTSD. When patients have refractory symptoms, providers may rapidly deplete therapies reviewed in the literature and practice guidelines. Off-label therapies and combination therapies are often utilized in treatment delivery for refractory symptoms. Often, real-world practice mandates deviation from established treatment guidance, and the consequences of such treatment may unpredictably impact symptom severity.

NO. 4

SEVERE MEDICATION INTERACTIONS ASSOCIATED WITH INCREASED MORBIDITY IN SERVICE MEMBERS WITH MILD TRAUMATIC BRAIN INJURY AND COMORBID PSYCHOLOGICAL HEALTH CONDITIONS

Speaker: Christopher Flinton, M.D.

SUMMARY:

In a study of 88 service members with traumatic brain injury (TBI) and comorbid psychological health conditions, major medication interactions were found to have a significant ($P=0.045$) association with increased Neurobehavioral Symptom Inventory (NSI) total scores in postconcussive symptom

reporting. In addition, higher numbers of medications in the daily regimens of mild TBI (mTBI) patients were also associated with higher NSI total scores. Health care providers treating patients with mTBI and comorbid conditions should consider the impact of severe drug interactions in patients on multiple medications, as this may result in increased morbidity. Polypharmacy may be an unavoidable consequence of caring for this patient population, but specific attention should be given to drug interactions so as to avoid inadvertently exacerbating symptomatology.

“HIGH TECH” SOLUTIONS TO IMPROVING INTERPROFESSIONAL COMMUNICATION AND PATIENT CARE IN INTEGRATED PSYCHOSOMATIC MEDICINE PROGRAMS

Chair: Sanjeev Sockalingam, M.D.

Discussant: Susan Abbey, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify frameworks for developing and implementing health information technology resources to improve medical psychiatry integrated care; 2) Describe evidence for the use of technology-enhanced psychosocial interventions in specific collaborative consultation-liaison psychiatry settings; and 3) Reflect on opportunities to further integrate technology-enhanced care to improve mental health outcomes within medical psychiatry integrated care settings.

SUMMARY:

With increasing focus in North America on integrated care models, there is a growing need for advanced and innovative education technology to facilitate improved interprofessional communication and tracking of quality outcomes. In 2006, Unutzer et al. called for greater technical support and integration of performance standards as critical to quality improvement at the interface of medical and psychiatry services. Further, there has been an emergence of literature highlighting the efficacy of psychosocial telephone and e-therapy interventions in patients with comorbid medical conditions. However, barriers to truly effective technology-enhanced care persist, and successful approaches to developing, integrating and evaluating technology-enhanced care in psychosomatic medicine (PM) are needed. This symposium will present data on the implementation and effectiveness of four novel technology-based interventions used in PM

integrated care settings to improve interprofessional communication, screening of psychiatric conditions and access to psychosocial interventions. Dr. Sockalingam will present a case example of implementing online and mobile delirium resources as part of a hospital-wide interprofessional delirium screening and training initiative to improve delirium care standards. He will present quantitative and qualitative data from users and data on delirium interprofessional training outcomes using these e-technology interventions. Dr. Carvalho will discuss the e-wHEALTH (Women's HIV Empowerment Life Tools for Health) intervention that is a web platform peer support intervention for HIV-positive women focused on coping with depression, isolation and HIV treatment adherence. She will also describe the development of a website and social media forum for HIV-infected women using the community-based approach. Dr. Hawa will present data from a recently published systematic review evaluating smartphone applications to manage bariatric surgery outcomes and will provide pilot data on a cognitive behavioral therapy (CBT) smartphone application to manage severe obesity, including implementation challenges. Dr. Sockalingam will present data from a randomized, controlled clinical trial examining the effectiveness of telephone-based CBT to improve binge eating outcomes in bariatric surgery patients after surgery. The presentation will include qualitative data from patient interviews describing their experiences with tele-CBT. Dr. Sheehan will discuss the use of a standardized interprofessional iPad psychosocial assessment tool used to generate narrative consultation notes, communicate psychosocial risks across health care professionals and track mental health outcomes. She will describe its development and present data from a mixed methods research study on user and clinical care process outcomes. Dr. Abbey will summarize tools and frameworks beneficial to the integration of health information technology within integrated care settings.

NO. 1
SUPPORTING HIV-POSITIVE WOMEN IN WAYS THAT WORK

Speaker: Adriana Carvalho, M.D., Ph.D.

SUMMARY:

While mortality from AIDS has been largely controlled in many countries through the use of antiretroviral therapy (ART), many physical and neuropsychiatric complications remain the focus of

serious health concerns. A diagnosis of HIV can carry with it tremendous social stigma. Stigma may be the most significant challenge for women living with HIV. It is associated with decreased self-esteem, increased hopelessness and increased psychological distress. It can also interfere with women's willingness or ability to access HIV-related services. Generating awareness of HIV and encouraging women living with HIV to access relevant health and social services has been a challenging endeavor and has yet to result in providing women-specific services. Dr. Carvalho will discuss the e-wHEALTH (Women's HIV Empowerment Life Tools for Health) intervention that is a web platform peer support intervention for HIV-positive women focused on coping with depression, isolation and HIV treatment adherence. She will also describe the development of a website and social media forum for HIV-infected women using the community-based approach.

NO. 2
EXPERIENCING THE UNEXPECTED: A MIXED METHODS STUDY OF CLINICIAN EXPERIENCES USING A NOVEL ADVANCED CLINICAL DOCUMENTATION IPAD TOOL IN A CONSULTATION-LIAISON PSYCHIATRY SETTING

Speaker: Kathleen Sheehan, M.D., Ph.D.

SUMMARY:

Electronic medical records and mobile technologies are revolutionizing the practice and delivery of health care. The opportunity for practice transformation is particularly apparent in integrated care clinics, where psychiatrists work with other physicians and health care professionals. The success of new technologies in these settings is contingent on having convenient, practical and clinically useful tools that facilitate communication. In this presentation, Dr. Sheehan will review the development of an iPad-based advanced clinical documentation tool (ACD) in our multidisciplinary and interprofessional bariatric surgery clinic. She will summarize a mixed methods study that examined clinicians' expectations of and experiences in using the ACD in clinical practice. She will conclude by discussing the importance of measuring the impact of new technologies in health care settings by exploring clinician and patient experiences, in addition to the use of process-related outcomes such as number of assessments completed.

NO. 3

“THERE’S AN APP FOR THAT”: USING MENTAL HEALTH SMARTPHONE APPLICATIONS IN INTEGRATED CARE SETTINGS

Speaker: Raed Hawa, M.D.

SUMMARY:

Over the past 10 years, there have been several advances and a proliferation of Internet, web-based and smartphone technologies. Patients are increasingly using mental health smartphone applications. A paucity of data has provided information on how to use these applications within integrated care settings with multimorbidity patients. Dr. Hawa will use an example from an integrated care program focused on severe obesity management to demonstrate how smartphone applications can be used by providers and patients. He will provide data from a systematic review on smartphone applications in this area and will provide a framework for evaluating applications in mental health settings. Further, he will discuss data from a pilot study examining the use and outcomes of a smartphone cognitive behavioral therapy application for obesity management and will highlight the use of this application within stepped care approach to obesity care. Opportunities and challenges to integrating smartphone psychosocial interventions within integrated psychosomatic medicine (PM) care settings will be discussed.

NO. 4

AN INTEGRATED TELEPHONE-BASED CBT INTERVENTION AFTER BARIATRIC SURGERY: A MODEL FOR INCREASING ACCESS

Speaker: Sanjeev Sockalingam, M.D.

SUMMARY:

Treatment of severe obesity with bariatric surgery can result in improved physical and mental health; however, the benefits of this treatment can be limited by postoperative psychosocial complications such as eating psychopathology. Effective care models providing sufficient psychosocial support after surgery are limited in the literature. Dr. Sockalingam describes an integrated care program for severe obesity management that provides accessible psychosocial support, specifically cognitive behavioral therapy (CBT), to patients after bariatric surgery. The presentation will discuss the iterative development of this intervention and clinical trial evidence for its efficacy and patient engagement with this intervention within an integrated surgical and psychosocial program. A

qualitative study evaluating patient experiences with using telephone-based interventions for psychiatric support and care will be summarized. Implications and use of telephone-based psychotherapy within integrated care settings will be discussed, including its role in increasing access to psychosocial care.

THE EVOLVING PICTURE OF ADHD

Chair: Niall Boyce, Ph.D., M.B.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Gain an overview of current knowledge regarding ADHD, with an emphasis on translational aspects, and an understanding of priority research questions; 2) Understand clinical care pathways for ADHD; and 3) Understand development of comorbidities and other difficult issues that clinicians face when managing ADHD in adults.

SUMMARY:

This symposium will provide both practical advice for the management of ADHD in children and adolescents and concise and authoritative insight into the latest findings in genetic and neurobiological research. The symposium will also cover the emerging area of ADHD as a lifespan disorder, with specific focus on the challenges of diagnosis and treatment of ADHD in an adult population. Finally, the issues of access to care, and potential over- and undertreatment of the condition, will be summarized and discussed.

NO. 1

CLINICAL CARE PATHWAYS FOR ADHD

Speaker: David Coghill, M.D.

SUMMARY:

This presentation will provide a concise outline of 1) The epidemiological and administrative prevalence of ADHD in children and adolescents; 2) The barriers and facilitators to access to care for ADHD and models of clinical care pathways; 3) A description of costs associated with ADHD; 4) An overview of service provision in order to deliver key recommended and evidence-based treatment approaches; 5) A focus on the issues above in relation to specific age groups including preschool children, adolescents requiring transition into adult services and adults.

NO. 2

THE GENETIC AND NEURAL BASIS OF ADHD

Speaker: Jonathan Posner, M.D.

SUMMARY:

Attention-deficit/hyperactivity disorder (ADHD) is a neurodevelopmental disorder characterized by developmentally inappropriate levels of inattention and hyperactivity/impulsivity. The heterogeneity of its clinical manifestations and the differential responses to treatment and varied prognoses have long suggested a myriad of underlying causes. In fact, over the past decade, clinical and basic research efforts have uncovered multiple behavioral and neurobiological alterations associated with ADHD, from genes to higher-order neural networks. In this presentation, we will review the neurobiology of ADHD by focusing on neural circuits implicated in the disorder and discuss how abnormalities in the circuitry relate to symptom presentation and treatment. This review will also summarize the literature on key ADHD-linked genes and gene-environment interactions and how these, in turn, may impact circuit function and relevant behaviors. We will evaluate past and current efforts at disentangling these issues and showcase the shifting research landscape toward endophenotype refinement in clinical and preclinical settings. Further, the review will cover various approaches being used to arrive at causality, including the use of animal models, neuromodulation techniques and pharmaco-imaging studies and raising questions that reflect the renewed urgency of the field to understand the neurobiological underpinnings of this complex disorder.

NO. 3

ADHD AS A LIFESPAN DISORDER

Speaker: Philip Asherson, Ph.D., M.B.B.S.

SUMMARY:

This presentation will provide a summary of key issues in the progression of attention-deficit/hyperactivity disorder (ADHD) from children to adults. Epidemiological surveys find around 5% of children and 3 – 4% of adults meet diagnostic criteria for ADHD. Meta-analysis of earlier follow-up studies found that 15% of children with ADHD retained the full diagnosis by the age of 25, with an additional 50% showing continued impairments with subthreshold levels of symptoms. More recent studies in Europe of children with *DSM-IV* combined type ADHD find persistence rates to be much higher, around 80%. Reasons for the persistence and

desistence of ADHD are not well-understood, but are of considerable interest, as they identify potential targets for early prevention and treatment. Factors potentially influencing course and outcome include general cognitive ability, severity, etiological factors (genes and environment), brain maturation and development, the presence of co-occurring mental health and neurodevelopmental problems, and protective factors such as exercise and diet. Understanding the relationships between comorbid conditions in adult ADHD, such as anxiety, depression, personality disorder, substance abuse, antisocial behavior and comorbid medical conditions, is crucial. The effect of long-term risks and benefits of pharmacotherapy is another vital, fast-growing research area. We conclude that effective management of ADHD is an essential component of adult mental health care.

BUILDING CAPACITY FOR PSYCHIATRIC CARE AND RESEARCH IN NIGERIA: CHALLENGES AND OPPORTUNITIES FOR INTERNATIONAL COLLABORATION

Chairs: Theddeus Iheanacho, M.D., Charles C. Dike, M.D.

Discussant: Shoyinka O. Sosunmolu, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the current state of mental health care and research in Nigeria, including personnel resources, facilities, funding, infrastructure and administrative structures; 2) List the various areas of psychiatric expertise of Nigerian diaspora psychiatrists including administrative, research, clinical and teaching specialties; 3) Describe the areas of psychiatric care, teaching, training and research in which Nigerian diaspora psychiatrists can have the most impact in Nigeria; 4) Describe ongoing and recent research, education and clinical care collaborations in Nigeria by teams that include diaspora psychiatrists and mental health specialists; and 5) Describe the potential policy implications of health services research in Nigeria and understand the legal framework guiding psychiatric practice in Nigeria and ongoing efforts to modernize it.

SUMMARY:

Nigeria, the most populous country in Africa with a population of over 160 million, has fewer than 160 psychiatrists working in psychiatric care, research and teaching. On the contrary, more than 1,000

psychiatrists in the United States and Canada obtained their initial medical training in Nigeria and are of Nigerian descent. About the same number can be found in Australia, the U.K. and other European countries. Most of these psychiatrists in the Americas are members of the Nigerian American Psychiatrists Association, a component of the American Psychiatric Association. There are even larger number of Nigerian physicians in other specialty areas working in the United States and Europe. Published surveys of these physicians indicate that most would like to return to Nigeria and contribute to the development of the health care system there. However, this desire to “go home” and “give back” is often tempered by multiple barriers. Given the severe shortage of psychiatric manpower in Nigeria and the relative abundance of experienced Nigerian psychiatric specialists in the diaspora, there is a need to explore mechanisms that can leverage the experience of these specialists through collaboration with mental health experts in Nigeria in research, training and clinical care. This symposium will focus on potential areas of collaboration between mental health experts in Nigeria and Nigerian psychiatric specialists in the diaspora with the goal of identifying key strategic and potentially high-impact research, training and clinical intervention opportunities. First, we will review the current state of mental health services in Nigeria, the manpower capacity, the gap between need for care and access to care, and the impact of these on the mental health of Nigerians. Three Nigerian-American psychiatrists who have collaborated with colleagues in Nigeria will describe details of their works and the lessons learned, while offering suggestions for future collaborations. Their collaborative efforts span psychiatric training, teaching, psychopharmacological research and capacity building. Nigerian-American psychiatrists with expertise in mental health and the law will discuss the current mental health legal framework in Nigeria juxtaposed with that in high-income countries. They will review pending mental health legislation in the Nigeria national assembly, including its potential impact on mental health services, access to care and human rights of those with mental illness. Experts in health services research will discuss the role of research evidence in shaping mental health policy, making mental health affordable and available in a low- and middle-income country like Nigeria. Participants will learn about models of collaboration between Nigerian-American psychiatrists and mental health experts in Nigeria.

Practical guides to establishing such collaborations to advance psychiatry and mental health care in Nigeria will be offered.

**NO. 1
BUILDING CAPACITY FOR AND CONDUCTING
BIOMEDICAL RESEARCH IN NIGERIA: LESSONS
LEARNED AND PROSPECTS**

Speaker: Ikwunga Wonodi, M.B.B.S.

SUMMARY:

Responding to the NIH Fogarty International Center’s mission “to support capacity-building, research infrastructure development, and research mentoring in order to develop a multidisciplinary mental health research workforce in low- and middle-income countries,” a collaborative research effort was successful in developing a project between U.S. and Nigerian investigators that built capacity for biomedical research at the Nigerian site. The study sought to characterize schizophrenia endophenotypes (or liability markers) in an endogenous sub-Saharan African cohort of Igbo and test the feasibility of performing endophenotype-based genetic studies in this homogenous old population. Findings would provide important insights for future genetic studies, including gene mapping in a population with smaller linkage disequilibrium blocks and different genetic architecture. In this presentation, the process of setting up the collaborations between Nigerian and U.S. researchers, some of the lessons learned and some findings from the studies will be discussed.

**NO. 2
CHILD MENTAL HEALTH CARE AND TRAINING IN
CHILD AND ADOLESCENT PSYCHIATRY IN NIGERIA:
OPPORTUNITIES AND PROSPECTS**

Speaker: Patricia Ibeziako, M.D.

SUMMARY:

Low- and middle-income countries (LMIC), including Nigeria, the most populous country in sub-Saharan Africa, have the largest numbers of children living in poverty with very limited access to mental health care. Thus, there is significant morbidity from child mental health disorders in these countries. Most adult mental health disorders begin before the age of 14, making early and effective intervention a necessary tool in reducing morbidity and mortality from these disorders. In Nigeria, up to 10% of children and adolescents suffer from depressive disorders, and an equal proportion have anxiety

disorders, yet most children and adolescents do not have access to counselors, therapists or psychiatrists. The severe shortage of trained mental health specialists in Nigeria disproportionately affects children and adolescents. Innovative, collaborative efforts are urgently needed to address the mental health needs of children and adolescents in Nigeria. This presentation will provide recent data on child and adolescent mental disorders in Nigeria and discuss efforts to 1) Complete a needs assessment through robust data collection; 2) Provide training in child and adolescent mental health; and 3) Explore the feasibility and acceptability of a school-based, teacher-led intervention for common mental health disorders in southwestern Nigeria.

NO. 3

THE ROLE OF HEALTH SERVICES RESEARCH IN IMPROVING ACCESS TO MENTAL HEALTH CARE IN NIGERIA

Speaker: Robert Rosenheck, M.D.

SUMMARY:

Evidence and data from health services research can inform policy making and strengthen national health delivery systems. In Nigeria, limited research exists on the use of evidence in health policy formulation. Health services research can potentially assist government agencies and private organizations in identifying priority areas, defining health problems, providing a wider range of policy options, informing health policy formulation and implementation, and setting the stage for evaluating the outcomes and impact of policies on individuals and the health care system. In the absence of robust data, policy makers are unable to make sustainable long-term health systems projections, leading to failed health policies and loss of confidence among the citizenry. This presentation will 1) Describe examples of effective and successful health policies informed by evidence from health service research; 2) Examine the feasibility and need to determine the cost effectiveness of antipsychotic medication for psychotic disorders in the Nigerian context; 3) Identify other priority mental health areas where specific outcome and cost-effectiveness analysis can have a high impact on policy making; 4) Describe current and recent collaborative health service research studies in Nigeria and other West African countries.

NO. 4

MENTAL HEALTH IN NIGERIA: SUFFERING IN THE MIDST OF PLENTY

Speaker: Theddeus Iheanacho, M.D.

SUMMARY:

With only about 160 practicing psychiatrists for a population of over 173 million people, Nigeria exemplifies the severe lack of capacity for mental health care services in low- and middle-income countries. An estimated 26% of adult Nigerians have a lifetime prevalence of at least one *DSM-IV*-coded mental disorder, yet only 10% receive any care irrespective of severity. This untenable statistic is due to the severe shortage of trained manpower, minimal public financing and lack of private investment in mental health care. Finding innovative approaches to increase access to effective mental health treatments by increasing the number of trained personnel and investment in mental health delivery in Nigeria is in line with World Health Organization (WHO) Millennium Development Goals. Successful efforts in Nigeria can also serve as models for other sub-Saharan countries with similar challenges. This presentation will review the data on mental health capacity and the epidemiology of mental disorders in Nigeria, the structure of mental health delivery in Nigeria, and the level of current public and private financial investment in the mental health sector. It will conclude with a look at ongoing collaborative dissemination research that seeks to train nonpsychiatrists to deliver specific mental health interventions in nonpsychiatric community settings.

NO. 5

PSYCHIATRY AND THE LAW IN NIGERIA: CHALLENGES AND PROSPECTS

Speaker: Charles C. Dike, M.D.

SUMMARY:

Psychiatric disorders are as prevalent in Nigeria as they are in other countries of the world. However, the laws guiding mental health care in Nigeria date from 1912, when the colonial government enacted the Lunacy Act, which was later amended in 1958. The Lunacy Act is fraught with outdated language and prone to very fluid interpretations, leading to concerns about human rights for those suffering from mental illness in Nigeria. Since 1991, efforts to repeal the archaic law and replace it with a new "Mental Health Act" have been unsuccessful. The result is a fractured mental health system with no office of mental health in the federal ministry of

health, a criminal justice system with no provision for adequate treatment of prisoners with mental illness and clinical practices that border on neglect and abuse in some instances. Many developed countries have mental health laws that have undergone reformations and revisions that can guide Nigeria's efforts in fashioning its "Mental Health Act." This presentation will provide an overview of the current mental health laws in Nigeria. Additionally, it will discuss key areas of the proposed "Mental Health Act" that may benefit from the experience of other countries that have recently revised or updated their mental health legislation.

NO. 6

STATE OF BEHAVIORAL HEALTH SERVICES IN NIGERIA: THE ROLE OF COLLABORATION IN IMPROVING CARE

Speaker: Ureh N. Lekwauwa, M.D.

SUMMARY:

Access to quality mental health care is a challenge worldwide, but it is more pronounced in developing countries like Nigeria because of the limitation in financial resources and trained manpower. Health illiteracy and stigma toward behavioral health also plays a role. This presentation will describe the author's findings during a five-day visit to a state in the southeastern corner of Nigeria, describe the ongoing effort of a group based in the Diaspora to collaborate with providers of behavioral health services in one local government of that state, describe ongoing discussion regarding a possible public-private partnership for the development of behavioral health services in that state, and hopefully start more conversations and collaborative effort on improving behavioral health care in Nigeria.

ETHICAL CHALLENGES AT THE INTERFACE BETWEEN PSYCHIATRY AND RELIGION/SPIRITUALITY

Chair: John Peteet, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the major ethical dilemmas presented by addressing religion/spirituality in the clinical setting; 2) Draw on ethical principles to construct an approach to dilemmas arising in the areas of forensic psychiatry, psychotherapy, psychiatric research, and international and disaster psychiatry; and 3)

Understand the ways that religion/spirituality can inform ethical reasoning in these areas.

SUMMARY:

Psychiatry and religion/spirituality (R/S) share an interest in human flourishing, a concern with beliefs and values, and an appreciation for community, yet historical tensions between science and religion have often obstructed dialogue, leaving clinicians uncertain about how to approach ethical questions arising between them. When are religious practices such as scrupulosity disordered? What distinguishes healthy from unhealthy religion? How should a therapist approach a patient's existential, moral or spiritual distress? What should clinicians do with patients' R/S convictions about faith healing, same-sex relationships or obligations to others? While discussions of psychiatric ethics have traditionally emphasized widely accepted principles, generally admired virtues and cultural competence, relatively little attention has been devoted to the ways that R/S inform the values of patients and their clinicians, shape preferred virtues, and interact with culture. Presenters in this symposium will provide mental health professionals with a conceptual framework for understanding the role of R/S in ethical decision making, as well as practical guidance for approaching challenging cases in a broad range of contexts: psychiatric diagnosis, R/S needs presenting in treatment, disaster psychiatry, community and international psychiatry, and psychiatric research.

NO. 1

ADDRESSING ETHICAL ISSUES OF PSYCHIATRISTS WHO RESPOND TO EMERGENCIES AND DISASTERS

Speaker: Samuel Thielman, M.D., Ph.D.

SUMMARY:

This presentation focuses on ethical aspects of psychiatric responses to emergencies and disasters. As psychiatrists have become increasingly involved in the societal response to catastrophic events, previously unanticipated ethical concerns have emerged. Of particular concern is the need to avoid harm through interventions that involve therapeutic innovations or costly but unproven interventions. This is a particular concern when therapies are applied in populations affected by catastrophes who are not known to be at risk and who are not seeking mental health care. We will also address issues of informed consent and confidentiality, documentation, and research during a disaster. Finally, we will discuss dual agency concerns that

arise, especially the ethical issues raised when psychiatrists employed by government entities and humanitarian relief organizations face situations where patient needs and organizational goals conflict. We outline ways to identify frequent areas of conflict during a disaster response, and we provide some possible solutions to common dual role ethical dilemmas.

NO. 2

ETHICAL CHALLENGES AT THE INTERFACE BETWEEN PSYCHIATRY AND RELIGION/SPIRITUALITY: DIAGNOSTIC CONSIDERATIONS

Speaker: Allan Josephson, M.D.

SUMMARY:

In psychiatry, diagnosis refers to more than description or labeling. It implies knowing the patient "through and through." McHugh (1998, 2005) points out that the DSM model may imply a homogeneity that does not exist, suggesting that diseases, dimensions, behaviors and life stories are all perspectives that inform the psychiatric diagnostic formulation. Integrating these perspectives highlights the ways that morality, existential meaning and suffering are important dimensions of diagnoses such as depression, post-traumatic stress disorder, anxiety disorder, conduct disorder and substance abuse. Eliciting relevant religious/spiritual (R/S) data in these areas requires skills in both screening and conducting an in-depth psychiatric assessment, following either the patient's narrative and/or the clinician's semi-structured interview. Two core ethical principles—beneficence (bring about good in all actions) and nonmaleficence (do no harm)—relate to making psychiatric diagnoses. This presentation will consider 1) The importance of an accurate diagnosis and the negative effects of misdiagnosis (e.g., misdiagnosed bipolar disorder); 2) Building an effective treatment alliance by respecting R/S aspects of the patient's life; 3) Respect for patient autonomy and avoidance of imposing therapist R/S values; 4) The importance of therapist's self-knowledge in conducting a thorough interview and in developing an accurate case formulation.

NO. 3

ETHICAL CHALLENGES OF THE INTERFACE BETWEEN PSYCHIATRY AND RELIGION/SPIRITUALITY: COMMUNITY AND INTERNATIONAL PSYCHIATRY

Speaker: Walid Sarhan, M.D.

SUMMARY:

Community psychiatry has been widely used to replace hospital-based psychiatry. While in psychiatric hospitals, clinicians rely upon the identity of the institution, which could differ from that of the patient's community; community-based practice is more engaged with the culture and religion/spirituality of the patient. As a result, understanding and respecting the patient's convictions has become an essential component of the ethics of community psychiatry. International psychiatry has been influenced by the immigration of refugees, and related issues of education and work, contributing to the diversity of culture and religion/spirituality at the boundary of medical and psychiatric practice. Examples raising ethical issues within Muslim cultures include the ethics of homosexuality, jinn possession and the use of the Quran as a positive influence in treating Muslim patients.

NO. 4

ETHICAL CONSIDERATIONS REGARDING RELIGION/SPIRITUALITY IN PSYCHIATRIC RESEARCH

Speaker: Alexander Moreira-Almeida, M.D., Ph.D.

SUMMARY:

Research on R/S needs to follow all international guidelines for studies involving human subjects. Some aspects related to ethical controversies will be covered, including 1) The ethical duty of studying R/S in psychiatry, since it impacts mental health and is a topic valued by psychiatric patients; 2) Ethics in performing interventions involving spirituality (e.g., to develop patients' spirituality or change negative religious coping)—What is the limit? Is it ethical to develop and test an intervention that may change a patient's values and worldviews? Interventions need to be patient centered; 3) Bias/conflict of interest based on spiritual/anti-spiritual researchers' and clinicians' views and the influence of researchers' own world views on research topic and methodology and ways to correct/minimize for this; 4) The need for respecting patients' R/S in designing and discussing a study and the obligation of publishing findings, irrespective of whether or not they agree with researchers', supporters' or prevalent views in society; 5) Dealing with sensationalism/distortion in media coverage of scientific findings on R/S, basing interviews on solid research data and being aware of unsupported inferences.

NO. 5

RELIGIOUS/SPIRITUAL NEEDS IN TREATMENT

Speaker: Len Sperry, M.D.

SUMMARY:

This presentation addresses the ethical considerations associated with the various R/S concerns that patients present in everyday psychiatric practice, beyond those noted in the "Religious or Spiritual Problem" (V 62.89) diagnoses in the *DSM-5*. The ethics of responding to these presentations, performing a spiritual assessment, functioning within a psychiatric scope of practice, responding to requests to pray with and for patients, and the use of spiritual interventions are discussed along with case examples.

WHAT IS THE EMOTIONAL PAIN OF SUICIDE?

Chair: Igor Galynker, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the role of "emotional pain" or "psychache" in suicidal behavior; 2) Discuss the differences between retrospective and prospective predictive validity of negative affects for suicide; and 3) Describe the relationship of "emotional pain" to anhedonia, desperation, entrapment, severe anxiety and panic.

SUMMARY:

In a landmark investigation of time-related predictors of suicide in major affective disorders, Fawcett et al. (1988) discovered that suicides within one year of study intake were associated with different clinical, affective features than suicides within 2 – 10 years of intake. The short-term predictors were hypothesized to relate to presuicidal "intolerable emotional pain," categorized as a state of fluctuating, unstable emotional turmoil combining anhedonia, anxiety, panic, hopelessness, depression and insomnia. Schneidman proposed the similar concept of "psychache," while others have developed the construct of the "suicide trigger state," comprised of dyscontrolled ruminative thinking, entrapment and desperation. The exact nature of "emotional pain" and its role in the evolution of suicidal behavior has not yet been determined. The purpose of this symposium is to synthesize and compare different constructs describing the "emotional pain" of suicide, to assess its importance with regard to near-term suicide risk and to establish future research directions needed to develop a single construct of the intense negative

affect preceding suicide. The first speaker (Gregory K. Brown) will introduce the issue of "psychache," or unbearable psychological pain, as a possible major risk factor for suicide, which mediates the effects of other psychological risk factors. The second speaker (Jan Fawcett) will bring into focus severe anxiety as a critical component of emotional pain and a risk factor for suicide by virtue of its severity. The third speaker (Zimri S. Yaseen) will conceptualize emotional pain as an acute disturbance in both reward and threat processing, manifested as simultaneous anhedonia and desperation. The final speaker (Igor Galynker) will present data on the validity of "emotional pain" as measured by the Acute Suicidal Crisis Intensity Scale (ASCIS) and on its use in predicting near-term suicidal behavior, compared to that of other negative affects measured by the same scale. Overall, this panel will provide a comprehensive, evidence-based overview of the current state of knowledge of the "emotional pain" construct and will assess the need for and the directions of future research in this area.

NO. 1

THE MEASUREMENT OF PSYCHOLOGICAL PAIN AND SUICIDE RISK

Speaker: Gregory K. Brown, Ph.D.

SUMMARY:

Shneidman (1993) has proposed that "psychache," or unbearable psychological pain, is a major risk factor for suicide and mediates the effects of other psychological risk factors. This presentation will encompass a brief review of Shneidman's theory as well as a review of the empirical literature that operationalizes this construct. Specifically, the psychometric properties of measures of psychological pain will be reviewed, including the predictive validity of these measures for suicidal ideation and behavior. Implications for the measurement and clinical treatment of emotional pain will be discussed.

NO. 2

ANXIETY SEVERITY AS AN ACUTE RISK FACTOR FOR SUICIDE

Speaker: Jan Fawcett, M.D.

SUMMARY:

Comorbid anxiety is common in depression, and there is literature supporting an association with severe anxiety, often but not always precipitated by adverse events, as an acute risk factor for suicide. If

anxiety severity is based only on patients' estimates of severity, rather than clinical estimates, this assessment will not help the clinician use severity of anxiety as a risk factor for suicide. This presentation will review this literature and will focus on the clinical use of the SADS-C Psychic Anxiety Scale to estimate the clinical severity of anxiety as a part of the clinical assessment of acute risk factors for suicide. Case examples will be presented.

NO. 3 REWARD- AND THREAT-PROCESSING CONTRIBUTIONS TO SUICIDALITY

Speaker: Zimri S. Yaseen, M.D.

SUMMARY:

Objective: Suicide remains a leading cause of death among U.S. adults. Basic functional domains that may exhibit transdiagnostic disturbance—reward (anhedonia), threat (anxiety, entrapment) and social support recruitment (attachment)—are important in the evolution of suicidality. We therefore sought to examine the independent contributions of each to the severity of suicidal ideation (SI) and risk for suicide attempts (SA) in patients acutely hospitalized for suicide risk. **Methods:** Anhedonia, state and trait anxiety, entrapment, and attachment security were assessed in 201 adults hospitalized for suicidality. Regression models examined relationships between symptom dimensions assessed at time of hospitalization; lifetime and concurrent suicidal ideation; and lifetime, recent and near-term (within two months of hospital discharge) suicide attempts (n=13) among the 121 patients reachable for follow-up. **Results:** Anhedonia and state anxiety were the sole independent correlates of severity of concurrent SI, whereas entrapment was the sole independent correlate of lifetime SI severity. No symptom dimension was independently associated with past SA. Anhedonia was a significant predictor of postdischarge SA, even when age, gender, substance abuse, concurrent SI and lifetime attempt history were included in the model. **Conclusion:** Acute disturbances in reward and threat processing may represent independent, treatable factors in the development of suicidality.

NO. 4 NEGATIVE EMOTIONS PREDICTIVE OF NEAR-TERM SUICIDAL BEHAVIOR

Speaker: Igor Galynker, M.D., Ph.D.

SUMMARY:

Intolerable “emotional pain” has been identified as one of the main reasons for suicide, but its nature has not been established. The 50-item Acute Suicidal Crisis Intensity Scale (ASCIS) assesses the intensity of emotional pain and other negative affects. In this context, we present data on the ASCIS individual item analysis in predicting future near-term suicidal behavior. ASCIS, which is based on the previously reported Suicide Trigger Scale version 3 (STS-3), was administered to 201 high-risk psychiatric inpatients prior to their discharge. Suicidal behavior (actual, aborted and interrupted attempts) was assessed in 121 participants (60% follow-up rate) within four to eight weeks after their discharge using the Columbia Suicide Severity Rating Scale (CSSRS). Out of 50 ASCIS items, 40 were significant predictors of future suicidal behavior. Six items, “panic attacks,” “hard to control urges,” “reality distorted,” “no way out,” “no good solutions” and “things never changing,” survived Bonferroni correction for multiple comparisons; none of the emotional pain items did. Forward logistic regression showed “panic attacks” and “hard to control urges” to be the sole predictors. Our data suggest that “emotional pain” may not be the best predictor of future near-term suicidal behavior. Other “painful” negative affects, such as panic, loss of control and entrapment, may be more closely related to imminent suicide.

HEALTH POLICY AND SOCIAL JUSTICE: THE ROLE OF PSYCHIATRY IN PROMOTING INTEGRATED HEALTH CARE

Chair: Howard J. Osofsky, M.D., Ph.D.

Discussant: John M. Oldham, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the development of a stepped care model of integrated care and the benefits for rural and underserved communities; 2) Appreciate the need for coordination of professional and public education in prevention, early detection and intervention for psychiatric disorders; and 3) Understand techniques used through social media to promote better public and professional education.

SUMMARY:

Psychiatry has played an increasingly important role in health policy that ensures social justice so that all patients have access to health care that promotes the mind and body connection. In addressing health policy and social justice, this symposium will describe and examine three innovative perspectives

undertaken by departments of psychiatry in different geographic regions of the country that include training, ethics, community and patient involvement, integrated care, and technology. All of the programs emphasize innovative approaches to address disparities in care, misunderstandings and stigmatization that can often accompany accessing mental health services. The Massachusetts General Hospital Center program values the critical role of professional education for clinicians, the general public and patients so that health care providers and patients can communicate and understand the role of mental health interventions whether in medical homes, schools or ACOs. Moving to the South, where, in recent years, disasters have influenced directions for the health care system, the Louisiana State University Health Sciences Center program has developed a strong focus on access to integrated care, both on site and by telepsychiatry. These services have been implemented in culturally diverse and often rural communities to improve and support positive mental health as demonstrated by increased resilience and decreases in both physical and mental health symptoms. The program at Stanford University School of Medicine has a strong focus on the five missions of advancing science, clinical innovation and service, educational excellence, community engagement and commitment, and professionalism and leadership development related to vulnerable populations in society and ethics in medicine. With an emphasis on multidisciplinary research, ethical standards are important, including issues such as inclusion of individuals with severe physical and mental illnesses in clinical and genetic research, studies of barriers to care and human rights issues for individuals with overlapping sources of vulnerability including homelessness, at risk ethnic minorities, and rural populations. These three presentations emphasize the need to consider ethical practices in all aspects of health policy and clinical care in order to achieve optimal outcomes and avoid underserving or exploiting more vulnerable populations. While these departments of psychiatry have unique approaches and geographic differences influencing populations served, they also share many similarities and emphasize the need to address disparities in care and cultural issues that play an important role in both access and approach to mental health services. Therefore, this symposium will provide important information about various combined approaches that may be applicable in other psychiatry programs.

**NO. 1
AN INNOVATIVE ACADEMIC-STATE
COLLABORATION TO BETTER MEET THE MENTAL
HEALTH NEEDS OF CHILDREN IN PRIMARY CARE
SETTINGS**

Speaker: David L. Kaye, M.D.

SUMMARY:

Mental health issues are the most common chronic conditions impacting children today. Despite the enormity of the public health impact, relatively few children and adolescents receive treatment. Stigma, inadequate payment systems, cultural mismatches and barriers to accessing services are major reasons for the chasm between public need and provision of treatment. A major factor in the dearth of services is the lack of child mental health professionals, particularly child and adolescent psychiatrists. It is unlikely that this will change in the foreseeable future. A more plausible, ecological, culturally attuned, practical solution is to support primary care providers (PCPs) to gain the skills and knowledge necessary to assess and treat common child mental health problems. Residency provides little training for pediatric or family medicine residents in child psychiatry, and when faced with the realities of everyday pediatric primary care, physicians quickly come to see the need for these skills. A number of models have been developed nationally to address this mismatch. One such model, the New York State Office of Mental Health-funded Child and Adolescent Psychiatry for Primary Care (CAP PC) program, has operated since 2010. This presentation will review the background, need and description of the CAP PC program, which is a unique program that has successfully brought together five university-based divisions of child psychiatry to work together to assist PCPs across the state.

**NO. 2
THE ROLE OF PSYCHIATRY IN ADVANCING
INTEGRATED CARE FOR UNDERSERVED AND RURAL
POPULATIONS**

Speaker: Howard J. Osofsky, M.D., Ph.D.

SUMMARY:

Louisiana is home to culturally diverse, largely rural communities with marked disparities in availability of mental health services. Access to psychiatric and mental health services, in general, is impacted by the need to travel long distances, the stigma associated with mental health services and misunderstandings about symptoms by community residents and

clinicians. Louisiana State University Health Sciences Center Department of Psychiatry has been delivering integrated mental health care in primary care clinics with careful consideration of cultural and ethical issues in parishes impacted by the gulf oil spill. This presentation will focus on training of psychiatrists to perform on-site and telepsychiatry services. The implementation of this program, the Mental and Behavioral Health Capacity Project, has resulted in not only a decrease in mental health symptoms, but also decreases in physical health problems and resilience within the population.

NO. 3

THE CRITICAL ROLE OF PUBLIC EDUCATION IN PATIENT-CENTERED COLLABORATIVE CARE

Speaker: Eugene V. Beresin, M.D., M.A.

SUMMARY:

With the advent of medical homes, accountable care organizations, population management and the increasing role of health care in community settings, coordination of professional and public education becomes increasingly important. The high prevalence of psychiatric disorders and their significant burden on society require improved integration of medical and psychiatric care. Since over half of psychiatric disorders begin in youth, prevention, early identification and intervention become increasingly important. The Massachusetts General Hospital Clay Center for Young Healthy Minds was established to provide readily accessible information for all who care for youth and families with the goal of achieving a better-informed public to enhance early intervention and more effective treatment of psychiatric disorders.

YOUR PATIENT AT WORK: PRIVACY, PERIL AND PUBLIC SAFETY

Chair: Jessica Ferranti, M.D.

Discussant: Charles Scott, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the epidemiology of patients with mental illness who pose a risk to others in the workplace; 2) Review evidence-based clinical factors found in workers with mental illness that are associated with an increased risk of threat to others in the workplace; 3) Highlight medical and legal management strategies of various patients who pose an increased risk of harm to others in the occupational setting; 4) Discuss management of

employer requests to providers for release of information related to patients at potential risk of harm to others; and 5) Review best practice approaches to recommending accommodations and/or management of potentially threatening patients.

SUMMARY:

General psychiatrists must often address important mental health questions related to a patient's potential risk of harm to others in the workplace. This symposium will discuss the current medical and legal principles that govern how treating providers should manage patients whom they identify pose an increased risk of harm at work. These general principles involve an understanding of medical, legal and ethical issues that influence the balance of patient confidentiality against the patient's risk of harm to the public. The increasing focus on the provider's assessment of gun ownership in patients with potential conflicts of such assessments will be noted. Employers commonly request patient-specific information from the provider to help address potential threats. Pertinent case law relevant to these requests will be reviewed. Best practice approaches to addressing disability requests, American with Disabilities Act accommodation requests and information related to fitness for duty will be highlighted. Finally, guidelines for avoiding malpractice claims based on overdisclosure or underdisclosure of a patient's impairment will be discussed.

NO. 1

PERSONS WITH MENTAL ILLNESS AT WORK: ARE THEY MORE VIOLENT?

Speaker: Jessica Ferranti, M.D.

SUMMARY:

Dr. Ferranti will provide an overview of the relationship between mental illness and violence. She will review a typology of workplace violence, including violence between coworkers, violence related to robbery and other criminal acts, customer/client/patient-related violence, and domestic violence spilling over into the workplace. She will specifically examine the relationship of mental health problems in the workplace to workplace violence. The relevant psychiatric literature related to this question will be discussed.

NO. 2

FUNDAMENTAL FOUNDATION OF RISK ASSESSMENT

Speaker: Jason Roof, M.D.

SUMMARY:

Dr. Roof will review important clinical risk factors associated with violence risk. In particular, Dr. Roof will discuss specific characteristics of symptoms such as paranoia, substance use and personality disorder that increase violence risk. Violent fantasies, particularly with reference to individuals in the workplace, will be discussed. Dr. Roof will also discuss the importance of obtaining collateral information and conducting clinical risk assessment in the context of the limitations that can arise in obtaining such information. Finally, Dr. Roof will review the emerging focus on gun use history in individuals with mental illness.

NO. 3

HOW TO HANDLE AT-RISK SCENARIOS

Speaker: Charles Scott, M.D.

SUMMARY:

Dr. Scott will review the legal obligation, if any, related to a patient's report of past history of violence. He will highlight different common scenarios that can arise. In particular, he will discuss clinical and legal scenarios involving violent fantasies, sexually harmful fantasies, and specific threats toward coworkers or the employer. Dr. Scott will also review *Tarasoff* doctrines and subsequent *Tarasoff* progeny related to a psychiatrist's duty when they learn of a specific threat.

ONLINE PSYCHOTHERAPY: A NEW METHOD OF DELIVERING THERAPY

Chair: Nazanin Alavi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand more about online CBT and online dialectical behavior therapy (DBT); 2) Understand the effect of online CBT on anxiety and depression; and 3) Understand the effect of online DBT on borderline personality disorder.

SUMMARY:

Background: Psychotherapy is one of the most widely investigated and practiced forms of treatment for mental health problems. However, there are some barriers in delivering this treatment, including long waiting lists, therapist shortage and

lack of access in remote areas. In addition, many patients suffering from mental health problems are resistant to taking part in group psychotherapy, a core aspect of psychotherapy, especially therapy focused on skill building. With Internet use ever rising, it makes sense to explore alternative methods to overcome these barriers. This symposium presents a variety of studies that examine the efficacy of delivering psychotherapy (CBT and DBT) through email to children, adolescents and adults.

Methods: The division of psychiatry at Queen's University provides different psychotherapy groups for individuals suffering from a variety of mental health problems. Applicants were offered the opportunity to choose the online format or live group sessions. All the patients participating in live groups or using the online format were assessed by different questionnaires for evaluating the efficacy of the treatment. In each online session, patients were provided with general information on a certain topic, an overview of helpful skills and homework sheets. The material and format directly corresponded with the live group therapy session. Participants were asked to send their homework sheet back to the therapist on a specific day. The therapist responded the next day, providing them with feedback, new information sheets and a new homework assignment. **Results:** Statistical analysis showed that this method of delivering psychotherapy significantly reduced patients' symptoms, decreased the number of people on waiting lists, increased the compliance of patients participating in psychotherapy and increased the number of people who were able to receive appropriate skill-building treatment. **Conclusion:** Despite the proven short- and long-term efficacy of psychotherapy, there are significant barriers to delivering this treatment. These barriers include patient resistance to participating in live sessions, living in rural or remote areas where treatment is not readily accessible, immigration to and working in another country in which cultural and language differences may impact treatment seeking and efficacy, and long wait lists. It is an unequivocal public health need to overcome these barriers through developing alternative methods of delivering therapy. With Internet use ever rising, delivering psychotherapy through email might be a new way of offering patients a variety of psychotherapy modalities.

NO. 1

CBT BY EMAIL FOR CHILDREN AND ADOLESCENTS WITH ANXIETY/DEPRESSION

Speaker: Sarosh Khalid-Khan, M.D.

SUMMARY:

Background: CBT is one of the most widely investigated and practiced forms of psychotherapy for the treatment of mood and anxiety disorders in children and adolescents. However, there are some barriers in delivering this treatment, including long wait lists, lack of access in remote areas and adolescents' resistance to participate in live groups. With Internet use rising, especially among adolescents, CBT by email can offer an alternative effective treatment for this group. **Methods:** Patients who were referred to the Division of Child and Adolescent Psychiatry at Queen's University with depression or anxiety were given the opportunity to choose between live or online CBT. They were all assessed using The Beck Anxiety Inventory (BAI) and Child Development Inventory before and after treatment. During each session, participants were provided general information on a topic, an overview of helpful skills, homework sheets and direct feedback from the therapist. **Results:** Statistical analysis using ANOVA showed that email-based CBT significantly reduced BAI scores. BAI scores did not change in the live group. **Conclusion:** Despite the proven short- and long-term efficacy of CBT, there are some barriers in delivering this treatment. Delivering CBT through email might be an effective new method, especially in children and adolescents, considering the high rate of Internet use in this group and also their resistance to taking part in live sessions.

NO. 2

CBT BY EMAIL IN PATIENTS WITH DEPRESSION AND/OR ANXIETY

Speaker: Nazanin Alavi, M.D.

SUMMARY:

Background: CBT is one of the most effective methods used in the treatment of depression and anxiety. Some barriers in delivering CBT treatment are immigration to and working in another country in which cultural and language differences may impact treatment seeking and efficacy. With increased use of the Internet all over the world, this study was designed to explore the efficacy of delivering CBT through email in cases of depression and anxiety. **Methods:** Farsi-speaking people living inside or outside Iran with depression or anxiety

participated in this study. Participants were randomly assigned to email-based CBT or to a wait list control condition. The Beck Anxiety Inventory (BAI) and Beck Depression Inventory (BDI) were used to assess them before and after treatment. **Results:** Statistical analysis using ANOVA showed that email-based CBT significantly reduced BDI and BAI scores as compared to the control group, both following 10 – 12 weeks of treatment and at six-month follow-up. **Conclusion:** Our study showed that CBT by email is a viable method of delivering CBT in adults suffering from depression or anxiety.

NO. 3

DIALECTICAL BEHAVIOR THERAPY (DBT)? THERE IS AN APP FOR THAT!

Speaker: Margo Rivera

SUMMARY:

Background: Borderline personality disorder (BPD) is a common psychiatric disorder. Although DBT has been proven effective in the treatment of this disorder, many patients are resistant to participate in group psychotherapy, a core aspect of DBT. With Internet use ever rising, online DBT can provide an alternative treatment. **Methods:** Participants applying for treatment were offered the opportunity to choose between the online format or live sessions of the Managing Powerful Emotions Group. In each of the 15 sessions, patients were provided information about different skills, homework assignments and feedback regarding the previous week's homework from the therapist. Participants were assessed by using a self-assessment questionnaire and the Difficulties in Emotion Regulation Scale (DERS). **Results:** Statistical analysis showed that both online and live DBT significantly reduced DERS scores in all six categories; there was significant change in functioning and level of symptomatology in both groups, and there was no significant differences in the changes in the scores in the live and online groups. **Conclusion:** Despite the proven efficacy of psychotherapy, there are some barriers, including resistance to participating in live sessions, long wait lists and transportation challenges. With Internet use rising, delivering online psychotherapy might provide alternative treatment. This is the first study that has examined online DBT in the treatment of BPD.

WORKSHOPS

MAY 14, 2016

THE WHAT, WHEN AND WHY OF EKG'S IN PSYCHIATRIC PRACTICE

Chairs: Rohul Amin, M.D., Adam Hunzeker, M.D.

Speakers: Jed P. Mangal, M.D., Aniceto Navarro, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize cardiotoxic effects of psychotropics in clinical psychiatric practice; 2) List drug-specific and patient-specific characteristics placing psychiatric patients at risk for sudden cardiac death; 3) Identify triggers for obtaining EKG in psychiatric practice based on available evidence and clinical guidelines; and 4) Demonstrate comfort with basic EKG interpretation skills including manual QTc measurements in small groups using clinical vignettes.

SUMMARY:

The clinical utility of electrocardiogram (EKG) in medicine can be of great value to the patient and the health care delivery system. In psychiatric practice, several classes of pharmacotherapeutic interventions affect the cardiac conduction system, and some drugs even carry black box warnings by the Food and Drug Administration (FDA). It also has diagnostic value in drug overdose toxidrome presentations. EKG is a cost-effective tool in the diagnostic evaluation of many clinical scenarios such as syncope or acute chest pain, for example. However, the value of EKG diminishes when obtained in healthy patients, and the interpretation of such studies is fraught with pitfalls. As such, the use of EKG in psychiatric practice requires skillful and purposeful selection. Obtaining EKGs for a psychiatrist almost always requires consultation with outside provider, creating time and financial burdens for patients. Therefore, obtaining EKGs in all psychiatric patients would be impractical and possibly harmful due to issues related to cost, time burden on the patient and the psychiatrist, and false positives. Psychiatric residency training and real-world practice do not sufficiently train psychiatrists in the knowledge or skills needed to navigate the clinical decision trees that are required to make effective use of EKGs as a tool in their psychiatric practice. While the skill of a psychiatrist to interpret EKGs diminishes over time, they still have to know and understand the timing and settings for obtaining consultation for an EKG. In this workshop, we hope

to enhance the knowledge and skills of the participants in understanding triggers and decision points regarding appropriate electrocardiographic evaluation in their clinical practice. These skills are important for optimal patient care, and the fundamentals can be delivered to practitioners in a nominal amount of time. We will approach this using workshop strategy. Utilizing four small groups, each of us will lead the groups in an interactive manner. We will provide pocket cards with a clinical decisional algorithm and basics of EKG interpretation. Additional materials will be provided to participants to build upon their learned skills and/or take back to their students for dissemination.

MAKING YOUR PRESENTATION MORE INTERACTIVE: THE BETTER WAY!

Chair: Jon S. Davine, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the superiority of interactive group teaching versus a traditional didactic model in changing physician behavior; 2) Use and participate in different group activities that enhance interactive group teaching; and 3) Maximize the use of "Hollywood" film clips and audiovisual patient events to enhance group teaching.

SUMMARY:

Educational literature has shown us that traditional didactic presentations are usually not effective in ultimately changing physician performance. Conversely, interactive learning techniques, particularly in smaller group settings, have been shown to be much more effective. In this workshop, we look at factors that can enhance interaction, including room arrangements, proper needs assessment and methods to facilitate interactive discussions. We will start the workshop with a needs assessment, which will involve the active involvement of the participants. We will then have a didactic component, discussing some of the literature in this area. The group will then have an interactive component, which will involve participating in different group activities, such as "Buzz Groups," "Think-Pair-Share" and "Stand Up and Be Counted," which enhance small-group interaction. The use of commercial film to enhance educational presentations has been coined "cinemeducation." We will discuss techniques to help use film as teaching tools, along with having an experiential component involving the direct viewing

and discussion of a film clip. We will also comment on how to maximize the use of audiovisual tapes of patient encounters as a teaching tool. This will also involve direct viewing of an audiovisual tape to illustrate these principles. We will end with a summary and get feedback from the group as to their reaction to these methods of teaching.

LEADING SYSTEM CHANGE TOWARD INTEGRATED CARE: UNFUNDED, NOT READY, UNSURE? START HERE

Chair: Glenda Wrenn, M.D.

Speakers: Christopher Hoffman, M.D., Courtney L. McMickens, M.D., M.P.H., Kevin M. Simon, M.D., Elizabeth A. Frye, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand leadership and change management principles that are relevant to efforts to transition from usual to integrated care; 2) Discuss examples of change effort implementation; and 3) Apply a readiness framework to assess organizations considering transition to integrated care.

SUMMARY:

The future is coming. Integration of behavioral health in primary care is advancing due to evidence of impact on health outcomes and policy shifts that have enabled sustainability of the model. Existing training enables psychiatrists to practice integrated care, without many actual readymade opportunities to use those skills. Leadership is needed. However, many practices where care is being provided continue to provide "usual care." Often, this is due to a lack of readiness, which can be addressed through education and training. In this interactive workshop, we will present and discuss (in small groups) strategies to develop skills to lead efforts to advance integrated practice. We will present a framework for readiness that is currently being field-tested. Participants will hear examples of successful development in community settings. Specifically, we will present case studies of implementation impacting community-based primary care (adult and pediatric clinics), a homeless population-serving federally qualified health center and a resident-led collaborative care "startup." We will also offer practical suggestions to address and resolve expected challenges successfully.

FORT HOOD TRAGEDY: AN INSIDE PERSPECTIVE

Chair: Kaustubh G. Joshi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the process that went into completing the competency to stand trial and criminal responsibility evaluations of the Ft. Hood shooter and discuss information from the evaluation itself; 2) Discuss the differences between the military justice system and the civilian justice system; 3) Have a greater appreciation of violence risk assessments; and 4) Understand the differences between terrorism and workplace violence.

SUMMARY:

The chair of this workshop was the chief evaluator of a Department of Defense tri-service-appointed mental health team composed of two forensic psychiatrists and one neuropsychologist that was tasked with establishing the competency to stand trial and criminal responsibility of Nidal Hasan, M.D. (the Ft. Hood shooter). The Ft. Hood tragedy in November 2009 was the deadliest domestic attack on a U.S. military installation. The workshop will delve into the complexities of this evaluation and highlight the difference between the military and civilian justice systems. It will explore the reasons and motives for the shooter's actions and touch on violence risk assessments.

DIMENSIONAL CONCEPTUALIZATION AND DIAGNOSIS OF NARCISSISTIC PERSONALITY DISORDER

Chairs: Elsa F. Ronningstam, Ph.D., Igor Weinberg

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Use the *DSM-5* Section III hybrid dimensional and trait-focused diagnosis for narcissistic personality disorder; 2) Apply a collaborative, exploratory diagnostic strategy that identifies the range of narcissistic personality functioning, fluctuating self-esteem and the co-occurrence of both self-enhancing grandiosity and self-depleting vulnerability; 3) Understand the influence of comorbid conditions, suicidality, bipolar disorder and substance use disorder on the diagnosis of NPD; and 4) Use guidelines for alliance building with patients with narcissistic personality disorder.

SUMMARY:

This workshop will inform participants about the new diagnosis for narcissistic personality disorder

(NPD) outlined in the *DSM-5* Section III, which applies a combined dimensional and trait model for personality disorders, including level of self and interpersonal functioning and pathological personality traits. The first presenter will address the evaluation of regulatory patterns in narcissistic personality disorder, including self-esteem and sense of agency. This will be formulated in terms of impairments in sense of identity, self-direction, empathic capability and intimate interpersonal relationships and traits of grandiosity and attention-seeking as outlined in *DSM-5* Section III. The diagnosis will be applied to videotaped case examples. The second presenter will discuss the influence of psychiatric conditions often co-occurring with NPD i.e., suicidality, bipolar disorder and substance use) on narcissistic personality functioning and their impact on the diagnostic process. The final part of the workshop will discuss integration of the diagnostic process with alliance building and preparation for treatment. An exploratory collaborative strategy that aims to help the patient attend to the range of his/her personality patterns and internal experiences will be outlined that connects diagnostic features, patients' experiences of problems, and treatment goals and strategies.

EAST AND WEST: INTEGRATING CONCEPTS OF MENTAL HEALTH THROUGH STORYTELLING IN THE REFUGEE POPULATION

Chairs: Shirali S. Patel, M.D., Sophia Banu, M.D.

Speakers: Jeffrey Khan, M.D., Asna Matin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explore how storytelling can help patient and provider build an alliance and explore questions outlined in the *DSM-5* cultural formulation; 2) Understand how to explain *DSM-5* symptoms and diagnoses to individuals for whom these constructs may be foreign to their idea of mental health and well-being; and 3) Recognize the transference/countertransference that may occur in patient and clinician not just toward each other, but also toward the regions/countries they are from/have come to.

SUMMARY:

Given the burgeoning number of displaced individuals amidst ongoing political, cultural and religious turmoil, it is becoming increasingly important to understand the experiences of refugee/migrant populations so that they receive

appropriate treatment while re-establishing their lives in new settings. Since refugees often come from non-Western cultures, it can be particularly difficult for both provider and patient to communicate directly about symptoms, diagnoses and, ultimately, the meaning of well-being and mental health. The *DSM-5* Cultural Formulation Interview highlights multiple areas that are important to address and understand during a mental health assessment. However, it is often difficult to directly ask and obtain accurate answers to these questions from a patient who has experienced trauma and recently landed in a foreign environment. While vital to understand, questions about cultural, religious and national identities; resilience and vulnerability; and distress and illness often get lost in translation secondary to language constraints. Furthermore, patients may not feel prepared or even be consciously aware of their own beliefs to immediately answer these weighty questions when asked, and providers may also become frustrated by the lack of clear responses from the patient. With the exception of acutely suicidal, homicidal and psychotic patients, it therefore seems imperative to approach case formulation for the refugee population in much the way a provider would approach a non-refugee patient seeking long-term therapy. Houston, TX, has long been a highly diverse city, but recently, it has also become a "resettlement magnet," accepting the majority of refugees resettled in the state of Texas and a sizable proportion of those settled in the U.S. overall. During this workshop, refugee patient encounters from the Harris Health Clinic for International Trauma Survivors will be presented, with the goal, through audience participation, of recognizing how storytelling can help develop an alliance between patient and provider, as well as provide space for the refugee to give more organic responses to those questions highlighted by the *DSM-5* Cultural Formulation Interview. Attention will also be paid to how this technique can help both patient and provider integrate Western and non-Western categorizations of symptoms and *DSM-5* disorders so that patients remain comfortable seeking help and are appropriately diagnosed and treated.

WHEN YOU HEAR HOOF BEATS, THINK HORSES AND ZEBRAS: THE IMPORTANCE OF A WIDE DIFFERENTIAL IN DELIRIUM/DEMENTIA CASES

Chair: Ana Turner, M.D.

Speakers: Sai Hu, D.O., Bruce Bassi, M.D., M.S., Uma

Suryadevara, M.D., Stephen Welch, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the similarities and differences in diagnosing delirium and dementia; 2) Express the association between delirium and higher health care costs, distress for patients and caregivers, reduction of independence, and significant morbidity and mortality; 3) Identify which laboratory and imaging studies are needed to complete an exhaustive delirium workup; 4) Identify medications known to cause or worsen confusion; and 5) Delineate other psychiatric conditions that could present very similar to delirium.

SUMMARY:

In hospital settings, identifying and treating the source of altered mental status among elderly patients can be very difficult. We propose a case-based workshop that will educate participants on the need to “cast a wide net” when identifying possible causes and treatments for altered mental status. While confusional states can be separated into two major categories—acute organic causes (delirium) and chronic psychiatric causes (dementia or major/ minor neurocognitive disorders)—etiology is frequently multifactorial. With this workshop, we will highlight the reason as to why the diagnostic clarification of delirium is exceedingly important and why it is essential to understand the similarities and differences between delirium and dementia. Research shows significant associations between delirium and higher health care costs, distress for patients and caregivers, reduction of independence, and significant morbidity and mortality. However, studies find that when underlying causes are effectively treated, delirium is more likely to be reversible; thus, the prompt diagnosis of delirium can reduce the risk of these potentially adverse outcomes. The second 30 minutes will illustrate a case that highlights the importance of obtaining a broad differential diagnosis for delirium, even when there are many to be found: Mr. G., a 57-year-old brought to the hospital involuntarily from hospice care for worsening agitation and psychosis over the prior two days. Prior to that, he had subtle confusion and occasional visual hallucinations for two months. We will elicit audience participation to delineate possible sources of acute, subacute and chronic cognitive changes. While referring to Mr. G.’s case, we will review medications known to cause or worsen confusion and identify which laboratory and

imaging studies are needed to complete an exhaustive delirium workup. In the last 30 minutes, we will break into small groups and discuss a case of altered mental status in which all signs point toward delirium. Mr. C. is a 64-year-old male brought into the hospital for worsening infection in his right hand that ultimately led to a transmetacarpal amputation and found to have significantly elevated blood glucose levels. The patient reported a history of nail biting, which led to the necrotizing infection, and a remote history of self-scratching. The patient’s family also reported a gradual change in personality and that he needs assistance with performing some of his activities of daily living. At first glance, the patient seems to have an underlining hypoactive delirium secondary to necrotizing fasciitis or possibly sepsis. However, on a closer review of his symptoms, other differentials may better account for his presentation, such as OCD, excoriation disorder or neurocognitive disorder, specifically frontotemporal dementia. We will guide the small groups to delineate other psychiatric conditions that could present very similar to delirium.

COGNITIVE BEHAVIOR THERAPY FOR PERSONALITY DISORDERS

Chair: Judith S. Beck, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Conceptualize personality disorder patients according to the cognitive model; 2) Improve and use the therapeutic alliance in treatment; 3) Engage Axis II patients in treatment; 4) Set goals; and 5) Describe advanced cognitive and behavioral techniques.

SUMMARY:

A number of studies have demonstrated the efficacy of cognitive behavior therapy in the treatment of patients with personality disorders. The conceptualization and treatment for these patients is far more complex than for patients with acute disorders such as depression and anxiety. Therapists need to understand the cognitive formulation for each of the personality disorders. They need to be able to take the data patients present to develop individualized conceptualizations, including the role of adverse childhood experiences in the development and maintenance of patients’ core beliefs and compensatory strategies. This conceptualization guides the clinician in planning treatment within and across sessions and in

effectively dealing with problems in the therapeutic alliance. Experiential strategies are often required for patients to change their core beliefs of themselves, their worlds and other people, not only at the intellectual level but also at the emotional level.

ONLINE EDUCATION: OPPORTUNITIES FOR TEACHING, COLLABORATION, FUNDING AND ADVANCEMENT

Chairs: Czerne M. Reid, Ph.D., Regina Bussing, M.D.

Speakers: Czerne M. Reid, Ph.D., Jacqueline A. Hobbs, M.D., Ph.D., Barry Setlow, Ph.D., Regina Bussing, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify clinical and/or basic science subject areas suited to a collaborative online graduate or other course or program; 2) Craft a convincing rationale for developing a new online course or program in his or her department; 3) Design a curriculum for an online graduate or other course or program; and 4) Identify departmental, institutional and other resources that can be corralled for an online course or program.

SUMMARY:

Universities have, to varying extents, embraced online education as a viable and cost-effective way to reach students both within and beyond their geographical boundaries. Online offerings range from individual for-credit courses to entire degree programs. Still other manifestations include free, not-for-credit massive open online courses—the so-called MOOCs—through platforms such as the nonprofit Coursera or MIT's edX. Colleges of medicine and departments of psychiatry are not excluded from online learning. They are, in fact, in a good position to take advantage of online education as a way to provide faculty members and trainees with opportunities for graduate and undergraduate teaching, collaboration, funding and academic advancement. To this end, the University of Florida (UF) Department of Psychiatry has availed itself of an online-friendly climate within the UF College of Medicine and the wider university. Our online education program includes undergraduate courses that help prepare students for medical school, a six-course Graduate Certificate in Addiction and Recovery, and other programs at varying stages of development. Using UF's Graduate Certificate in Addiction and Recovery as an example, this

workshop will use small-group activities to explore how departments of psychiatry may use online education to provide channels for faculty, fellows, residents and graduate students to gain teaching credit and experience, collaborate, and earn teaching-related university funds for their departments. We will also look at financial, logistical and other barriers and solutions associated with developing online programs.

PRODROMAL PSYCHOSIS: ETHICAL CHALLENGES IN CLASSIFICATION, DIAGNOSIS AND TREATMENT

Chairs: Raquel Gur, M.D., Dominic Sisti, Ph.D.

Speakers: Dominic Sisti, Ph.D., Monica E. Calkins, Ph.D., Erich M. Dress, B.S., Andrea G. Segal, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the key nosological controversies that underpin related ethical issues; 2) Identify ethical issues related to research involving minors who are on the psychosis spectrum; and 3) Discuss the unique forms of stigma associated with at risk states for serious mental illness.

SUMMARY:

Schizophrenia does not develop de novo; rather, it develops over time, emerging from what researchers and clinicians now recognize as a prodromal stage. Observable clinical signs of this stage typically occur during adolescence or early adulthood. New assays and technologies—including imaging studies, neurologic and neurocognitive testing, genetic analysis, and psychometric screening—are now being used to try to understand neurodevelopmental changes occurring at this stage with the ultimate goal of potentially predicting or even preventing the onset of schizophrenia. Clinicians and researchers continue to grapple with the ethical and policy ramifications of these technologies as they grow increasingly concerned with providing adolescents and their guardians appropriate information about their presumptive at risk status. The effects of diagnosing and disclosing the symptoms of attenuated psychosis syndrome are not well understood. As such, it is necessary to empirically investigate attitudes and perceptions toward mental illness among these individuals and their primary social supports. This workshop will provide an analysis of the key ethical issues related both to the research and treatment of presumptive risk states, including how to properly disclose and explain risk information, unique forms of stigma

associated with at risk states and questions about appropriate preventative treatments. These issues are ultimately grounded in a key nosological question that continues to confound researchers: What are the precise boundaries of the psychosis prodrome? In this workshop, we will describe philosophical, ethical and empirical findings from our prodromal schizophrenia empirical and ethical nexus (PSEEN) collaborative study at the University of Pennsylvania.

TEACHING DIAGNOSTIC REASONING SKILLS AND THE MITIGATION OF COGNITIVE BIAS

Chairs: Adam Hunzeker, M.D., Rohul Amin, M.D.

Speakers: Jarred Hagan, D.O., Allison Webb, M.D., Adam Hunzeker, M.D., Rohul Amin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Summarize typical diagnostic processes and methods of clinical reasoning; 2) Recognize four common types of cognitive biases leading to diagnostic thought errors among psychiatrists; 3) Summarize at least two techniques to reduce thought errors in psychiatric diagnostic evaluations; 4) Using small groups, demonstrate techniques to teach diagnostic reasoning to your residents and fellow psychiatrists; and 5) Using provided deliverables and lesson content, implement the workshop in your didactics over a single session at your institution.

SUMMARY:

Psychiatry is a constantly evolving clinical science. As the body of knowledge grows, practitioners must constantly incorporate new information into their practice. This evolution is fraught with ambiguity manifesting itself in day-to-day clinical encounters. Without deliberate attention paid to the diagnostic process, practitioners can inadvertently commit thought errors and invite cognitive bias. These preventable errors can lead to incorrect diagnosis and costly, inappropriate interventions. While mistakes are inevitable, it is essential that psychiatrists hone their diagnostic skills to mitigate the effects of cognitive bias and cognitive error. It is necessary for practitioners of medicine to focus inward and to analyze how they employ cognitive strategies, utilize heuristics, mitigate cognitive bias and utilize fast versus slow thinking. Only by understanding how we diagnostically approach ambiguity can we begin to mitigate the effects of cognitive error. Data have shown that through

education, providers can decrease diagnostic error and improve clinical outcomes. The objective of this workshop is twofold. The first objective is to help learners become familiar with various cognitive strategy theories and learn to mitigate personal contributions of diagnostic error. The second goal is to assist teachers to create a concise approach to educating residents and fellow psychiatrists on these principles. Residency programs and daily practice are filled to capacity with educational requirements. Many curricula compete for the limited time available to residents and attendings. The goal of this workshop is to deliver this lesson in a single 90-minute session. While not comprehensive, it will provide a foundation for continued self-learning and clinical growth. Participants will be provided teaching content and other deliverables to easily incorporate this workshop into their residency's curriculum.

TRAUMA, CONDUCT DISORDER AND VIOLENCE PREVENTION IN THE COMMUNITY

Chair: Lara J. Cox, M.D., M.S.

Speakers: Matthew L. Dominguez, M.D., M.P.H., Anish R. Dube, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the overlap between trauma-related symptoms and problems such as conduct disorder and aggressive behavior with regards to epidemiology, phenomenology, neurocognition and neurobiology; 2) Describe the prevalence of trauma in justice-involved youth and high-risk youth in the community and its impact on mental health and legal outcomes; and 3) Understand how trauma-informed interventions can have an impact on violence among criminally involved youth in the community, and learn practical skills for implementing one of these interventions.

SUMMARY:

Youth involved in criminal activity and in the justice system have high rates of trauma and adverse childhood experiences (ACEs). In the juvenile justice system, almost 95% of youth have been exposed to at least one traumatic event or ACE, with most experiencing multiple events including exposure to community violence. Despite high rates of trauma exposure, few justice-involved youth carry a diagnosis of PTSD; those who do are three to five times as likely as their peers to be diagnosed with conduct disorder in addition to PTSD. Trauma-

related symptoms have strong overlap with conduct disorder, particularly in youth who do not meet criteria for the limited prosocial emotions specifier. This is true not only in terms of risk factors and behavior, but also changes in neurocognition and neurobiology. This includes hypersensitivity to threat that can lead to reactive aggression, which becomes part of the epidemic of community violence. This is perpetuated by the victim-perpetrator dichotomy, which focuses on punishing the behavior; this often results in placement in the juvenile justice system rather than mental health treatment. Involvement with the justice system is associated with significant negative outcomes across multiple domains. Nearly half of detained youth have at least one diagnosable mental illness at five-year follow-up. Annual mortality rates for youth who have been in juvenile detention are four times higher than those of their non-detained peers, and more than 90% of these deaths are due to homicide, usually by gun. The majority of those detained are rearrested within five years. Of note, there is a strong correlation between number of adverse childhood experiences and recidivism risk. Community interventions such as Cure Violence in Chicago have been shown to significantly reduce violence by using a public health model and trusted community ambassadors. The addition of a trauma-focused CBT approach to this viral violence model, which shifts the approach to violence from the victim-perpetrator dichotomy to seeing it as a traumatic event affecting the entire community, has further potential to reduce violent behavior and perhaps prevent long-term involvement in the criminal justice system. Community ambassadors can be provided with education about trauma, means of screening for trauma-related symptoms, and initial CBT techniques for immediate symptom management as a step toward this goal. A pilot project, Cure Violence/Heal Trauma, is underway, which is designed to shift focus to place the emphasis on providing services to all individuals exposed to the trauma. During weekly meetings with high-risk youth, trauma education, mental health screenings and CBT exercises are employed to identify and reduce exaggerated responses to triggers that may perpetuate violence. These exercises may also be useful to clinicians working in the community, and several will be described and practiced in this workshop.

DIAGNOSING DEMENTIA: A GUIDE TO BIOMARKER TESTING IN THE CLINIC

Chair: Vimal M. Aga, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Enumerate the indications for CSF and neuroimaging biomarker testing in the work-up of dementia; 2) Identify the CSF and neuroimaging signatures of the common dementias; and 3) Order and interpret these biomarker studies in their own clinical practices.

SUMMARY:

Dementia is a clinical syndrome, and unlike the primary psychiatric syndromes, establishing a disease-specific diagnosis is not only possible in most cases but is also now the standard of care. There are several reasons for this. Reversible etiologies must be identified and treated. Even in the primary neurodegenerative dementias, a disease-specific diagnosis guides treatment of both cognitive and behavioral symptoms in all stages of the disease. Families are becoming increasingly aware of the various etiologies of dementia and routinely seek this information. Establishing a disease-specific diagnosis can also aid further genetic testing, if necessary, of the patient and, at times, of family members. CSF and neuroimaging biomarker studies are a critical part of the diagnostic work-up of dementia and can greatly increase the specificity of clinical diagnoses. Biomarkers have now been incorporated into some of the newer diagnostic criteria. In clinical practice, CSF biomarker testing is usually reserved for selected cases. Structural neuroimaging, on the other hand, is recommended in all patients with a new diagnosis of dementia; in some of these, functional neuroimaging may also eventually be necessary. Brain imaging is now done mostly to rule in neurodegenerative disorders that result in dementia rather than to simply rule out treatable causes of dementia. The common dementias are known to have pathognomonic CSF and neuroimaging signatures, and the latter are usually not commented upon by radiologists in the imaging report. Therefore, it is imperative that clinicians working with dementia patients have a thorough understanding of when and how to order appropriate CSF biomarker and neuroimaging studies. Furthermore, dementia patients will often bring in reports of biomarker studies that were previously done elsewhere, so clinicians need to know how to interpret such studies regardless of who ordered them. This practical workshop, the second of two in this series on diagnosing dementia

in the clinic, will introduce the clinician to biomarker testing in patients with dementia, with emphasis on structural brain imaging, primarily MRI. Clinical cases from the presenter's own practice will be used again to illustrate key points. Indications for ordering FDG-PET scans to further differentiate between the various dementias and the issue of reimbursement will also be covered briefly. A working knowledge of human neuroanatomy will be helpful, but is not essential to participate in this workshop.

SPORTS PSYCHIATRY: PROVIDING BEHAVIORAL HEALTH and PERFORMANCE SERVICES TO SPORTS ORGANIZATIONS/TEAMS AT HIGH SCHOOL/CLUB, COLLEGE and PROFESSIONAL LEVELS

Chair: David R. McDuff, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Become aware of the common mental health, substance use and performance problems seen in athletes in different sports and competitive levels; 2) Design, staff and provide year-round psychiatric services to sports organizations and teams; 3) Develop specific evaluation and treatment skills during the life cycle of the sport's year (off-season, preseason, season, postseason); 4) Develop different strategies for negotiating and designing services for teams at different competitive levels; and 5) Become skilled at dealing with an athlete's typical conflicts with family members, friends and coaches at different competitive levels.

SUMMARY:

Most members of sports organizations and teams will utilize psychiatric services at very high levels throughout the year if broad in scope and if offered on-site at the training facility at no cost to individuals. Services should be comprehensive and include substance misuse prevention; stress control; conflict resolution/crisis intervention; sleep and energy management; injury recovery and pain management; mental preparation; mental disorder treatment; and advice about team composition, chemistry and unity. Services should ideally be offered to all members of the organization, including the front office, coaching staff, team staff (medical, conditioning, equipment, video, etc.), players and their families. Team executives such as owners, general managers, athletic directors and head coaches/managers are especially receptive to services that evaluate emotional maturity, character and mental toughness; ensure performance

consistency; and determine the presence and manageability of common mental disorders in recruited and rostered athletes. Coaches are interested in services that improve player performance by minimizing barriers such as stress, insomnia, anxiety, inattention and impaired learning and increasing the use of mental strategies in practice and competition. Players will readily use on-site services if they see them as enhancing mental toughness and performance or dealing with distractions such as relationship conflicts or distress in family members. This workshop will outline a general way to design and offer services to teams during the preseason, season, postseason and off-season. The critical services, staffing patterns, job descriptions and contract design will be discussed for club/high school, college and professional teams. Specific services and strategies for the off-season related to player recruitment, such as mental illness screening and character/resiliency assessment, will be highlighted. In addition, suggestions for reducing coaching staff stress levels and improving their fitness and flexibility will be discussed. For the preseason, suggestions on how to engage players in goal setting, handling pressure, performance monitoring and mental skill acquisition will be outlined so that they reach their full potential. Finally, for the season and postseason, techniques for maintaining team unity, managing player/coach conflicts, rebounding from losses and mistakes, preventing off-the-field incidents, and attaining peak performance will be detailed using a once- or twice-a-week on-site model at practices and/or competitions. Utilization of service rates should exceed 50% in a year with these approaches.

HOW TO USE ALCOHOLICS ANONYMOUS IN CLINICAL PRACTICE

Chair: Marc Galanter, M.D.

Speakers: Joseph J. Westermeyer, M.D., Ph.D., John A. Fromson, M.D., Alphonse Kenison Roy III, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Apply appropriate selection criteria for referral to Twelve Step groups; 2) Integrate patients' experience in AA into ongoing therapy; 3) Make use of adjunctive AA for inpatient settings; and 4) Develop the optimal relationship between outpatient clinic treatment and community-based AA groups.

SUMMARY:

This workshop is designed to help clinicians improve patient outcomes in relation to alcohol and drug dependence, psychiatric disorders of high prevalence with 14% and 7.5% of the population, respectively, meeting established diagnostic criteria. Although 3% of the population reports having attended an AA meeting, the AA triennial survey of its membership revealed that only 4% of the respondents were referred to this fellowship by "medical professionals," likely reflecting a disjunction between clinical need and effective practice. Why is there an apparent deficit in use of AA relative to its potential use by psychiatrists? Most psychiatrists have had limited exposure in their training regarding 1) Who is suitable for referral; 2) How AA works to promote abstinence; and 3) How best to refer patients to this fellowship. This workshop is designed for participants to gain an understanding of the role this fellowship can play in clinical practice to 1) Improve their skills in patient selection for AA; 2) Achieve effective referral; and 3) Employ optimal patient management relative to its use. Three speakers expert in these issues will each present techniques for how to achieve this in respective patient settings, followed by an exchange with the attendees on how to best apply the skills discussed. The workshop will be divided as follows: three 15-minute presentations, each followed by a five-minute QandA from the attendees, followed by full discussion. The presentations are as follows: 1) Integrating AA Referral Into Clinical Office Practice: Utility for patients with severe substance use disorder and for some patients with moderate disorder, how to help a patient make use of the AA encounter, and using techniques drawn from the NIAAA format for Twelve-Step facilitations; 2) Integrating AA Use in the Inpatient Setting: Balancing Twelve-Step involvement with medication and CBT-oriented programs, drawing on AA volunteers to conduct Twelve-Step groups in proximity to the unit as appropriate, managing staff to make appropriate referral to AA, and referral of aftercare patients to AA-based step-down programs; and 3) Using People in AA-Based Recovery in Outpatient Settings: Defining the appropriate role for such parties as adjunctive to professional care, employing recovering people in ambulatory networks such as physicians health programs, the appropriate relationship between professionally based outpatient programs and community-based AA meetings, and the distinction between the use of AA and Narcotics Anonymous. The last half hour will address clinical problems encountered by attendees

relative to the use of Twelve-Step programs. Exchanges between attendees and with panel members will focus on specific clinical situations relative to patients encountered in practice and how clinical outcome can be maximized in those situations.

EFFECTIVE MANAGEMENT OF REASSURANCE-SEEKING BEHAVIOR IN OCD: STRATEGIES FOR CLINICIANS AND FAMILY MEMBERS

Chairs: Phillip J. Seibell, M.D., Megan Hughes-Feltenberger, Ph.D.

Speakers: Phillip J. Seibell, M.D., Megan Hughes-Feltenberger, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explain why reassurance-seeking is a compulsion and why providing reassurance makes OCD worse; 2) Describe how to effectively use the "reassurance notebook" to gradually reduce reassurance-providing over time; 3) Describe strategies that can be used by psychiatrists and other clinicians to gradually decrease reassurance-providing during treatment of patients with OCD; 4) Learn how to provide psychoeducation to family members regarding how to gradually reduce reassurance-providing at home; and 5) Discuss reassurance-seeking regarding medications and their effects during medication management sessions in the context of effectively providing appropriate medication education.

SUMMARY:

Reassurance-seeking is a common symptom of obsessive-compulsive disorder (OCD). Although it is natural to want to help a patient (or family member) with OCD feel better by answering reassurance-seeking questions, we know that providing reassurance makes OCD worse. In this workshop, background information about reassurance-seeking behavior will be provided. There will be a discussion regarding how to provide psychoeducation to family members so they can distinguish between true information-seeking and reassurance-seeking, how to respond to reassurance-seeking and how they can regroup after accidentally providing reassurance. In addition, reassurance-seeking regarding medications and their effects during medication management sessions will be discussed with a focus on how to effectively provide appropriate medication education in this context. Part of the presented strategy will include demonstrating and describing

how to effectively use the “reassurance notebook” to gradually decrease reassurance-providing over time. Throughout the workshop, the presenters will role-play parts of a therapy session in which an OCD client attempts to seek reassurance about various issues, including medication. The reassurance-seeking will be effectively managed by the clinician. Examples will be elicited from the audience throughout the workshop. Audience members will be engaged in a lively discussion about the management of reassurance-seeking behavior in OCD.

PRACTICING COGNITIVE BEHAVIOR THERAPY: AN EXPERIENTIAL WORKSHOP

Chair: Judith S. Beck, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Implement standard components of the session structure; 2) Elicit and evaluate key cognitions; and 3) Elicit and use patient feedback to strengthen the therapeutic alliance.

SUMMARY:

Much empirical literature has demonstrated that cognitive behavior therapy (CBT) is efficacious in the treatment of depression and anxiety, as well as many other psychiatric disorders and psychological problems. While many psychiatrists have read about or attended professional presentations on this approach, they have not had the opportunity to practice fundamental strategies. In this experiential workshop, basic techniques of CBT will be discussed and then demonstrated through role-play. Participants will then practice techniques in dyadic role-play. The role-playing “patient” will provide the role-playing “therapist” with feedback, and a large group discussion will address questions and hone participants’ performance. Techniques will include how to set goals with clients, how to educate patients about the cognitive model, how to set an agenda, and how to identify and evaluate automatic thoughts.

DRAWING HEALING FROM WITHIN: ART THERAPY AND SOLDIERS IN CRISIS

Chairs: Sebastian Schnellbacher, D.O., Brenda Maltz, M.A., R.N.

Speaker: Brenda Maltz, M.A., R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify ways that art therapy can help service members; 2) Better understand ways art therapy can be included in the multidisciplinary team; and 3) Appreciate a gallery of art created in a military therapeutic environment.

SUMMARY:

Group art therapy is a therapeutic modality that brings withdrawing, socially avoidant and at-risk service members into a therapeutic space where they can express themselves in a safe manner. The art therapist guides the creative process to promote individual self-awareness, emotional regulation and cognitive reframing and encourages therapeutic dialogue between the group members. While more frequently used in the civilian environment, art therapy also allows nonverbal processing of experiences unique to military culture and related stressors. This workshop will focus on the benefits of incorporating this therapy into the multidisciplinary team environment normally seen in military inpatient wards and intensive outpatient programs. Finally, a gallery of art created within a military therapeutic environment will be presented and used to demonstrate how art can reveal pertinent information about a soldier’s interpersonal and psychosocial impairment, trauma-related issues and suicidality.

CHILD AND ADOLESCENT PSYCHIATRY “NOVELTIES”: NEW TRENDS IN ADOLESCENT ADDICTION, EATING/FEEDING DISORDERS AND PSYCHOSOMATIC MEDICINE

Chair: Susan Samuels, M.D.

Speakers: Matthew Shear, M.D., Jonathan Avery, M.D., Susan Samuels, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Better understand *DSM-5* diagnostic criteria and treatment options for feeding and eating disorders in children/adolescents; 2) Effectively identify symptoms consistent with current/common drugs of abuse, as well as approaches to address adolescent addiction; and 3) Appreciate the unique interplay between chronic medical illness and psychiatric presentations in the child/adolescent population.

SUMMARY:

Within the field of child and adolescent psychiatry, several commonly encountered but less well-

understood diagnostic and treatment challenges often require unique approaches essential to successful results. Among these diagnoses, feeding and eating disorders may require unique clinical acumen. In this workshop, basic guidelines for encouraging underweight children to eat will be provided, as well as treatment strategies for such a psychiatric illness for which there is no FDA-approved medication. Furthermore, management, as a psychiatrist, of the medical consequences of eating disorders and interactions with other disciplines that may be involved will also be discussed. Adolescent substance use disorders, also often requiring a unique skill set, will be covered, in particular how to detect and assess for use of novel drugs of abuse, how and when to use medications targeting adolescent addiction, and guidelines for interacting with other disciplines involved. Finally, because chronic medical illness in children and adolescents can pose significant psychosocial stressors, it is essential to understand how these stressors can lead to or be complicated by psychiatric symptoms, including suicidality. General principles for assessment of evolving anxiety, depression and suicidality in this population will be discussed.

AT WHAT COST? PSYCHIATRY, THE FINANCES INVOLVED AND THE FUTURE OF THE FIELD

Chairs: Matthew D. Erlich, M.D., Sharat P. Iyer, M.D., M.S.

Speakers: Matthew D. Erlich, M.D., Sharat P. Iyer, M.D., M.S., Andres Barkil-Oteo, M.D., M.Sc., Leslie Marino, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the impact of the economic transformations in behavioral health care and subsequent implications to the future of mental health services; 2) Address the growing importance of how fiscal constraints and new funding opportunities are shifting the roles of psychiatrists and other allied mental health professionals; 3) Learn novel recovery-oriented, outpatient approaches that are currently used (and in development) to deliver recovery-oriented care due to health care refinancing; 4) Understand how mental health research priorities will need to change in order to address a shifting delivery system and newly emerging pay-for-performance demands; and 5) Determine 21st century psychiatry residency training needs to enhance the knowledge base of

future psychiatrists in the new economics of behavioral health.

SUMMARY:

The rapid transformation of psychiatry comprises a “fourth psychiatric revolution” reshaping the field in the areas of service delivery, policy, research and education. While many experts opine about the potential impacts this may have, the views of the newest psychiatrists entering the field amidst these changes is not a central focus. New psychiatrists find the ground moving beneath them, with health care reform policies, financial transformations and shifting demands challenging the newest members of the professional workforce. This workshop will provide an interactive discussion of various viewpoints on the future of psychiatry with respect to economics. We will discuss how to best confront financial changes and challenges with a panel of members-in-training and early-career psychiatrists in roles that span the spectrum of the field, though the discussion will include psychiatrists at all stages to help guide the future of psychiatry. Although our profession is adept at training clinical management, future psychiatrists will need to be fluent in administrative and financial concerns related to behavioral health. This will become an increasing priority among training programs, as future psychiatrists will need to understand the transformations occurring with respect to how behavioral care is delivered, how pay-for-performance measures will impact care, how contracted governmental not-for-profit care is altering the safety net for SMI consumers and the increasingly diverse workforce from psychiatrists to peers to managed care medical directors. Whereas there remain multiple “evidence gaps” regarding the dissemination and implementation of evidence-based treatments into community-based care, there is an increasing need to bridge the financing realities of behavioral care and understand what new services have emerged and which are no longer fiscally prudent. Without understanding the new economics of behavioral care, we will continue to train new psychiatrists in a model of care that is no longer viable. Importantly, the promises of the future have never been brighter. Health care reform offers new funding opportunities to improve the recovery-oriented care of people with mental illnesses at a population level, improving integrated models of care with incentives to align with our medical colleagues and enhancing supportive, community-oriented psychosocial services that will

enhance reentry into the community and maintaining wellness in the community. New modalities derived from managed care coordination may enhance best-practices, and improved measurements should help ensure better treatment of the consumers. Finally, with the ever-changing landscape of psychiatric research and treatment comes the novel opportunity to reshape psychiatric training to better address future models of care, especially regarding fiscal fluency.

MINDFULNESS AND QIGONG FOR STRESS REDUCTION

Chair: Colleen Loehr, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand scientific evidence regarding mindfulness and qigong as interventions to reduce stress; 2) Practice mindfulness and qigong exercises to reduce stress; and 3) Teach stress-reducing mindfulness and qigong exercises to patients.

SUMMARY:

This workshop will provide highlights from the growing body of scientific evidence regarding the effectiveness of mindfulness and qigong at reducing stress and improving overall well-being. Participants will be guided through several exercises that combine the energizing movements and deep breathing of qigong with the focused present moment awareness of mindfulness. The presenter will relate experiences of teaching mindful qigong practices to psychiatric inpatients at a forensic hospital. Participants in this workshop will have the opportunity to feel both invigorated and calmed by engaging in a variety of mindful qigong exercises.

MENTAL HEALTH AND THE CASE FOR SINGLE PAYER POST-ACA

Chairs: Leslie H. Gise, M.D., Steven S. Sharfstein, M.D., M.P.A.

Speakers: J. Wesley Boyd, M.D., Ph.D., Stephen B. Kemble, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate how the ACA and current health care reform disproportionately penalize psychiatrists and their patients; 2) Understand how private insurers have adversely affected the practice of psychiatry; 3) Appreciate the

changes in mental health spending versus total health spending over the past thirty years; and 4) Understand how a single payer national health program would be universal with better quality and lower costs.

SUMMARY:

There is broad consensus that our health care system should provide quality, affordable health care for all, but the ACA is failing to deliver improved outcomes, lower costs and universal coverage. The deficiencies of the law disproportionately affect psychiatrists and patients with mental health problems. There is not consensus on how to proceed. This workshop will examine alternatives including a publicly funded single payer national health program. Of the 30 million people who will remain uninsured after full implementation of the law, psychiatric patients are over-represented. With a single payer system, everyone would automatically be covered at birth, including psychiatric patients. Half of psychiatrists don't accept insurance primarily because of low reimbursement, which is a barrier to access to mental health services. With single payer, a doctors' group, like the AMA, would be included in negotiations of standardized, reasonable rates so psychiatrists would participate. To improve health outcomes, the law relies on new payment models and new delivery systems, which are unproven. Data indicate that our poor health outcomes are linked to lack of insurance. With universal coverage, our health outcomes would improve and be comparable to other developed countries. The U.S. spends twice as much on health care as other developed countries. In addition, public funds are being used to subsidize private insurers who have disproportionately targeted spending for mental health and shifted the practice of psychiatry away from psychotherapy toward psychopharmacology. Insurers act like mental health treatment will break the bank, but mental health spending has stayed at 1% of GDP since 1986, while total health spending has climbed from 10% to 17% of GDP. Psychiatrists spend the highest percentage of their time on administration compared to other specialties: >20%. Replacing our inefficient, multi-payer, private insurance system with a publicly funded national health program, like an expanded and improved Medicare for all, would save at least \$400 billion annually by slashing the administrative waste associated with the private insurance industry. The overhead of our public Medicare is low, 2%. The savings would be enough to cover all the uninsured

and upgrade benefits, including psychotherapy, for everyone else. The APA has position statements supporting universal health care and universal access to psychiatric care, and the Assembly passed “health care is a right,” but access to mental health care is limited by private insurers. Other national medical professional organizations support single payer reform and there are bills in Congress that would establish single payer reform. Psychiatrists are disproportionately penalized by low reimbursement, denial of claims, intrusions into psychiatric practice and excessive administrative burden. The APA has been fighting for parity, and a single payer system would achieve that goal.

THE ULTIMATE BALANCING ACT: MEDICINE, MARRIAGE, MOTHERHOOD AND ME

Chairs: Sarah M. Fayad, M.D., Almari Ginory, D.O.

Speakers: Jacqueline A. Hobbs, M.D., Ph.D., Sarah Johnson, M.D., Misty Richards, M.D., M.S., Kimberly Gordon, M.D., Molly McVoy, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review expectations women psychiatrists have for their careers, roles, life transitions and the challenges they experience developing a work-life balance; 2) Describe how this delicate balancing of roles has been navigated by other physicians; 3) Discuss pearls and pitfalls in balancing multiple roles and express the barriers to career satisfaction in psychiatry among women and underrepresented minorities; 4) Explain strategies that individual women and institutions can employ to enhance professional growth by development of a mentoring network; and 5) Demonstrate techniques that facilitate stress reduction and time management to prevent burnout and work-life conflict for women physicians.

SUMMARY:

The percentage of women entering medicine has expanded markedly in recent years, with females comprising half of medical student and resident populations. These women typically have a multitude of roles: physician, spouse and mother. They must also care for themselves. Unfortunately, many of these roles conflict with the others, yet many strive to “have it all.” Each day, these women are faced with difficult decisions in which one decision can significantly affect one of their other roles in life and lead to disequilibrium. Learning to successfully manage the careful balance between

these roles is challenging. It is seldom discussed openly, and there is a lack of female mentorship to help guide the new generation of women physicians. Younger generations of physicians, including women, are seeking greater work-life balance and have a unique perspective on their careers and personal lives. With the new landscape of accountable care organizations and growing demands of mental health care delivery, women psychiatrists are invested in maintaining the profession and require support to accomplish their career goals without compromise to their personal ambitions and family obligations. Many women delay marriage and childbearing due to the demands of medicine. This delay can be quite problematic, as the years in which most women are pursuing their medical education and completing residency are the years in which most women are having children. This can lead to difficulty with conceiving or other health issues. Those who do not delay often face difficulties managing the balance of being a mother and spouse with the role of a busy, practicing psychiatrist. These role conflicts can frequently impede a woman’s career success or her home life. In addition, they often take on more home responsibilities than their spouse, which can limit their time to work toward promotion and/or tenure. We will discuss challenges with this balancing act with a variety of women and provide an open forum for discussion of the aforementioned issues. Each of the following cases will provide a personal glimpse at their daily balancing act: 1) An early-career married African American/minority psychiatrist coping with fertility issues and the care of parents with end of life issues; 2) An early-career married psychiatrist with spouse and two children who changed jobs based on family demands while dealing with cancer; 3) An early-career married Hispanic, LGBT psychiatrist with two children; 4) An early-career psychiatrist who experienced divorce; 5) An early-career psychiatrist who is single and adopted a child; and 6) A seasoned psychiatrist and program director with a child, older stepchild in medicine and live-in in-laws.

NONVERBAL LEARNING DISABILITY (NVL D): MYTH AND REALITY

Chairs: Cindy Vargas Cruz, M.D., M.B.A., Auralyd Padilla Candelario, M.D.

Speakers: Sheldon Benjamin, M.D., Ellen Braaten, Ph.D., Stephen Nowicki, Ph.D., Steven Schlozman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define Nonverbal Learning Disability (NVLD); 2) Compare and contrast NVLD with congenital right hemisphere dysfunction; 3) Understand the impact of early diagnosis, treatment and prognosis; 4) Diagnose and properly refer patients with NVLD; and 5) Learn an ideal model to manage children diagnosed with NVLD and find the resources available for this population.

SUMMARY:

Although there is ample evidence of NVLD's existence and impact, diagnosis and intervention are often delayed due to poor recognition of the syndrome by mental health professionals. The use of different names for NVLD has slowed research; our understanding of NVLD has been hampered by inconsistent nomenclature. Even the commonly used name, Nonverbal learning disability, could be seen as suggesting these individuals are nonverbal. In reality, they are highly verbal but have deficits in areas such as visuospatial skills, pragmatics, emotional prosody, attention, calculation and other cognitive domains. There are few resources available through schools or private agencies, but with timely diagnosis, interventions to improve outcome can be implemented in the classroom and at home. Failure to promptly diagnose these individuals leads to their being labeled with various behavioral or emotional problems rather than being recognized as suffering from a neurocognitive disorder. It may also lead to depression, anxiety, withdrawal and even devastating outcomes such as suicide. It is hoped that increasing awareness of NVLD will lead to increased research, reliable diagnostic criteria and new opportunities for offering support and treatment.

A COGNITIVE BEHAVIORAL APPROACH TO WEIGHT LOSS AND MAINTENANCE

Chairs: Judith S. Beck, Ph.D., Deborah Beck Busis, L.C.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Teach dieters specific "pre-dieting" cognitive and behavioral skills; 2) Keep motivation high long-term; and 3) Facilitate permanent changes in eating.

SUMMARY:

A growing body of research demonstrates that cognitive behavioral techniques are an important

part of a weight loss and maintenance program, in addition to exercise and changes in eating. An important element that is often underemphasized in weight loss programs is the role of dysfunctional cognitions. While most people can change their eating behavior in the short run, they generally revert back to old eating habits unless they make lasting changes in their thinking. This interactive workshop presents a step-by-step approach to teach dieters specific skills and help them respond to negative thoughts that interfere with implementing these skills every day. Participants will learn how to engage the client and how to solve common practical problems. They will learn how to teach clients to develop realistic expectations, motivate themselves daily, reduce their fear of (and tolerate) hunger, manage cravings, use alternate strategies to cope with negative emotion, and get back on track immediately when they make a mistake. Techniques will be presented to help dieters respond to dysfunctional beliefs related to deprivation, unfairness, discouragement and disappointment and continually rehearse responses to key automatic thoughts that undermine their motivation and sense of self-efficacy. Acceptance techniques will also be emphasized as dieters come to grips with the necessity of making permanent changes and maintaining a realistic, not an "ideal," weight that they can sustain for their lifetime.

NOT YOUR GRANDFATHER'S VA: INNOVATIVE HEALTH CARE OFFERING EXCEPTIONAL PSYCHIATRIC CAREERS

Chair: R. Jill Pate, M.D.

Speakers: Shahla Ali, M.D., Erin L. Patel, Psy.D., Shaqufta Jabeen, M.D., Jennifer Bean, Pharm.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify three benefits of employment at VHA and three strategies to successfully seek employment at VHA; 2) Discuss teaching, scholarly and career development opportunities offered for young career clinicians through VHA; and 3) List three ways that VA is incorporating interprofessional competencies into training and clinical practice to provide innovative health care delivery.

SUMMARY:

The VHA has made great strides toward innovative clinical training, enhanced care delivery and promotion of a healthy work-life balance for its

employees. Past notions about the VA are no longer valid, as it has become a serious contender as the employer of choice for early- and mid-career psychiatrists. Within the past three years, the VA has emphasized the importance of evidence-based practice and integrated care clinic design. Clinical training has evolved to emphasize these care initiatives. As examples, TVHS has created integrative outpatient clinics utilizing telemedicine, specialized geriatric clinics and clinics to assist veterans with complicated medical and mental health comorbidities. With support from various disciplines, TVHS has also enhanced clinical practice with a focus on evidence-based practice using various clinical guidelines and the use of assessment and outcome measures in routine clinical practice. Mental health integrative clinics and training provide an infrastructure that supports interprofessional education and collaborative practice, which has become the gold standard of patient care around the globe. Innovative clinic designs provide an excellent opportunity to fulfill clinicians' passion for research and quality improvement projects while maintaining confidence that care delivery is of the highest quality. Diversity and cultural competence is linked to the VA mission and success. The VA aims to recruit, retain, develop and engage the highest quality workforce. The VA recognizes and respects all that makes any individual unique. Furthermore, the VA allows early-career psychiatrists the opportunity to treat a diverse population of patients and veterans of a wide variety of educational, socioeconomic and occupational backgrounds. The VA cultivates an inclusive work culture, which creates an environment that reflects the rich diversity of our increasingly global community. The VHA is an employer invested in employee development and retention. Early-career and mid-career psychiatrists can expect a variety of employment opportunities, many of which are incentivized through educational debt reduction. A generous leave allowance is offered, making work-life balance a key feature of employment. VHA views continuing education and leadership development as an integral strategy. Career development through leadership courses and funding toward additional degrees are available. Exceptional career opportunities are accessible in this health care system. Psychiatric trainees, early-career psychiatrists and professionals looking for a positive work culture focused on individuality, training and innovation are encouraged to take a new look at opportunities in the VA. The VA has transformed into

an organization that is dedicated to continuous improvement and innovation in the pursuit of providing excellent care to veterans by recruiting outstanding staff and supporting career development.

CHALLENGES AND SUCCESSES IN CONDUCTING PRACTICE-BASED RESEARCH IN PSYCHIATRY

Chairs: Farifteh F. Duffy, Ph.D., Diana E. Clarke, Ph.D., M.Sc.

Speakers: Joyce C. West, Ph.D., M.P.P., Eve Moscicki, Sc.D., M.P.H., Farifteh F. Duffy, Ph.D., Keila D. Barber, M.H.S., Diana E. Clarke, Ph.D., M.Sc., Bernadette Cullen, M.B.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify challenges to conducting practice-based research in psychiatry; 2) Describe successful application of research findings to inform APA educational programming and practice; and 3) Identify optimal approaches to conducting practice-based research to meet the needs of practicing psychiatrists and improve participation.

SUMMARY:

The Practice Research Network (PRN) of the American Psychiatric Association Foundation was launched in 1993 with the intent to bridge the gap between the science base and the clinical practice of psychiatry. It began as a nationwide network of psychiatrists and has evolved to conduct large-scale, clinical and policy research studies using randomly selected samples of psychiatrists from the AMA Physician Masterfile. PRN studies complemented traditional research methods by generating information across patients, treatments and settings so that a wide range of clinical and policy issues could be examined. In recent years, the PRN has implemented a number of pilot and full-scale studies. These studies varied in 1) Topic area, for example, smoking cessation practices in psychiatry, use of computers in clinical practice and the *DSM-5* Field Trials in Routine Clinical Practice Settings; 2) Study design, including cross-sectional surveys and longitudinal field trials; 3) Mode of data collection, including pencil and paper and web-based surveys; 4) Type of incentive, such as American Psychiatric Publishing gift certificates, other monetary incentives, continuing medical education credits or a copy of the *DSM-5*; and 5) Length of time required for participation, ranging from, e.g., 15 minutes for a

one-time survey to several months to complete multiple measures over time. The response rates for these research efforts ranged from 20 to 30%. Despite the challenges in encouraging participation, findings from the PRN research have made important contributions to APA initiatives such as the development of practice guidelines, testing the utility of *DSM-5* nosology in a variety of clinical practice settings, and informing works of APA councils and workgroups, as well as educational programming. In this workshop, presenters will discuss the challenges and successful applications of findings from several PRN studies implemented in recent years, including the Study of Psychiatrists' Use of Information Resources in Clinical Practice, Tobacco Cessation Practices in Psychiatry, and the *DSM-5* Field Trials in Routine Clinical Practice Settings. The goal of this workshop is to engage practicing psychiatrists and researchers in a discussion of challenges in conducting practice-based research and identify ways in which practice-based research methods can be enhanced to meet the needs of busy psychiatrists and encourage participation.

FOCUSING ON IMPROVEMENT EVERY DAY: THE CONTEXT AND APPLICATION OF A LEAN DAILY MANAGEMENT SYSTEM AT A BEHAVIORAL HEALTH CARE SYSTEM

Chair: Sunil Khushalani, M.D.

Speakers: Steven S. Sharfstein, M.D., M.P.A., Robert Roca, M.D., M.P.H., Antonio DePaolo, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the context and importance of engaging everyone in performance improvement in a health system today; 2) Describe the structure and functioning of a lean daily management system (LDMS) and experience a virtual demonstration of a lean daily management system; and 3) Evaluate and compare the experience of a front-line physician with the experience of management as they participate in an LDMS.

SUMMARY:

The goal of any health care system is to maximize value for all customers. However, the "quality chasm" between what is desired and what exists in our national health care system is still significantly deep. Every behavioral health organization has challenges pertaining to safety, quality and care delivery, which can seriously impact the outcomes of

the patients they serve. These are problems that every health care leader has to grapple with. To achieve the "Triple Aim"—simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per capita cost of care—a health care organization will have to improve across the domains of safety, quality and care delivery while acting as a good steward of all available resources. Leadership can't accomplish these goals by themselves or even in conjunction with their small quality departments. Facilitating audits to keep up ever-increasing regulatory pressures will not engage everyone in improving quality—it is neither inspiring nor enough to keep up with all the demands of performance improvement. Leaders can achieve this monumental task by creating an infrastructure and culture that will allow all providers to not only do their jobs well, but also to be fully engaged in improving the system as they do their daily work. Lean is a value-creation and waste-reduction philosophy that was initially developed at Toyota but that is now being widely used in many service industries throughout the world. Based on this time-tested philosophy, the "lean daily management system" (LDMS) is one tool to achieve and sustain performance improvement for any selected strategic initiative decided upon by any organization. LDMS engages the front-line providers of care and the management team in a disciplined daily problem solving exercise to focus on improving processes that impact an organization's key strategic objectives. John Toussaint, in his book *Management on the Mend: The Health care Executive Guide to System Transformation* described the lean daily management system as "a constructive pipeline for intelligence from the front line that flows up through the organization and an equally robust line of communication and strategy from the top back to the front line." If effectively orchestrated, problems are solved more timely, treatment teams are more engaged and the organization can achieve the alignment needed to tackle complex systemic challenges. This workshop will demonstrate one large behavioral health care organization's efforts to create a culture of improvement by deploying a daily management system.

ENHANCING RESILIENCE IN COLLEGE STUDENTS: DEVELOPMENTAL PERSPECTIVES IN THE PRACTICE OF COLLEGE PSYCHIATRY

Chair: Doris Iarovici, M.D.

Speakers: Doris Iarovici, M.D., Preston Wiles, M.D.,

Daniel Kirsch, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Enumerate advantages of using a developmental model when working with young adults; 2) Discuss how “speaking to the emerging adult” through a developmental frame facilitates clinical work, informed consent and shared decision-making; 3) Understand the normal processes and diverse presentations of distress after college student relationship breakups and the wide spectrum of clinical outcomes; 4) Provide a developmentally informed response to grief and mourning in emerging adults following the death of a family member; and 5) Understand the psychiatrist’s role in creating rational campus policies for student mental health, which fit within the framework of IOM report concerns about flagging young adult health.

SUMMARY:

Mental health problems continue to increase in prevalence and severity among college students, yet the distinct developmental needs of emerging adults receive inadequate clinical attention. The landmark 2014 Institute of Medicine and National Research Council report, “Investing in the Health and Well-Being of Young Adults,” acknowledged the unique features of the “critical developmental period” between ages 18 – 26, noting young adults are “surprisingly unhealthy” and under “greater demands” in a changing world. Identified as a “critical concern,” behavioral health is responsible for the majority of disability in this age group. While 75% of mental disorders begin before 24 years of age, in this era of helicopter parenting and trigger warnings, emotional frailty is perceived as the norm among students. Resilience, or the ability to adapt to adversity or trauma, can promote positive mental well-being independent of levels of stress in students, even when they engage in maladaptive responses to stress. A developmental framework best allows psychiatrists to attend to resilience and differentiate between psychopathology and normal emotional struggles, applying the best evidence-based treatment when needed. In this workshop, we will explore ways to prioritize a developmental perspective in work with college students, highlighting the challenges and enormous opportunities. Because breakups in romantic relationships and loss of a parent or family member during college are frequent causes for consultation

to college mental health centers, we will review the role of attachment and identity formation in relationship disruption and mourning during college. We will suggest approaches that help students create a coherent personal narrative after loss, which can mitigate high distress that is often not psychopathological. Beyond the age of majority and legal competence to make their own medical decisions, emerging adults have yet to fully inhabit their adult roles. Their incomplete neurological, psychological and cognitive development renders them especially vulnerable to poor decision making. We will discuss how a developmental lens allows for less frustrating and more fun alliance building, informed consent and shared decision making. Many colleges and universities struggle to balance student autonomy and free expression with the needs of the community, often creating policies in reaction to rare but frightening and highly publicized events, such as campus shootings. We will examine the psychiatrist’s role as a consultant on campus, helping other campus stakeholders apply a developmental perspective so that mental health problems are neither ignored, nor unnecessarily amplified.

PHYSICIAN BURNOUT, DEPRESSION, SUICIDE: IDENTIFICATION, ASSESSMENT, TREATMENT AND PREVENTION

Chairs: Almari Ginory, D.O., Michelle Chaney, M.D., M.Sc.

Speakers: Anu Mathur, M.D., Jacqueline A. Hobbs, M.D., Ph.D., Lisa J. Merlo, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the prevalence of depression among resident physicians; 2) Assess the underlying risk factors for depression among resident physicians; 3) List perceived barriers to treatment for resident physicians; 4) Compare different state laws with regards to mental health treatment and licensing reporting; and 5) Assess procedures for residency programs to identify and evaluate at risk residents.

SUMMARY:

Previous research has demonstrated that physician burnout and depression are prevalent across medical training and practice, with particularly high rates during residency training. These mental health concerns are associated with a significantly increased risk of committing medical errors, in addition to representing significant risk for physician

suicide. Indeed, rates of suicide are higher among physicians than the general public, and the data indicate that the majority of physician suicide victims never sought mental health treatment. The purpose of this workshop will be to increase awareness of resident depression among faculty psychiatrists, residents and medical students in order to better address this critical issue. During the session, education will be provided regarding the high prevalence of depression among residents, risk factors for suicide and barriers to treatment (e.g., time constraints, confidentiality and licensing concerns). Example interventions to improve access to mental health treatment for resident physicians will be discussed (including discussion of interventions implemented by the workshop presenters at the University of Florida College of Medicine and review of selected interventions implemented elsewhere). Rules, regulations and state laws regarding mental health treatment and reporting for resident physicians will be presented, with opportunity for discussion of state-specific differences based on geographic representation of the workshop attendees. Policies and procedures for identifying and treating at-risk residents will be presented, as well as discussions regarding the balance between privacy, safety and mandated reporting. Finally, case-based examples will be utilized for workshop attendees to participate in a small-group activity designed to highlight how to encourage identification of at-risk residents, how at-risk residents might “fall through the cracks,” how training programs can increase awareness of available resources and how to decrease stigma associated with seeking help. Case examples will be utilized to foster discussion with attendees and encourage sharing of additional ideas to improve policies and procedures across various programs. The goal will be to have an open forum where attendees may discuss their own concerns and questions.

DRAWING DEPRESSION: A LOOK AT MENTAL HEALTH THEMES IN VISUAL MEDIA

Chair: Swathi Krishna, M.D.

Speakers: Deepak Penesetti, M.D., Aparna Atluru, M.D., Swathi Krishna, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the widespread popularity and impact factor that visual media provides to the general public and, therefore, their

own patients; 2) Identify the representation of mental health illness in examples of visual media; 3) Identify specific resources that use illustration and animation to talk about mental health symptoms such as comics, animation and illustrated books; 4) Recognize how visual media resources can provide patients with relatable characters that display common symptoms of mental illnesses such as depression and anxiety; and 5) Choose one appropriate example of popular comics, cartoons or illustrated books that they themselves would recommend to patients and families dealing with specific mental health diagnoses.

SUMMARY:

With the ever-growing popularity of visually based media, many artists are using animation and illustration as an outlet to portray serious themes in mental health in a simple and relatable fashion. Some artists use these themes to depict their own private struggles with mental illness, whereas others use them bring mental health issues to the forefront of public awareness and reduce public stigma. Along with comic strips and animated series, mental health themes are popping up in such places as doodle blogs, New York Times op ed cartoons and even children’s storybooks. Some of the specific mental health themes that can be found in these outlets are loss, depression, social anxiety, PTSD, sexuality and eating disorders. If mental health professionals knew more about these resources, they could be used as tools that would give patients valuable insight and relatable information regarding common symptoms and outcomes of these mental health disorders. Our workshop will introduce participants to themes of mental illness in all of the previously mentioned visual media sources by showing them examples of each. We will provide information regarding common mental health themes within specific comics and illustrations and when they could provide positive mental health education, as well as when they could have negative impact on patients and insight. We will also discuss specific examples of how comics and visual media could be used to help patients who are challenged with learning disorders, limited literacy and limited intellectual functioning. During our workshop, we will provide participants with audio and video statements from visual media artists and include discussion of a recent ComicCon panel dedicated to mental health in which forensic psychiatrists and comic book artists discussed the portrayal of mental health themes in comics. We will also showcase video commentary by the managing

editor of Panels.net, an internet website dedicated to comic readership, regarding the demographics and interests of the modern-day comic audience.

DIVERSITY EXPERIENCES IN RESIDENCY TRAINING

Chair: Beverly Fauman, M.D.

Speakers: Aida Spahic Mihajlovic, M.D., M.S., Jacob Sperber, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand three models of residency training to increase sensitivity to the diverse populations we serve. In the 1980s, the RRC implemented a requirement for such training; 2) Stimulate the audience to consider how to identify their particular needs based on the location of their programs to increase residents' awareness of diversity; 3) Encourage training programs to identify the resources they have to facilitate diversity training; and 4) Facilitate the ability of training programs to recognize and maximize the resources within their own complement of trainees with regard to diversity.

SUMMARY:

In the 1980s, residency training programs were charged with ensuring that their trainees were aware of the needs of the various populations they served; this initially focused on the minority populations in the neighborhoods around teaching hospitals, but clearly must also look at needs of LGBT, Asian and Hispanic patients, as well as various religious populations. Three presenters from programs in Detroit, New York and Chicago will describe how they implemented tracks in their training programs to facilitate their trainees' sensitivity to minority and diversity issues.

THE EXPLORATION OF FAITH AND SPIRITUALITY IN THE PSYCHIATRIC ASSESSMENT AND TREATMENT OF MINORITY PATIENTS

Chair: Danielle Hairston, M.D.

Speakers: Lynneice Bowen, M.D., M.Ed., Matthew L. Dominguez, M.D., M.P.H., Josepha Immanuel, M.D., Ayana Jordan, M.D., Ph.D., Jennifer Severe, M.D., Annabelle K. Simpson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the importance of spirituality in the mental health of minorities and how it can be used as a tool for assessing and

strengthening therapeutic alliances with patients; 2) Understand the bidirectional stigma, assumptions and misconceptions between underrepresented faith-based communities and mental health providers; 3) Identify effective methods for assessing patients' faith and spiritual beliefs, including discussing the *DSM-5* Cultural Formulation Interview as it pertains to faith and spirituality; and 4) Identify and discuss methods to reach faith-based populations, including faith-based screenings and CBT to engage those minority patients who might be hesitant to participate in treatment.

SUMMARY:

Under-represented individuals within the U.S. health care system underutilize mental health services and are often underdiagnosed and/or misdiagnosed. Obstacles including stigma, mistrust of mental health professionals and limited access prevent patients from under-represented groups from obtaining optimal health care. Findings from the National Comorbidity Survey (2003), a nationally representative general population survey of 8,098 adults in the U.S., show that a higher percentage of people sought help for mental disorders from clergy (25%) compared to psychiatrists (16.7%) or general medical doctors (16.7%). Understanding the importance of faith/spirituality pertaining to cultural identity is necessary for reducing stigma, assessing, treating and reinforcing therapeutic alliances. Discussing spirituality/faith with a patient in a culturally competent manner is frequently insufficiently taught or emphasized in medical training and clinical practice. An understanding of the influence of faith beliefs on help-seeking behaviors and the individual's comprehension of mental health is vital to understanding minority patients who are hesitant to participate in or even prematurely terminate care. The *DSM-5* Cultural Formulation Interview includes a supplemental module that promotes the understanding of spirituality, religion and moral traditions using cultural humility. This module can be successfully adopted, taught and implemented for trainees and practicing psychiatrists. Under-represented populations show a consistent data trend of seeking help for emotional and behavioral issues from spiritual leaders at higher rates than they do from primary care physicians and psychiatrists. The highly influential role of spiritual beliefs in the emotional wellness of a patient compels the mental health provider to become adept in appropriately integrating faith beliefs and traditions into

assessment and treatment while at the same time recognizing their own stigma/discomfort with incorporating faith and spirituality into treatment. It is well-established that under-represented groups are less likely to access mental health treatment. Organizations of faith provide an invaluable tool to study the assessment of psychopathology, delivery of screening tools and utilization of evidence-based treatment, namely cognitive behavioral therapy (CBT). This workshop will promote understanding of the benefits of spiritual health assessment through presentation of cases and culturally relevant approaches in psychiatric education, assessment and evidence-based treatment. The audience will interact with the presenters through case presentations and discussions of effective management and treatment planning. This workshop is endorsed by the APA Council on Minority Mental Health and Health Disparities.

MAY 15, 2016

FUNCTIONAL IMAGING TO IMPROVE DIAGNOSIS IN PATIENTS WITH SUSPECTED DEMENTIA

Chairs: Saima Hedrick, M.P.H., Yvette Sheline, M.D., M.S.

Speakers: Norman L. Foster, M.D., John Seibyl, M.D., Yvette Sheline, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe issues associated with the recent availability of SPECT and PET tracers in the clinic; appropriate clinical questions; and referrals, limitations, and appropriate training; 2) Discuss the appropriate role of beta-amyloid detection using imaging or CSF biomarkers for revised diagnostic and nosologic criteria for Alzheimer's dementia; 3) Identify the PET and SPECT imaging tracers for dopamine transport, beta-amyloid deposition and brain metabolism; 4) Explain clinical and pathological characteristics of Alzheimer's disease; and 5) Identify inclusion and exclusion criteria for the Imaging Dementia-Evidence for Amyloid Scanning (IDEAS) Study.

SUMMARY:

The purpose of this workshop is to provide participants with an update on the clinical implementation of recently approved PET radiotracers for detecting brain amyloid deposition. The emphasis will be on appropriate clinical use and difficult diagnostic and disease monitoring issues. In

particular, focus will be on training, clinical challenges of image interpretation, appropriate referrals and looking forward to issues of incorporating image quantitation into clinical practice. A discussion of cases with audience and faculty will focus on whether to scan or not.

THE CLINICAL EVALUATION AND MANAGEMENT OF SUBSTANCE USE DISORDERS IN TRANSGENDER PATIENT POPULATIONS

Chairs: Hector Colon-Rivera, M.D., Elie Aoun, M.D.

Speakers: Jack Pula, M.D., Brian Hurley, M.D., M.B.A., Petros Levounis, M.D., Tamar Carmel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the incidence, prevalence and risk factors for substance use disorders among transgender individuals; 2) Review the evidence-based approaches to treating substance use disorders in transgender populations; 3) Apply a competency based medical education framework on sexual orientation and gender identity to educate providers and communities about the substance-related health needs of transgender individuals; 4) Reflect on the specificities in the clinical evaluation of minority stress in the transgender population and mitigating factors associated with poorer substance use treatment outcomes; and 5) Identify and develop a treatment model to engage transgender patients in substance use disorder treatment in their communities.

SUMMARY:

The epidemic of substance use disorders (SUD) and prescription medication overdoses supports the need for increased training, both for general community members and health care providers. Lesbian, gay, bisexual and transgender (LGBT) people are well-documented to experience higher risks for substance use disorders and substance-related morbidity and mortality. The Institute of Medicine identified transgender populations as understudied, with significant need for health research, and the literature contains little guidance for the treatment of mental health and substance use disorders for these populations. Transgender people have been found to have a higher prevalence of mental health disorders, including depression, anxiety and substance-related conditions, in comparison with the general population. Transgender populations are disproportionately affected by health conditions associated with alcohol

and prescription drug abuse, with culturally unique pathways to substance use disorders. Several theories, including minority stress, other reactions to societal stigma and discrimination, and culturally condoned drug and alcohol use, have been proposed to explain higher rates of substance use disorders in transgender individuals. This workshop will introduce participants to gender identity terminology and demographics, review the epidemiology of substance use disorders in transgender populations and engage participants in a practical guide to develop clinical skills for working with transgender patients, specifically focusing on patient assessment and treatment planning. The relationship between transgender gender identity and substance use disorders, as well as its implications with regard to addiction education and clinical practice, will be reviewed. Finally, a model of using essential elements of current SUD treatments as applied to transgender individuals will be discussed. Session participants will leave the workshop able to apply a framework for addressing substance use disorders in transgender patients.

THE AGING PHYSICIAN: POSSIBILITIES AND PERILS

Chairs: Paul H. Wick, M.D., Nada L. Stotland, M.D., M.P.H.

Speaker: Glen O. Gabbard, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the common psychological characteristics of physicians; 2) Describe the challenges that aging and retirement present to physicians; and 3) Propose strategies to deal with the balancing of work and leisure time as one enters retirement age.

SUMMARY:

For most of us, the practice of medicine is a calling and not simply a job. Recent surveys of physicians indicate that late-career physicians, compared to early- or mid-career, are generally the most satisfied and have the lowest rates of distress. Perhaps it is the profound gratification medicine offers physicians that makes aging a challenge. Being a physician is often the core of the doctor's identity. For many doctors, trying to slow down or retire may equate with losing one's self-image. Hence, physicians frequently struggle with retiring gracefully. In this educational session, the difficulties and gratifications of the "golden years" will be discussed. Research on

successful aging will be considered and recommendations offered.

SOCIAL NETWORKING IN PSYCHIATRIC PRACTICE AND TRAINING: DOS AND DON'TS FOR PHYSICIANS

Chair: Almari Ginory, D.O.

Speakers: Wesley Hill, M.D., Michelle Chaney, M.D., M.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize inappropriate and unprofessional uses of social networking; 2) Maintain appropriate boundaries in online patient interactions; 3) Review examples of appropriate professional pages; and 4) Discuss real case examples of unprofessional content in social networking.

SUMMARY:

Social networking has become part of one's daily life. Words such as tweeting, blogging, posting, tagging and selfies have become part of regular vernacular. Young physicians are training in a society where they are transitioning from social users of these sites to professionals, where patients are sending them friend requests and searching for information. More seasoned physicians are adjusting to this new technology and incorporating it into their business models. The ACGME acknowledges the importance of social media and has incorporated maintaining professional boundaries in communication into milestone ICS2. A simple Google search of a physician's name will grant a patient access to their health grades; reviews by other patients; publications; office website; social networking site accounts; and, on some occasions, cell phone number, email and home address. With more and more young physicians using the web for both personal and professional reasons, caution should be taken in the amount of information available, and physicians should be wary of possible HIPAA and boundary violations. Unfortunately, several physicians have made national headlines over information posted on social networking sites. Young physicians should be aware of potential pitfalls if patients have easy accessibility to physicians, such as a suicide threat sent via Facebook message, text or email. However, when used responsibly, these sites can also be beneficial professionally and personally. This is a difficult balance, which we will discuss as a group. The purpose of this workshop will be to provide education to residents and medical students

about the specific guidelines as they relate to interfacing with social networking sites in both personal and professional interactions. We will review ICS2 and what skills residents will need for the ACGME milestone. In previous workshops, there was over an hour of questions related to physician interactions with social networking sites. These questions will be incorporated into the presentation, as there appears to be several gray areas that physicians struggle with. We will also discuss physician rating sites and possible interventions. We will use real-life examples to foster discussion with attendees. The goal will be to have an open forum where attendees can ask questions and discuss issues/concerns. They can present their own examples and brainstorm how to adjust their sites for maximal use. For residents, the goal will be to provide the education for them to return to their programs, modify policies and achieve their milestone.

TREATING PTSD IN VETERANS USING NEW MODALITIES: SOCIAL MEDIA, VIRTUAL REALITY, RTMS AND ADVANCED PHARMACOTHERAPIES LIKE KETAMINE AND MDMA

Chair: Niranjan Karnik, M.D., Ph.D.

Speakers: Barbara Rothbaum, Ph.D., Sheila A. M. Rauch, Ph.D., Margaret Harvey, Psy.D., Mark H. Pollack, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define Nonverbal Learning Disability (NVLD); 2) Compare and contrast NVLD with congenital right hemisphere dysfunction; 3) Understand the impact of early diagnosis, treatment and prognosis; 4) Diagnose and properly refer patients with NVLD; and 5) Learn an ideal model to manage children diagnosed with NVLD and find the resources available for this population.

SUMMARY:

American warriors deployed after September 2001 during Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF) and Operation New Dawn (OND) are returning home with the physical and psychological wounds of war. Diagnosed as post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), substance abuse, depression and other mood disorders, these unseen wounds frequently have a crippling effect on the lives of veterans and their families. Since 2001, more than 2.4 million men and women have been deployed to Iraq and

Afghanistan to protect our nation's freedom. Of those who have served, an estimated one in three will experience PTSD, and one in five will suffer from TBI. In this workshop, leaders in the field of research on PTSD among military veterans will present innovative research that is emerging from academic medical centers that have embraced the mission to serve veterans and their families alongside the existing Veterans Administration system. The presenters in this session all come from sites that are part of a newly formed collaborative termed the Warrior Care Network. Participants will briefly hear an overview of the current evidence-based treatments for PTSD in veterans (15 minutes). Then the workshop will move into brief presentations on new and innovative treatments, including social media (15 minutes), prolonged exposure using virtual reality (10 minutes), rTMS (10 minutes) and advanced pharmacotherapies including MDMA and ketamine-augmented treatments (10 minutes). Participants will have time (30 minutes) to meet in smaller groups to discuss these areas further with the faculty presenters.

THE NIGHTMARE OF CYBERBULLYING: A REVIEW AND DISCUSSION OF CYBERBULLYING IN MIDDLE SCHOOL- THROUGH COLLEGE-AGED YOUTH

Chair: Gabrielle L. Shapiro, M.D.

Speakers: James Murphy, M.D., Louis Kraus, M.D., Ishaeta Zalpuri, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the impact of cyberbullying on children, adolescents and young adults; 2) Identify the numerous types of cyberbullying that exist at this time; and 3) Demonstrate an understanding of differences in cyberbullying amongst minority groups.

SUMMARY:

In recent years, social media has been a dominant platform for communication amongst youth in our communities. By 2010, the proportion of American teens using social media had risen to 73% from 65% in 2008. A report from 2012 indicated that at least 77% of American teens (12 – 17 years old) had cell phones, and 23% owned smartphones. With the ever-growing use of technology, bullying now exists in cyberspace and can lurk where its origins cannot be identified. Cyberbullying has been defined in various terms in the literature, with most definitions stating that the behavior is harmful, intentional and

inflicted through the means of electronics. Given the faceless aspect of cyberbullying and the potential threat of anonymity, which reduces accountability, it can have a graver and more profound impact on children, adolescents and young adults at risk, including those with special needs such as autism spectrum disorder, ethnic minorities, LGBTQ and students in relational conflicts, as compared to traditional bullying. The impacts of cyberbullying can range from minor distress and frustration to severe psychosocial distress, depressive symptoms and even suicide. In this workshop, speakers will review current research and data pertaining to cyberbullying, highlight the numerous types of cyberbullying and use case vignettes with special focus on minority groups to foster a discussion on the expanding impact and ramifications this has on middle school- through college-aged youth.

THE USE OF BUPRENORPHINE IN ABSTINENCE-BASED TREATMENT FOR ADDICTION

Chair: Alphonse Kenison Roy III, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the usefulness of buprenorphine in abstinence-based treatment; 2) Understand the usefulness of abstinence-based treatment in patients maintained on buprenorphine; and 3) Mediate controversies among advocates for partial agonist maintenance and advocates for abstinence-based treatment.

SUMMARY:

There has been controversy about the use and usefulness of buprenorphine in “abstinence-based” treatment and treatment programs. The goal of this workshop is to review the literature on the success of abstinence-based treatment for opioid addiction and the success of maintenance therapy with buprenorphine and then report successful treatment protocols that combine the modalities. A group of addiction medicine physicians and the multidisciplinary staff of a 12-Step-oriented treatment program have developed a practice with policies and protocols that support the individualized prescription of buprenorphine for patients with opioid addiction who are participating in this abstinence-based, 12-Step-oriented treatment for addiction. These patients participate side by side with opioid-addicted patients who are prescribed extended release naltrexone and patients who are prescribed no opioid-specific medications and side

by side with patients whose addiction is to drugs other than opioids. The policies include contractual descriptions of the requirements for ongoing prescription and the commitments on the part of the prescribers. The protocols include an agreement to randomized urine drug testing and ongoing participation in the treatment process. The success is noted in the participation through completion of treatment by patients who have been previously unable to complete and through the initiation of treatment by those who have previously been unwilling to begin. In addition, the experience has been that peer pressure is more often in the direction of premature discontinuation of buprenorphine treatment than it is in the direction of initiating buprenorphine in those currently unmedicated or being treated with naltrexone. The difficulties have been the messages received in 12-Step meetings and from treatment program peers that buprenorphine is “just another drug” or, “You are just substituting one drug for another.” This has resulted in premature discontinuation and, often, subsequent relapse, requiring re-initiation of medication and subsequent restabilization in most cases.

THE ACADEMIC HOSPITAL CLINIC: ADAPTING TO CHANGING NEEDS IN PATIENT CARE, RESIDENCY TRAINING, REGULATIONS AND REIMBURSEMENT

Chair: Jess Zonana, M.D.

Speakers: Breck Borcharding, M.D., John Q. Young, M.D., M.P.H., Mark Zimmerman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Characterize administrative and educational challenges for academic hospital clinics; 2) Identify quality improvement goals for patient care paired with strategies to improve outpatient resident education; and 3) Describe approaches to implementing adaptive clinic programs and protocols that balance the needs of patients, residents and hospitals in the current health care environment.

SUMMARY:

As hospital systems, regulatory requirements and psychiatry education evolve, academic hospital clinics have a unique set of challenges. This workshop will identify these challenges in developing an outpatient clinic infrastructure that meets the needs of the patient communities it serves, provides a context for quality resident

education, and supports the academic and economic mission of the hospital at large. Presenters will share their strategies for addressing the many demands on the clinic. Speakers will offer ways they have incorporated research into clinic operations, addressed quality issues for patients enduring frequent resident turnover, made improvements to resident education, and integrated lessons from the private sector to improve patient care and administrative functioning. The workshop will provide an interactive format for discussing ways to better integrate resident education, quality patient care and academic goals within the context of a hospital system with complex payor and regulatory demands.

PHYSICIANS FOR CRIMINAL JUSTICE REFORM: HOW DO I FIT IN?

Chairs: Nzinga Harrison, M.D., Osvaldo Gaytan Jr., M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the spectrum of detrimental health consequences that result from negative interactions with the criminal justice system; 2) Describe three core issues for which physicians can be leaders in the movement for criminal justice reform; and 3) Describe how physicians can employ our medical expertise to advocate for meaningful, lasting criminal justice reform.

SUMMARY:

The session will be interactive and include didactic presentation and QandA followed by a call to action. The call to action will be for physicians to identify how they fit into criminal justice reform and an invitation to join Physicians for Criminal Justice Reform (PfCJR). Content will focus on current data regarding the bidirectional relationship between criminal justice and health, specifically related to mental health and addictive disorder, juvenile justice and correctional health care. We will introduce evidence-based interventions that have been shown to be effective in addressing each of the core issues and provide a description of strategies that have been designed to place physicians of all specialties in a position to use our medical expertise to advocate for criminal justice reform.

LEARNING FROM EACH OTHER: FACILITATORS AND BARRIERS IN HEALTH CARE ORGANIZATIONS FOR

IMPROVING QUALITY OF CARE—INSIGHTS FROM THE U.S., U.K. AND ZAMBIA

Chair: Sunil Khushalani, M.D.

Speakers: Steven S. Sharfstein, M.D., M.P.A., Ananta Dave, M.D., Subodh Dave, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Promote the concept of clinician engagement, which is crucial for initiatives of quality improvement to succeed; 2) Learn about facilitators and barriers within each health care system and learn of some best practices in quality improvement that can be adopted by anyone within their organization or country; and 3) Enable reflective learning, which is an important part of the continuous development in quality improvement leadership roles.

SUMMARY:

This workshop will present approaches to quality improvement activities of a large private nonprofit institution that is working within the framework of a multi-payer U.S. health care system, health care trusts within the NHS, and the developing country of Zambia through a combination of audience participation, group reflection and speaker presentations. The psychiatric system of care in both the U.S. and the U.K. is at a very crucial juncture and is in its early stages of development in Zambia. In this era of strained resources, there is a common need to increase the value of the psychiatric services we each provide. Also, there are increased expectations amidst the heightened challenge of managing highly complex patients with multiple comorbidities and psychosocial needs. There are several top-down initiatives that are pushed to the level of the front-line providers in the form of regulations, practice guidelines and accreditation requirements, with a goal of quality assurance. However, one is also witness to a growing number of local innovations and bottom-up approaches that try to address the urgent need for improving the performance of our systems. One deals with a unique set of facilitators and barriers in each setting. Two of the presenters play a lead role in their respective organizations in maintaining and improving quality of care provided and would, therefore, be able to share their personal experiences and the suggestions they propose from their own perspectives. One of the presenters has a national lead role in medical education and is interested in how it can contribute to quality

improvement in health care. He will share his experiences of running such a project as part of an initiative in Zambia. We can all learn from each other's perspectives and need to borrow each other's insights, as today's challenges demand an accelerated pace of quality improvement in a time of constrained resources.

CBT FOR SUICIDE RISK

Chair: Donna M. Sudak, M.D.

Speakers: Jesse H. Wright, M.D., Ph.D., Judith S. Beck, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the common psychological characteristics of physicians; 2) Describe the challenges that aging and retirement present to physicians; and 3) Propose strategies to deal with the balancing of work and leisure time as one enters retirement age.

SUMMARY:

Suicide is the 10th leading cause of death in the United States (2013). CBT approaches to the suicidal patient have been proven to reduce rates of future attempts. Active and collaborative work to reduce hopelessness and specific antisuicide plans are important features of this approach to patients. This workshop will briefly review research on CBT for treating suicidal patients. Then the central features of CBT methods for suicide risk will be demonstrated. Role-play demonstrations will illustrate key points. Particular attention will be paid to the collaborative development of an antisuicide plan in a depressed patient.

PLACEBO: PARSING AND USING ITS THERAPEUTIC ACTION

Chair: Donald J. Meyer, M.D.

Speakers: Robert C. Joseph, M.D., M.S., Don Lipsitt, M.D., M.A., Philip R. Muskin, M.D., M.A., Malkah T. Notman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the differing meanings of placebo in medicine, the known neuroscience of placebo and the current research of placebo effects on subjective symptoms of somatic disease; 2) Identify the role of placebo and nocebo in the course and treatment of medically unexplained symptoms; 3) Identify so-called placebo factors in

the doctor-patient relationship; 4) Identify the role of placebo in the management of chronic illness; and 5) With a clearer conceptual understanding of placebo and its science, know how to modify their own actions to foster well-being effects with their patients.

SUMMARY:

In the 1400s, placebo was "a pious fraud:" a substance, devoid of medicinal activity, prescribed by physicians to foster a patient's subjective sense of well-being. In 2015, placebo has two different and somewhat contradictory meanings, one in research and the other in clinical practice. The placebo arm in a randomized controlled trial (RCT) attempts to isolate a proposed therapeutic intervention as an independent variable separate from the morass of uncontrollable variables such as the natural history of a disease, the impact of being a research subject and the unpredictable effect of events of daily living. The effects of both placebo and its inverse, nocebo, refer to a patient's altered subjective well-being in the absence of a medicinally active intervention. Though actual progression of disease depends on pathophysiology and the state of the host, a patient's subjective experience of well-being and illness may be independent of pathological disease progression. Patients' feelings of well-being are profoundly affected both by their beliefs, whether deduced with reason or not, and by their relationships, including relationships with those who minister to them. Patient expectation and attribution are the central nonmedicinal mechanisms that modify well-being. In an uncertain world, patients treat themselves with beliefs and relationships, merging past experience with present circumstances into current expectation. Once pejoratively referred to as "nonmedical factors," current research has begun to identify the neural circuits and genetics that form the physiological foundation of placebo's effect on subjective well-being. Informed by this updated science and by a critical examination of the concept of placebo, the presenters will, in a highly interactive format, use clinical vignettes to illustrate the role of placebo in the doctor-patient relationship, psychotherapy, medically unexplained symptom disorders and chronic disease management. Attendees will be encouraged to discuss examples of their own encounters with placebo and, by their participation, better clarify how to foster the activity of this active, not inert, agent in their own practice.

THE “F” WORD—FEEDBACK: IF IT’S SO IMPORTANT, WHY IS IT SO DIFFICULT TO DO?

Chairs: Josepha A. Cheong, M.D., Marcia L. Verduin, M.D.

Speakers: John Luo, M.D., Robert J. Boland, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the barriers to providing effective feedback in a timely manner; 2) Develop a method to formulate thoughtful and effective feedback; and 3) Develop a method of teaching faculty how to give negative content feedback.

SUMMARY:

In academic education, clinical training and career development, the process of feedback to enhance development and advancement is a critical factor. Yet despite recognition of its importance, feedback is seldom provided in an effective and timely matter. In the current culture of “everyone gets a trophy,” feedback that is anything other than laudatory is delayed or avoided completely. This workshop will identify the barriers to providing feedback. In addition, concepts from the business development literature, such as coaching for performance and crucial conversations, will be applied to the development of a regular “practice” of feedback. Participants are encouraged to facilitate the discussion by providing examples of difficult feedback discussions that they are currently addressing. In addition, innovative methods of using technology in feedback will also be explored.

MILITARY BEHAVIORAL HEALTH THROUGH THE LENS OF THE 4077TH: THE REALITIES AND MYTHS OF MILITARY BEHAVIORAL HEALTH SHOWN ON M.A.S.H.

Chairs: Sebastian Schnellbacher, D.O., Wendi Waits, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explain the current theories of combat operational stress control; 2) Describe the effects of a prolonged conflict on military behavioral health; and 3) Better understand the perspectives of a military behavioral health provider.

SUMMARY:

From 1972 to 1983, the characters of the television series M*A*S*H provided a humorous, powerful and

occasionally accurate portrayal of the life of military medicine. Twelve of these episodes had a mental health focus. This workshop will utilize the 4077th Mobile Army Surgical Hospital as a lens to focus on the realities and myths of military medicine after 15 years of war. Over the course of 60 minutes, small clips from 12 episodes of this series will be shown and interspersed with brief lectures and group discussion.

PSYCHIATRY IN THE COURTS: APA CONFRONTS LEGAL ISSUES OF CONCERN TO THE FIELD

Chair: Marvin S. Swartz, M.D.

Speakers: Paul S. Appelbaum, M.D., Howard Zonana, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the process and criteria by which APA decides to become involved as a friend of the court in major cases; 2) Discuss the challenges to physician speech and practice posed by bans on firearms discussion in physician-patient encounters; 3) Recognize the mental health-based arguments underlying administration of persons found incompetent to stand trial; and 4) Appreciate the issues involved in expanding the Tarasoff-type duties of mental health professionals.

SUMMARY:

The Committee on Judicial Action reviews ongoing court cases of importance to psychiatrists and our patients and makes recommendations regarding APA participation as amicus curiae (friend of the court). This workshop offers APA members the opportunity to hear about several major issues that the Committee has discussed over the past year and to provide their input concerning APA’s role in these cases. Three cases will be summarized, and the issues they raise will be addressed: 1) Wollschlaeger v. State of Florida upholding the Florida law restricting physicians’ ability to communicate with patients about gun safety. Wollschlaeger raises the question of how statutes may appropriately limit the types of inquiries physicians make of their patients in the conduct of medical care; 2) Allmond v. DHMH, a Maryland State case defending the appropriateness of involuntary medication over the objection of a patient found incompetent to stand trial for murder in Maryland. This case raises the question of whether or not involuntary administration of medications is legally permitted under such circumstances; 3) Volk v. DeMeerleer, a Washington

State case expanding the duty of mental health professions to warn or protect potential, but unforeseen, victims of a patient's violence. Since new cases are likely to arise before the Annual Meeting, the Committee may substitute a current issue on its agenda for one of these cases. Feedback from the participants in the workshop will be encouraged.

THE IMPACT OF SOCIAL MEDIA AND SOCIETAL CHANGE ON YOUNG GAY MEN'S DEVELOPMENT: IMPLICATIONS FOR INTIMACY, SEXUALITY AND PSYCHOTHERAPY

Chair: Marshall Forstein, M.D.

Speaker: Lawrence McGlynn, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify at least three types of social media that impact young gay male sexual identity development; 2) Identify two psychosocial factors that contribute to risky sexual behavior; and 3) Identify the psychological issues of how sexual behaviors, fantasies and attachments are affected by instant access to casual sex and pornography.

SUMMARY:

Evolving social norms abetted by new technology are redefining what is discoverable, desirable and feasible for young gay men exploring personal realms of intimacy and sexuality. On the one hand, legal recognition of same-sex marriage supports the ideal of long-term relationships and the establishment of families; on the other hand, instant hook-up services, unlimited access to pornography and a reification of masculinity within some gay social worlds has influenced gay men in more complex positive and negative ways. These influences coexist with cultural values arising from religious beliefs and ethnic-racial identities. In this multidimensional context, young gay men must consider critical questions about identity, intimacy and sexuality as they embark on a wide array of possible developmental trajectories. Monogamous, open or polyamorous relationships; multiple sexual partners; or casual encounters remain options for the young man beginning to explore what being gay means to him. Early sexual experience may provoke unprotected sexual behavior in the absence of a consolidation of identity, including the development of self-protective coping strategies. The role of substances, sexual abuse, and racial and sexual prejudice in the development of a consolidated

sexual identity will be explored using the biopsychosocial model. This workshop will explore the impact of social constructs, social media, racial/ethnic and religious contexts on the development of identity of gay men and how conflicts present in the clinical setting. Often, there is conflict between ideological constructs and internal comfort that presents in unsafe or risky behavior. Case vignettes will be presented to illustrate some of the issues brought to psychotherapy, with attention on the therapist's countertransference. Most of the workshop will be a discussion of clinical cases and therapeutic interventions.

THE DSM-5 ANXIOUS DISTRESS SPECIFIER: CONVERGENT VALIDITY AND CLINICAL IMPLICATIONS

Chairs: Gayle M. Wittenberg, Ph.D., William Coryell, M.D.

Speakers: Jan Fawcett, M.D., Brenda W. Penninx, Ph.D., Marsha Ann Wilcox, Ed.D., Sc.D., Justine M. Kent, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the rationale behind the development of the five-item *DSM-5* anxious distress specifier; 2) Review the clinical characteristics of patients selected based on the specifier; 3) Compare the convergence of the specifier with DSM-based measures of anxiety; and 4) Discuss implications of the implementation of the anxious distress specifier in the clinic.

SUMMARY:

In the latest edition of The Diagnostic and Statistical Manual of Mental Disorders (DSM), a specifier is included to diagnose patients as "MDD with anxious distress." Patients meet criteria for this diagnosis if they exhibit at least two of the following symptoms for most of a major depression episode: 1) Feeling keyed up or tense; 2) Feeling unusually restless; 3) Difficulty concentrating due to worry; 4) Fear that something awful may happen; and 5) Feeling loss of control of himself or herself. A detailed description of the patient cohort identified using this new diagnostic has not yet been reported. In this workshop, we will first describe the rationale behind the development of the *DSM-5* anxious distress specifier. We then report on the performance of the specifier within patient cohorts drawn from two independent studies. The Netherlands Study of Depression and Anxiety (NESDA), a 9-year

longitudinal study, included 1,080 MDD patients at the baseline visit. The National Comorbidity Survey-Replication (NCS-R), a cross-sectional sample representative of the U.S. population, included 1,091 participants with a lifetime diagnosis of a major depressive episode (MDE). In the NESDA study, the *DSM-5* anxious distress specifier was defined by five matching self-report items at the baseline visit. In the NCS-R, four items were matched, reported as being experienced during the patient's worst MDE. The fifth item, "Feeling loss of control of himself or herself" was not available, but patients were still required to endorse two or more items to meet criteria for the specifier. In each study, we demonstrate that there is convergent validity against DSM-based anxiety disorders for all anxiety constructs. However, each study identified patients with the anxious distress specifier who had no anxiety disorder and patients without the anxious distress specifier who had a diagnosed anxiety disorder. In both studies we observe an association of the specifier with greater depression severity, poorer functional outcomes and increased suicidal behavior. In the longitudinal NESDA study, the *DSM-5* anxious distress specifier performed better as a predictor of longitudinal outcomes. However, the specifier has a high correlation with general depression severity indicators, and correcting for baseline depression severity and functional disability, the prediction of longitudinal outcomes becomes nonsignificant. Both studies suggest the anxious distress specifier may be a useful risk indicator of suicidal ideation and behavior in patients with MDD. Among the component items evaluated, "fear that something awful might happen," a symptom commonly associated with panic, appears to be most predictive. A structured discussion will focus on the utility of the *DSM-5* anxious distress specifier for the identification of patients at risk for poorer overall outcomes and who are at increased risk for suicide attempts.

TRAUMATIC BRAIN INJURY AND PTSD: EASING THE PAIN

Chairs: Subhash C. Bhatia, M.D., Venkata B. Kolli, M.B.B.S.

Speakers: Sriram Ramaswamy, M.D., Vani Rao, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the epidemiological link and clinical symptom overlap of PTSD and TBI; 2) Recognize and learn the phenomenology of

neuropsychiatric comorbidity in persons with TBI and PTSD; 3) Learn the value of emerging mild TBI and PTSD research from civilian, veteran and military trauma centers; and 4) Comprehend effective pharmacological and nonpharmacological interventions for management of this population.

SUMMARY:

In the United States, around 1.7 million individuals suffer traumatic brain injury each year. The Department of Defense and the Defense and Veteran's Brain Injury Centers estimate that 22% of veterans returning from recent combat zones in Iraq and Afghanistan have brain injuries, also called a "signature wound" of these conflicts. Approximately 60 – 80% of soldiers who experience blast injuries may also have concussive TBI. Eighty percent of all civilian TBI is mild (mTBI). In general, TBI doubles the risk of PTSD. Manifestations of TBI and PTSD, including increased risk of substance use disorders and suicide, overlap. Moreover, there is an overlap regarding intervention for these disorders. Patients with TBI often have other physical injuries and medical conditions like epilepsy and pain syndromes. Treating these multiple conditions often requires multiple medications that further complicate management. Patients with both TBI and PTSD tend to have a chronic course, and the management of this is hindered by absence of guidelines for this patient population. In this interactive workshop, we will discuss the relationship between TBI and PTSD, specifically similarities and differences in manifestation of cognitive and psychosocial symptoms between civilian and veteran/military populations. We will also review and discuss contemporary neuroimaging research findings as well as role of predisposing, precipitating, perpetuating and preventive factors associated with these disorders. We will discuss the symptom-focused, evidenced-based treatment of PTSD, mTBI and other comorbid conditions, specifically cognitive processing, prolonged exposure and selective serotonin reuptake inhibitors (SSRIs) and role of interdisciplinary teams for management of both mTBI and PTSD. Both these disorders negatively impact the family system; therefore, family engagement and support will be discussed. In complex severely injured patients, referral to polytrauma systems of care like the ones in the Veterans Health Administration can add tremendous value to care of this population. The workshop will conclude following interactive discussion with the attendees.

SHE FOR ALL: ENGAGING COMMUNITY LEADERS TO ADVANCE GLOBAL MENTAL HEALTH

Chair: Christina Tara Khan, M.D., Ph.D.

Speakers: Mary Kay Smith, M.D., P. Lynn Ouellette, M.D., Geetha Jayaram, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define global mental health and characteristics of low-resource settings that require creative/innovative approaches to mental health care; 2) Describe community-based programs that engage female leaders to address mental health problems within low-resource settings; and 3) Identify key features of programs that effectively engage community leaders to advance the mental health of their communities.

SUMMARY:

Around the world, mental illness is a leading cause of disability and mortality, yet there are inadequate resources available to address the enormous burden of disease. One major objective of the World Health Organization's Mental Health Action Plan is to provide comprehensive, integrated and responsive mental health and social services in community-based settings. Innovative programs targeting women community leaders have been employed to address this gap and bolster the natural role women leaders take on in supporting their families and communities. Programs that integrate mental health education and intervention into primary care and social care settings have the potential to decrease stigma and reach exponentially more individuals and families than direct care alone. In this workshop, we will highlight examples of such programs in communities across the globe and identify key components of such programs for addressing the global burden of mental illness. Program 1: In rural India, one third of women experience physical or sexual violence during their lives, and 70% of these affected women suffer from severe mental illness. Women suffer disproportionately from completed suicide triggered by interpersonal problems, domestic disputes and financial stress. Project Maanasi is a program that aims to educate, train and treat women and children in villages in Southern India through humanitarian grants and services. Key elements of the program include integration with primary care, use of village female community health workers, and education and training via culturally congruent means. An 11-minute video will

be shown and results of care summarized. Program 2: In Kenya, where the leading cause of death for many years has been HIV/AIDS, there are enormous unmet physical and mental health needs. Many, including children, carry the burden of having lost multiple family members to AIDS, and because of stigma, the grief over loss to AIDS is disenfranchised and silenced. In a village with 1,000 AIDS orphans, despite being provided for in many ways, there has been no program to address this burden of grief. Doing so in a culturally appropriate way became the focus of this presenter's collaboration with the community counselor and culminated in a community-wide "Day of Remembrance," the first of an annual ceremony and ritual to foster community healing of unresolved grief. Program 3: The Women's Development and Empowerment Conference at Kafakumba Training Center began when women leaders from nearby villages collaborated with women from the U.S. to begin addressing a variety of health-related, economic and educational needs of local women. Lessons learned in northern Zambia, especially around the importance of interconnectedness and community engagement, were in turn brought back to the U.S. to form the core of a workforce development initiative at an academic health center.

TREATMENT OF PEOPLE WITH FIRST-EPISODE PSYCHOSIS IN FORENSIC PSYCHIATRIC HOSPITALS: CHALLENGES AND OUTPATIENT FOLLOW-UP

Chair: Ann Hackman, M.D.

Speakers: Keith Gallagher, M.D., Elizabeth Jane Richardson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe evidence-based approaches to psychopharmacological treatment of people with their first episode of psychosis; 2) Identify challenges to treating individuals with new onset psychosis in forensic psychiatric hospitals; and 3) Discuss strategies for outpatient treatment of individuals who have had their initial treatment for psychosis in a forensic psychiatric hospital.

SUMMARY:

The literature does not provide precise information on the number of people who first receive care for psychotic illness within forensic psychiatric facilities; however, such individuals are seen with some regularity in forensic psychiatry units and then by first episode outpatient teams. There are clear

guidelines and recommendations around the psychopharmacological treatment of first episode psychosis, including use of the least effective doses of medications and use of recovery-oriented approaches such as shared decision making. The literature suggests that in forensic inpatient psychiatric facilities, issues such as prevention of violence and safety may lead to use of higher amounts of medication and polypharmacy; further, there may be significant barriers to a recovery-oriented approach to treatment. In a first episode outpatient program in urban Baltimore, we have treated several young adults whose first encounter with mental health care occurred in a forensic psychiatric hospital following an arrest. In this workshop, we will discuss Mr. S., one of our clients who, after being arrested for behaviors that occurred when he was experiencing severe psychotic symptoms, spent 18 months in a forensic hospital before coming to our program. At his release, he was taking multiple medications, experiencing severe sedation (possibly compounded by sleep apnea), was prediabetic and had gained more than 120 pounds during his hospitalization. He also had little idea of what medications he was taking and why. We will discuss his recovery process and review literature relevant to this case, addressing recommendations for first episode treatment as well as problems specific to providing treatment in forensic hospitals. Then, with our audience, we will discuss patient-, provider- and system-based challenges for individuals with first episode psychosis in forensic hospitals and then upon release into the community. With our audience, we will problem solve ways to optimize treatment for these individuals.

CHILDREN OF PSYCHIATRISTS

Chairs: Michelle B. Riba, M.D., Leah Dickstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Hear from children of psychiatrists regarding their experiences growing up in a household where at least one parent or guardian was a psychiatrist; 2) Understand what some of the problems have been for children of psychiatrists; and 3) Problem solve with the audience regarding some of the challenges and opportunities of having a parent as a psychiatrist.

SUMMARY:

For close to 20 years, we have presented this workshop on children of psychiatrists at the APA Annual Meeting. Each year, we have a standing room audience because this topic is very important to those of us in psychiatry who are already parents, may be thinking about being parents, are themselves children of psychiatrists or, as clinicians, want to better understand how parental employment might affect children. This is always an exciting, important and powerful workshop with much audience participation. New and fresh material seems to always be provided by the children as new technologies and challenges drive the kind of problems we all face. This topic is important for psychiatrists and children throughout the world, so we are very honored that so many of our international colleagues participate in and attend this workshop.

PSYCHIATRIC COMMUNICATION STRATEGIES: INTERVENTION MODELS FOR INPATIENT MEDICAL/SURGICAL SETTINGS

Chair: Daniel Safin, M.D.

Speakers: Joel J. Wallack, M.D., Nancy Maruyama, M.D., Stephanie Cheung, M.D., Simona Goschin

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe methods for rapid bedside patient-focused assessments that improve patient behavior and compliance in the medical setting; 2) Identify strengths and weaknesses of interdisciplinary communication models in a medical/surgical setting; and 3) Propose methods for enhanced interdisciplinary communication models at participants' home institutions.

SUMMARY:

Medical/surgical inpatient units have an increasing need for more efficient management of difficult comorbid behavioral problems in acutely medically ill patients. Intervention models, both old and new, are being introduced and/or reintroduced around the country to address these needs in a rapidly shifting clinical environment. The workshop will briefly review patients' adaptive and maladaptive reactions to illnesses and hospitalizations and how to approach difficult patient behaviors. The workshop will then engage the participant with brief presentations highlighting the salient communication strategies currently in use at large tertiary care teaching hospitals in New York City. Three intervention models on inpatient

medical/surgical units will be highlighted: structured-communication consultation models, behavioral response codes and embedded psychiatric care. Data will be presented regarding the positive and negative impact of these models. This information will be incorporated into clinical vignettes related to each of the three different intervention models. Each vignette will highlight strengths and limitations and be used as a foundation for lively discussion among participants. The workshop will aid in developing a deeper understanding of the dynamic factors and system issues that cause such intervention models to succeed or fail. The participant will come away with enhanced knowledge and skills for addressing communication issues in their practice.

SEEKING REFUGE: EFFECTS OF PSYCHOLOGICAL EVALUATIONS IN ASYLUM CASES

Chairs: Nina E. Sreshta, M.D., J. Wesley Boyd, M.D., Ph.D.

Speakers: Robert P. Marlin, M.D., Ph.D., M.P.H., Sarah R. Sherman-Stokes, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the significance of a psychological evaluation in the outcome of an asylum case as well as the process of offering and performing asylum evaluations; 2) Understand how asylum-seekers with mental illness face disadvantages with respect to credibility determinations in U.S. immigration courts; and 3) Discuss ways psychiatric professionals and immigration lawyers can work together to establish a more equitable system that protects those who display mental illness based on significant trauma.

SUMMARY:

The United States admits a congressionally predetermined number of asylum-seeking refugees each year. Asylum eligibility requires that an applicant fear persecution on the basis of race, religion, nationality, political opinion or social group in his or her country. The topic of asylum has become particularly germane recently given flaring concerns about migration issues driven by human rights violations and humanitarian crises produced by the Syrian civil war, as well as conflicts in Latin America and Africa. Between 2013 and 2014, asylum claims worldwide rose by 45%. Refugees have significant trauma exposure and are thus at high risk for developing post-traumatic stress disorder; the

United Nations High Commissioner for Refugees (UNHCR) has stated that rates of PTSD among refugees range anywhere between 39% and 100%. The mental health of an asylum seeker impacts his or her chances of asylum in several ways. First, trauma can dictate an asylum seeker's perceived credibility. The REAL ID Act of 2005 amended immigration law to uphold a standard of credibility that mandates accurate reporting of even minor details and inconsistencies, and failure to do so can be the basis for removing an asylum seeker from the United States. Additionally, an applicant's credibility is judged by his or her "demeanor, candor or responsiveness." In turn, symptoms of PTSD such as disordered memory, numbness and reduced responsiveness to the outside world can cause asylum seekers to be deported. This is problematic because it means asylum is denied based on symptoms of trauma directly related to the reason an individual sought asylum in the first place. Second, those seeking asylum must file a claim within one year of entering the United States, unless they can prove that extraordinary circumstances prevented them from doing so. Though the UNHCR advises countries to account for how traumatic experiences prevent refugees from speaking freely, the American immigration system is not well-equipped to identify or provide procedural safeguards for individuals with histories of trauma or mental illness that impair their ability to communicate freely or adeptly. Psychiatrists can assist asylum seekers and immigration courts by acting as expert witnesses and providing corroborating evidence of trauma for applicants. Specifically, psychiatrists can help present a more accurate understanding of credibility and how psychiatric illness can cause delayed asylum claim filings or difficulties in communication. Given the drastic increase in traumatized refugee populations, the tools of psychiatry can be useful in rethinking the inequities caused by current practices in asylum law.

OUR TOUGHEST ADDICTION CHALLENGE: TREATING TOBACCO USE DISORDERS IN PATIENTS WITH MENTAL ILLNESS AND ADDICTIONS AND INFORMING THEM ABOUT E-CIGARETTES

Chair: Sunil Khushalani, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn to appreciate the prevalence and impact of tobacco use disorders on individuals suffering from psychiatric disorders and

the growing phenomenon of e-cigarette use; 2) Learn about misconceptions and challenges in the treatment of tobacco use disorders; and 3) Learn to bring together a diverse skill set in the service of treatment of tobacco use disorders and also to advise patients about e-cigarette use.

SUMMARY:

At least half a million people die from tobacco-related deaths annually in the United States. The age-adjusted rate of smoking in the first quarter of 2015 was reported at an all-time low of 15.3%. This phenomenal drop in the rate of smoking has not been experienced by individuals suffering from mental illnesses and addictions. Mentally ill and addicted individuals reportedly consume around 44% of the cigarettes sold in the U.S. A study found that individuals with severe mental illness may die about 25 years earlier compared to their peers without severe mental illness, largely due to their greater predilection for tobacco use. Tobacco addiction is perhaps the leading cause of death in recovering alcoholics. We, as psychiatrists, owe it to our patients to help them not only get mentally healthy and into recovery, but also free of this lethal addiction. It has also been reported that e-cigarette use is on the rise. The use of e-cigarettes by high school students has reportedly surpassed their use of traditional cigarettes. Many smokers who are resorting to e-cigarettes to quit smoking are finding that they are ending up as dual users of cigarettes and e-cigarettes. We are uniquely positioned to help patients with treatment of tobacco use disorders. We spend much more time with our patients compared to other physicians. We have an understanding of biopsychosocial aspects of our patient's lives. We have in our armamentarium a whole range of therapies, from cognitive behavioral therapy to motivational enhancement therapies. We are trained how to use medications indicated for this disorder, such as bupropion, and also have been informed about cytochrome interactions, which come into play in the treatment of tobacco use disorders. What are some of our own misconceptions about our patients when it comes to treatment of tobacco use disorders? How can we weave this important topic in the treatment of our patients, so that this significant item on their list of problems does not get ignored? How can we take the best that we have to offer and help our patients suffering from psychiatric disorders and addictions break free from this formidable addiction? How do we advise our patients who ask us about e-

cigarettes? In this workshop, in addition to speaker presentations, we will use small-group and interactive discussions around some vignettes in order to help psychiatrists become competent in this much-needed skillset and have a more informed mindset in order to deal with the treatment of tobacco use disorders.

ADDRESSING THE DEMAND FOR MENTAL HEALTH CARE NEEDS OF HISPANICS IN THE UNITED STATES

Chairs: Esperanza Diaz, M.D., Jose E. de la Gandara, M.D.

Speakers: Julio Ballestas, M.D., Andres Barkil-Oteo, M.D., M.Sc., Daniel Castellanos, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand who the Hispanics in the U.S. are and the meaning of other terms used such as Latinos and Latin Americans; 2) Learn the ratio of Hispanics to the Hispanic populations per state and identify which geographic areas are in demand; 3) Identify the causes and consequences of a shortage of Hispanic psychiatrists; 4) Identify interventions to address the problem; and 5) Identify interventions used by other countries to address similar shortages of psychiatrists.

SUMMARY:

According to the U.S. Census Bureau, in 2014 the estimated Hispanic population living in the U.S was 54 million, representing approximately 17% of the total U.S. population, making Hispanics the nation's largest ethnic minority group. It is estimated that by the year 2060, this number will increase to 119 million, representing 28.6% of the total U.S. population. By that point, nearly one in three U.S. residents would be of Hispanic descent. These demographics have a major impact in health care and particularly mental health, considering that the physical and mental health of Hispanics has been shown to deteriorate once they immigrate to the U.S. Some of the factors contributing to the development of psychiatric disorders include the stress related to their immigration process, perceived discrimination, family cultural conflicts, lack of health insurance, low socioeconomic status and limited English proficiency. In addition, the lack of access to health care and poor information about the available resources may further deteriorate their health status. Significant gaps between the demand and availability of mental health services for Hispanics already exist, particularly for those with

limited English-language proficiency. The lack of culturally and linguistically appropriate mental health services keeps many Hispanics with mental illness from seeking services, as language barriers often result in miscommunication and misinterpretation. Hispanics as an ethnic entity, although similar, are not a homogeneous group; each subgroup has many idiosyncrasies and individual needs that require a genuine understanding of their specific subculture in order for providers to diagnose and formulate effective treatment plans. The importance of addressing the above is of particular interest considering that in the near future, these issues will no longer relate to a minority group but to a third of the U.S. population. This workshop aims to re-evaluate strategies to increase the future availability of bilingual and culturally sensitive psychiatrists by 1) Reviewing the current crisis; 2) Identifying geographic areas of deficit; 3) Assessing the impact of the shortage; and 4) Highlighting potential solutions to better serve the mental health needs of the Hispanic community.

RECOVERING INSIDE: IS CORRECTIONAL PSYCHIATRY AN OXYMORON?

Chair: Dominic Sisti, Ph.D.

Speakers: Philip Candilis, M.D., Jeffrey L. Metzner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Evaluate and discuss several ethical challenges of correctional psychiatry; 2) Discuss the policy and ethics frameworks that permit the current environment to persist; and 3) Describe strategies and policies most likely to advance correctional psychiatric care.

SUMMARY:

There are approximately 2.5 million people incarcerated in the U.S., which equates to the world's highest incarceration rate (700/100,000 people). It is estimated that 50% of inmates in jails and prisons have a mental illness, and 15 – 20% have a serious mental illness. Critics argue that a shadow health care system exists behind bars, with a substantial amount of behavioral health care delivered there. In this workshop, we explore the disturbing trends in how mentally ill inmates are treated in jails and prisons. Forensic psychiatrist Philip Candilis will discuss the policy and ethics frameworks that permit the current environment to persist. Jeffrey Metzner, a medical educator and

forensic psychiatrist with extensive experience studying and monitoring correctional psychiatry, will describe the strategies and policies most likely to advance correctional care. Medical ethicist Dominic Sisti will present arguments in support of a reformed system that provides not more or better mental health care in correctional settings, but rather psychiatric rehabilitation and recovery centers aimed at providing a safe, healing setting for incarcerated individuals diagnosed with mental illness.

MARIJUANA: WHAT CLINICIANS NEED TO KNOW

Chair: John Douglas, M.D.

Speakers: Kevin Hill, M.D., M.H.S., Brian Hurley, M.D., M.B.A., Petros Levounis, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the signs and symptoms associated with both cannabis intoxication and withdrawal; 2) Differentiate between the many cannabis-related products and routes of administration; 3) Organize and focus a differential diagnosis when cannabis use co-occurs with other psychiatric symptoms and conditions; 4) Summarize the evidence of the risks and benefits associated with the use of cannabis and related agents; and 5) Discuss the history of cannabis's legal statuses, describe current legal trends and anticipate the psychiatric impacts associated with these legal trends.

SUMMARY:

Cannabis sativa is the plant whose leaves are dried to make marijuana. This plant is used both medically and recreationally by an increasing number of Americans. To date, twenty-three states and the District of Columbia have legalized cannabis for medical use, and four states and the District of Columbia have legalized cannabis for recreational use. In this evolving legal landscape, cannabis use has become increasingly prevalent, particularly among teenagers and young adults. Nine percent of adult and seventeen percent of adolescent cannabis users have been found to develop addiction to cannabis. In this context, community and public psychiatrists are on the front lines in addressing the psychiatric consequences associated with the changing landscape of cannabis use. Further, there are policy opportunities now evident from the experience of states where cannabis is decriminalized or legalized to amplify the benefits

and mitigate the drawbacks to these legal approaches. The role of community and public psychiatrists as advocates for scientifically informed public policy will be emphasized during this session. This workshop will introduce the major forms of cannabis-related products for recreational use, which include marijuana, hashish, hash oil and synthetic cannabinoids. The intoxication effects, physical signs and pharmacology of these products will be discussed. Evidence of the long-term adverse effects and known medical benefits of various cannabis-related products, including current FDA-approved medications, will be summarized. The prevalence of cannabis use among various subpopulations will be reviewed. This session will also demonstrate how to assess and manage cannabis intoxication and withdrawal and approach the treatment of cannabis use disorders. The presenters will discuss when cannabis use disorder should be considered in the differential diagnosis of patients with psychiatric symptoms. Given the widespread use and evolving legal policies surrounding the use of these cannabis-related products, a review of our current state of knowledge has important implications for educators, clinicians and policymakers. This workshop will use a case example to illustrate clinical assessment and treatment options for patients who use cannabis and have other psychiatric symptoms. Audience members will be invited to participate in a facilitated case discussion and asked to identify a differential diagnosis, identify what additional data they would seek to help narrow their differential diagnoses and select which treatment approaches they would utilize to manage common cannabis-associated clinical features. A facilitated discussion involving the presenters and workshop attendees will critique the assessment and management of the case along with highlighting critical implications for clinical practice, research and public health.

A PENNY FOR YOUR THOUGHTS: PAYING CASH TO FOSTER MEDICATION COMPLIANCE IN PATIENTS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS

Chair: John Maher, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how positive health behaviors are fostered through social or taxation policies that use financial incentives; 2) Understand voluntary adherence; ; and 3) Understand if a lack of insight or extreme violence clearly justify payment in

certain cases.

SUMMARY:

Many positive health behaviors are fostered through social or taxation policies that use financial incentives. Tokens and rewards have a long history of efficacy in behavioral management programs. It is estimated that 70% of psychiatric patients do not take their meds as prescribed. By introducing payment into the equation, will voluntary adherence falter or be reinforced? Does paying for adherence undermine the basis for informed consent? When does an incentive become coercive? Would such transactions represent inappropriate commodification of certain personal choices? Does lack of insight or a history of extreme violence clearly justify payment in certain cases? Should saving society money by decreasing hospital admissions be a major factor in the ethical calculus? Why do some people react so strongly and negatively to the idea of anyone being paid to make "the right choice?" Is pragmatic action being undermined by naïve social indignation and some ethical red herrings?

WHOSE INFORMATION IS IT ANYWAY? ETHICAL ISSUES IN THE AGE OF ELECTRONIC HEALTH RECORDS

Chair: Mark Komrad, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the history of medical record keeping from an ethical and legal perspective and state the basic purposes of the record; 2) Understand the conclusions of research regarding patients' accessing their own electronic health records (EHR); 3) Appreciate psychiatric patients' different needs, vulnerabilities and risks when accessing their EHR compared to other specialties; 4) Deploy specific principles of documentation when charting in EHRs in the era of patients' access to their psychiatric EHR; and 5) Identify and attend to specific ethical issues at stake in record keeping: confidentiality, beneficence, nonmaleficence and autonomy.

SUMMARY:

Medical records have long been repositories of highly sensitive information that serves many purposes for clinicians, patients and interested third parties. Historical policies and case law support this sensitivity. Psychiatric records may contain

particularly vulnerable information, so the ethical values of confidentiality, privacy and stewardship are critical when composing and handling records. Electronic health records (EHRs), and their networking into larger health care systems, pose new challenges regarding security, access and distribution. Emerging initiatives to give patients access to their own EHRs are starting to include psychiatric records in many institutions. Written psychiatric documentation is a potentially powerful source of both healing and harm, so careful consideration for its composition and handling are vital when sharing records with others and when allowing patients to review their own records, which are now far more easily accessible electronically, often without clinical supervision. Psychiatric patients may need special considerations in this regard that are not identical with other parts of the health care system. A one-size-fits-all policy regarding EHRs in an institution could be ethically problematic.

SEXUAL ASSAULT IN THE MILITARY: FAILURES TO REPORT, FALSE ALLEGATIONS, SOURCE MONITORING ERRORS AND REVISING THE SYSTEM

Chair: Connie Thomas, M.D.

Speakers: Philip Candilis, M.D., David Johnson, M.D., Jennifer Yeaw, Psy.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify characteristics unique to the military that discourage victims from reporting rape; 2) Understand the Congressional debate about revising the military justice system; 3) Describe the common challenges that lead to nonprosecution of rape cases; 4) Understand source monitoring errors and the role of alcohol, date rape drugs, and psychotropic medications in sexual assault cases; and 5) Describe two mainstream risk mitigation strategies.

SUMMARY:

Over the last decade, increasing media and political attention has been directed toward sexual assault in the military because of victims failing to report sex crimes, a significant rate of false allegations and concerns that the military justice system underprosecutes the accused. This workshop seeks to illuminate unique characteristics of the military that may discourage victims from reporting rape and the Congressional debate about revising the military justice system, especially moving decision to

prosecute from commanders to independent military lawyers. Factors that lead to non-prosecution will also be explored, including the challenge of inconsistent or delayed reports, fear of false allegations, memory distortion and victim characteristics such as respectability and level of observed emotion. Specifically, the effect of confounders like alcohol, psychotropic medications, date rape drugs and source monitoring errors (e.g., memory and cognitive distortions) on the investigation of sex crimes will be presented. Examples of possible risk mitigation strategies will be described, including the use of cognitive interviewing techniques or the Forensic Experimental Trauma Interview, to minimize the possible production of false memories. The workshop will conclude with a discussion of the potential application of workshop recommendations to historical and hypothetical cases.

BRAIN-FRIENDLY TEACHING: INCORPORATING BRAIN LEARNING PRINCIPLES INTO TEACHING ACTIVITIES

Chairs: Jane Ripperger-Suhler, M.D., M.A., Kari M. Wolf, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List seven key brain learning principles that can be used to enhance learning and apply at least three in a teaching mini-session; 2) Evaluate one's own and other's teaching for use of key brain learning principles; and 3) Incorporate key brain learning principles into one's real-time teaching on a regular basis.

SUMMARY:

Neurobiology can inform teaching and improve student learning, but application of what is known about the neurobiology of learning to teaching requires a change in practice. Teachers often think about teaching in the way they were taught, which usually involves conveying information via lecture and PowerPoint. Ideally, teachers would be thinking about neurobiology and how it affects learning of their topics at all times and apply neurobiological principles at every opportunity. A change in practice first requires translation of new information to practice and then "practice, practice, practice." In this workshop, a flipped classroom technique will be used to provide information ahead of time in the form of a paper from *Academic Medicine* (Friedlander M, et al: What can medical education

learn from the neurobiology of learning? Acad Med: 86(4): 415-420, April 2011.) On the workshop day, presenters will lead a simulation activity that translates the learned information into practice and provides one round of practice. Participants will be divided into small groups and assigned specific key aspects mentioned in the paper. Groups then plan a teaching mini-session of their assigned key aspects, using these same key aspects in their teaching. Groups then present their teaching mini-session to the whole group and participate in evaluation of their successes. As an extension activity, participants will brainstorm ways to use key aspects in teaching their own home-assigned topics and groups.

ADVANCED ETHICAL ANALYSIS AND PRACTICAL, CLINICAL GUIDELINES FOR PSYCHIATRISTS, ESPECIALLY THOSE WHO ARE ETHICS CONSULTANTS OR ON ETHICS COMMITTEES

Chair: Edmund G. Howe III, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify ethical problems that arise for patients and families that require advanced knowledge of ethical analysis and apply this knowledge in gaining a resolution most effectively; 2) Understand when to take initiatives to give patients and their families better options and outcomes when they face conflicts with their own interests and those of medical organizations and/or the law; 3) Recognize atypical ethical conflicts that require their being able to appreciate interventions they can apply "outside the box" to better meet patients' and families' idiosyncratic best interests; 4) Know and apply exceptional approaches to ethical problems that arise when patients and families are more vulnerable and thus less likely to respond as optimally to standard interventions; and 5) Soundly assess when they might justifiably respond to patients' and families' ethical conflicts on the basis of their own values, when they should not and, when they shouldn't, what they should do.

SUMMARY:

Psychiatrists and other providers often see patients and families who confront ethical problems in their nonpsychiatric medical care. Providers may also serve as ethics consultants and members of ethics committees. If these providers have advanced knowledge of current ethical thinking and reasoning and of practical approaches clinicians now find most useful in helping these parties resolve these moral

dilemmas, this may help immensely in these patients' care. This workshop will provide advanced knowledge and edge-of-the-field practical approaches to resolving ethical dilemmas arising on the wards. This advanced reasoning and approaches will be derived in largest part from articles written by experts in this work over the past 25 years in over 100 issues of the *Journal of Clinical Ethics*, which focuses on how providers can apply abstract ethical knowledge and reasoning to patient care "at their bedside." The presenter has been the editor-in-chief of this journal since it began. Concepts addressed will include how providers can best test ethical conclusions for consistency; when they should accept suboptimal ethical outcomes; what they should do when patients and families are from different cultures than their own; how they should check for hidden agendas; how they should anticipate and preempt unwanted connotations; initiatives they should take to increase patients' and families' ethical options; ways to decrease risk of stereotyping patients and families; and when, if ever, to consider going beyond applicable laws. Each principle or guideline will be illustrated with a specific case example in which it has applied or would apply. Participants will be given time after each example to comment and raise questions.

A RESIDENT'S GUIDE TO BORDERLINE PERSONALITY DISORDER: FROM THE EXPERTS (PART 1 OF 2)

Chair: Brian Palmer, M.D., M.P.H.

Speakers: Brian Palmer, M.D., M.P.H., John Gunderson, M.D., Marianne Goodman, M.D., Kenneth R. Silk, M.D., Perry Hoffman, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Diagnose BPD and understand its relationship to other disorders; 2) Structure an effective psychotherapy for BPD; 3) Thoughtfully choose psychopharmacological approaches that fit within a formulation of a patient's problems; 4) Effectively integrate family work into a treatment plan; and 5) Assess suicide risk and determine the appropriate level of care.

SUMMARY:

This is a repeat of a series of popular workshops held in New Orleans in 2010, Philadelphia in 2012, San Francisco in 2013, New York in 2014 and Toronto in 2015. Those resident-only workshops were very successful, with high levels of attendance (>100 each session) and engagement. We are thus presenting

two workshops here in the same manner in which we submitted the prior presentations. Patients with BPD represent approximately 20% of both inpatient and outpatient clinical practice, and their effective treatment requires specific knowledge skills, and attitudes that will be addressed in this workshop. This workshop is designed for and limited to residents, fellows and medical students, who often struggle in training with the treatment of these patients. In a highly interactive format, trainees will learn from and along with experts in the field of borderline personality disorder (BPD) to broaden and deepen their understanding of the disorder and its treatment. Alternating brief presentations of salient points with audience participation will allow participants to increase their knowledge and skills and to synthesize and apply the content as presented in the workshop. The workshop will be presented in two sessions (part 1 and part 2). The workshop moves from an overview of BPD to essentials of psychotherapy and psychopharmacology, family therapy, and suicide assessment and interventions. An overview of neurobiology is included. Specifically, participants will review the diagnosis of BPD and its relationship with other disorders in order to build a basis for case formulation. Following this, the workshop examines core features of effective psychotherapy as well as aspects (features) of treatments likely to make patients worse. Based on these principles, the workshop then examines suicide risk assessment and hospitalization with an emphasis on practical approaches for patients in the emergency setting. Strategies and common pitfalls in psychopharmacological treatment for BPD are examined, with case material from both experts and participants. Finally, principles of family involvement are presented, including data supporting the idea that families can and should learn effective ways of decreasing reactivity and increasing effective validation. Participants are encouraged to attend both parts, though we will, in part 2, review material from part 1, so if necessary, either session could be attended independently.

INFECTIOUS DISEASE/PSYCHIATRY HIV COLLABORATIVE CARE: AN INNOVATIVE MODEL FOR PERSON-CENTERED CARE FOR THE SOUTHERN UNDERSERVED

Chair: Daena L. Petersen, M.D., M.P.H.

Speakers: Edward Kantor, M.D., Cassandra Salgado, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explain the relevance of integrated psychiatric services within an academic center outpatient HIV clinic funded by Ryan White federal funds and summarize the first-year outcomes; 2) Explore lessons learned when developing a nested psychiatry clinic from both clinical and resident education perspectives; 3) Identify areas of need for further development of the nested psychiatric clinic; and 4) Review strategies to employ assets and overcome barriers moving into year two of the project.

SUMMARY:

In August 2014, a collaborative effort between the Medical University of South Carolina (MUSC) Department of Psychiatry and Behavioral Sciences (Psychiatry) and the Division of Infectious Diseases (ID) established an exploratory model for collaborative psychiatric care within the Ryan White HIV outpatient services program. The effort was initiated with the belief of MUSC ID practitioners that there were many HIV patients presenting for care with significant psychiatric and behavioral symptoms that decreased participation in treatment, including medication adherence, which resulted in a diminished quality of life, possibly aggravated by a lack of care coordination amongst providers and systems of care. These patients were largely from urban and semirural poor areas of South Carolina and predominantly ethnic minorities, where both HIV and mental illness were highly stigmatized. At the same time, the Psychiatry residency program was exploring ways to expand training opportunities in high-quality, well-supervised integrated care experiences for residents, particularly amongst populations with health disparities or the greatest need for services. This workshop will review and discuss the decision making related to the clinic's combined goals of education and clinical care through the implementation parameters necessary to stay true to both visions. The initial outcome data demonstrated that some HIV patients with complex physical and mental health problems who have engaged in psychiatric care increased their engagement with their HIV care providers. Others refused psychiatric services or never engaged in services despite attempts by their HIV providers to engage them in mental health care. This workshop will also review and discuss lessons learned in the development of the project from inception through the year of operation and expansion. The

educational, systemic, cultural and individual challenges will be explored and discussed relating to working in this nested context, including limitations of regional services available to HIV psychiatry patients given the complexity of patients and the nature of the project. The workshop will share practical knowledge and utilize shared experiences of the participants to inform similar endeavors to reach underserved communities with HIV. Discussion will support the learning of participants and their ability to apply lessons in their own clinical settings.

“CLOSED”: RESIDENT TALES FROM THE FRONT LINE—AND WHAT WE CAN LEARN—WHEN A PSYCHIATRIC EMERGENCY DEPARTMENT SHUTS ITS DOORS

Chairs: Sol Adelsky, M.D., M.P.P., Jon Berlin, M.D.

Speakers: Rachel Glick, M.D., Steve Miccio, B.A., Leslie Zun, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the unique circumstances leading a hospital to close its psychiatric emergency department; 2) Discuss implications of a major change in delivery of psychiatric emergency care for trainees, staff and patients; 3) Understand the latest evidence around best practices for settings and modes of delivery of emergency psychiatric care; and 4) Appreciate the perspectives of nonpsychiatrists—including those of emergency physicians and those of patients—regarding the experience of emergency psychiatric care.

SUMMARY:

Psychiatric visits comprise a significant and growing burden on emergency departments, forcing hospitals to adapt in a variety of ways. This workshop will utilize a real case as a launching point for a discussion of broader trends in emergency psychiatric care. In a highly interactive format, a resident will introduce and discuss the experience of being a trainee in a hospital that closes its psychiatric ED. With this case as a backdrop, the workshop will proceed with presentations from a range of perspectives salient to emergency psychiatric care, including those of an emergency physician, a psychiatry educator and a patient advocate. It will conclude with a presentation reflecting on larger trends in emergency psychiatric care, with an eye toward how these trends compare to the evidence for best practices. Attendees will be

invited to participate in a lively discussion at the conclusion of the workshop.

CLOSE ENCOUNTERS OF THREE KINDS: CHALLENGES IN THE RESIDENTS’ CLINIC

Chair: Joan Anzia, M.D.

Speakers: Molly Lubin, M.D., Alexandra Regenbogen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify common challenges residents face when beginning psychotherapy training; 2) Use critical thinking and a working knowledge of basic interpersonal dynamics to problem solve three clinical conundrums; and 3) Empower participants to feel confident navigating complex clinical scenarios within a safe therapeutic frame.

SUMMARY:

Beginning resident psychotherapists enter clinical practice with a wealth of information gleaned from textbooks, didactics and supervision. Challenges initially arise in implementing and applying this information to real-life patients, and residents may often find themselves in situations in which they feel underprepared. In addition, the early period of psychotherapy is critical to building a therapeutic alliance; residents may feel that altering the frame of therapy to support complex, challenging patients may be beneficial in establishing rapport, only to learn later that damage has occurred. This workshop will examine common scenarios that emerge in psychotherapy and prove challenging to the beginning therapist. Cases will be presented by both residents and experienced senior clinicians using video patient vignettes. Each case will contain questions at various points in the vignette regarding transference/countertransference and specific methods/techniques for management of these difficult patient situations, with encouragement of active participation and discussion by attendees. Workshop participants will leave with increased knowledge and comfort in identifying common pitfalls in psychotherapy and also with real-time demonstration of skills and techniques used to engage and manage these challenging patients.

BRAVE NEW TECHNOLOGY FOR THE NEXT GENERATION: A CASE FORMULATION FOR INTERNET GAMING DISORDER

Chair: Dongchan Park, M.D.

Speaker: Tim Fong, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe how Internet gaming disorder (IGD) impacts a patient in the developmental stages; 2) Identify the most current diagnostic criteria proposal; 3) Recognize various challenges of dealing with the disorder in other countries; and 4) Increase awareness of treatment options and strategies for IGD.

SUMMARY:

Internet gaming disorder (IGD) was included in the *DSM-5* under appendix III for further areas of research. This marks the first time that a behavioral addiction was included in the DSM, along with gambling disorder. IGD is still being refined for diagnostic clarification internationally, and the majority of past research comes from Asian countries, where it is thought to be more prevalent. It is estimated that 1.5 to 8% of the general population in the U.S. and in Europe meet criteria. This workshop will begin with a case formulation of a patient who suffers severely from IGD. We will review the current diagnostic criteria, epidemiology and treatment options of IGD. We will also provide an overview of what is known about the etiology and clinical course of IGD and how it compares to other addictive disorders. The discussant panel will then review current challenges and barriers surrounding IGD in South Korea and the United States. Attendees will be encouraged to participate in the discussion about the disorder by bringing up similar case studies and clinical experiences that they have encountered.

GRADEING "EVIDENCE" IN PSYCHIATRY: THE CASE OF MEDICAL MARIJUANA FOR PSYCHIATRIC INDICATIONS

Chairs: Deepak Cyril D'Souza, M.D., M.B.B.S., Rajiv Radhakrishnan, M.D., M.B.B.S.

Speakers: Rajiv Radhakrishnan, M.D., M.B.B.S., Samuel Wilkinson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List the components of the GRADE (Grading of Recommendations Assessment, Development and Evaluation) method in evaluating the quality of evidence; 2) Apply the GRADE method to evaluate the quality of evidence for medical

marijuana in psychiatric conditions; and 3) Identify key elements that characterize studies with high quality.

SUMMARY:

Psychiatrists are constantly faced with the task of evaluating scientific literature and adapting treatment practices to current evidence. The GRADE (Grading of Recommendations Assessment, Development and Evaluation) method offers a systematic way of evaluating and rating the quality of evidence based on risk of bias, precision, consistency and indirectness. The legalization of medical marijuana in many states in the U.S. for psychiatric indications such as post-traumatic stress disorder (PTSD), agitation in Alzheimer's disease (AD) and Tourette's syndrome (TS) have left psychiatrists in a quandary regarding whether medical marijuana is indicated in their patients. The workshop will provide participants with an opportunity to familiarize themselves with the GRADE method, apply the GRADE method to sample studies and examine the quality of evidence for "medical marijuana" for PTSD, AD and TS. Participants will be able to appraise the following facts: 1) There are no randomized controlled trials (RCTs) examining the efficacy of marijuana for TS, PTSD or AD; 2) Lower-quality studies have examined the efficacy of marijuana, THC and nabilone; and 3) The overall strength of evidence for the use of cannabinoids for these conditions is very low.

CHALLENGES IN COGNITIVE BEHAVIOR THERAPY: OVERCOMING BARRIERS TO EFFECTIVE TREATMENT

Chairs: Jesse H. Wright, M.D., Ph.D., Judith S. Beck, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Detail key strategies for overcoming common challenges to effective implementation of cognitive behavior therapy; 2) Describe common problems in implementation of successful cognitive behavior therapy; and 3) Develop CBT formulations to address barriers to effective treatment.

SUMMARY:

Two authors of widely used texts on cognitive behavior therapy (CBT) will discuss common challenges in delivering effective treatment and invite participants to present dilemmas they have encountered in implementing CBT. The initial focus

of the discussion will be on modifications of CBT for patients who have personality disorders or other chronic cognitive and behavioral patterns that may influence the success of treatment. An open forum will follow in which participants can share their experiences in treating difficult cases and receive suggestions from session leaders and other participants. Flexibility, creativity and persistence will be emphasized in finding solutions to treatment challenges.

TEACHING THE DSM-5 CULTURAL FORMULATION INTERVIEW: INNOVATIVE WEB-BASED APPROACHES AND VIDEOS TO DEMONSTRATE CULTURALLY APPROPRIATE ASSESSMENT SKILLS

Chairs: Russell F. Lim, M.D., M.Ed., Roberto Lewis-Fernandez, M.D.

Speakers: Roberto Lewis-Fernandez, M.D., Francis Lu, M.D., Russell F. Lim, M.D., M.Ed.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the *DSM-5* Outline for Cultural Formulation; 2) Utilize the *DSM-5* Cultural Formulation Interview to obtain culturally relevant information for use in the *DSM-5* Outline for Cultural Formulation; and 3) Describe the 12 supplemental modules of the *DSM-5* Cultural Formulation Interview.

SUMMARY:

The publication of the *Diagnostic and Statistical Manual, Fourth Edition (DSM-IV)* in 1994 was a watershed moment for cultural psychiatry with its new Outline for Cultural Formulation (OCF), glossary of culture-bound syndromes, culturally relevant diagnostic categories and cultural considerations in the narratives introducing each chapter. *DSM-5* advances the evolution of the practice of cultural psychiatry with the new Cultural Formulation Interview (CFI), designed to help clinicians elicit information relevant for the revised OCF. Located in Section 3 of the *DSM-5*, the CFI is a 16-question semi-structured interview in four sections: 1) Cultural Definition of the Problem (1–3); 2) Perceptions of Cause, Context and Support (4–10); 3) Cultural Factors Affecting Self-Coping and Past Help-Seeking (11–13); and 4) Cultural Factors Affecting Current Help-Seeking (14–16). In addition, online at www.psychiatry.org are 12 Supplementary Modules—Explanatory Model; Level of Functioning; Psychosocial Stressors; Social Network; Cultural Identity; Spirituality, Religion and Moral Traditions;

Coping and Help-Seeking; Patient-Clinician Relationship; Immigrants and Refugees; School-Age Children and Adolescents; Older Adults; and Caregivers. *The APA Practice Guidelines on the Psychiatric Evaluation of Adults, 3rd edition, 2015*, references the CFI as a clinically useful tool to obtain cultural information. This workshop will highlight innovative web-based and video teaching methods that originate from both Columbia University/New York State Center of Excellence for Cultural Competence and UC Davis to teach residents and practicing psychiatrists how to use the 16 questions of the CFI. Participants will have the opportunity to discuss these and other methods of teaching the CFI during 30 minutes of discussion.

INTIMACY AFTER INJURY: COMBAT TRAUMA AND SEXUAL HEALTH

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Christopher Nelson, M.D.

Speakers: Elspeth C. Ritchie, M.D., M.P.H., Christopher Nelson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the main effects of wounds from the wars in Iraq and Afghanistan; 2) Know the sexual side effects of medications used for TBI and PTSD and how to mitigate them; and 3) Understand the effects of physical wounds of war on sexual functioning, such as amputations and genitourinary injuries.

SUMMARY:

2.7 million U.S. service members have served in the wars since 9/11. Often discussed have been PTSD and TBI, the so-called “invisible wounds of war.” These injuries directly affect intimate relationships. The treatment of these wounds involves medications that often have sexual side-effects. Another set of war wounds are those that directly involve sexual functioning. These include, but are not limited to, lower extremity amputations and genitourinary injuries. In addition, facial disfigurement or burns may significantly impact self-esteem. The majority of wounded warriors are male, but injuries happen in female service members as well. Sexual assault causes severe harm to intimate relationships as well. This workshop will focus on the subject of “intimacy after injury.” The purpose would be to encourage medical personnel to 1) Discuss sexual health with their patients; 2) Learn how to evaluate and treat erectile dysfunction, including effects from SSRIs;

and 3) Understand how to mitigate the effects of physical injury, pain and disability on sexual functioning.

RESIDENT WELL-BEING: STRATEGIES TO PREVENT BURNOUT

Chair: Ijeoma Chukwu, M.D., M.P.H.

Speakers: Ijeoma Chukwu, M.D., M.P.H., Stella Cai, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the signs and symptoms of burnout; 2) Understand how burnout can negatively impact resident well-being; 3) Understand how burnout can negatively impact patient care; and 4) Identify methods to prevent burnout.

SUMMARY:

Residency training is arguably one of the most challenging periods of a physician's career. A multitude of stressors are encountered during residency training and have been cited as factors contributing to the challenges of residency training, including long work hours, sleep deprivation, limited family interaction and relationship strain. Several studies examining physician health and wellness have purported high rates of "emotional exhaustion, depersonalization and reduced personal accomplishment" in a state known as burnout. Burnout has been shown to negatively affect both resident mental and physical health. Burnout has been identified in residents across all specialties and has been associated with suboptimal patient care. This workshop will present a review of the signs and symptoms of burnout. The impact of burnout on resident well-being will be discussed, and several strategies to prevent burnout will be identified in an interactive session. Finally, participants will have the opportunity to practice burnout prevention techniques.

INTERACTIVE TRAINING AND DISSEMINATION OF TOBACCO CESSATION IN PSYCHIATRY: AN RX FOR CHANGE

Chair: Smita Das, M.D., Ph.D.

Speakers: Smita Das, M.D., Ph.D., Andrew J. Saxon, M.D., Jill M. Williams, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explain the relevance and

importance of tobacco cessation treatment in psychiatric settings; 2) Review smoking and mental illness epidemiology, medication interactions, nicotine, dual diagnosis and withdrawal symptoms; 3) Provide brief skills for clinicians using behavioral techniques for smoking cessation including the 5 A's and increase knowledge of pharmacological cessation aids and their use in psychiatric settings; and 4) Be able to access Rx for Change, a web-based curriculum to disseminate tobacco treatment training for health care professionals, including specific training for psychiatric settings.

SUMMARY:

Smoking and smoking-related mortality/morbidity continue to disproportionately affect those with mental illness. Among individuals with mental illness, smoking prevalence is two to four times that of the general population. Smokers with mental illness and addictive disorders purchase nearly half of cigarettes sold in the United States. Smoking is important to psychiatric practice for a variety of reasons such as use or withdrawal effects on behavior/mood, association with future suicide attempts and psychotropic drug level changes. Treating smoking is one of the most important activities a clinician can do in terms of lives saved, quality of life and cost efficacy. The APA recommends that psychiatrists assess the smoking status of all patients, including readiness to quit, level of nicotine dependence and previous quit history, and provide explicit advice to motivate patients to stop smoking. In a recent national AAMC survey of physicians, psychiatrists, as compared to other doctors, were least likely to participate in cessation activities and most likely to feel that there were greater priorities in care and that smoking cessation would worsen other symptoms. Only half of U.S. psychiatry residency programs provide training for treating tobacco, while 89% of program directors have interest in a model tobacco treatment training curriculum. "Rx for Change" is a mental health-focused tobacco treatment training program informed by a comprehensive literature review, consultation with an expert advisory group, interviews with psychiatry residency training faculty and focus groups with psychiatry residents. Rx for Change emphasizes a transtheoretical model of change, stage-tailored approach with other evidence-based tobacco treatments such as nicotine replacement, bupropion, varenicline and psychosocial therapies (integrating 5 A's: ask all patients about tobacco use, advise to quit, assess

readiness, assist and arrange follow-up). The four-hour training, when included in curriculum for psychiatry residents, is associated with improvements in knowledge, attitudes, confidence and counseling behaviors. This workshop will offer abbreviated, psychiatry-focused tobacco cessation training with a secondary goal to provide a resource for participants to use at their sites. Rx for Change is available online via <http://rxforchange.ucsf.edu> at no cost and offers a packaged training tool for improving treatment of tobacco use in psychiatric care. After the training, participants will receive material from the website that can be accessed later. An expert panel will close the session with an interactive question and answer opportunity. We hope that APA attendees who participate in the workshop, as leaders at their institutions, disseminate the training. Dissemination of an evidence-based tobacco treatment curriculum has the potential of dramatically increasing the proportion of smokers with mental illness who receive assistance with quitting.

BREAKING BAD: COMMUNICATING “BAD NEWS” TO PATIENTS AND FAMILIES

Chair: Jeanne Lackamp, M.D.

Speakers: Jennifer M. Brandstetter, M.D., Christine Koniaris, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review common errors that clinicians make when breaking “bad news” to patients and family members; 2) Practice identifying these errors in simulated vignettes, and practice reframing problematic communication styles; and 3) Teach and practice new communication skills of breaking “bad news,” which can then be incorporated into clinicians’ routine practice.

SUMMARY:

Many clinicians find it difficult to break “bad news.” Providers may see bad news as reflective of failure on their part or the part of the medical profession. They may feel frustrated with the patient or with his or her illness. They also may feel sad because of their patient’s medical condition. Thus, reactions and strategies for breaking bad news are varied. Some colleagues evade the topic altogether. Some colleagues find themselves “botching” the act of breaking bad news, with resulting negative reactions on the part of their patients. Still other colleagues may think that they are communicating clearly,

when in reality their patients are confused and unclear about their illness, prognosis or treatment planning. Psychiatrists and palliative medicine specialists in the general hospital often help patients navigate difficult life events, including illnesses, loss of sense of self, end-of-life goals and death. These providers also assist medical colleagues in learning the art of breaking bad news and putting this knowledge into action. The present workshop will address the three types of errors listed above. We will share common examples of the struggles inherent in breaking bad news. Participants will be provided with cases highlighting the errors above and will identify avoidance, erring and ambiguity. Participants will then practice breaking bad news and will learn strategies to teach their colleagues how to break bad news more effectively. The speakers in this workshop will include two consultation-liaison psychiatrists and a palliative medicine specialist who collaborate with each other and who also provide consultation/liaison services to primary teams in a major academic medical center.

TREATING ADOLESCENTS WITH EATING DISORDERS: SPECIAL ISSUES

Chair: Matthew Shear, M.D.

Speakers: Tom Hildebrandt, Psy.D., Evelyn Attia, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Better understand the *DSM-5* diagnostic criteria and treatment options for avoidant/restrictive food intake disorder in adolescents; 2) Understand the evolution and current applications of the family-based treatment model of treating eating disorders in adolescents; and 3) Better understand how to manage some unique issues that arise in treating eating disorders in adolescents in an inpatient setting.

SUMMARY:

Eating disorders are severe psychiatric conditions, often first diagnosed in adolescence. Early identification and intervention have been associated with better outcomes. This workshop will discuss several issues of specific interest to psychiatrists who evaluate and treat young patients with eating disorders. Dr. Evelyn Attia, Director of the Center for Eating Disorders at Columbia University and Weill Cornell Medical Centers, will discuss avoidant/restrictive food intake disorder (ARFID), a diagnosis that was newly described in *DSM-5* that

commonly presents during childhood and adolescence. Dr. Tom Hildebrandt, Director of the Eating and Weight Disorders Program at Mount Sinai Hospital, will discuss family-based therapy for anorexia nervosa, an outpatient intervention for adolescents that has significant empiric support. Dr. Matthew Shear, director of a specialized eating disorders inpatient program at New York-Presbyterian Hospital, will discuss inpatient management of adolescents who require intensive treatment for these life-threatening disorders.

A RESIDENT'S GUIDE TO BORDERLINE PERSONALITY DISORDER: FROM THE EXPERTS (PART 2 OF 2)

Chair: Brian Palmer, M.D., M.P.H.

Speakers: Brian Palmer, M.D., M.P.H., John Gunderson, M.D., Marianne Goodman, M.D., Kenneth R. Silk, M.D., Perry Hoffman, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Diagnose BPD and understand its relationship to other disorders; 2) Structure an effective psychotherapy for BPD; 3) Thoughtfully choose psychopharmacological approaches that fit within a formulation of a patient's problems; 4) Effectively integrate family work into a treatment plan; and 5) Establish a concrete plan for integrating BPD into their further psychiatric training.

SUMMARY:

This is a repeat of a series of popular workshops held in New Orleans in 2010, Philadelphia in 2012, San Francisco in 2013, New York in 2014 and Toronto in 2015. Those resident-only workshops were very successful, with high levels of attendance (>100 each session) and engagement. We are thus presenting two workshops here in the same manner in which we submitted the prior presentations. Patients with BPD represent approximately 20% of both inpatient and outpatient clinical practice, and their effective treatment requires specific knowledge skills, and attitudes that will be addressed in this workshop. This workshop is designed for and limited to residents, fellows and medical students, who often struggle in training with the treatment of these patients. In a highly interactive format, trainees will learn from and along with experts in the field of borderline personality disorder (BPD) to broaden and deepen their understanding of the disorder and its treatment. Alternating brief presentations of salient points with audience participation will allow participants to increase their knowledge and skills

and to synthesize and apply the content as presented in the workshop. The workshop will be presented in two sessions (part 1 and part 2). The workshop moves from an overview of BPD to essentials of psychotherapy and psychopharmacology, family therapy, and suicide assessment and interventions. An overview of neurobiology is included. Specifically, participants will review the diagnosis of BPD and its relationship with other disorders in order to build a basis for case formulation. Following this, the workshop examines core features of effective psychotherapy as well as aspects (features) of treatments likely to make patients worse. Based on these principles, the workshop then examines suicide risk assessment and hospitalization with an emphasis on practical approaches for patients in the emergency setting. Strategies and common pitfalls in psychopharmacological treatment for BPD are examined, with case material from both experts and participants. Finally, principles of family involvement are presented, including data supporting the idea that families can and should learn effective ways of decreasing reactivity and increasing effective validation. Participants are encouraged to attend both parts, though we will, in part 2, review material from part 1, so if necessary, either session could be attended independently.

ADDRESSING DIVERSITY IN PSYCHIATRIC TRAINING: OUR PAST, PRESENT AND FUTURE WITH DIVERSITY SYSTEMIC/ACADEMIC STRATEGIC INITIATIVES

Chairs: Roberto E. Montenegro, M.D., Ph.D., Auralyd Padilla Candelario, M.D.

Speakers: Roberto E. Montenegro, M.D., Ph.D., Paula Marie Smith, M.D., Daena L. Petersen, M.D., M.P.H., Ed Childs, Ranna Parekh, M.D., M.P.H., Lisette Rodriguez-Cabezas, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the history of psychiatry training programs with an emphasis on minority/underrepresented groups; 2) Appreciate the current state of training experiences of minority residents/fellows in relation to mentorship, advocacy and unconscious bias; and 3) Explore new diversity strategic initiatives (Diversity 3.0) and how to implement Diversity 3.0 into training programs in efforts to improve the workforce.

SUMMARY:

The primary aim of this workshop is to survey the progress that minorities in psychiatric training have made in the last 50 years while calling special attention to modern forms of subtle exclusion and oppression based on social differences that include, but also go beyond, race. The aim is to increase the awareness and accountability of the impact that suboptimal mentorship, advocacy and sustained unconscious bias can have on the recruitment, training, professional development and retention of under-represented trainees. The workshop will begin with a quick introduction by Dr. Lisette Rodriguez-Cabezas; she will provide a quick review of the progress our field has made in diversifying the makeup of psychiatrists within the U.S. Following this short introduction, three APA members-in-training will share their experiences of how workforce diversity, or a lack thereof, and sustained unconscious bias leading to marginalization in residency impact their professional development vis-à-vis mentorship and advocacy. Dr. Roberto Montenegro will discuss his perspectives as a Latino male, more specifically, how his background facilitates his ability to serve as an advocate for underserved patients. He will also discuss the importance of having a faculty advocate that understands minority trainee needs. Dr. Paula-Marie Smith will discuss the importance of mentorship in the professional development of minority trainees. She will specifically talk about inter- and intra-ethnic countertransference and the importance, if any, of an ethnically concordant supervisor. Dr. Daena Petersen will discuss her experiences as a lesbian white woman and the inherent unconscious biases she has faced during her training. She will provide examples of difficult encounters she has had due to assumptions made by colleagues and patients alike and the role that this unconscious bias has played on her professional development. Following these 45 minutes, there will be a 20-minute question-answer session followed by a short summary by Dr. Ranna Parekh, coauthor of *Overcome Prejudice at Work* (2012), and Dr. Ed Childs, Chair of Surgery at Morehouse School of Medicine. The workshop will end with a discussion about novel, innovative programs focused on aligning diversity initiatives within psychiatry with broader academic/university/medical school curricula specific to recruitment and retention of under-represented trainees.

OPTIMIZING PSYCHOPHARMACOLOGY TRAINING DURING RESIDENCY

Chair: Jeffrey J. Rakofsky, M.D.

Speakers: Jeffrey J. Rakofsky, M.D., Sidney Zisook, M.D., John Q. Young, M.D., M.P.H., Ira Glick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the value of “prescribing confidence” as a novel metric that can assess residents’ readiness for real-world practice; 2) Understand the advantages, disadvantages and potential uses of a comprehensive and portable psychopharmacology curriculum; 3) Appreciate how a performance assessment tool improves the quality of feedback residents receive on their medication management skills; and 4) Practice using a performance assessment tool in giving feedback to peers during a simulated medication management visit.

SUMMARY:

The practice of psychopharmacology has grown tremendously over the last few decades with the advent of new psychiatric medications, greater polypharmacy and the ability to treat illnesses that were previously treated exclusively with psychotherapy. Psychiatry residency program directors and faculty attendings must ensure that their residents develop the skills necessary to competently treat a variety of psychiatric illnesses with psychotropic medications. Recent innovations in teaching residents psychopharmacology will be discussed, including the measurement of prescriber’s confidence, the implementation of a multimodal and up-to-date psychopharmacology curriculum, and the use of a performance assessment tool to provide residents feedback on their medication management skills. Following these presentations, an expert in teaching psychopharmacology will lead an interactive discussion of these topics and emphasize the importance of teaching the teachers. The audience will then participate in a simulated medication management visit to gain practice using the residents’ performance assessment tool.

ADDRESSING STIGMA USING ACCEPTANCE AND COMMITMENT THERAPY

Chair: Kenneth P. Fung, M.D.

Speaker: Kenneth P. Fung, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the six core ACT

processes; 2) Describe the relationship between ACT processes and stigma; and 3) Lead a group exercise based on ACT principles to decrease stigma.

SUMMARY:

Social exclusion and discrimination arising from stigma affects many diverse marginalized populations, including discrimination based on ethnicity, gender, sexual orientation and illness. Further, stigma can be internalized. To combat enacted and internalized stigma, scalable strategies need to be developed. Some common approaches include education, protest and contact-based methods. There is an inherent assumption that erroneous beliefs must be corrected. However, this may at times lead to “political correctness” or defensiveness without addressing the underlying interactive individual and interpersonal processes that perpetuate both internal and enacted stigma. In this workshop, we will focus on the use of a mindfulness-based psychotherapeutic approach, acceptance and commitment therapy (ACT) and its adaptation to address stigma. ACT consists of six core processes: acceptance, defusion, present moment, self-as-context, values and committed action. We will examine the relationship between these psychological processes and stigma and how its application may be able to decrease internalized and enacted stigma and increase mobilization of valued actions to decrease external societal stigma. The workshop will draw on our experience of using ACT to decrease HIV stigma and stigma against mental illness in our community-based research. Participants will be led through experiential ACT exercises that have been used to decrease stigma for those who have been directly affected by it (i.e., those with HIV or mental illness), as well as members of the community who have not.

CRISIS IN TRANSIT: PERSPECTIVES ON GLOBAL REFUGEE AND MIGRANT MENTAL HEALTH

Chairs: Damir Huremovic, M.D., M.P.P., Nyapati R. Rao, M.D.

Speakers: Guitelle St. Victor, M.D., Jacob Sperber, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the scope of current major global migrant and refugee crises and mental health challenges associated with contemporary forced migration; 2) Identify and recognize unique mental health needs of

migrant/refugee populations, both predating their arduous journey and arising with transit and on arrival in host countries/cultures; 3) Identify cultural challenges that are superimposed on acute issues associated with interfacing host, transit and refugee populations (cultures); and 4) Formulate strategies to provide better screening and access to mental health care tailored to address unique needs of migrant/refugee groups, individuals and families.

SUMMARY:

Conflicts, violence and forced displacement of population have unfortunately accompanied human existence throughout history. At any given time, about one percent of the global population is forcibly displaced from their homes and their communities, seeking refuge. Deleterious effects of emotional and psychological trauma sustained during displacement have long been acknowledged and studied. The landscape of refugee and migrant trauma remains ever evolving. While there are general principles of organizing mental health services for refugees and migrants that can be studied within the context of disaster psychiatry, each new crisis produces unique challenges that may have ripple effects across the globe. Recent years have seen a tremendous rise in refugees from the Middle East (Syria and Iraq), as well as waves of refugees in Southeast Asia (Myanmar) and Europe (Ukraine) and a tide of unaccompanied minor migrants from Central America (El Salvador, Honduras). Already significantly traumatized prior to their flight, refugees in different parts of the world are encountering new sources of trauma—they are often forced to transit through volatile and sometimes outright hostile regions that in the recent past used to be sources of refugees (Balkans) and migrants (Mexico). Poorly equipped to deal with social impact of refugees, transit societies react with pattern of rejection, backlash and violence. Eruptions of violence further traumatize refugees and migrants, leave them vulnerable to exploitation and human trafficking, and propel them farther geographically in their quest for safe havens. This workshop provides an overview of the refugee and migrant crises at the global level and provides an understanding of forced migration as a truly global phenomenon. Panelists will outline unique features of contemporary refugee/migrant crises that include transiting through hostile regions and compounded trauma; dimensions of human trafficking; risk and fear of “importing” terrorism; cultural issues, mismatches and clashes; phenomenon of migrant

unaccompanied minors; sexual exploitation; and developments in refugee/asylum policies. The workshop is designed to provide updated screening and intervention tools when approaching patients with recent migrant/refugee experiences. It concludes with advances in public mental health that are geared toward assisting individuals, families and entire communities in their transition, resettlement or repatriation. Panelists include experts with extensive experience of working in war-ravaged regions, with refugees and across cultures. Ample time will be provided to participants to ask questions, engage in discussion, or provide their personal experiences and/or perspectives.

ONLINE DATING, CYBERBULLYING AND HARASSMENT IN THE 21ST CENTURY: PREVALENCE, PSYCHIATRIC CONSEQUENCES AND STRATEGIES FOR PREVENTION

*Chairs: Christopher F. Ong, M.D., Almari Ginory, D.O.
Speakers: Laura Ginory, M.D., Yuliet Sanchez-Rivero, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Examine the various subtypes of online harassment; 2) Review current knowledge regarding the prevalence of the various subtypes of online harassment; 3) Discuss methods for screening and preventing online harassment; and 4) Provide real world examples of online harassment as they pertain to providers and patients in the 21st century.

SUMMARY:

The transition to adolescence brings on a whole new set of life challenges and experiences, arguably the most important of which is the increased emphasis on dating and relationships. While this concept is not new, the ever growing ease of access to the Internet via ubiquitous devices such as mobile phones and tablets is definitely new. With up to 98% of young adults using cell phones in 2013 alone, it begs the question as to how the Internet has changed the way teenagers make the transition into that specific stage in life where dating and relationships become a higher priority. A body of research is already available regarding non-Internet-related adolescent dating violence and abuse. However, research related to online adolescent dating violence and abuse is still sparse. Many authors argue that online adolescent dating violence and abuse is merely an extension of, rather than a distinct form of, offline adolescent dating violence and abuse. Others argue

that online adolescent dating violence and abuse allows for a unique type of harassment never seen in society previously. The purpose of this workshop will be to provide education to residents and medical students about the subtypes of online harassment and the prevalence of various forms of online harassment. As the body of knowledge regarding this budding field of research continues to grow, we will discuss the latest updates regarding psychiatric consequences of online harassment, as well as methods for screening and prevention. After providing a good foundation of knowledge, we will provide specific examples of online harassment before concluding with future directions of research in this upcoming field. We will discuss how to screen adolescent patients for online harassment and provide education to the patient. The goal will be to have an open forum where attendees can ask questions and discuss issues/concerns. For residents, the goal will be to provide the education for them to return to their programs and modify policies.

WHAT CAN MENTAL HEALTH PROVIDERS LEARN FROM PEDIATRIC PRACTICES REGARDING PREVENTION AND MANAGEMENT OF CANNABIS USE BY YOUTH?

*Chair: Geetha A. Subramaniam, M.D.
Speakers: Sharon Levy, M.D., M.P.H., Stacy Sterling, M.P.H., M.S.W.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List at least two reasons that underscore the importance of routine screening for substance use among pediatric patients presenting to mental health care; 2) Identify recommended prevention, early intervention and treatment strategies to prevent or reduce adolescent marijuana use; 3) Anticipate potential obstacles to implementing systematic SU screening and management in pediatric mental health setting, and potential solutions to those obstacles; and 4) Discuss ideas for developing and strengthening linkages between primary care, mental health and substance abuse treatment providers and settings, in order to facilitate care coordination .

SUMMARY:

The onset of substance use is typically during adolescent years. Psychiatric disorders such as ADHD, Anxiety Disorders and Depression have been established as risk factors for the initiation and maintenance of substance use and substance use

disorders (SUD). Moreover, untreated SUD has been shown to complicate mental health treatment and negatively impact mental health outcomes. Cannabis use among youth has continued to rise while rates of alcohol and tobacco use have either declined or remained steady. This phenomenon has occurred in conjunction with an increasing number of states legalizing medical or recreational marijuana use, increasing routes of access and decreasing youth perception of risk. Thus, mental/behavioral health providers (i.e. psychiatrists, psychologists, social workers, nurse practitioners and others) can play a crucial role in preventing or limiting the progression of adolescent-onset cannabis use and associated problems. Recommendations for addressing cannabis use in medical settings includes universal screening with validated tools and a systematic approach to delivering interventions to match level of experience with cannabis, - from health-based prevention messages for abstinent youth to motivational enhancement approaches for youth with problematic or disordered use. Mental Health providers can also play a critical role in engaging families in the SU treatment process, as many families are more amenable to mental health treatment than substance use treatment. Preliminary work conducted in pediatric medical settings and select mental health settings will be used to highlight these strategies. Drs. Sharon Levy and Stacy Sterling will respectively open the workshop with a didactic component laying out the framework for screening and management strategies in pediatric medical and mental health settings. This is to be followed by a structured and interactive discussion with the audience regarding lessons learned, potential barriers and opportunities, some provider and family perspectives, and implementation strategies for application with youth who present at pediatric mental health settings.

MAY 16, 2016

INVOLUNTARY INPATIENT PSYCHIATRIC TREATMENT: PAST, PRESENT AND FUTURE

*Chairs: David A. Nissan, M.D., Julie B. Penzner, M.D.
Speakers: Raymond Raad, M.D., M.P.H., David A. Nissan, M.D., Paul S. Appelbaum, M.D., Julie B. Penzner, M.D., Mark J. Russ, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the social, legal and clinical changes that have contributed to the current

requirements of involuntary treatment of patients in psychiatric hospitals; 2) Understand what social, political and legal forces may contribute to changes in these requirements; and 3) Appreciate current evidence of the impact court-ordered treatment has on psychiatric patients.

SUMMARY:

Before the late 1970s, commitment laws in individual states were based on a patient's mental illness and their need for treatment. Laws began to gradually change as states adopted stricter standards, making the restriction of a person's liberty require imminent danger to the patient or another person and separating involuntary hospitalization, which remains initially a clinical decision, from involuntary medication, which in most jurisdictions is left for judicial determination in all but emergent situations. The development of these current systems is discussed. The current systems, which vary from state to state, are usually associated with some delay in this decision, which correlates with higher rates of assaultive behavior, restraint, seclusion and other adverse clinical outcomes. Recent data evaluating the impact of this treatment delay is discussed. Finally, we discuss current social, political and legal trends that may lead to changes in these systems.

STRUCTURED CLINICAL INTERVIEW FOR DSM-5 - CLINICIAN VERSION (SCID-5-CV)

Chair: Michael B. First, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Provide culturally competent care for diverse populations; 4) Describe the utility of psychotherapeutic and pharmacological treatment options; 5) Integrate knowledge of current psychiatry into discussions with patients; and 6) Identify barriers to care, including health service delivery issues.

SUMMARY:

Abstract not available.

NEUROMODULATION PRIMER FOR RESIDENTS: AN INTRODUCTION TO ECT, TMS AND DBS

*Chair: Almari Ginory, D.O.
Speakers: Richard Holbert, M.D., Herbert Ward,*

M.D., Jacqueline A. Hobbs, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Self-evaluate individual progress on ACGME milestones relevant to neuromodulation therapies; 2) Discuss the different types of electroconvulsive therapy (ECT) as well as the risks, benefits and dose parameters; 3) Identify indications for deep brain stimulation (DBS) in mental illness and the role of the psychiatrist; and 4) Review the literature on transcranial magnetic stimulation (TMS) and dTMS.

SUMMARY:

As more research becomes available, nonpharmacological, device-mediated interventions for treatment-resistant psychiatric illnesses are becoming increasingly common. Residents need to have an understanding of brain stimulation treatment alternatives, as they will likely have patients who would benefit from these treatments or may be the ones conducting them. In addition, residents must demonstrate ACGME milestones related to electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS) and other emerging neuromodulation therapies prior to graduation. ECT has been available in the U.S. since the 1940s. With movies such as *One Flew Over the Cuckoo's Nest*, ECT has lost favor for many patients; however, it is still considered the gold standard for treatment-resistant depression. We will review some of these media examples of ECT, as these, unfortunately, guide patients' decision making, including more recent positive examples (*Homeland*). We will review subtypes of ECT, indications, risks, dose parameters and efficacy for each. Deep brain stimulation (DBS) has been used in movement disorders, in particular Parkinson's disease, for many years but has only recently made its way into psychiatric disorders. It has received the most attention in depression and OCD. We will cover how an OCD patient is chosen for DBS, what expertise the treatment team should have, the basics of stereotaxic surgery, how to program the stimulator for optimal benefit and what a typical course of treatment would include. The anatomy and specifics of programming of the most common target for DBS in OCD will be covered. We will discuss side effects, data on efficacy and safety. Additionally, the ethical considerations of brain surgery on psychiatric patients will be presented to foster discussion on this issue. TMS induces electrical

stimulation through a coil producing small alternating currents to the superficial layers of the cortex. It is mostly used for treatment-resistant depression, and research is ongoing for uses in other psychiatric conditions such as bipolar disorder, substance use disorders, and autism. We will review current research, indications and side effects. We will illustrate the procedure using videos as well. The workshop leaders have significant experience in the use of neuromodulation therapies both clinically and in research protocols, as well as educating residents. Participants will assess their progression on neuromodulation-related milestones pre- and post-participation. Patient case examples will be presented to allow for small group discussions and active participation. These examples and videos will be used to foster discussion and application to real patients. The goal will be to provide residents with knowledge of brain stimulation techniques for treatment-resistant mental illnesses while having an open forum for discussion and questions.

TRAINING AMERICAN PSYCHIATRISTS AS GLOBAL MENTAL HEALTH INVESTIGATORS, IMPLEMENTERS AND PARTNERS: WHAT HAVE WE LEARNED THAT CAN INFORM BEST PRACTICES?

Chairs: Michael D. Morse, M.D., M.P.A., Anne Becker, M.D., Ph.D.

Speakers: James Griffith, M.D., Bibhav Acharya, M.D., Joseph Reginald Fils-Aimé, M.D., M.Sc., Milton Wainberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe diverse approaches to developing missions for global mental health training, services delivery and research; 2) Articulate emerging guidelines and best practices for global mental health training, services delivery and research; 3) Describe clinical competencies, learning objectives, and clinical experiences that can address training gaps as psychiatric trainees prepare to work in low- and middle-income countries; 4) Articulate guidelines for creating successful and sustainable collaborations with local health care professionals and organizations in low- and middle-income countries; and 5) Identify and prevent harmful unintended consequences associated with global mental health interventions in low- and middle-income countries, settings of armed conflict and refugee crises.

SUMMARY:

Increasingly, American teaching hospitals and research universities are responding to the enormous mental health needs in low- and middle-income countries, settings of armed conflict, and refugee crises by developing mentored, field-based learning, creating innovative curricula and forging institutional collaborations that expand the scope of learning and career development in global mental health. Likewise, there is unprecedented interest among American psychiatric trainees in learning opportunities that meaningfully advance global mental health. At this juncture, we can ask what we have learned from notable educational and programmatic initiatives that have thus far emerged. How can North American teaching hospitals and research universities best equip psychiatry trainees to make high impact contributions within global mental health while also enriching their own professional development? What have we learned about elements that are essential to successful and sustainable collaborations that meet local mental health delivery challenges? How should the success of global mental health training be evaluated? What core elements and principles, such as bi-directional learning, in-country capacity building and long-term institutional commitments, may be indispensable? How does our experience to date inform best practices? Importantly, how do we teach trainees practices that will guard against harmful unintended consequences while conducting educational and research projects within the complex psychosocial ecosystems of low- and middle-income countries? In this workshop, global mental health clinicians, educators, researchers and trainees will discuss lessons drawn from different models for services delivery, research and training in global mental health.

BEST PRACTICE IN INTERNATIONAL MEDICAL GRADUATES' TRAINING AND ASSESSMENT

Chair: Subodh Dave, M.D.

Speaker: Nyapati R. Rao, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know the key factors hampering acculturation of IMGs; 2) Know the key factors that facilitate acculturation of IMGs; 3) Know the key challenges in designing culturally competent assessment tools; and 4) Implement culturally competent assessment methods in practice.

SUMMARY:

High-income countries (HICs) such as the U.K., the U.S., Canada and Australia have a large number (up to 40%) of international medical graduates (IMGs) in their postgraduate training schemes. This is particularly true of psychiatry, which is experiencing a recruitment crisis. However, IMGs' acculturation to their host country is hampered by a range of factors such as language difficulties, differences in learning styles, different cultural codes and practices both at a personal and a professional level, and the challenge of working in a different health system. Poor acculturation leads to differential attainment in high-stakes exams and poor career progression. This workshop will explore cultural factors impacting IMGs' training and assessment, drawing upon examples in North America and Europe. The interactive workshop should enable participants to experience the use of psychotherapy and appropriate clinical and educational supervision as acculturation tools. The workshop will also explore the cultural challenges involved in designing fair assessment tools for IMGs. At the end of the workshop, participants will 1) Know the key factors hampering acculturation of IMGs; 2) Know the key factors that facilitate acculturation of IMGs; 3) Know the key challenges in designing culturally competent assessment tools; and 4) Learn examples of culturally competent assessment methods.

THE ASHLEYMADISON.COM HACK: UNDERSTANDING AND TREATMENT OF INFIDELITY FROM DISCOVERY TO RECOVERY

Chair: Scott Haltzman, M.D.

Speakers: Robert Hsiung, M.D., Scott Haltzman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify three assumptions of the "illusion of privacy" and its impact on electronic communication users; 2) Identify two internal and one external element associated with the initiation of affairs; 3) Recognize the typical patterns of discovery associated with infidelity; and 4) Teach patients/clients/couples the four steps to enhance recovery once an affair is revealed.

SUMMARY:

Estimates of the rate of infidelity range from 25 – 40% of all married American couples. The use of electronic communications, from text messages to Facebook "meetings," makes it easier than ever to initiate and perpetuate an affair. The rate of individual who describe being affected by e-affairs

soared from six percent to 60 percent in the decade between 2002 and 2012. The rise in e-communicés appears to increase the risk of having an affair, but simultaneously increase the risk of being discovered, as almost all modes of digital interactions leave a trace. AshleyMadison.com is a website that promotes affairs between adults, at least one of whom is already in a committed relationship. It promotes its mission with the adage "Life is short. Have an affair." A month after the site was hacked in July 2015, approximately 33 million users' names from around the world were released to the public. The consequences highlight a betrayal on two fronts: 1) The site's promise of privacy to the subscriber and 2) The spouse's promise of fidelity to his or her partner. Objective studies of the emotional, social or financial impact of the release have not yet been published, but anecdotal evidence indicates that many couples who have been affected by the data dump experienced distress, while others have kept their marriages intact. This workshop looks at the assumptions that individuals make about privacy when partaking in e-communication and at the principles involved in forming a committed monogamous relationship. It reviews the allure of "privacy" of web-based communication and explains the limitations and risks therein. It describes some of the interpersonal and situational variants that lead to infidelity and the typical dynamic of "uncovering" of an affair. Finally, it reviews therapeutic approaches to healing from infidelity and what practitioners can do to help preserve a marriage bond threatened by an affair.

THE KIDS ARE NOT ALL RIGHT: MENTAL HEALTH IMPACT OF PARENTAL INCARCERATION

Chairs: Courtney L. McMickens, M.D., M.P.H., Barbara Robles-Ramamurthy, M.D.

Speakers: Joyce Arditti, Ph.D., Mia Everett, M.D., Otis Anderson, M.D., Anish R. Dube, M.D., M.P.H., Courtney L. McMickens, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the multiple stressors and potential risk factors for families and children whose parents have experienced incarceration; 2) Assess children's symptoms, risk factors and protective factors that have been shown to be associated with parental incarceration; and 3) Identify resources and effective interventions for improving outcomes of children with behavioral and

emotional problems who have experienced parental incarceration.

SUMMARY:

Most recent statistics show that 2.3% of the population under the age of 18 in the U.S. are children of incarcerated parents, disproportionately affecting Black and Hispanic children. This number has increased 80% from 1991 to 2007. Within the outpatient treatment population, studies have shown that at least 40% of the children in mental health treatment have experienced parental incarceration. Several studies have shown an association between parental incarceration and attentional problems, behavioral problems, antisocial traits and learning difficulties in children. Incarceration is also associated with caregiver feelings of helplessness, parental instability and changes in caregiver role that can have a negative impact on their ability to be effective parents. Though there is some debate over the isolated impact of parental incarceration on a child's mental health, the social determinants of mental health closely interrelated to incarceration, such as poverty, racial inequality and educational inequalities, have a negative impact on outcomes for these children. This workshop includes an overview parental incarceration in the U.S. and its impact on family structure, discussion of child mental health problems associated with parental incarceration and current clinical practices for working affected families. Drs. Dube and McMickens discuss the multifaceted impact of parental incarceration on child mental health outcomes based on recent data. They will also provide context for considering incarceration as a social determinant of health. Dr. Arditti, a developmental psychologist, discusses the psychological underpinnings of the effect of incarceration on the family dynamic and presents data from her qualitative research on families of incarcerated adults. Dr. Anderson discusses his work with families within the Mississippi Department of Corrections. Dr. Everett discusses her work at Children of Promise, a community-based nonprofit organization in Brooklyn, NY, that provides comprehensive psychosocial services for children of prisoners.

THE BEHAVIORAL ADDICTIONS AND THE BRAVE NEW WORLD OF THE DSM-6 (YES, SIX)

Chairs: Mayumi Okuda, M.D., Petros Levounis, M.D.

Speakers: Silvia Bernardi, M.D., Ariel Kor, M.S.,

Mayumi Okuda, M.D., Petros Levounis, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Summarize research findings demonstrating similarities between behavioral addictions and substance-related disorders in clinical expression, brain origin, comorbidity, physiology and treatment; 2) Explain the rationale behind gambling disorder's inclusion as an addictive disorder in *DSM-5* as an example of a behavioral addiction; 3) Formulate problematic use of pornography within an addiction framework and describe the development and testing of a Problematic Pornography Use Scale (PPUS); and 4) Recognize the implications of operationalizing other behaviors as behavioral addictions in future diagnostic classifications.

SUMMARY:

For the first time, the Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition (*DSM-5*) introduced non-substance-related disorders as psychiatric diagnoses. This workshop will serve as a platform to discuss the main controversies surrounding the conceptualization of excessive behavioral patterns as addictive disorders. While data supporting the consideration of certain excessive behaviors (e.g., gambling disorder) as addictive disorders is stronger, data for other excessive behaviors has been more mixed. For instance, some empirical studies support the conceptualization of obesity as an addictive disorder based on data suggesting overlapping molecular and cellular mechanisms and reward brain circuits as well as shared genetic vulnerabilities, but other studies have provided contradicting evidence. To illustrate this debate, the workshop will begin with a review of available evidence demonstrating the overlap between excessive behaviors and substance use disorders in terms of etiology, biology, comorbidity and treatment. The workshop will include a review of the rationale behind the evolving definition of gambling disorder in the *DSM-5*. Using problematic use of pornography as another example, the workshop will also describe the conceptualization of other excessive behaviors within an addiction framework. Finally, the workshop will allow for debate on the significance of operationalizing excessive behaviors of emergent interest (texting, shopping, emailing) as behavioral addictions in future diagnostic classifications.

TELEPSYCHIATRY AND ITS MYRIAD APPLICATIONS FOR TREATING PEOPLE WITH SERIOUS MENTAL ILLNESS IN THE PUBLIC SECTOR (AND FOR RESIDENCY TRAINING)

Chair: Rachel Zinns, M.D., Ed.M.

Speakers: Li-Wen Grace Lee, M.D., Gregory Miller, M.D., M.B.A., Matthew B. Perkins, M.D., M.P.H., Matthew D. Erlich, M.D., Rachel Zinns, M.D., Ed.M.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify strategies for expanding the use of telepsychiatry in the public sector; 2) Recognize opportunities for education and training through telepsychiatry; and 3) Anticipate potential barriers to the implementation of novel telepsychiatry services and discuss strategies for successful implementation.

SUMMARY:

Telepsychiatry has been an increasingly popular proposed solution to addressing the needs of underserved patient populations and patients in physician shortage areas. However, implementation of telepsychiatric services has been relatively limited to the private sector. There is a limited evidence base for telepsychiatry services, especially for people with serious mental illness, and few published examples of telepsychiatry initiatives in the private sector. In New York State, there have been numerous initiatives aimed at expanding the use of telepsychiatry within the state mental health system. We plan on presenting these initiatives, focusing on implementation strategies, clinical outcomes and bridging of clinical services with residency training: 1) State strategy for improving access to services and physician recruitment and retention through telepsychiatry; 2) Telepsychiatry for forensic evaluations and services in state prisons; 3) Telepsychiatry for psychiatric consultation services to state psychiatric centers; 4) Telepsychiatry on inpatient units for engagement in and transition to outpatient services (resident-run service); 5) Creation of a telepsychiatry track in child fellowship training programs to provide services to schools and remote child and adolescent mental health clinics; 6) Telepsychiatry for long-term outpatient treatment at rural adult mental health clinics—we will present several examples of telepsychiatry services for adult outpatients, including development of a residents' clinic. We will also present a model of physician leadership through telepsychiatry in a clinic where all physician services

have been provided remotely (including clinical outcomes as well as service system outcomes from the first eighteen months of telepsychiatry services).

PRE-EXPOSURE PROPHYLAXIS (PREP) FOR HIV: THE SCIENCE, PSYCHOLOGY AND IMPLICATIONS FOR CLINICAL PRACTICE

Chair: Kenneth Ashley, M.D.

Speakers: Marshall Forstein, M.D., David W. Purcell, J.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define PrEP (pre-exposure prophylaxis) and the ARTs (antiretroviral treatments) that are currently available for PrEP; 2) Identify populations at risk for HIV that might benefit from PrEP; 3) Formulate a clinical situation in which PrEP might be appropriate and safe; 4) Identify two potential adverse outcomes of a population's use of PrEP; and 5) Understand the unique role psychiatrists may have in the use of PrEP.

SUMMARY:

HIV continues to be a worldwide epidemic. In the United States, approximately 50,000 new infections occur yearly, with the major incidence in men who have sex with men (MSMs). Men of color are disproportionately infected, and young men continue to participate in unprotected sex in spite of having knowledge about the use of condoms. The advent of multidrug treatment for HIV that has increased health and longevity among those infected has had the effect of decreasing the sense of fear and anxiety about acquiring HIV as a life-threatening disease. Young people who have not experienced the scourge of HIV in their peer communities often believe that if they get infected they "simply need to take medication." Based on a number of studies, many multinational, antiretroviral medications have been shown to effectively block infection by HIV if taken daily (pre-exposure prophylaxis [PrEP]). Studies vary in the effectiveness for preventing HIV from 44% to 95%. Given the enormous impact of HIV on at-risk populations, both the CDC and the World Health Organization recommend PrEP for "high-risk" individuals who are serologically tested to be HIV-negative. These population-based recommendations do not adequately assess the impact of PrEP on individuals with regard to psychological readiness or the capacity for adequate adherence to daily dosing. Antiretroviral therapy for people infected with HIV that suppresses viral replication has already been

shown to have a significant impact on reducing the transmission of HIV from HIV-infected to noninfected individuals. Concerns have been voiced about spending resources on PrEP rather than on treatment for those already infected, especially in resource-poor nations. This workshop will present a few brief presentations on the science of PrEP, the translation of research into clinical practice, the psychotherapeutic and psychosocial issues, and the ethical implications of using costly medications in healthy people. The unique role that psychiatrists might play in the use of PrEP will be explored. The long-term unintended consequences will be discussed as social, political, intrapsychic and public health issues. The following questions will be raised in brief presentations: 1) How effective is PrEP when used in the clinical setting compared to research protocols? What variables in the protocols might not be present in the clinical setting? 2) What social, psychological and financial issues must be considered when applying research findings to a specific clinical situation? 3) How will the use of PrEP affect decision making and risk taking among a variety of MSMs? 4) How will resources applied to PrEP affect access to care and treatment for people infected with HIV? 5) How should psychiatrists and mental health clinicians incorporate PrEP into an ongoing treatment for high-risk individuals? What countertransference issues might arise?

THE CONTEXT OF PSYCHOSIS: CULTURAL CURIOSITY AND ENHANCED CLINICAL CARE

Chairs: Jerome H. Taylor, M.D., Jennifer Severe, M.D.

Speakers: Hector Colon-Rivera, M.D., Tanuja Gandhi, M.D., Roberto Lewis-Fernandez, M.D., Caroline D. Brozyna, M.D., Ayana Jordan, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the particular challenges that can arise when assessing and treating ethnic and racial minorities with psychotic disorders; 2) Perform a psychiatric evaluation that identifies cultural factors affecting psychotic symptoms.; 3) Appreciate different international perspectives on psychosis; 4) Consider the psychodynamic implications of working with patients and families when the patient and family cultural backgrounds differ from the clinician's cultural background; and 5) Develop culturally informed treatment plans.

SUMMARY:

As the United States becomes more diverse, it is increasingly important for mental health clinicians to understand the cultural factors affecting the assessment and treatment of psychotic symptoms. In this workshop, the racial and ethnic health disparities in schizophrenia spectrum disorders will be reviewed. This workshop will discuss how culture, race, ethnicity, sex, language, religion and socioeconomic status influence patient and clinician perceptions of psychosis. Dr. Lewis-Fernandez, who led the development of the *DSM-5* cultural formulation, will review the *DSM-5* cultural formulation. The workshop will also address using the *DSM-5* Cultural Formulation Interview in patients with psychotic disorders. Additionally, strategies to integrate cultural practices into psychosocial and family interventions will be described. An ethnically diverse panel of psychiatrists will discuss how their cultural backgrounds inform their clinical practice using case-based examples with a particular focus on African-American, Hispanic-American and South Asian trainee perspectives. After the presentations, workshop participants will be invited to discuss how cultural factors have presented both challenges and opportunities when caring for their patients with psychotic symptoms.

DOES OPEN ACCESS BEAT TRADITIONAL SCHEDULING?

Chair: R. Kaan Ozbayrak, M.D., M.B.A.

Speakers: R. Kaan Ozbayrak, M.D., M.B.A., Cynthia Grant, Ph.D., L.C.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss operational and clinical characteristics that impact the decision to move from traditional scheduling to Open Access; 2) Learn about the rewards and challenges a move toward Open Access had caused at a community mental health center; 3) Use the available tools to facilitate operations and culture change as they move from traditional scheduling to Open Access; and 4) Be prepared for common pitfalls as an organization moves towards Open Access and anticipate problems that can and cannot be avoided.

SUMMARY:

Traditional scheduling for initial psychiatric evaluations and follow-up appointments tends to clog up access to medication services, leading to very long wait times, poor clinical care because of lack of follow-up availability and high rates of no shows and

cancellations. Open (or advanced) access, as it is frequently prescribed, mandates same-day, walk-in availability, which invites high levels of unpredictability into the system, frustrating both patients as they spend long time in waiting rooms and clinical staff as they find themselves trying to accommodate uneven workloads changing from day to day. This workshop presents a modified implementation of open access that decreases the time to next medical appointment significantly without introducing any unpredictability into the system. Despite its clear benefits in many areas, open access is not without its headaches for some, and these areas will be visited. With audience participation, we will have an opportunity to build strategies for obtaining buy-in and training of multiple stakeholders, such as patients, medical providers, support staff, administrators and payers. Tools pertaining to training, operations and quality measurement will be discussed in detail, supported by a presentation and analysis of concrete outcomes at a community mental health setting, including reduction in wait times for an initial psychiatric evaluation from an average of six weeks to less than six days within three months of implementation.

NO POSTER. NO PUBLICATION. NO PROBLEM! A STEP-BY-STEP GUIDE TO GET YOU STARTED IN THE SCHOLARLY ACTIVITY PROCESS

Chair: Rashi Aggarwal, M.D.

Speakers: Nicole Guanci, Cristina Montalvo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify barriers to the scholarly activity process; 2) Use concrete steps towards choosing a topic for an abstract; 3) Discuss how to do a literature search and start writing; and 4) Assess ideas for abstracts and publications presented by peers.

SUMMARY:

Resident scholarly activity is encouraged for all psychiatry residents as per the 2007 ACGME program requirements. However, the ACGME does not delineate specific requirements regarding what type of scholarly work should be accomplished by residents. Studies show that fewer than 10% of psychiatry residents will choose research as a career, but scholarly activities such as abstracts and publications are important for any psychiatrist interested in an academic career or in compiling a more competitive curriculum vitae. However, many

residents (and faculty) lack the necessary skills required, e.g., how to choose a topic and how to prepare an abstract for poster presentation. According to a study, only 30% of residents had national presentations, with 54% having no publications. Further, many psychiatric training programs lack faculty members who are able to mentor residents in these activities. The goal of this workshop is to assist participants in initiating scholarly activity at the beginner level—whether medical student, resident, fellow or practicing physician. We aim to facilitate the scholarly activity process by identifying barriers to productivity and delineating specific techniques for tackling these barriers. We will provide concrete guidelines on how to identify novel and relevant cases, undertake a literature search, find the most appropriate format for conveying ideas (poster, case report, letter) and start the writing process. These guidelines are not only helpful for potential writers, but are also useful for residency program directors and faculty wanting to create an academic environment that fosters scholarly activity. Ultimately, we will focus on scholarly activities most attainable for busy residents and departments without significant grant support, including poster presentations and publications such as letters and case reports. During this workshop, we will offer examples of scholarly activities by residents in our own program, which produces a high number of poster abstracts every year. Our workshop will be highly interactive, and the process of taking a rough idea and then narrowing it into a research question will be demonstrated by role play. Participants will be able to discuss some of their own research ideas or ideal patients for case reports and will be guided through the process in order to be more prepared to tackle their first poster or first publication. By the end of this workshop, participants will be better equipped with practical knowledge of progressing from the inception of an idea to completing a scholarly activity.

EEG IN PSYCHIATRIC PRACTICE

Chairs: Nashaat Boutros, M.D., Oliver Pogarell, M.D.

Speakers: Oliver Pogarell, M.D., Nashaat Boutros, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the effects of combat-related PTSD on homicide and suicide-by-cop; 2) Peer review of one of the presenters' case formulation that included the defendant's PTSD,

Bipolar Disorder, attempted suicide-by-cop and intentional dissimulation of that phenomenon; and 3) Learn how combat-related PTSD may or may not help in mitigation.

SUMMARY:

EEG remains an underutilized method for assessing organic factors influencing psychiatric presentations. Through this workshop, clinicians will achieve an understanding of several clinical areas where EEG may provide valuable differential diagnostic information. Following a brief summary of historical developments, the psychiatrist will learn the basics of a normal EEG exam and understand both the limitations of EEG testing and the general classes of medical and organic variables that are reflected in abnormal EEG patterns. Specific clinical indicators ("red flags") for EEG assessment will be stressed. More detailed coverage of selected areas will include 1) EEG in psychiatric assessments in the emergency department; 2) EEG in the assessment of panic and borderline patients; and 3) The value of EEG in clinical presentations where diagnostic blurring occurs (i.e., differential diagnosis of dementia, differential diagnosis of the agitated and disorganized psychotic patient, and psychiatric manifestations of nonconvulsive status epilepticus). Specific flowcharts for EEG evaluations with neuropsychiatric patients will be provided. Numerous illustrated clinical vignettes will dramatize points being made. This workshop is intended for the practicing clinician and is designed to enable the practicing clinician to utilize EEG effectively (i.e., avoid over- or underutilization), to help with the differential diagnostic question and to be able to determine when an EEG test was adequately (technically) performed. At the conclusion of this workshop, the participant should be able to understand the limitations of EEG and broad categories of pathophysiology that produce EEG abnormalities. The participants will have a complete grasp of the general indications and specific diagnostic uses of the clinical EEG. Attendees will also develop an understanding of how EEG can be useful in monitoring ECT and pharmacotherapy.

HOW SHOULD WE DETERMINE WHAT IS MOST ETHICAL? A FRAMEWORK FOR ANALYZING ETHICS DILEMMAS IN PSYCHIATRIC PRACTICE

Chair: Robert Weinstock, M.D.

Speakers: William C. Darby, M.D., Robert Weinstock, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the many roles psychiatrists assume and the associated duties with differing ethical priorities, but also the need to retain medical values nonetheless even when not primary; 2) Use the method of dialectical principlism to analyze and resolve complex ethical dilemmas in practice; 3) Prioritize conflicting ethical duties such as to a patient and society contingent on the specific role and context; 4) Weigh and balance conflicting and competing ethical principles for themselves in order to resolve ethical dilemmas; and 5) Determine what action is most consistent with the professional and personal values of individual psychiatrists when they encounter complex ethical dilemmas in professional practice.

SUMMARY:

Ethical dilemmas arise when competing duties make it impossible to satisfy one without impinging on another. Psychiatrists will be faced with the task of analyzing and resolving these dilemmas. Ethical guidelines cannot address all situations, and while organizations should not punish psychiatrists where no consensus or guideline exists, psychiatrists will still want to determine what is most ethical. Dialectical principlism was introduced by Dr. Weinstock at his 2014 Presidential Address for the American Academy of Psychiatry and The Law (AAPL). Along with resident Dr. Darby, they are developing this method and its applications further in dilemmas encountered in all psychiatric roles and contexts. Ethical concerns are laid out, prioritized according to role and context, and then balanced to reach a conclusion. These dilemmas will be analyzed using the APA annotations and the principles of bioethics. Substantial time will be devoted to audience participation and possible alternative conclusions using this method. One example is physician-assisted suicide. Many states have adopted laws permitting this. Psychiatrists are asked to determine whether patients are competent to choose to obtain medication to end their lives. Several issues are in conflict here. Physicians are healers. It is a potentially dangerous slippery slope to facilitate killing, even if for the beneficent purpose of ending suffering when requested by competent patients. Some patients may be reacting to a temporary crisis. Others may be hopeless from a treatable depression that was not detected initially by other physicians not as skilled as psychiatrists in diagnosing it. But psychiatrists who perform these

evaluations have no clear guidelines to follow. Mood problems may severely impede the ability of patients to give competent, informed consent to end their lives. There are also problems if patients refuse medications or ECT to treat their depression or they may have received inadequate previous treatment. Competing considerations will be identified and balanced. An analogous issue is the death penalty. Physicians are forbidden by the AMA, APA and AAPL from participating in a legally authorized execution, but they consider competence to be executed evaluations to be ethical. Assessments early in the process for either side are ethical. However, some roles may present ethical problems despite no consensus. For example, it may be unethical to seek aggravating factors for the prosecution at the sentencing phase in order to obtain a death sentence. Finally, although informed consent is usually essential, in some situations, beneficence might well outweigh autonomy to protect the patient and others. For example, it might be good to not tell patients prior to a risk assessment that statements regarding danger to self or others could result in involuntary hospitalization and a loss of their guns. That is because it is most important not to dissuade honest answers.

RESIDENTS TEACHING ABOUT RACISM: A NOVEL EDUCATIONAL APPROACH TO COMBATING RACIAL DISCRIMINATION IN MENTAL HEALTH CARE

Chairs: Andrew D. Carlo, M.D., Jerrold F. Rosenbaum, M.D.

Speakers: Morgan Medlock, M.D., Anna Weissman, M.D., Andrew D. Carlo, M.D., Mary C. Zeng, M.D., Derri Shtasel, M.D., M.P.H., Jerrold F. Rosenbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize three levels of racism that affect psychiatric care and outcomes; 2) Appreciate the need for psychiatry residency programs to systematically incorporate teaching about racial discrimination as part of the core training experience; and 3) Identify potential benefits to patients and communities from effective teaching about racism.

SUMMARY:

In a groundbreaking report by the Institute of Medicine, racial bias was identified as a critical factor contributing to health care inequities. Studies have shown that racism and discrimination have a

profoundly detrimental impact on mental health access, diagnosis, treatment and outcomes. It has been shown that undergraduate and graduate medical training present a critical window of opportunity to address implicit racial bias. Psychiatric curricula that move beyond cultural competency and address racism directly are needed. This workshop will demonstrate an approach to teaching about racism in a standard, longitudinal curriculum, using a three-tiered paradigm— institutional, interpersonal and internalized racism— as its organizing framework. It will further show participants the ways in which such a curriculum meets the evidence-based criteria for effective diversity training by addressing the formal, informal and hidden curricula that are integral to changing racial attitudes. Piloted at Massachusetts General Hospital as a resident-led lecture series, this novel educational approach shows promising results. In a survey of PGY-3 residents completing our training on interpersonal racism, 100% identified “racism” as a topic that should remain in their didactics, felt the course was effectively taught and believed that the resident speakers were ideal teachers. Curricula addressing racism may play a role in helping trainees identify their own biases and become better advocates for victims of racial discrimination.

STIGMA, DISCRIMINATION AND THE CRIMINALIZATION OF HIV/AIDS IN THE UNITED STATES: CHALLENGES FOR PSYCHIATRISTS IN THE DELIVERY OF COMPASSIONATE CARE

Chairs: Lawrence McGlynn, M.D., M.S., Mary Ann A. Cohen, M.D.

Speakers: Mary Ann A. Cohen, M.D., Antoine Douaihy, M.D., Daena L. Petersen, M.D., M.P.H., Lawrence McGlynn, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Assess the impact of stigma and discrimination in patients and their community; 2) Advise patients about practices that may lead to criminal prosecution; 3) Assess for behaviors that lead to transmission of HIV and apply the basics of motivational interviewing to move patients toward change; and 4) Deliver compassionate psychiatric care and education to the patient living with HIV and their community.

SUMMARY:

Every 9½ minutes, one person in the United States is infected with HIV. Approximately 50,000 are newly

infected each year. One in seven Americans with HIV is unaware of being infected and can unknowingly become ill or infect others. HIV/AIDS is a complex illness with medical and psychiatric manifestations. It differs from other complex illnesses in that it is entirely preventable and is associated with stigma, discrimination and criminalization. HIV does not affect populations equally. Some communities have been hit harder than others and include those living in the South and African-American men who have sex with men (MSM). The reasons for these statistics are complex; however, it is accepted that stigma and discrimination play major roles in these differences. Psychiatrists can play a significant role in the HIV pandemic by becoming aware of significant risk behaviors and providing individuals with options for change. Psychiatrists can also help to ameliorate HIV stigma and suffering and provide care for persons infected with and affected by HIV. Whether in prevention or treatment, it is crucial that psychiatrists become aware of factors that contribute to stigma and discrimination, as these become barriers to the delivery of compassionate care. Laws criminalizing some behaviors in those with HIV may also deter people from being tested or seeking medical care. Common HIV criminalization practices include the enactment of laws subjecting patients with HIV to criminal penalties or the confiscation of condoms and the use of condoms as evidence in prostitution-related offenses. Psychiatrists need to be aware of the legal aspects of HIV. Psychiatrists are in a unique position to provide compassionate care, teach communication skills and coordinate the care of persons with HIV/AIDS. Once in care, communication skills are key to development of trust and rapport as well as to adherence to risk reduction, behavior change and medical treatment. Effective options in treatment and prevention are available. The challenge remains in the delivery of these prevention and treatment options. This workshop will provide participants with strategies for delivering compassionate care to patients and communities affected by HIV. Participants will gain an understanding of the roles of stigma and discrimination in the presentation of those living with HIV and how criminalization practices may hinder the delivery of care to those at risk of becoming infected with HIV and those already living with HIV/AIDS.

MEDICAL CONDITIONS MIMICKING PSYCHIATRIC DISORDERS VERSUS PSYCHIATRIC DISORDERS

MIMICKING MEDICAL CONDITIONS: DIAGNOSTIC AND TREATMENT CHALLENGES

Chair: Catherine Crone, M.D.

Speaker: Yu Dong, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Provide culturally competent care for diverse populations; 4) Describe the utility of psychotherapeutic and pharmacological treatment options; 5) Integrate knowledge of current psychiatry into discussions with patients; and 6) Identify barriers to care, including health service delivery issues.

SUMMARY:

Abstract not available.

THE HISTORY, ETHICS AND PROMISE OF PSYCHEDELIC THERAPIES

Chair: Dominic Sisti, Ph.D.

Speakers: Paul Summergrad, M.D., Rick Doblin, Ph.D., Matthew J. Baggott, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explore the history and ethics of psychedelics in psychiatry ; 2) Understand the history of the first development of psychedelics in research ; and 3) Understand the role of psychedelics in both therapy and self-discovery.

SUMMARY:

Recent research on psychedelics, cannabis and dissociative drugs has opened new vistas of therapeutic options for individuals with mental illnesses. The early results have been promising: MDMA is currently being studied for PTSD, cannabis for a range of disorders, and ketamine for refractory depression. All of these compounds share the unfortunate legacy of social stigma, prohibition and politicization. In this session, three speakers will explore the history and ethics of psychedelics in psychiatry. Jonathan Moreno will provide an historical sketch of the ways psychedelics were first developed and how research was suppressed in the mid-20th century. Rick Doblin will describe the ways his organization, MAPS, has built a multinational research network to examine the safety and efficacy of psychedelic-mediated psychotherapy. Paul

Summergrad, immediate past president of APA, will offer reflections on the role of psychedelics in both therapy and self-discovery.

EXPLORING BARRIERS TO TREATMENT FOR CHILD TRANSGENDER PATIENTS IN THE INSTITUTIONAL AND INPATIENT PSYCHIATRIC SETTINGS

Chair: Rabiya Hasan, M.D.

Speaker: Chioma Linda Iheagwara, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the barriers to treatment for transgender patients in the acute child psychiatric setting; 2) Learn and be aware of the challenges facing the patient, their families, staff and community members in treating the patient and supporting strength; 3) Suggest and learn about possible solutions to such barriers through group discussion; and 4) Understand the need for psychiatric institutions that can cater to the needs of gender dysphoria/transgender patients upon discharge from the hospital.

SUMMARY:

Though standards of care for transgender adolescents is outlined by the World Professional Association for Transgender Health (WPATH), there is still much debate among health practitioners on what is the appropriate course of treatment through evidence-based medicine and ethical reasoning. Furthermore, these standards of care do not address the needs of transgender adolescents in an inpatient psychiatric setting. A case of a 12-year-old male to female (MTF) transgender adolescent who was admitted for depression and suicidal ideation (a common mental health comorbidity in transgender individuals) brought to light many difficulties for the treatment team with regard to: 1) Supporting unit staff with managing the patient; 2) Need for privacy protection from other patients and their families while also addressing their concerns about the transgender patient on the unit; 3) Room assignments and gender-specific bathrooms; and 4) Difficulties with discharge placement to residential treatment facilities (RTF) unequipped to deal with a transgender adolescent. Of note, very few physicians feel comfortable treating transgender youth; thus, not surprisingly, hospital and RTF staff (nurses, techs, etc.) encounter similar difficulties. Furthermore, though awareness of the transgender community is growing in the media, the psychiatric and medical communities are still very much in the

dark regarding transgender mental health concerns. Our workshop's aim is to start a conversation regarding what issues or barriers to treatment others have encountered with transgender patients in child psychiatry inpatient and institutional settings and what solutions were found to be helpful or not helpful. We will present the case and break off into small-group discussion with specific topics in mind and come together as a large group at the end to share our ideas and experiences. Such discussion can be an important step in bringing awareness to the need for further research as well. This is an important conversation the psychiatric community needs to have in order to best serve this minority population and their unique treatment needs. We will also seek to discuss the results of an anonymous staff survey regarding transgender issues on the child psychiatry inpatient unit.

CRIMINALIZATION OF BLACK MALES: THE EFFECTS OF UNTREATED BIPOLAR, ADHD AND SUBSTANCE ABUSE DISORDERS

Chair: Napoleon B. Higgins Jr., M.D.

Speakers: Otis Anderson, M.D., Timothy Benson, M.D., Ericka Goodwin, M.D., Johnny Williamson, M.D., Rahn Bailey, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss racial disparities in diagnosis, treatment options and research in multicultural populations related to Bipolar Disorder, ADHD and Substance Abuse Disorders; 2) Understand differences in incarceration rates of black males in comparison to other ethnic backgrounds and how governmental policies helped promote these disparities; and 3) Identify how impulse control and behavior disorders are inappropriately treated in the legal/criminal justice systems, as well as discrepancies in law enforcement interactions with the mentally ill.

SUMMARY:

ADHD, bipolar disorder and substance abuse disorders are neurobehavioral disorders that are characterized by impulsivity, poor decision making, anger, inattention and odd behavior. This presentation will discuss evidence-based practices and interventions in decreasing black male incarceration rates and often fatal police interactions. The alarming rate of incarcerated mentally ill African-American males goes largely ignored and inadequately researched, which leads to

inappropriate treatment of black males via the legal system. This has a major impact on African-American communities, as well as their families. Mandatory prison sentences and "The War on Drugs" for people with drug offences have forced substance abusers into incarceration without provisions for substance abuse treatment. There are unique differences in metabolism among various cultural populations that impact the differential effects of psychotropic medications. Many jails and prisons have replaced psychiatric hospitals and house many persons with the severest forms of mental illness. Participants will be able to identify how black males with comorbid mental illness and substance abuse are receiving inappropriate care in incarcerated settings. There is currently limited focused study on the specific effects of psychiatric medications in African Americans. This talk will focus on basic psychopharmacology and drug classes in the treatment of bipolar disorder and ADHD in African-American men.

FUTURE OF THE DSM: AN UPDATE FROM THE DSM STEERING COMMITTEE

Chair: Paul S. Appelbaum, M.D.

Speakers: Michael B. First, M.D., Kenneth Kendler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the vision for the future revision of the DSM; 2) Have an awareness of the criteria that must be met for changes to be made to the classification; and 3) Appreciate the process by which revisions will be undertaken.

SUMMARY:

Anticipating the need for updating the *DSM-5*, the APA Board of Trustees established a Work Group on the Future of the DSM in Spring 2013. The Work Group produced a report, which was presented to and approved by the Board at its March 2014 meeting. The report presented a model for iterative updating of individual diagnostic categories as new data become available to support such changes. It offered recommendations for governance of the process, identification of targets for revisions (including changes to existing categories, additions of new categories and deletions of existing categories), drafting of proposed revisions, and review and approval of proposed revisions. Based on the recommendations in the Work Group's report, the DSM Steering Committee was appointed in

Spring 2014. Since that time, the Steering Committee has developed criteria and procedures for reviewing proposals for changes to the DSM. The purpose of this workshop is to introduce the psychiatric community to the APA's vision for the future of the DSM, the criteria by which proposed revisions will be judged and the process that interested clinicians and researchers can follow to submit proposals for revisions. Ample time will be available to interact with the chair and vice-chairs of the Steering Committee.

TOP 10 GERIATRIC PSYCHIATRY ISSUES FOR THE GENERAL PSYCHIATRIST: AN UPDATE

Chairs: Josepha A. Cheong, M.D., Iqbal Ahmed, M.D.
Speaker: Shilpa Srinivasan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the key issues in the geriatric patient presenting in a general clinic setting; 2) Initiate appropriate treatment and management of cognitive disorders; 3) Manage behavioral disturbances in an elderly patient with neurocognitive impairment and disorders; 4) Identify strategies for assisting caregivers of patients with neurocognitive disorders; and 5) Identify the appropriate management of end-of-life issues.

SUMMARY:

With the ever-increasing population of older adults over the age of 65, the population of elderly patients in a general psychiatry practice is growing exponentially as well. Within this patient population, diagnoses and clinical presentations are unique from those seen in the general adult population. In particular, the general psychiatrist is likely to encounter a rapidly increasing number of patients with cognitive disorders and behavioral disorders secondary to chronic medical illnesses. Given the usual multiple medical comorbidities as well as age-related metabolic changes, the geriatric patient with psychiatric illness may present unique challenges for the general psychiatrists. This interactive workshop will focus on the most common presentations of geriatric patients in a general setting. In addition to discussion of diagnostic elements, pharmacology and general management strategies will also be presented. This small interactive session will use pertinent clinical cases to stimulate the active participation of the learners.

DISRUPTIVE BEHAVIOR IN PRESCHOOL CHILDREN: WHAT DOES IT MEAN? DIFFERENTIAL DIAGNOSIS AND PHARMACOLOGICAL APPROACHES

Chair: Jean M. Thomas, M.D.

Speakers: Jean M. Thomas, M.D., Caroline D. Brozyna, M.D., Swathi Krishna, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the most common disruptive behaviors that present in early childhood; 2) Group early disruptive behaviors into two developmental patterns based on combinations of risk factors; 3) Identify two distinct developmental patterns—neurodevelopmental/disruptive disorders and non-neurodevelopmental/disruptive disorders—during group diagnosis of video examples; 4) Explain why family-centered therapy is the first choice treatment over pharmacological approaches and how it supports the regulation of the young child's early emotions and behavior; and 5) Identify first choice pharmacological treatments for young children with early disruptive behavior disorders and how they should be administered.

SUMMARY:

Currently, there are few resources and training programs that guide clinicians in assessment, diagnosis and treatment of early childhood behavior disorders. This workshop's goal is to highlight two common patterns of disruptive behavior in early childhood and how clinicians can differentiate these patterns based on risk factors to target specific treatment modalities. Participants will learn to identify and categorize these two primary early disruptive behavior patterns as neurodevelopmental/disruptive disorders (with cognitive, language, motor and/or neurobehavioral differences) and non-neurodevelopmental/disruptive disorders (with anxiety, depression and/or parent-child relational difficulties). In addition, participants will review three risk domains—1) Child characteristics; 2) Parent characteristics; and 3) Parent-child relationships, all required for differential diagnosis of early disruptive disorders—and how these relate to the evolving biopsychosocial formulation of the developing child. Participants will view video cases of young children with disruptive behavior disorders and discuss group observations followed by guided diagnosis that differentiates children with neurodevelopmental/disruptive disorders and non-neurodevelopmental disorders. Participants will also

learn about available clinical diagnostic measures including the Bayley Scales of Infant Development II, the Brief Rating Inventory of Executive Function–Preschool Age and the Child Behavior Checklist–Ages 1.5–5, which all correlate with expert diagnosis of neurodevelopmental/disruptive versus non-neurodevelopmental/disruptive disorders. This workshop will highlight the importance of early identification of neurodevelopmental differences and how delays in identification may affect specific treatments, including appropriate referrals. Participants will learn how family-centered treatment supports parent-child interactions that increase the child’s emotional and behavioral regulation. Participants will also discuss the benefits and risks of family-centered therapy versus pharmacological interventions and understand when and how each is indicated in the treatment course.

ACHIEVING HEALTH EQUITY: PSYCHIATRY, PUBLIC POLICY AND THE ELIMINATION OF CHILDHOOD POVERTY

Chairs: Kenneth Thompson, M.D., Steven Adelsheim, M.D.

Speakers: Benard Dreyer, M.D., Steven Adelsheim, M.D., Kenneth Thompson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the role childhood poverty has in increasing the nation’s burden of ill health, including mental illness, and its role in creating health inequity; 2) Appreciate the public policy options and political decisions that hold the promise of eliminating childhood poverty; and 3) Work with pediatricians and other concerned physicians to advocate local, regional and national policies leading to the elimination of childhood poverty.

SUMMARY:

According to the most recent U.S. census data, more than one in five children in the United States live in poverty. For young children, the number is one in four. Given what we now know about the relationship between childhood poverty, adverse childhood events and lifelong health, the national burden of illness generated by these numbers is staggering. Recognizing this, and appreciating efforts in the U.S., the U.K. and other countries to reduce and even eliminate childhood poverty as a public health measure of extreme importance, the American Academy of Pediatrics convened a Poverty

and Child Health Leadership Work Group, led by Benard Dreyer, M.D.. Recently, the Children’s Defense Fund (CDF) has launched a national campaign to end childhood poverty. This workshop will review the efforts of the Work Group and the CDF and address the following issues: 1) Why childhood poverty matters as an issue of health and public policy; 2) What “healthy public policies” might help eliminate childhood poverty; and 3) How psychiatrists, pediatricians and other physicians might join together and work with the national advocacy crusade to raise a generation without poverty.

THE COLLABORATIVE ASSESSMENT AND MANAGEMENT OF SUICIDALITY AT WALTER REED: A CLINICAL INTERVENTION FOR SUICIDAL PATIENTS AT WALTER REED MEDICAL CENTER

Chair: Benjamin R. Hershey, M.D.

Speakers: Jennifer A. Crumlish, Ph.D., Lobna Ibrahim, M.D., Bryan M. Pelka, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the challenges inherent to meeting the clinical needs of suicidal patients in both outpatient and inpatient settings; 2) Understand the potential benefits of using the Collaborative Assessment and Management of Suicidality (CAMS) model as a framework for providing care to suicidal patients; 3) Describe the way in which the CAMS model has been integrated into the behavioral health care of patients at the Walter Reed Medical Center, particularly on the inpatient psychiatry unit; and 4) Consider how CAMS in general and the Walter Reed approach in particular could be adapted to meet the unique clinical needs in other treatment settings.

SUMMARY:

The Collaborative Assessment and Management of Suicidality (CAMS) is a framework for addressing the challenging needs of suicidal patients that has been developed and refined over the past 25 years and has an extensive and growing body of evidence to support its use. The philosophy of CAMS eschews a traditional “medical model” approach in which suicide is viewed as merely a symptom of a mental disorder and places the focus of treatment on patient-identified problems that compel them to consider suicide as a means to relieve their suffering. By taking an empathetic stance toward suicide and collaborating with the patient on identifying the

“drivers” of their suicidal states, the assessment itself can be inherently therapeutic. Due to the fact that CAMS serves as a “nondenominational” platform for guiding a suicide-specific intervention process that is commonsense and flexible; it has been adopted in a variety of clinical settings. As a process improvement project started in early 2013 to address concerns about the rising rates of suicide among active duty service members, CAMS has been integrated into a wide range of behavioral health services at the Walter Reed National Military Medical Center. Through use of standardized forms that are a part of the CAMS platform, including the SSF (a multipurpose risk assessment, treatment planning, tracking and clinical outcome instrument), stabilization plan and outcome/disposition tools, critical insight into the nature of a patient’s suicidality can easily be documented and conveyed from one service to the next as a patient’s level of care escalates or de-escalates at Walter Reed. During this workshop, we will highlight the theoretical and evidenced-based benefits of CAMS while also providing details of how it has been assimilated into the delivery of care model and training methods employed on the inpatient psychiatry service at Walter Reed. As a way of demonstrating its wide-ranging utility to the audience members, the presenters will discuss the finer points of how the CAMS platform was integrated into our acute care, teaching hospital setting by contrasting our variant with how it has been adapted more broadly in other venues (outpatient clinics and long-term inpatient). In order to promote a stimulating and interactive learning environment, we will break into small groups so that a richer understanding of the CAMS framework can be appreciated, some of the collaborative techniques can be demonstrated, criticisms can be voiced, and audience members can consider implementation into their own clinical practice.

FAMILY AND CULTURE: CLINICAL TOOLS FOR EVERYDAY PRACTICE

Chair: Alison M. Heru, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Use simple clinical tools to interview families about each family member’s culture of origin and its impact on current family functioning and child rearing; 2) Conceptualize their own cultural location and its intersectionality with gender, race and individuality; and 3) Co-create, with

their patient and their family in family treatment, a ritual or task to support the family’s emerging culture.

SUMMARY:

The individual and the family develop in the context of community and culture. Many families are composed of individuals from differing cultural backgrounds. Family conflict can arise when there is a lack of awareness of the impact of family heritage and culture of origin on family life. Cultural family conflicts about values, beliefs and behaviors can stress the development of the children. Resolution of these cultural family conflicts allows a more coherent sense of self and well-being in the children. Understanding the cultural beliefs and rituals inherent in each culture gives the family a deeper understanding of their challenges and strengths, which, in turn, facilitates family change. This workshop provides the clinician with clear concepts to inquire about the role of culture in the families of their patients. Participants will learn how to use clinical tools such as the cultural genogram, family play genogram, community genogram, and Family Cultural Formulation Interview (FCFI) with their families. These tools provide the clinician with easy entry points at the intersection of family and culture. These tools allow the clinician to highlight areas of conflict and provide guidance for new methods of connection in families. Behavioral tasks such as developing or altering family rituals enable family members to co-create a richer and less conflicted family culture. The presenters will illustrate these tools using three family case examples: a family stressed by caregiving, a remarried couple unable to create family rituals to become an effective stepfamily and a family with two separate cultures of origin that has resulted in two essentially separate families, rather than one family. The workshop has three parts. In part one, Dr. Berman and Dr. Heru discuss the use of the FCFI and the various genograms. In part two, the participants will examine their own cultural heritage and family rituals and how they affect/enrich their therapeutic work. This occurs in small groups. In part three, the participants will join back together for an interactive discussion on culturally focused behavioral tasks and rituals in the families of their patients.

ACKNOWLEDGING AND ACCOMMODATING AGE AND ABILITY

Chairs: Paul H. Wick, M.D., Nada L. Stotland, M.D., M.P.H.

Speakers: Paul H. Wick, M.D., Norman A. Clemens, M.D., Sheila Hafter Gray, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand ways to assess clinical competence and reduce correctable variables; 2) Demonstrate specific challenges facing late-career physicians and be able to begin discussions with professional organizations and systems to take steps to prepare and better manage these transitions; and 3) Understand steps senior physicians may take to successfully transition from clinical practice into productive retirement.

SUMMARY:

Recent efforts to identify quality in health care have emphasized the relationship of aging and competence to the practice of medicine. Many senior physicians practice medicine safely and effectively, but there is a pivotal point where age and competence intersect. Organizations and systems are considering development of well-designed screening processes. Identifying correctable variables both in the individual and the practice environment will be considered. The presenters will explore ways that physicians may anticipate and prepare for late-career transitions that promote well-being and avoid unprofessional manifestations. How academic medical centers and professional organizations in collaboration with local health-related organizations may better understand these challenges and support physicians in managing late-career effects will be reviewed. Adulthood does not represent the culmination of psychosocial development and is optimally followed by a period of maturity in which one is challenged to consolidate integrity or fall into despair. Transitioning into maturity requires the cognitive and emotional capacity to envision a future different from the present. For senior physicians, this requires planning for a time when one no longer sees patients but can look back on one's clinical work with satisfaction, a sense of a task done well enough to leave. We will explore ways to plan for retirement in a way that maintains integrity and promotes mental health.

USING STAR WARS TO TEACH PSYCHOPATHOLOGY

Chair: Susan Joy Hatters-Friedman, M.D.

Speaker: Ryan Hall, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the utility of using popular culture to teach about psychiatric disorders; 2) Explain common characteristics of intimate partner violence perpetrators as demonstrated by Anakin Skywalker as an aide-memoire; and 3) Describe common characteristics of various personality disorders with various Star Wars characters as aides-memoires.

SUMMARY:

The Star Wars trilogies are among the most popular films of all time and are well-known to students, residents and psychiatry attendings. A new Star Wars film was released in late 2015. This workshop session will highlight psychopathology and themes demonstrated by various Star Wars characters, which can be helpful in teaching. Examples include a vast array of issues and diagnoses: borderline, narcissistic, histrionic, obsessive-compulsive and dependent personality traits; psychopathy; PTSD; partner violence risk; developmental stages; oedipal conflicts; ADHD; anxiety; kleptomania; pedophilia; perinatal psychiatric disorders; prodromal schizophrenia; pseudo-dementia; frontal lobe lesions; pathological gambling; and malingering. Using Star Wars characters as a springboard for teaching has tremendous potential to engage trainees. In addition to psychopathology, the Stars Wars universe can be a way to teach diagnostic systems such as the personality disorder alternatives in *DSM-5* and aspects of "cultural interviewing." Lively audience discussion is anticipated regarding diagnostic categories and teaching opportunities.

**INTERNATIONAL MEDICAL GRADUATES:
REFLECTIONS ON CROSS-CULTURAL TRAINING AND
LEARNING**

Chairs: Tanuja Gandhi, M.D., Rama Rao Gogineni, M.D.

Speakers: Pedro Ruiz, M.D., Dinesh Bhugra, Ranna Parekh, M.D., M.P.H., Jasmin G. Lagman, M.D., Meredith A. Okwesili, M.D., Daniel Kim, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Have a better understanding about the challenges faced by IMGs caring for cross-cultural patients; 2) Identify different strategies that could be adopted in enhancing the training received by IMGs with cultural sensitivity training; 3) Provide better, patient-centered care for patients from cross-cultural communities; and 4) Appreciate the

importance and utility of a cultural formulation while treating cross-cultural patients.

SUMMARY:

With about 36,000 members, the American Psychiatric Association is home to many renowned psychiatrists, including those who are or have been international medical graduates (IMG). There has been a tremendous growth in the cultural diversity of the United States, but existing training does not prepare IMGs for the unique challenges-presented by the U.S. health system. Searight et al. discuss the importance of including behavioral science education in the training of IMGs pursuing family medicine in an effort to address several challenges faced by IMG residents in providing quality care. Interestingly, though psychiatric training practices emphasize the role of a biopsychosocial formulation, the current structure of training insufficiently captures the social dimension of this formulation considering the rapid growth of multiculturalism all over the world. Improving cultural sensitivity in psychiatric care is possible by enhancing our knowledge of cross-cultural psychiatry. Deficits in our system of training lay particularly in recognizing and integrating diversity while there is an ongoing shift from the desire for societal “colorblindness” or “melting pot” idealism to the acceptance of multiculturalism. Use of cultural schemas that include personal beliefs, perceptions, attitudes about racial differences and attributions of poverty will also serve to enhance the care provided by IMGs. Thus, a cultural sensitivity training program encompassing multicultural counseling training, attitudes toward racial differences, attributions of poverty and, in general, sensitivity to cultural practices different from one’s own could help improve awareness of these issues and further improve the quality of care provided by IMGs. Furthermore, training programs could adopt multilayered interventions to address cross-cultural challenges going beyond cultural and linguistic challenges. IMGs often deal with the loss of culture, family and identity while trying to integrate, adopt and assimilate into a new culture. Training programs can play a crucial role in enhancing this process of acculturation. In this workshop, each speaker will share valuable pearls from their personal experiences of being an internationally trained clinician and the challenges they faced and had to overcome while caring for cross-cultural patients. The speakers will enhance interactions by alternating between presentations and answering

questions. The presenters will discuss with the audience and identify aspects of psychiatric training that could be improved both from a professional and personal perspective. The unique experience of the presenters will be utilized to explore issues such as transference, countertransference, cultural prejudice and utilization of evidence-based treatments in further detail. The presenters will finally conclude with recommendations to aid in closing this IMG transition gap through emphasis on tailored cultural sensitivity training.

LORETA NEUROFEEDBACK AND QUANTITATIVE EEG: AN APPROACH CONSISTENT WITH NIMH RESEARCH DOMAIN CRITERIA

Chair: Deborah R. Simkin, M.D.

Speaker: Deborah R. Simkin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Be familiar with research using quantitative EEG (qEEG) and neurofeedback for the treatment of ADHD and autism; 2) Be familiar with the research that demonstrates how qEEGs have been co-represented with diffuse tensor spectroscopy (DTI), magnetic resonance imaging (MRI), and functional MRI (fMRI); 3) Be familiar with research that demonstrates not only the enduring effects but the continued improvement once neurofeedback is discontinued; 4) Be familiar with the differences between surface neurofeedback and LORETA neurofeedback; and 5) Be familiar with how psychiatric diseases may be related to dysfunction connectivity in the brain, with a live demonstration and case studies.

SUMMARY:

Objective: New “transdiagnostic” approaches have been proposed by the National Institute on Mental Health to define psychiatric disorders based on dysfunctional connectivity under the research domain criteria. Neurofeedback (NF) interventions are particularly significant because neurofeedback targets dysfunctional connectivity. Clinicians will want to familiarize themselves with possible new treatment interventions that may target these transdiagnostic symptoms based on quantitative EEG (qEEG). **Methods:** A review of the literature on the research and science behind quantitative EEG and low-resolution electromagnetic tomography (LORETA) Z score neurofeedback will be covered as it pertains to children and adolescents. Case studies will be reviewed, and a live demonstration of how to

use LORETA neurofeedback will be presented. **Results:** Neurofeedback (NF), based on operant conditioning, began over 40 years ago with the seminal research of Stermann and Lubar in regard to psychiatric disorders. Since 1971, there have been over 1,143 peer-reviewed human EEG biofeedback journal articles listed in the National Library of Medicine database and 4,623 journal articles using the search terms "brain-computer-interface." Further scientific research has led to the development of Z score NF and LORETA Z score neurofeedback to target specific circuits and hubs known to play a role in symptoms associated with psychiatric disorders. Neurofeedback now has multiple randomized controlled trials (RCT) showing efficacy in the treatment of ADHD. Other RCT studies include Kouijer et al. for autism (effect size of 1.45), Choi et al. for depression (effect size of 1.06), Cortoos et al. for insomnia (effect size of 1.04), Peniston and Kulkosky for post-traumatic stress disorder (effect size of 1.30), and Scott et al. for alcohol abstinence (effect size of 0.47). In meta-analysis, NF consistently decreased seizures in severe cases of epilepsy that could not otherwise be controlled. A study by Levesque not only demonstrated improvements in inattention but also demonstrated that training in children increased activity in the left caudate nucleus and right anterior cingulate cortex (ACC) (regions involved in selective attention, learning and memory) on fMRI. The use of qEEG for NF targeting ADHD symptoms has increased effect size (1.78 – 2.2 for attention and 1.22 – 1.78 for hyperactivity/impulsivity) over stimulant medication (effect size of 0.84 for methylphenidate for ATT and 1.01 for hyperactivity/impulsivity). In addition, unlike medication, neurofeedback has shown enduring effects and continued improvement for ADHD symptoms after the intervention ended for up to two years. These enduring effects and continued improvement were also demonstrated in studies targeting autism and learning disorders. Randomized controlled studies of LORETA NF have been correlated with fMRI. **Conclusion:** Neurofeedback shows promise as an adjunctive treatment for ADHD and autism.

ADDRESSING THE SOCIAL DETERMINANTS OF MENTAL HEALTH THROUGH INTEGRATED BEHAVIORAL HEALTH

Chair: Monica Taylor-Desir, M.D., M.P.H.

Speakers: Ruth Shim, M.D., M.P.H., Lori Raney, M.D., Dyanna Leolani Ah Quin, M.S.W., LeRoy C. Eswonia,

B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the social determinants of mental health that apply to their communities of practice; 2) Discuss the role of culture as a social determinant of mental health; 3) Identify strategies and techniques to implement integrated behavioral health in their communities of practice; 4) Appreciate the utility of integrated behavioral health in promoting health equity and eliminating physical and mental health disparities; and 5) Delineate the value of psychiatrists investing in training of and collaboration with behavioral health consultants.

SUMMARY:

Integrated behavioral health has gained increasing momentum as the preferred approach to care for persons with comorbid chronic physical health and mental health conditions. A wide variety of social determinants of mental health also affect one's physical health, including adverse early life experiences, poverty, unemployment, underemployment, poor access to mental health care and stigma. Social determinants of mental health may be addressed through a multilevel framework that includes examining life course; parents, families and households; community; local services, which include the attitudes and availability of health care providers; and country-level factors. This workshop will benefit practitioners who are considering integrated behavioral health in communities with limited resources. We will highlight an integrated behavioral health model in a Hispanic community with effective improvement in PHQ9 scores, quality of life scores and problem areas in diabetes scores. We will also examine integrated behavioral health in a Native American community and the importance of culture as a social determinant. Dr. Raney will serve as the discussant, leading the audience to share and collaborate with other providers in the room.

A COLLABORATORY FOR PSYCHIATRIC APP DEVELOPMENT

Chairs: Seth Powsner, M.D., Victor J. A. Buwalda, M.D., Ph.D.

Speakers: Robert Kennedy, M.D., John Torous, M.D., Victor J. A. Buwalda, M.D., Ph.D., Seth Powsner, M.D., John Luo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about the aims and objectives of the Psychiatric Application Collaboratory; 2) Learn about the ethical challenges and pitfalls in the field of app (software application) development; and 3) Learn about the initiatives and work of the AATP.

SUMMARY:

More and more technology is being used in routine clinical practice. Outcome measurements have also become important in determining the value of specific interventions. Unfortunately, psychiatrists have been slow in adapting technology to clinical practice, despite a growing demand for psychiatric care and technical innovation. New technology could be a psychiatric force multiplier, give patients greater access to care and empower them to participate more actively in their treatment. However, it is difficult to develop and evaluate new technology, especially applications (apps) for use in routine practice. We believe psychiatrists should be able to participate directly in this technological revolution. American Association for Technology in Psychiatry (AATP) members brainstormed about this challenge at the 2015 APA Annual Meeting in Toronto. We discussed ways to make psychiatrists more comfortable with information technology, ideally helping them participate in this revolution and helping them develop their own apps. This led to the idea of creating a “collaboratory” where psychiatrists can participate in a protected environment to explore technology, including novel application development: The Psychiatric Application Collaboratory. For the 2016 APA Annual Meeting, we will discuss The Collaboratory and our initial work. This will serve as an open invitation to APA members to participate in this creative environment and an opportunity for clinicians and patients to improve the quality of care. This workshop is sponsored by the AATP, an APA affiliated organization. Our presenters will review the objectives of the Collaboratory and AATP plans to facilitate collaboration. Presenters will review what is already operational, current projects and ethical issues and will give a demonstration of how to build an app. Finally, there will be a discussion of privacy, confidentiality and intellectual property.

MY PATIENT JUST GOT PHARMACOGENETIC TESTING; WHAT DO I DO NOW?

Chairs: Simon Kung, M.D., Scott Schmidt, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the genetic principles behind pharmacogenetic testing; 2) Discuss some of the evidence for the utility of pharmacogenetic testing in mood, anxiety and attention deficit disorders; and 3) Decide when pharmacogenetic testing can be useful for a patient in different scenarios.

SUMMARY:

Pharmacotherapy for psychiatric illnesses such as mood disorders, anxiety disorders and attention-deficit/hyperactivity disorders is frequently a trial-and-error process. Medications are chosen and increased over six to eight weeks, after which the ideal situation is that patients report a reduction in symptoms without a significant side effect burden. In clinical practice, patients may not respond to the first few medication trials and subsequently undergo several trials, resulting in long durations of untreated symptoms and frustrated patients and providers. One attempt at reducing this trial-and-error process is the use of pharmacogenetic testing. The tests range from pharmacokinetic tests to identify how patients metabolize medications to pharmacodynamic tests to identify whether certain medications might provide better response. Pharmacogenetic testing has been clinically available for about 11 years, and commercial companies offering these tests continue to proliferate. However, there is still controversy surrounding the amount of evidence supporting the use of such testing and whether the testing is clinically useful. Furthermore, many insurance companies do not reimburse for the testing. Regardless of this controversy, patients are obtaining these tests, and providers are asked about them. In this workshop, we explain the theoretical framework behind pharmacogenetic testing, review some of the efficacy data and discuss the practical clinical applications toward mood, anxiety and attention-deficit disorders. The workshop faculty consists of an adult psychiatrist and a child and adolescent psychiatrist experienced in the practical clinical use of pharmacogenetic testing. The overall workshop goal is for providers to have more comfort with the possibilities and limitations of pharmacogenetic testing. The session level is between introductory to intermediate and can be tailored to the audience’s needs.

FROM DEMENTIA TO NEUROCOGNITIVE DISORDER: UNDERSTANDING THE CHANGES MADE IN THE DSM-5

Chair: Mehrul Hasnain, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the differences between *DSM-IV* Dementia and *DSM-5* Neurocognitive Disorders; 2) Understand the basic layout and diagnostic criteria scheme of the *DSM-5* Neurocognitive Disorders; 3) Understand unique features of specific common types of *DSM-5* Neurocognitive Disorders; and 4) Understand how to implement and practice *DSM-5* Neurocognitive Disorders in clinical practice.

SUMMARY:

DSM-5 classification and criteria of neurocognitive disorders is a significant shift from the *DSM-IV* dementias. Amnesic symptoms are no longer required criteria to diagnose a neurocognitive disorder. Instead, emphasis now is on six neurocognitive domains and several subdomains. Now, Alzheimer's disease is no longer a "prototype" of dementia, and we have distinct criteria for common types of dementias, including Alzheimer's disease, vascular dementia, dementia with Lewy bodies, Parkinson's disease dementia, frontotemporal dementia and alcohol-induced dementia. *DSM-5* has also introduced the distinction of "mild" and "major" categories of neurocognitive disorders, with emphasis on assessment of functional abilities to make the distinction. Furthermore, *DSM-5* emphasizes tools of objective assessment, such as neuropsychological testing and brain imaging, to establish the diagnosis of the specific type of neurocognitive disorder. Considering all these changes, there is a major change between *DSM-IV* dementias and *DSM-5* neurocognitive disorders. Many general psychiatrists are having difficulty understanding the changes and modifying their clinical practices accordingly. With the growing aging population and the limited number of geriatric psychiatrists, most elderly with cognitive deficits will likely to be assessed by general psychiatrists. It is imperative to improve the knowledge of general psychiatrists so they can transition their clinical practices to the current diagnostic criteria. This workshop will 1) Walk the participants through the major differences between our previous diagnostic approach to dementias versus current diagnostic approach to neurocognitive disorders; 2) Help them

understand the importance of neurocognitive domains in assessment of neurocognitive disorders; 3) Help them understand the value and cost-effective use of objective tools of assessment; and 4) Help them understand how to modify their clinical practices to transition from *DSM-IV* dementias to *DSM-5* neurocognitive disorders. The workshop will use clinical case scenarios to encourage discussion and facilitate learning.

PSYCHIATRY AND HEALTH CARE REFORM: WHERE ARE WE? WHAT'S AHEAD?

Chairs: Kristin Kroeger Ptakowski, Philip Wang, Dr.P.H., M.D.

Speakers: Joyce C. West, Ph.D., M.P.P., Anita Everett, M.D., Irvin L. Muszynski, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify challenges to the nation's psychiatric workforce and health care services delivery systems in realizing the goals of the Affordable Care Act; 2) Characterize the extent to which psychiatrists are participating, or plan to participate, in new financing arrangements and Medicaid- and Medicare-integrated services delivery models; 3) Understand how health care reforms may affect the practice of psychiatry; 4) Recognize major federal and state policy issues related to the implementation of HCR; and 5) Discuss potential approaches for psychiatry in meeting the challenges of health care reform.

SUMMARY:

The Patient Protection and Affordable Care Act (ACA) has initiated unprecedented, large-scale changes in the financing, organization and delivery of health care in the United States. Beginning January 1, 2014, the ACA introduced dramatic insurance reforms with the implementation of health insurance exchanges and Medicaid expansions up to 133% of poverty in the majority of states that opted for these expansions. The ACA was also designed to bring significant payment and performance monitoring reforms as well as new "integrated care" services delivery models, including patient-centered health homes and accountable care organizations (ACOs). The impact of these changes on psychiatry and quality care for psychiatric patients is unclear. In order for these reforms to work, physician participation in Medicaid, Medicare, new organized delivery systems and health insurance provider networks will be important. At

the same time, current Medicaid, Medicare and even some private insurance fees remain economically unsustainable for many psychiatrists. While the ACA seeks to increase access to health care for those previously uninsured and underinsured, given the complexities and scale of the reforms being implemented during a period of fiscal austerity, there may be unintended effects for psychiatrists and their patients. This workshop will include one presentation of important findings from a study the APA implemented to better understand health care reform issues facing psychiatry and to help the APA advocate for a strong psychiatric workforce and access to quality mental health care for patients. Data were collected from a sample of 2,800 psychiatrists randomly selected from the AMA Physician Masterfile. The information includes psychiatrist-, practice- and caseload-level data to facilitate rigorous assessment of current workforce and health care reform issues and potential treatment gaps and access issues facing psychiatrists and their patients. Participants will be encouraged to share their own experiences. The presentation will be followed by a discussion of 1) How health care reforms are affecting practicing clinicians; 2) The major federal and state policy and implementation challenges to realizing the intended goals of the ACA; and 3) Potential approaches for psychiatry in meeting the challenges of health care reform and improving access to mental health care for the full range of individuals in need of mental health and substance abuse treatment.

SEXUALITY DURING PREGNANCY AND THE POSTPARTUM PERIOD

Chairs: Damir Huremovic, M.D., M.P.P., Guitelle St. Victor, M.D.

Speakers: Madhavi Nagalla, M.D., Nyapati R. Rao, M.D., Ateaya Lima, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explore and understand variations in sexual drive, dynamics and activity during pregnancy and the postpartum period and its interplay with underlying mood disorders and/or cultural factors; 2) Actively and appropriately screen for issues affecting sexuality during pregnancy and the postpartum period, including depression; and 3) Increase clinical and cultural competence and comfort level in discussing sexuality for clinicians providing care to expectant couples and expectant mothers.

SUMMARY:

Pregnancy and childbirth represent a special period in the lives of expectant mothers and expectant couples. They involve intense physical, hormonal, psychological and social changes in a woman and often induce a resonating psychological response in her partner as well. Such changes are likely to affect expectant mothers' sexual drive and behavior and the couple's overall sexual relationship. A pregnant woman may have an increased need for closeness and reassurance, while at the same time experiencing diminished interest in sex or having concerns about sexual activity during pregnancy. Experiencing anxiety or guilt regarding sex during pregnancy can adversely affect the sexual relationship. Several studies showed that sexuality often decreases as pregnancy progresses due to several factors such as physical symptoms (83%), fears of harming the baby (67%) and women's hypoactive sexual desires (33.4%), among others. Studies also show that depression is an important predictor of reduced sexual desire and sexual satisfaction during pregnancy. Sexual desire changes as the pregnancy progresses, and specific changes occurring during each trimester may have significant influences on sexual behavior. A proper sexual interaction in a couple during pregnancy can promote sexual health and well-being and lead to a greater depth of intimacy. Problems in sexual functioning, on the other hand, may result in an additional strain on an already stressed relationship. A tactful and timely inquiry and intervention originating from providers who are performing even routine evaluations during pregnancy can go a long way in terms of providing reassurance, education and counseling. Unfortunately, it has been documented that, in most cases, antenatal and postnatal providers show little interest in or shy away from discussing issues of sexuality with pregnant patients and expectant couples. This workshop will explore psychological and sexual changes in the postpartum period and the types of sexual activity preferred by pregnant women and explore strategies to help the nonpsychiatric staff discuss and counsel women about their sexuality during these periods of their lives. An open discussion about this during antenatal and postnatal visits can also result in better screening for depression during pregnancy and the postpartum period. A comprehensive overview of current literature on sexuality during pregnancy and the postpartum period will be presented and reviewed.

Ample time will be allowed for discussion among panelists and for questions and remarks from the audience.

“OH, THE PLACES YOU’LL GO”: OPPORTUNITIES TO TEACH CHILD PSYCHIATRY IN LOW- AND MIDDLE-INCOME COUNTRIES THROUGH IACAPAP VOLUNTEER PROGRAMS

Chair: Julie A. Chilton, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the mental health treatment gap in child and adolescent mental health that is especially present in low and middle income countries; 2) Review free, online, evidence-based child psychiatry curricula produced by the International Association of Child and Adolescent Psychiatry and Allied Professions; 3) Explore several options for teaching child psychiatry using these free online resources in your current setting in the U.S., as well as through volunteer programs abroad arranged by IACAPAP; 4) Participate in reviewing the utility of the online curricula in a U.S. academic setting (Yale Child Study Center) and in an international pilot (Addis Ababa, Ethiopia); and 5) Discuss the pros and cons of the resources and consider application for the volunteer project.

SUMMARY:

Child and adolescent mental health (CAMH) problems are common, serious and treatable. Robust evidence-based treatments have been developed for most CAMH problems in high-income settings, though there is still a shortage of clinicians to provide treatment. In low- and middle-income countries (LAMIC), the “mental health treatment gap” between those needing treatment and receiving it is even greater. In this workshop, we will describe some initiatives of IACAPAP to assist local care providers in addressing CAMH needs worldwide, both in U.S. settings and abroad. IACAPAP has recognized the need to assist capacity building for child mental health professionals worldwide and is developing a range of free, online training resources. The IACAPAP textbook is largely for child psychiatrists and trainees. It is already widely used in low- and high-income settings, with over 100,000 readers to date, and is now being expanded to include downloadable PowerPoint presentations, clinical exercises and end-of-chapter questions. As there is a shortage of child psychiatrists, many practitioners do not have time

away from clinical duties to prepare high-quality didactic materials. These IACAPAP resources will provide evidence-based tools to teach CAMH with minimal preparation by the lecturer, so less time is spent recreating the wheel and more time can be devoted to actual class time. Many academic institutions have adopted the IACAPAP online textbook for teaching child and adolescent psychiatry, including the Yale Child Study Center and the Karolinska Institute in Sweden. However, many training centers are not aware of this free, online curriculum and the advantages it provides by being a living virtual resource with links to many useful clinical tools. For more basic learning in child psychiatry, IACAPAP is debuting a massive open online course, or MOOC, in early 2016 geared toward pediatricians, social workers, medical students and community health providers around the world. The MOOC will require about six hours a week for five weeks and will be divided into 20 short video modules (about 10 – 15 minutes each) covering the whole area of CAMH on an introductory level. Each video is followed by questions to emphasize content, with extra quizzes at the end of the week. There will also be online interactions with other students and teachers and peer grading. By the end of the MOOC, it is possible to earn a certificate for completion of the course. After completing the MOOC, participants will be eligible to apply for a face-to-face training in their own countries, provided by iCAMH (international child and mental health) volunteers. This credential is a more advanced diploma than the MOOC and will include an orientation about WHO’s mhGAP program. Participants of the workshop will be eligible to apply to be iCAMH volunteer teachers and also understand how to organize a training in their home country, if desired.

JOINING FORCES: THE NEUROLOGY-PSYCHIATRY CONNECTION: BRIDGING EDUCATION AND PATIENT CARE ACROSS DISCIPLINES

Chairs: Ann Schwartz, M.D., Wendy Baer, M.D.

Speakers: Jaffar Khan, M.D., Adriana Hermida, M.D., Martha C. Ward, M.D., Joash T. Lazarus, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the challenges and approaches to the treatment of patients from the perspective of both neurology and psychiatry; 2) Discuss opportunities for collaboration of psychiatry and neurology in the care of significantly disabling

disorders; 3) Review strategies to integrate training in neuropsychiatry in residency programs; and 4) Discuss innovative clinical and training approaches to further integrate psychiatry and neurology.

SUMMARY:

There is significant intersection between the practices of psychiatry and neurology, yet unfortunately, its training programs and the specialties' practices too often operate as independent entities. For the most part, neurologists are trained to focus on disorders that affect our shared organ, the brain, with defects in movement, circulation, electrical activity and cognition (e.g., dementia). Psychiatrists in turn focus more on emotions, perceptions, thinking disorders and behavior. Training programs have often struggled to find ways to better leverage the expertise of both fields and the neurosciences to ultimately improve patient care. To this end, the mission of one of our national societies, the American Neuropsychiatric Association, is to "improve the lives of people with disorders at the interface of psychiatry and neurology." Finally, there are good reasons why there is only one ABMS certification for both specialties. In this integrated workshop, we would like to share examples of topics and approaches we have used at Emory to achieve the goal of better coordinating our training programs in psychiatry and neurology with a few examples. Our workshop will present drug-induced movement disorders, or tardive syndromes, neuropsychiatric manifestations of Parkinson's disease, and strategies for bridging neurology and psychiatry in education. Drug-induced movement disorders are an increasingly recognized group of iatrogenic disorders that frequently confront psychiatrists and other specialists. In broad terms, they can present with hyperkinetic, hypokinetic or combined phenotypes. Although tardive dyskinesia and drug-induced Parkinsonism are familiar to most physicians, long-term use of psychoactive medications can also lead to the development of the individual or combinations of tremor, akathisia, tics, dystonia, myoclonus and dyskinesias. Distinguishing the phenomenology of these disorders from the primary neurologic conditions, particularly in the most vulnerable, thus has significant clinical implications. We will present a number of typical and atypical cases that will guide the discussion on risk factors, pathophysiology, diagnosis and management of drug-induced movement disorders. The neuropsychiatric symptoms of Parkinson's disease (PD) have the

potential to be more debilitating than the motor features of the disorder and usually prompt patients to earlier institutionalization. So important are these psychiatric features that some suggest they have a larger impact on quality of life (QOL). This talk will review the prevalence of behavioral manifestation of PD, the evidence of current treatment options and the experience of the Emory Comprehensive Care Clinic for PD in addressing patients with a multidisciplinary approach to improving their QOL. Our workshop will conclude with a discussion of innovative clinical and training approaches toward better integration of psychiatry and neurology.

EVIDENCE-BASED MANAGEMENT OF PATIENTS AT RISK FOR SUICIDE: VA/DOD CLINICAL PRACTICE GUIDELINES FOR THE PREVENTION OF SUICIDE

Chairs: John Bradley, M.D., Brett Schneider, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appraise the scope and quality of available evidence to date for the biopsychosocial factors related to suicide and suicide prevention so that providers can select appropriate treatments for patients; 2) Develop improved skills in suicide risk assessment by learning how to perform suicide risk stratification to determine the appropriate setting of care to best manage the acute risk of suicide; 3) Understand the evidence base for suicide-focused medication- and psycho-therapies to reduce risk of suicide attempt in your patient; 4) Develop an understanding of how safety planning can reduce the risk of suicide re-attempt and allow for safe discharge from the hospital setting; and 5) Improve communication and coordination of care between all support systems (medical, community services, family) to enhance the safety of transitions of care.

SUMMARY:

Suicide is the 11th leading cause of death in the United States amongst all age groups and the 3rd leading cause of death in young adults. It is the leading cause of morbidity, mortality and clinical risk in psychiatric practice and the leading cause of tort litigation for mental health clinicians. Suicide risk stratification is complex and often difficult to perform in the increasingly brief clinical encounters throughout to continuum of health care settings. The positive prediction of suicidal behaviors and death by suicide is even more complex. This workshop will describe the work of national experts in suicidology to develop a clinical practice guideline

for the assessment and management of suicidal behaviors that guides the care of patients presenting to primary care, specialty care, emergency care and mental health care settings. While the focus is on military and veteran populations, the recommendations can be generalized to wider populations. We will describe the guideline development process, review the literature that served as the basis for the recommendations of the guideline, and present the recommendations for the assessment of suicide risk and prediction of self-directed violence and the referral and treatment recommendations for patients at risk. A recovery model will be described in detail and used to guide clinical decision making. The myriad risk factors, protective factors and warning signs that have been validated in the literature will be reviewed and incorporated into a risk assessment tool that will guide clinical care. A collaborative assessment strategy will be offered to aid in the clinical assessment of the interpersonal, psychodynamic, cognitive and behavioral factors that lead to the hopelessness and perceived burdensomeness that drive suicidal feelings. The factors that lead to isolation, withdrawal and the creation of barriers to help-seeking behavior will be discussed and understood. A model for instilling hope and recovery will be offered to reduce barriers to treatment and engage the patient with the positive expectation of healing.

ACTIVE SHOOTER HOSPITAL LOCKDOWN: TO TREAT OR NOT TO TREAT

Chair: Edmund G. Howe III, M.D.

Speakers: Kyle J. Gray, M.D., M.A., James C. West Jr., M.D., Gary H. Wynn, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe major ethical arguments employed in providers' duty to treat when faced with a significant threat to themselves; 2) Recognize how the "active shooter" scenario differs from similar ethical conflicts between duty to treat and personal safety, such as epidemics; 3) Provide an ethical framework that providers can apply when seeking to resolve this conflict for themselves in this and other contexts; and 4) Consider appropriate preparation and actions on an inpatient psychiatric ward in response to an active shooter event.

SUMMARY:

On July 6, 2015, Walter Reed National Military Medical Center in Bethesda, Maryland declared an active shooter incident, and the entire facility went into lockdown, requiring all personnel to shelter in place. Across the hospital, all staff and patients, including providers, were to lock their doors and await a signal that all was clear. A psychiatric intern holding the hospital pager in case there was a cardiac arrest requiring cardio-pulmonary resuscitation faced the question, "What do we do if this goes off?" This question was among a host of hypothetical questions that the providers in the hospital faced that day, prompting a hard look at what providers should do when faced with similar situations. Ethically analogous dilemmas that could arise for psychiatrists during an active shooter lockdown include other kinds of emergencies, such as a patient becoming violent and threatening or attempting suicide. This discussion will begin with a case presentation of a real-life situation in which providers' duty to care came into direct conflict with their desire for self-preservation. Using a point/counterpoint format and interactive polling, a panel of providers and a medical ethicist will discuss this increasing dilemma. The discussion will draw comparisons between these active shooter scenarios and other more typical scenarios in which this same kind of ethical conflict is raised, such as during an epidemic. In the context of an epidemic, arguments have been made regarding duty to treat that fall into several categories: a virtue-based ethics, express consent, implied consent, special training, reciprocity and professional oaths. Speakers will address the applicability of these arguments as well as previously unexamined variables that figure into the moral calculus that the more direct threat of an active shooter presents. This discussion adds to the question of duty to treat and how providers think about their own actions if faced with such an event. Ample time will be allotted for plenary discussion.

COMORBID POST-TRAUMATIC STRESS DISORDER, PAIN AND OPIATE ADDICTION

Chair: Ayman Fareed

Speakers: Pamela Eilender, Psy.D., Bethany Ketchen, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the pathophysiologic mechanism of the comorbidity between Post-traumatic Stress Disorder (PTSD), pain and opioid use disorder; 2) Identify pharmacological

interventions that are appropriate for treating opioid addiction, chronic non-cancer pain and PTSD in patients with comorbid PTSD, pain and opioid use disorder; and 3) Identify evidence-based nonpharmacological approaches for management of pain and PTSD symptoms for patients with opioid use disorder.

SUMMARY:

Being exposed to life-threatening physical traumas, for example, a motor vehicle accident or combat-related injury, may contribute to the development of chronic physical pain and PTSD. The use of opiates to treat chronic pain may result in the development of opiate addiction. Therefore, PTSD, pain and opiate addiction commonly co-occur. The signs and symptoms of these disorders may overlap, which can make it challenging to determine which led to which. For example, the opioid withdrawal syndrome may mimic the hypervigilance and exacerbated startle response in patients with PTSD. A common neurobiological circuit is suggested for the pathophysiologic mechanism of this comorbidity. There is evidence that opioid substitution therapy may improve opioid addiction and chronic pain outcomes in patients with comorbid PTSD, pain and opioid addiction. Nonpharmacological approaches utilizing integrated psychological treatment models for co-occurring PTSD and substance use disorders will be discussed. Further, treatment for co-occurring pain and opiate addiction utilizing cognitive behavioral therapy and acceptance therapy show promise in addressing treatment needs; however, additional research is needed to validate these results. In this workshop, the prevalence and etiology of these comorbidities will be reviewed. The neurobiological link between PTSD, pain and opiate addiction will be discussed. The available treatment options for these co-morbidities with a focus on illicit opiate use, PTSD and pain will be elaborated. The audience will be updated about the basic and most recent information available about these comorbidities. Then the gap in the current treatment and the need for future research will be mentioned. The workshop will be divided into a formal 60-minute presentation where the three speakers will cover the educational objectives. This will be followed by discussion of clinical cases, where the audience will interact with the speakers for 30 minutes.

THE EVOLUTION OF INTEGRATED CARE FOR HIV AND MENTAL ILLNESS

Chair: Francine Cournos, M.D.

Speakers: Marshall Forstein, M.D., William W. Thompson, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify three basic models of integrated care-collocated care, consultation and embedded psychiatrist-and begin to understand the benefits and disadvantages of each model; 2) Explain how integrated care nodes address issues related to stigma; 3) Effectively apply integrated approaches in their own practices; and 4) Be able to lead/participate in the development of more integrated care in their programs.

SUMMARY:

Integrated care is now a major focus for psychiatry. Some of the earliest models of such care evolved in the context of responding to the HIV epidemic, where multiple epidemics involving people with HIV infection, hepatitis B and hepatitis C infection, substance use disorders, and other mental illnesses came together in the context of a strong advocacy movement to provide comprehensive services. Integrated care includes multidisciplinary team collaboration and substantial efforts to connect patients to enhanced case management, addressing complex psychosocial needs such as homelessness, poverty and treatment adherence. There is a "triple stigmatization" associated with having HIV, a mental illness and a substance use disorder. This workshop will address components and barriers to integrated care. This workshop, which includes a CDC presenter, will trace the history of integrated care within HIV, examining the evolution of team-based models for addressing the needs of very complex patients, including where we have been, lessons we have learned and where we are going. We will begin with a clinical vignette of a typical complex patient with HIV infection, demonstrating the challenges involved in meeting a full range of medical and psychiatric needs. We will review the models that initially developed out of necessity and also look at how they evolved over time into the current models of collocated care, consultation and embedded psychiatrist/mental health providers. Additional vignettes will be presented, each illustrating the strengths and weaknesses of these models of integrated care from the patient, provider and system points of view. Presentations will explore how to best achieve a comprehensive, compassionate, patient-centered approach to

treating people with multimorbid medical and psychiatric illnesses in a way that is consistent with participants' particular circumstances (e.g., rural vs. urban settings). An interactive discussion will encourage participants to present their experiences as providers with their own complex patients and their suggestions for improvements moving forward.

BRIEF COGNITIVE BEHAVIORAL INTERVENTIONS TO AUGMENT PSYCHOPHARMACOLOGY IN MOOD AND PSYCHOTIC DISORDERS

Chairs: Mohammed A. Khan, M.D., Mark Famador, M.D.

Speakers: Dana Foglesong, B.S., Narsimha Pinninti, M.D., D.P.M., Donna M. Sudak, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify sources of nonadherence to medications in specific disorders; 2) Treat nonadherence to medications in mood disordered psychotic patients by using brief cognitive behavioral interventions; and 3) Employ methods to train residents and clinicians to use these CBT techniques to enhance adherence.

SUMMARY:

Multiple studies in adult and pediatric psychiatric disorders have shown medication compliance rates of 20–70%, depending on the specific disorder. Outpatient antidepressant compliance is approximately 40%. Noncompliance in schizophrenics is 74%. Three months after initiation, only 50% of patients take ADHD medications. Poor understanding and misconceptions about illness and the need for medications and comorbidity contribute to this problem. Family dynamics, cultural and economic factors, cognitive distortions, psychodynamic factors, and unrealistic expectations are cited as causative factors. Medication noncompliance, now called nonadherence, leads to recurrence of symptoms and rehospitalizations. Many authors argue that compliance is an inadequate construct because it fails to capture the dynamic complexity of autonomous clients who must navigate decisional conflicts in learning to manage disorders over the course of years or decades. Compliance is rooted in medical paternalism and is at odds with principles of person-centered care and evidence-based medicine. Using medication is an active process that involves complex decision making and a chance to work through decisional conflicts. It requires a partnership

between two experts: the client and the practitioner. Shared decision making provides a model for them to assess a treatment's advantages and disadvantages within the context of recovering a life after a diagnosis of a major mental disorder. Wright, Sudak, Turkington and Thase cite evidence that the combination of medication and psychotherapy improves outcomes for many psychiatric illnesses, including depression, bipolar disorder and schizophrenia. Eliciting the patient's cognitions about having any disorder and taking medication and incorporating CBT techniques to work with these thoughts improves adherence and reduces the risk of relapse. Normalizing the experience of hallucinations, examining the evidence for the validity of the voice content (e.g., "You're stupid," "You deserve to die," "You should have never been born"), coaching the patient on useful behaviors to lower the intensity and the influence of the voices, and writing out a coping card for managing the voices can reduce the distress associated with psychotic symptoms and improve the ability to function in everyday life. Cosgrove's study (2011) concluded psychosocial (psychoeducation, cognitive behavior therapy, interpersonal and social rhythm therapy, and family-focused therapy) interventions as adjuncts to pharmacological treatment may improve medication adherence as well as bolster cognitive and interpersonal coping skills, ultimately lengthening intervals between episodes and improving overall quality of life. This workshop will illustrate methods for developing a partnership between two experts—the client and the practitioner—and ways of developing shared decision making.

UPDATE ON BODY DYSMORPHIC DISORDER: CLINICAL FEATURES, NEUROBIOLOGY AND TREATMENT

Chairs: Katharine A. Phillips, M.D., Jamie Feusner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand key clinical features of BDD; 2) Discuss evidence-based pharmacological and psychosocial treatments for BDD; and 3) Understand possible etiologic factors, including abnormalities in visual processing.

SUMMARY:

Body dysmorphic disorder (BDD) is an often-debilitating disorder that is classified in the *DSM-5*

chapter "Obsessive-Compulsive and Related Disorders." BDD is common but often overlooked in clinical practice. It consists of distressing or impairing preoccupation with perceived defects or flaws in appearance that are not observable or appear only slight to others. All individuals with BDD, at some point during the course of the disorder, perform excessive repetitive behaviors (mirror checking, grooming, skin picking, reassurance seeking) or mental acts (comparing his/her appearance with that of others) in response to their appearance concerns. Patients typically experience marked impairment in psychosocial functioning and very poor quality of life. A high proportion experience suicidal ideation or attempt suicide, and rates of completed suicide appear markedly elevated. The development of BDD in any given individual is likely the result of a complex interaction between genetic and environmental influences, which include developmental, social, neuropsychological, cultural, cognitive behavioral and neurobiological factors. Although the field is still young in terms of understanding their relative contributions, examples of such potential contributory factors include a history of abuse or teasing, distorted cognitions, a tendency to experience obsessive thoughts and compulsive behaviors, evolutionary and cultural influences regarding physical appearance, and visual perceptual abnormalities. Some of these factors may be etiologic, whereas others may contribute to the maintenance of BDD symptoms. Dr. Phillips will review BDD's key clinical features and will discuss evidence-based treatment approaches, both pharmacological and psychosocial, as well as how to engage patients in treatment. Dr. Feusner will discuss findings that may be relevant to this disorder's etiology and maintenance, both biological and psychosocial, with a focus on abnormalities in visual processing. This will lead to an interactive session in which audience members can ask questions and discuss their cases. Audience participation will be encouraged. The workshop will help audience members develop a broader understanding of factors that likely combine in any individual patient to result in the expression of BDD symptoms. Such knowledge will be useful for individually tailored treatment planning, which the workshop will also focus on. We have given this workshop at the annual meeting for the past several years; we propose to give an updated version at the next annual meeting because interest in BDD and research on this severe disorder continues to increase, because the workshop has been well-

attended in the past, and because past participants had many questions and cases to discuss.

SEXUAL OFFENDERS: A PSYCHIATRIC PERSPECTIVE

Chair: Renee Sorrentino, M.D.

Speakers: Abhishek Jain, M.D., Susan Joy Hatters-Friedman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn the roles of psychiatrists in sex offender evaluation and treatment; 2) Become familiar with the training opportunities for psychiatrists interesting in working with sexual offenders; and 3) Become familiar with the legal and ethical issues that arise in the management of sexual offenders.

SUMMARY:

The management of sexual offenders in the United States has largely been under the clinical expertise of psychologists. However, when the construct for civil commitment of sexually dangerous persons was enacted almost 20 years ago, psychiatrists, including the APA, were in a position to become involved in sex offender management. Although the role of psychiatrists in sexual offender management has been accepted by some, others have rejected the role of psychiatrists in this area, identifying a lack of training and experience as well as a lack of clarity as to what specifically psychiatrists can offer sexual offenders. The literature is clear: sexual offenders have the lowest risk of sexual offender recidivism when treated with a combination of biologic and psychologic treatment. More specifically, evidence-based practice supports the use of biologic treatment, namely antiandrogen and hormonal medications, in dangerous sexual offenders. The costs and consequences of sexual violence are vast. The best available research tells us that sexual violence victimization costs the United States \$450 billion annually. The answer to preventing sexual abuse is effective evaluation and treatment of sexual offenders. Psychiatrists are an integral part of this solution. This workshop will focus on how to develop an expertise in the field of paraphilias and sex offender management. The panel will identify ways to gain training, mentorship, research and funding in working with sexual offenders. The particular challenges in this field will be reviewed, as well as recommendations and strategies to prevent burnout and vicarious traumatization.

NOT JUST NATIONAL NEWS: CAN MULTIPLE ISOLATED INCIDENTS OF RACIALLY OR ETHNICALLY MOTIVATED VIOLENCE TRAUMATIZE THE LARGER MINORITY GROUP?

Chair: Mawuena Agbonyitor, M.D., M.Sc.

Speakers: Meredith Harewood, M.D., Racquel E. Reid, M.D., Rubiahna Vaughn, M.D., M.P.H., Aleema Zakers, M.D., M.P.H., Danielle Hairston, M.D., Mawuena Agbonyitor, M.D., M.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the deleterious impact that media exposure to discrimination-based violence can have on patients; 2) Discuss the literature surrounding traumatization from media coverage of racially or ethnically motivated violence on various minority groups; 3) Provide culturally sensitive treatment to patients vulnerable to such re-traumatization; and 4) Identify community resources for patients suffering in the aftermath of such trauma.

SUMMARY:

During this workshop, we will present cases of trauma experienced by minorities exposed to discrimination-based violence through the media, review the available literature regarding media-based traumatization of various minority groups, discuss clinical recommendation for psychiatrists treating patients affected by this type of trauma and provide information on available resources that can benefit this population. A review of the literature notes that traumatic stress due to discrimination is different from classic or complex post-traumatic stress disorder because the stress-inducing insults are often subtle, ambiguous, unconscious, expectable and persistent. In contrast to these earlier studies on discrimination, recent violent events involving Black victims in Ferguson, MO, and Charleston, SC, as well as the increasing incidence of homicides of LGBTQ people of color in 2015, are overt actions resulting in death or serious injury. Individuals classified in the same marginalized groups who witness these incidents via media sources can also experience fear and anxiety even though they are not direct victims of violence. While symptoms of discrimination-based traumatic stress include fear, anger, worthlessness, anxiety, depression and humiliation, there has been no research done on the scale of traumatization due to media exposure of discrimination-based violence. However, as psychiatrists, it is important for us to be

aware of the effect of such traumatization on the mental wellness of our patients. Participants will be involved in our workshop by having opportunities to describe their reactions after exposure to media coverage of discrimination-based incidents, discuss their approach to patients who have experienced that type of trauma and participate in the 30-minute QandA session after the presentation. This workshop has been created by MFP SAMHSA and Diversity Leadership Fellows.

ACCESS TO PHYSICIAN-ASSISTED SUICIDE FOR INTRACTABLE SUFFERING AND CHRONIC MENTAL ILLNESS: AN APPROACHING ETHICS CRISIS

Chair: Mark Komrad, M.D.

Speakers: Mark Komrad, M.D., Robert Roca, M.D., M.P.H., Samuel J. Leistedt, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the history of physician assisted suicide (PAS) in the U.S. and the varying criteria for eligibility to access this increasingly available legal “right”; 2) Understand the developing trend in Europe to allow access to PAS for “intractable suffering,” not just terminal illness, and its implications for chronically ill patients; 3) Learn how expanding PAS for “chronic suffering” allows our patients with mental disorders (who aren’t terminally ill) to access PAS—a new potential consequence of “parity”—and how we might respond; 4) Hear how legal PAS for chronic suffering and mental illness has affected the thinking and practice of psychiatrists in Belgium and how this might affect patients and treaters if allowed in the U.S; and 5) Reflect on the fundamental core values of physicianship and the psychiatric profession and on the increasing complexity of interpreting the ethical dictum “do no harm”.

SUMMARY:

For some years, a few states in the U.S. and other governments have permitted physician-assisted suicide (PAS). This option is generally confined to patients with terminal “medical” conditions. Over the last 10 years, however, Belgium and the Netherlands have started to allow patients with chronic conditions, including mental illnesses, who are deemed “untreatable” by their doctors, to also have access to PAS. These patients are not terminally ill, but chronically suffering. This is a very significant step, with profound ethical implications, that strikes at some of the core and common activities of

psychiatrists: to prevent suicide, increase hope and find alternative paths to the future. Framed in the language of autonomy, self-determination and minimizing discrimination, advocates of this right for the mentally ill are deploying the concept of "parity" in an entirely new way. In this workshop, we will review the legal and ethical history of PAS in this country and its implementations. We will explore the ethical controversies around allowing people with psychiatric disorders access to PAS, beginning in Europe and making its way toward the U.S. The audience will be able to hear from a Belgian psychiatrist about the experience in that country, which is at the vanguard of this development. There will be ample time for audience discussion. The session will consist of 1) A 20-minute presentation by Robert Roca, M.D. (Geriatric Psychiatrist and Internist, Medical Director, Sheppard Pratt, Baltimore, MD), who will be giving an overview of the topic of PAS, historical aspects, the implications of "capacity" in the chronically mentally ill and associated ethical controversies; 2) A 20-minute presentation by Mark Komrad, M.D. (Psychiatrist, member of the APA Ethics Committee and Ethicist-in-Residence, Sheppard Pratt), overviewing the issue of giving those with nonterminal but persistent mental illnesses access to this "right," the ethical implications of psychiatrists authorizing and aiding their patients' suicides, and challenges to the core values of psychiatry; 3) A 20-minute presentation by Samuel J. Leistedt, M.D., Ph.D. (Forensic Psychiatrist, Professor, Université Libre de Bruxelles), presenting a Belgian psychiatrist's experience of this issue as it is playing out in that country for people with mental illnesses and how Belgian psychiatrists are reacting to it; and 4) 30 minutes for open discussion between the audience and the panel.

PLANES, TRAINS, AUTOMOBILES AND BOATS: PSYCHIATRISTS AS EMERGENCY FIRST RESPONDERS

Chairs: Jean E. Aycock, M.D., Lee S. Hyde, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify at least 10 needs psychiatrists can easily meet in attending victims in a variety of emergency settings with little to no equipment; 2) Acquire a higher degree of confidence and competency in emergency medical situations as first responders; 3) Acquire skills for seamless interaction with EMT teams, police and firemen; 4) Have the opportunity to share first responder stories, discuss questions and receive supportive

feedback from other participants and the speakers; and 5) Answer the questions "Am I supposed to offer aid in public emergencies?" and "What is my liability?".

SUMMARY:

Many psychiatrists feel hesitant to answer the call, "Is there a doctor here?" in public settings due to lack of use of or recent familiarity with first aid skills, time away from training, and the sense that, as psychiatrists, we have little to offer in such a setting. When we do become involved, we may afterward express feelings of helplessness and guilt at "not having known what to do," not being sure we did the right thing and at not having thought of what we might have done. At the same time, we feel responsible as medical doctors for offering care. This combination of factors can lead us to either not offer our involvement or experience such situations as unnecessarily traumatic. In actuality, there are many ways in which we can be helpful, and common codes of ethics for physicians consider response in emergencies as a duty. This workshop is intended to address the mental and emotional barriers that have prevented us from responding and from feeling competent as first responders in emergency medical situations in public and to identify first response skills that almost all psychiatrists already possess. Some very basic teaching of emergency medical response will be included. Some common inquiries that will be addressed are "What's my liability if I should make a mistake?" "Should I give my name or say that I'm a doctor?" "What supplies are reasonable for me to carry?" "Can I help the EMT team?" and "What am I supposed to do with no equipment?"

FROM THE GERIATRIC HOSPITAL BED TO THE WITNESS STAND: DELIRIUM IN THE COURTROOM

Chair: Alberto M. Goldwaser, M.D.

Speaker: Alberto M. Goldwaser, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Outline of presentation and course of Dementia and Delirium and their clinical contrasts; 2) Demonstrate the importance of effectively assessing the mental status of individuals in inpatient hospital settings, as well as those in nursing home, assisted living facilities and outpatient locations. The medical records should contain clinical information to help the clinicians design a helpful treatment protocol and the jurist who eventually

reviews these medical records to understand and arrive at legal conclusions; 3) Educate on ethical (autonomy, beneficence, non-maleficence) and legal (competence, testamentary capacity, undue influence) concepts that are becoming commonplace in geriatric neuropsychiatry; and 4) Proficiently explain and clarify opinions concerning the state of mind of patients engaging in carrying out legal choices.

SUMMARY:

Using forensic neuropsychiatric case illustrations, I will review the concepts of autonomy, competence, testamentary capacity and vulnerability to undue influence. I will use hospital records to emphasize the importance of assessing for patients' mental status, particularly for the presence of delirium, which is so often unappreciated by hospital staff. This neglect interferes with the foundation of legal inquiry and the establishment of legal decisions. I will discuss how dementia and delirium influence the individual's ability to make specific legal decisions and the importance of educating judges on the difference between these two processes.

HOW DOES COUNTERTRANSFERENCE FIT IN MODERN HEALTH CARE: IMPACT OF PROVIDER FEELINGS ON DIAGNOSIS AND MEDICAL DECISION MAKING

Chair: Nidal Moukaddam, M.D., Ph.D.

Speakers: Asim Shah, M.D., Veronica Tucci, M.D., J.D., Nidal Moukaddam, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Summarize the concept of countertransference (CT) in its traditional, psychodynamic form, along with operational applicability of CT in modern health care, both psychiatric and nonpsychiatric; 2) Discuss how countertransference (both positive and negative) may affect formation of differential diagnoses as well as differences amongst medical specialties in response to patients; 3) Develop appreciation of how activation of CT dimensions (e.g., helpless/criticized dimensions) affects medical decision making and order workup, potentially affecting adherence to medical algorithms; and 4) Identify how to use CT to improve patient care.

SUMMARY:

Countertransference (CT), the psychodynamic concept representing feelings of providers toward

patients, has been "known" to affect decision making. However, despite multiple anecdotal reports that CT affects health care, that field is markedly understudied. We know, quite intuitively, that medical decision making is not an objective process, despite the presence of medical algorithms for work-up and diagnosis. The reasons for difficult patient-provider interactions can be due to the patient as well as the provider. Bias in medical decision making can cause costly mistakes in treatment and has been linked to race, gender and socioeconomic status, but does not fully explain fluctuations in how providers make decisions. This could be due to bias being an incomplete facet of more complex, under-recognized and under-addressed countertransference issues. Our presentations will summarize the results of our team's work in linking CT and medical decision making and future directions in this exciting new field. Starting with a historical perspective on countertransference, the presentations will guide participants to this rich psychodynamic concept, including how it has evolved through modern care to lend itself more to formal study. Countertransference can be operationalized into eight dimensions, according to recent work by Westen et al.: overwhelmed/disorganized, helpless/inadequate, positive, special/overinvolved, sexualized, disengaged, parental/protective and criticized/mistreated. Using this operationalized format, the second presentation will illustrate how CT has been shown to relate to the way providers from multidisciplinary backgrounds may think about patients, formulate differential diagnoses, and order testing and work-up. Results reported will include specialties ranging from psychiatry to internal medicine, obstetrics/gynecology and family practice. Last, the discussion will move to positive versus negative CT dimensions and how to identify and address these feelings in everyday patient encounters. Traditionally, being mindful of countertransference has belonged to the realm of psychotherapy, but as health care evolves and changes, time constraints challenge clinicians' ability to discuss CT in depth on a routine basis. Even so, difficult patients remain a core part of challenging clinical practice, and we believe that incorporating an appreciation of countertransference can be helpful in optimizing accurate diagnoses and patient outcomes.

CLINICAL ISSUES IN SCHIZOPHRENIA WITH COMORBID DISORDERS: UPDATE

Chairs: Jean-Pierre Lindenmayer, M.D., Michael Hwang, M.D.

Speakers: Cabrina Campbell, M.D., Peter Buckley, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize and diagnose schizophrenia with challenging comorbid psychiatric disorders; 2) Be familiar with and able to discuss multi-disciplinary assessment of schizophrenia with common comorbid conditions; 3) Understand psychosocial and pharmacological treatment intervention of challenging comorbid disorders in schizophrenia; and 4) Be familiar with clinical management and discuss the clinical implications of schizophrenia with comorbid disorders.

SUMMARY:

Patients with schizophrenic disorder present with diverse clinical phenomena and treatment outcomes. This is due to the underlying heterogeneity in biopsychosocial pathogenesis that may affect their symptom manifestation and treatment response. The clinical and biological nature of comorbid disorders in schizophrenia has been long debated and remains a clinical challenge. Current clinical and research evidence support recognition and treatment of comorbid disorders for the optimal outcome. Emerging evidence in recent years also suggests that some comorbid conditions in patients with schizophrenia may constitute a schizophrenic subtype with distinct psychobiological pathogenesis that requires specific pharmacological and behavioral treatment interventions. Furthermore, increasing emphasis on recognition and treatment of associated symptoms in schizophrenia, as well as recent advances in symptom-specific pharmacological treatment, has raised clinician awareness in patients with schizophrenia and comorbid disorders. Recent clinical and research findings suggest that specific comorbid disorders such as panic and OCD, impulsive-aggressive or suicidal behaviors further compound the clinical course and call for specific treatment interventions. In this workshop, we will review the current clinical and research advances in challenging comorbid conditions in schizophrenia and discuss their treatment issues. Dr. Lindenmayer will review the current clinical and research evidence of pharmacobehavioral treatment in impulsive-aggressive schizophrenic patients.

PTSD IN PSYCHIATRISTS: A HIDDEN EPIDEMIC

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

Speakers: Michael F. Myers, M.D., H. Steven Moffic, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the types of clinically related traumatic events that may cause PTSD in psychiatrists; 2) Understand the role of shame and humiliation in the genesis of PTSD symptoms; 3) Recognize the potentially harmful effects of subclinical PTSD on physician wellness; and 4) Advocate for effective prevention and treatment programs tailored specifically to psychiatrists, psychiatric residents and other physicians.

SUMMARY:

PTSD is under-recognized in physicians, even though it may be more prevalent in physicians than in the general population in the United States. Psychiatrists, in particular, may be predisposed to PTSD because of their repeated exposure to violent or suicidal patients and high patient-related stress in general. Other potentially traumatizing events, such as malpractice litigation and medical errors resulting in serious adverse outcomes, may cause PTSD. Medical students and residents are also at high risk to develop PTSD related to clinical training. In addition, psychiatrists who are "second victims" in the sense that they are indirectly exposed to trauma may develop PTSD. PTSD affects the well-being of psychiatrists and their ability to care for patients. Traumatized physicians may, in fact, unwittingly and iatrogenically cause PTSD in their patients due to impaired and nonempathic behavior. Because physicians with PTSD often suffer in silence, there needs to be an appreciation of the role of shame and humiliation in developing PTSD symptoms. In the course of helping others, psychiatrists may deny that they are vulnerable to the same risks as their patients. The cumulative effect of work-related stress could result in subclinical PTSD manifested by burnout, substance abuse, relationship problems, depression or even death. The workshop leader and panelists have either experienced traumatic events related to clinical practice or are specialists in physician health. They each bring their own unique perspectives to this workshop, and their presentations will include several brief clinical vignettes. Not infrequently, patients meet diagnostic criteria for one or more other *DSM-5* diagnoses (especially mood- and substance-related disorders),

necessitating an assessment and treatment plan that demands rigor and a comprehensive biopsychosocial vision. At least one-third of the workshop will be reserved for discussion and interaction with the attendees. Workshop participants will be encouraged to discuss disguised clinical cases from their practices as well as their own personal stories of trauma, symptoms and treatment experiences. The steps considered prerequisite for recovery will be explored, including the challenges associated with implementing effective treatment and support programs.

MANAGING VIOLENCE RISK AND INTERVIEW SAFETY: A PRIMER FOR RESIDENTS

Chair: Tobias Wasser, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the lack of sufficient training in understanding violence risk and safe interviewing techniques available for psychiatry residents; 2) Demonstrate the ability to recognize characteristics of patients and situations that elevate the risk for violence; 3) Make appropriate adjustments to the interview milieu in all clinical encounters to attend to their safety and that of their patients; and 4) Increase their efforts to be cognizant of their own internal state while sitting with patients and take action based on their observations.

SUMMARY:

Recent evidence suggests that 25 – 64% of psychiatry residents are the victims of assault by patients, with numerous potential physical and psychological consequences. Only a minority of residents, however, feel they receive adequate safety and violence training. To address this disparity, the author designed and implemented at the author's institution a workshop entitled "Recognizing and Managing Safety in the Psychiatric Interview: A Brief Intervention." The workshop focused on improving residents' ability to recognize violence risk and increase attention to safety in the psychiatric interview. The workshop was designed to help residents understand the risk factors and recognize the warning signs that precede violent behavior, with the ultimate goal of decreasing the likelihood of residents becoming the victims of future violence by their patients. The initial workshop was piloted on a small group of psychiatry residents at the author's institution. After participating in the workshop, the number of

residents citing appropriate safety concerns when faced with an agitated patient at risk for violence increased significantly (from 38 to 92%). Following this pilot, the workshop curriculum was published as a milestone toolkit by the Model Curriculum Committee of the American Association of Directors of Psychiatric Residency Training (AADPRT). The present workshop presentation will begin by providing residents with an understanding of the significant and unique risks and consequences of patient assaults against trainees. Participants will then be provided the opportunity to participate in the interactive workshop "Recognizing and Managing Safety in the Psychiatric Interview: A Brief Intervention." In this workshop, they will have the chance to learn valuable information about violence risk assessment and management and hone their skills in managing safety during the course of the psychiatric interview. In particular, the session will focus on how to recognize the risky patient and the risky situation, how to attend to safety during the psychiatric interview, and how to recognize and manage the escalating patient. Following the completion of this interactive workshop, participants will have the opportunity to discuss cases in which violence and/or safety were concerns and receive support and feedback.

CULTURAL FAMILY THERAPY: INTEGRATING FAMILY THERAPY WITH CULTURAL PSYCHIATRY

Chairs: Vincenzo Di Nicola, M.D., Ph.D., Ellen Berman, M.D.

Speakers: Vincenzo Di Nicola, M.D., Ph.D., Ellen Berman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand families in cultural context to learn to listen to family stories in order to identify their mental and relational predicaments as expressions of their unique cultures; 2) Select with cultural sensitivity, using translators and cultural mediators as needed, at least three clinical tools that help families tell their trauma stories; 3) Define culture change and identify its mental health impacts on families as a cascade of consequences; and 4) Learn how to negotiate intervention strategies that are both culturally congruent and clinically effective for families undergoing culture change.

SUMMARY:

This interactive, case-based workshop is designed for clinicians who work with families presenting mental health challenges across cultures. In Part I, the workshop leader will present cultural family therapy (CFT), a synthesis of systemic family therapy and cultural psychiatry. In numerous publications and international workshops over the last 30 years, the workshop leader has elaborated a model of CFT, presented in his book, *A Stranger in the Family: Culture, Families, and Therapy* (1997). CFT weaves together family stories that express their mental and relational predicaments and conceptual tools for conducting clinical work. CFT is an ongoing update of our notions of “family” and “therapy” on one hand and of “culture” and “psychiatry” on the other. Three basic principles and processes for CFT are 1) The deep parallels between the notions of “family” and “culture” mean that “culture” supersedes the notion of family “system;” 2) Each family is the bearer of the larger culture(s) in which it is embedded and creates a culture of its own, so the family is the vehicle for intergenerational cultural transmission, for maintaining culture (cultural coherence) and for generating its own small-scale cultural adaptations, yielding three yoked family functions: cultural transmission, cultural maintenance/coherence and cultural adaptation; 3) At the heart of systemic family theory and cultural psychiatry is a relational psychology that inverts theorizing from self to society by redefining the notions of identity and belonging through relations. With its relational and sociocultural approach, CFT is uniquely responsive to working with families undergoing culture change within and across cultures. In a world with huge global flows of migrants and refugees instigated by conflict, disasters, or economic and social reasons, CFT offers clinical tools to understand and treat families experiencing severe stress due to rapid and massive culture change. These processes will be explained, illustrated in case examples and distributed to the workshop participants in handouts (30 mins). In Part II, participants will divide into two groups for discussion of CFT theory and practice, illustrated by two family cases in treatment: 1) An adolescent from South America whose disturbing experiences appear as psychotic out of family and cultural contexts and 2) A young adult from a multicultural family with parents living in two countries, Canada and Haiti, whose uncertain, shifting sense of belonging is as unanchored as her changing tableau of anxiety-depressive symptoms. A senior psychiatrist/family therapist will serve as co-facilitator in the small

groups. Participants will apply the three core principles and processes to these cases (35 mins). In Part III, the participants will reconvene for an interactive discussion, with a focus on applying CFT treatment strategies to their own clinical work with families across cultures (25 mins).

THE GENERAL PSYCHIATRIST’S APPROACH TO PERSONALITY DISORDERS: PRACTICAL APPLICATIONS OF TRANSFERENCE-FOCUSED PSYCHOTHERAPY (TFP) PRINCIPLES

Chair: Richard Hersh, M.D.

Speakers: Frank E. Yeomans, M.D., Eve Caligor, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the overarching theory of TFP; 2) Use elements of the structural interview in the psychiatric assessment of personality disorders; 3) Establish and make use of a treatment contract, even if the clinician is not practicing individual psychotherapy; 4) Utilize TFP principles in the management of patient crises; and 5) Apply TFP principles in pharmacological management.

SUMMARY:

Transference-focused psychotherapy (TFP) is one of the evidence-based treatments for borderline personality disorder (BPD). The principles of TFP as an individual psychotherapy are applicable to other settings of psychiatric practice and can be useful to clinicians treating patients with personality disorder symptoms, even if those clinicians are not practicing individual psychotherapy. This workshop is designed to introduce general psychiatrists to the fundamentals of TFP as tools to manage challenging work with personality disorder patients. The foundations of TFP include the structural interview, the treatment contracting process and the understanding that the patient’s perception of interactions with others is rooted in largely unconscious internal images of self in relation to others. The structural interview aims to clarify both the personality disorder diagnosis (consistent with *DSM-5* nosology) and the patient’s level of organization, informed by object relations theory. The treatment contracting process is a central element of TFP as an individual psychotherapy, and focus on the treatment contract and maintenance of the treatment frame can benefit psychiatrists in various settings. TFP principles in handling patient crises, common in treatment of BPD, can be used by

clinicians in multiple inpatient and outpatient settings. The ways TFP principles can aid prescribers will be explored. This interactive workshop will involve participants in discussions of their own clinical challenges with patients and explore ways TFP principles might aid them in their future work.

THE EXTENSION FOR COMMUNITY HEALTH OUTCOMES (ECHO) MODEL: CREATING A COMMUNITY OF MENTAL HEALTH AND ADDICTIONS PRACTICE

Chairs: Allison Crawford, M.D., M.A., Sanjeev Sockalingam, M.D.

Speakers: Allison Crawford, M.D., M.A., Sanjeev Sockalingam, M.D., Paul Kurdyak, M.D., Ph.D., Eva Serhal, M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List the steps and best practices necessary to create a community of practice through telemedicine; 2) Review a comprehensive approach to evaluating ECHO outcomes at provider, patient and health systems levels using Moore's framework; and 3) Apply these steps through participation in a simulation of an ECHO for mental health and addictions.

SUMMARY:

The high burden of mental illness and inequitable distribution of health human resources present an imperative to devise novel models for the delivery of mental health services. Through an active group simulation, we will introduce participants to the ECHO model, first developed at the University of New Mexico. The ECHO model engages psychiatrists and interprofessional providers in a community of practice. The community, established through telehealth, creates a knowledge network in which evidence-based treatment approaches are shared between academic and primary care sites through case-based learning and co-management of patients. In this workshop, we will involve participants in enacting the operational, clinical, interprofessional, learning and evaluation strategies necessary for the successful implementation of ECHO. The ECHO model has been demonstrated to result in patient outcomes for hepatitis C that are equivalent to outcomes of tertiary academic hospitals. Few mental health ECHO models exist at this time, and approaches to implementing mental health ECHO programs are needed. With an emphasis on implementation and process and outcomes

evaluation, we are attempting to establish best practices for the use of ECHO in mental health. Dr. Crawford will begin the session by providing an overview of the ECHO model, its core features and related telepsychiatry competencies. Dr. Sockalingam will summarize data from a systematic review on ECHO outcomes and relate these findings to mental health ECHO program development. Ms. Serhal will provide an overview of how to use multiple data points to inform ECHO mental health curriculum development. Dr. Kurdyak will provide critical perspectives on the evaluation of ECHO, including health systems outcomes. All presenters will lead a large-group interactive exercise simulating an ECHO session. Preliminary data on ECHO mental health outcomes will be presented, and resources will be shared.

ONE DOCTOR, ONE HAT: ENDING PSYCHIATRY'S MIXED LOYALTIES

Chair: Philip Candilis, M.D.

Speakers: Richard Martinez, M.D., Laura Roberts, M.D., M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the unifying concepts of professionalism based on the essential habits and skills of the ethical practitioner; 2) Understand the common mixed or dual agency dilemmas ; and 3) Understand the dramatic changes in psychiatry and scope of work.

SUMMARY:

Psychiatry faces dramatic changes in its autonomy and scope as practitioners enter increasingly complex relationships with industry, insurers, allied health and government agencies. Obligations to patients are muddled by conflicts of interest and mitigation policies that result in role-specific duties that vary by the practice setting. Hospitals balance resource stewardship with the obligation to provide care, insurers incentivize providers to restrict patient choices, correctional settings weigh security against privacy, and military agencies consider treatment alongside the maintenance of an adequate fighting force. The many approaches to these competing allegiances contribute to a splintering of the profession into job-specific requirements that require more guidance than the role alone can provide. This workshop by authors in ethics and professionalism offers cohesion to an often splintered profession. Using unifying concepts of

professionalism based on the essential habits and skills of the ethical practitioner, the profession's underlying goals and purposes and the protection of vulnerable persons and values, Drs. Laura Roberts, Richard Martinez and Philip Candilis will join the multiple perspectives of patient, professional and community into a professionalism that cuts across all settings. Discussion will center on common mixed or dual agency dilemmas ranging from clinical and research to forensic and military psychiatry.

MAY 17, 2016

ADAPTATION AND DISSEMINATION OF EVIDENCE-BASED PSYCHOTHERAPIES FOR USE IN ACUTE PSYCHIATRIC CARE

Chairs: Aliza T. Stein, B.A., Patricia Marino, Ph.D.

Speakers: Kean J. Hsu, Ph.D., Patricia Marino, Ph.D., Amanda McGovern, Ph.D., Theresa A. Morgan, Ph.D., Victoria Wilkins, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate an understanding of evidence-based psychotherapies that are available for use in acute psychiatric care; 2) Review data on symptom reduction, skill acquisition and patient satisfaction and discuss the clinical implications of research findings; 3) Identify and discuss adaptations that may be suitable treatments for use in similar treatment settings; and 4) Evaluate strengths, challenges, limitations and future research needs in this area.

SUMMARY:

Implementing evidence-based psychotherapies in acute psychiatric settings poses several challenges, since many cognitive behavioral interventions were originally designed and evaluated in clinical trials for outpatient use. Patients presenting for treatment in acute psychiatric settings (partial hospital or inpatient) often have a range of primary and comorbid psychiatric disorders. Evidence-based psychotherapies that target underlying principles of psychopathology need to be adapted and studied to determine the transdiagnostic efficacy and utility of such treatments as applied in acute care settings. Adaptations of four evidence-based psychotherapy treatments—dialectical behavior therapy (DBT), acceptance and commitment therapy (ACT), Engage, and cognitive behavior therapy (CBT)—will be presented by expert clinicians in the field. This workshop will have two parts. The first will provide

an overview of each therapy, with opportunity for audience questions after each presentation. Adaptations of DBT for use in inpatient and partial hospital programs will be presented. This discussion will explore the efficacy of DBT for patients with comorbid mood and personality pathology, as well as the efficacy of DBT for the treatment of anxiety disorders. The research presented will highlight the benefits of treatments that target maladaptive cognitive behavioral processes (e.g., emotion regulation and distress tolerance) that are components of a broad range of psychopathology. An overview of adaptations to ACT will be presented with treatment outcome data from a partial hospital program that uses adapted forms of both ACT and mindfulness for treatment of patients with mood, eating, anxiety and personality disorders. Next, an adaptation of Engage, a neurobiology-informed, behavioral intervention for use on geriatric inpatient units, will be presented. Finally, a modified CBT protocol used in a women's inpatient unit will be presented. Patient feedback and satisfaction data, which highlights the importance of flexible application and adaptation of CBT in this setting, will be reviewed. In second part of the workshop, participants will collaborate in small groups to brainstorm strategies for implementing similar programs in their respective clinical settings. During this time, the presenters will facilitate the group discussion and provide feedback. Presenters will provide suggestions to overcome challenges of implementing these adaptations and conducting clinical research. This workshop will provide attendees with an integrated perspective on how psychotherapies can be modified for use in acute psychiatric settings. Participants will also leave with an understanding of the challenges and limitations of conducting clinical research on such therapies. The longer-term goal of this research is to identify effective transdiagnostic protocols and promote dissemination of evidence-based practice in acute psychiatric care.

WHAT IS NEW IN SUICIDE PREVENTION? FROM PRIMARY TO TERTIARY PREVENTION IN PHYSICIANS, YOUTH AND MEDICALLY ILL PATIENTS

Chairs: Tatiana Falcone, M.D., Jane C. Timmons-Mitchell, Ph.D.

Speakers: Ruby C. Castilla-Puentes, M.D., Dr.P.H., Fernando Espi Forcen, M.D., Tatiana Falcone, M.D., Jane C. Timmons-Mitchell, Ph.D., Margo Funk, M.D., M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify risk factors for suicide in physicians, youth and chronically ill patients; 2) Identify effective means of preventing suicide; and 3) Demonstrate tools for suicide prevention.

SUMMARY:

Every 40 seconds, one person loses their life to suicide; at least 800,000 suicides occur in the world every year. In this workshop, we will address suicide in physicians, youth and the medically ill. Depression and suicide are frequent among physicians, who often fail to recognize their own depression. Many physicians avoid treatment; the statistics on physician suicide are frightening: Physicians are twice as likely to kill themselves as non-physicians and female physicians three times more likely than their male counterparts. Although physicians globally have a lower mortality risk from medical conditions (e.g., cancer) relative to the general population, they have a significantly higher risk of dying from suicide. The assessment and management of suicidal ideation in the medically ill can be challenging. Often, symptoms of depression and medical illness overlap. Fatigue, low energy, low appetite, sleep disturbance, and difficulties paying attention and concentrating are common symptoms that manifest in oncology settings and can impact the mood of the patient. Evidence from research in patients with chronic illness suggests a more specific assessment of depression focusing on the emotional symptoms in patients with serious medical problems. Undertreated pain, fear of being a burden to others and living without dignity, loss of meaning in life, and anxiety about the afterlife are often related to thoughts of suicide. We will review the general assessment and management of suicide risk in oncology and palliative care settings. Every year, approximately 157,000 youth receive medical care for suicide-related injuries at emergency departments throughout the U.S. Suicide rates are high among young people; it is the second leading cause of death in 15- – 24-year-olds and accounts for 13% of all adolescent deaths annually. Suicidal ideation and suicide attempts are frequent in adolescents; 22% seriously considered suicide in the last year, 15% had made a plan and 8% reported that they had attempted suicide. Suicide remains the most serious complication of any psychiatric disorder, and the suicide rates in the U.S. have not decreased in the last 20 years. Prevention of suicide-related deaths is a major unmet public health

challenge. Effective means of preventing suicide include 1) Train people close to the person (gatekeepers) to recognize signs of suicide, discuss with the person and refer to mental health professionals; 2) Follow up with people who present to the emergency department by postcard, phone call or visit; 3) Contract with the person in a collaborative process to manage suicidal risk; and 4) Introduce new technology-assisted tools for suicide prevention. A statewide suicide prevention program will be discussed. Key features include an RCT to test the effectiveness of combined psychiatric and community-based interventions as well as expanded gatekeeper training for those who work with veterans.

ADOLESCENTS' DECISION MAKING CAPACITY IN THE CONSULTATION-LIAISON SETTING: FROM JUVENILE RIGHTS TO CASE LAW

Chairs: Anish R. Dube, M.D., M.P.H., Barbara Robles-Ramamurthy, M.D.

Speakers: Megan E. Baker, M.D., Hassan M. Minhas, M.D., M.B.B.S., Lara J. Cox, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the consultation context with regards to medical decision making capacity in adolescents; 2) Learn about the trend towards increasing juvenile (“young peoples”) rights across the globe; 3) Review case laws pertaining to adolescent decision making capacity and juvenile rights more broadly; 4) Review the recent use of neurobiology of adolescent brain development to argue for and against adolescents’ culpability versus decision making abilities; and 5) Discuss the ethical aspects of an adolescent’s right to self-determination versus the ethical duties of the physician.

SUMMARY:

The Connecticut Supreme Court recently mandated that a minor, known as “Cassandra C.” in court documents, be placed in the custody of the state’s Department of Children and Families (DCF) and undergo chemotherapy for Hodgkin’s lymphoma against the wishes of Cassandra and her mother. This case revisits a challenging issue that pediatricians and pediatric consultation-liaison psychiatrists are sometimes faced with, that is, an adolescent’s capacity to refuse life-saving treatments and what the role of a pediatric consultation-liaison psychiatrist is in such situations.

This workshop explores elements of a capacity evaluation of adolescents refusing life-saving treatment within the larger context of a global trend towards increasing juvenile and adolescent rights to self-determination. The Connecticut case regarding Cassandra C. is reviewed against similar cases in other jurisdictions that have set the precedent in this matter and in related matters (right to refuse treatment, right to die, juvenile sentencing and “mature minor” statutes). This is further weighed against the burgeoning literature suggesting differential adolescent brain development and a particular vulnerability toward peer influences and a lack of impulse control during this critical developmental phase. With respect to this case and in similar circumstances, a “mature minor” standard has been argued that allows for a minor’s self-determination rights. As this case demonstrates, the burden of proof to establish that an adolescent is a “mature minor” lies with the adolescent and her parents. While it may be within an adolescent’s due process rights to establish her status as a “mature minor” and therefore make decisions regarding her own body, she must be able to convince the court of this status. Furthermore, the establishment of “mature minor” status does not automatically confer competency for self-determination in medical decision making. Just as with adults, the capacity for self-determination in making life-saving medical decisions, while generally assumed, must be established when and if concerns are raised. Not only can an adolescent’s decision making capacity be suspect, but that of her parents can be as well and should therefore be assessed, whether formally or informally. It is also noteworthy that recent Supreme Court decisions such as *Miller v. Alabama* may reflect an American judicial system that appears to be giving increasing weight to findings in neurobiology regarding adolescent brain development. (That is, the maturation of parts of the brain that regulate emotion and impulse control may lag behind the maturation of those regions associated with rational thinking and reasoning.) We review the prevailing ethical and philosophical considerations for pediatric consultation-liaison psychiatrists when faced with such cases.

ELEMENTS FOR EFFECTIVE ADVOCACY FOR THE PROFESSION OF PSYCHIATRY

Chair: John Bailey, D.O.

Speakers: Debra Koss, M.D., Matthew D. Erlich, M.D., Michael Hann, M.D., M.S., Altha J. Stewart, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand APA’s advocacy operations; 2) Identify APA’s current federal and state advocacy priorities; and 3) Identify several ways to become engaged as an active participant in APA’s advocacy efforts.

SUMMARY:

Advocacy is the necessary and essential means through which the APA and its state organizations support and advances the profession of psychiatry in the areas of public and private policymaking and popular opinion. The goal of advocacy is to influence the development of legislation and regulations—both on the federal and state levels—that directly or indirectly have a positive impact on the profession of psychiatry and the patients we serve. Successful advocacy requires a sustained, multi-pronged effort that includes defining solid priorities and objectives, establishing relationships with key decision makers, and working collaboratively to construct and deliver clear and effective messages that advance the profession and the care of the persons we serve. Successful advocacy requires both proactive and reactive strategies. Successful advocacy requires flexibility, patience and perseverance. Most importantly, successful advocacy demands the active participation of every APA member. This workshop is designed to educate the APA’s members on the association’s advocacy operations, as well as to promote greater member participation in ongoing advocacy efforts. It will feature five panelists, four of whom will serve as speakers and one primarily as a moderator. The moderator will begin by introducing each speaker and providing a general overview of advocacy and the importance of member engagement in APA advocacy efforts. The first speaker will provide an overview of the APA’s advocacy operations and current advocacy priorities, including reimbursement, comprehensive mental health reform, parity enforcement, workforce development, scope of practice and research investment. The second speaker will provide an overview of various ways APA members can engage in advocacy efforts, such as communicating and building relationships with members of Congress and becoming a member of APAPAC. The third speaker will provide an overview of the APA’s ongoing advocacy-in-action on the federal level, using comprehensive mental health reform as an example. The fourth speaker will provide an overview of the APA’s ongoing advocacy-in-action on the state level,

using scope of practice as an example. Finally, the moderator will offer concluding remarks before facilitating a robust QandA session between speakers and participants.

THE TREATMENT OF NARCISSISM: TAILORING THE THERAPY TO THE PATIENT

Chair: Glen O. Gabbard, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify subtypes of narcissistic personality disorder; and 2) Adjust the psychotherapeutic approach to the subtype of narcissistic personality disorder.

SUMMARY:

This workshop will identify and describe specific subtypes of narcissistic personality disorder. By the end of the session, participants will have experience in adjusting their psychotherapeutic approach to the appropriate subtype of narcissistic personality disorder.

NOVEL APPROACHES TO THE TREATMENT OF CATATONIA

Chairs: Stephen J. Warnick Jr., M.D., Kamalika Roy, M.D.

Speaker: Richard Balon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify additional treatment methods beyond the traditional therapies of benzodiazepines and ECT, including memantine, amantadine, amisulpride, aripiprazole, rTMS and stimulants; 2) Provide indications for use of alternative treatments for treatment-resistant catatonia; 3) Understand risk factors that predict probability that catatonia may not respond to benzodiazepines; and 4) Describe the neurobiological rationale for the actions of adjunct treatment for catatonia.

SUMMARY:

Catatonia remains a common diagnosis in psychiatry, affecting up to 10% of admitted patients on inpatient psychiatric units. This common clinical syndrome, however, can progress, causing severe symptoms that can be life threatening. There is a strong evidence base for benzodiazepines and electroconvulsive therapy (ECT) in catatonia, but there are limitations to treatments with these

modalities. Situations where ECT is not readily accessible due to a lack of clinicians or administrative hurdles, or when patients do not respond quickly to high doses of benzodiazepines, necessitate psychiatrists to seek alternative treatments for their patients. This session will examine the evidence base for medications such as amantadine, memantine, stimulants and antipsychotics, as well as procedures such as rTMS, including the neurobiological rationale for how these treatments theoretically treat catatonia. The workshop will use a didactic format to cement core principles and progress to an interactive session, including a case-based discussion of treatment-resistant catatonia. The session will then conclude with a unique evidence-based journal club, splitting participants into small groups to discuss the literature available for each novel therapy, after which each group will briefly present their findings to the entire workshop, including their thoughts on further areas of research and inquiry into the treatment of catatonia.

“I WANT TO CHECK MYSELF IN”: DETERMINING WHO NEEDS PSYCHIATRIC HOSPITALIZATION

Chairs: Kenneth M. Certa, M.D., Jessica Mosier, M.D.

Speaker: Daniel Neff, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify characteristics of treatment systems that influence the use of inpatient care; 2) List aspects of patient presentations that predict outcomes of inpatient care; and 3) Describe benefits and risks of the use of inpatient care to patients and systems.

SUMMARY:

The evolution of the mental health care system continues. Numerous factors have led to a decline in the use of inpatient beds in many places, along with the development of community support services. For some people, the hospital is the last place they want to go for mental health care; for others, it is the first thing that comes to mind when faced with a crisis. Often, there is a disconnect between what psychiatrists see as the appropriate use of services and what patients and families see as desirable. Financial pressures, in both directions, can play a role; availability of beds, insurance coverage, presence of alternative treatment or residential sites, and community standards all factor in the decision. The relationship with emergency medicine

providers can be a major factor, as EM physicians, physician assistants and nurse practitioners are often the first-line providers of care and are under their own pressures for rapid throughput. In some circumstances, the decision to admit may occur without much psychiatric input. The co-chairs practice in very different settings, one in urban Philadelphia, the other in Kalispell, Montana. They will present a survey of different models of care, focusing on accessing inpatient services; exactly how such decisions are made, and by whom and with what parameters, will be reviewed. Common and disparate practices will be identified. Participants will be encouraged to share their own experience with admission decision making. Multiple case studies will be presented, with participants weighing in on how patients would be managed within their own systems. We look forward to a spirited discussion of what works, what does not, and how systems of care and assessment techniques might be improved.

TRANSCRANIAL MAGNETIC STIMULATION: WHAT YOU NEED TO KNOW

Chairs: Todd Hutton, M.D., Philip G. Janicak, M.D.

Speakers: Kim K. Cress, M.D., Richard A. Bermudes, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the science behind transcranial magnetic stimulation (TMS) including the physics, mechanism of action and how TMS treatment is thought to exert its antidepressant effects; 2) Understand the clinical trial evidence for the efficacy and safety of TMS and where it fits into the treatment algorithm for major depression; 3) Recognize the four FDA-cleared TMS systems that are available to psychiatrists for the treatment of major depressive disorder and how they differ; and 4) Understand the various TMS treatment parameters and how to develop a TMS treatment plan with the understanding of treatment length, tapering and maintenance.

SUMMARY:

Transcranial magnetic stimulation (TMS) is one of the newest and fastest-growing treatment modalities in psychiatry, with four different devices now FDA-cleared for use in major depression, yet few psychiatrists have been trained in or have had direct clinical experience with this treatment. This workshop will provide a fundamental understanding

of TMS technology and the practical knowledge of how to assess when and for whom TMS may be indicated. The workshop will use an interactive format to assist the psychiatrist in analyzing the research supporting the use of TMS. Information will be presented from a variety of sources in order to truly assess where TMS fits in current clinical practice and how to best utilize it as a treatment option. Panelists will address how TMS works, including the physics and mechanism of action of the treatment. We will also examine the current safety and efficacy data from the latest studies. In addition, we will review the four magnet systems that are currently FDA-cleared and compare and contrast the properties of each device. We will describe the patient experience, as well as where TMS fits in the treatment algorithm based on the data from current literature and real-world applications. Finally, the discussion will address issues such as the durability of the effect and the role of maintenance treatment. At the conclusion of the session, practitioners will have gained an insight into both the clinical research and the real-world application of transcranial magnetic stimulation and be able to use this knowledge to address questions on TMS from their patients.

COMORBIDITY IN SCHIZOPHRENIA: BIOLOGICAL PATHOGENESIS AND CLINICAL IMPLICATIONS

Chairs: Michael Hwang, M.D., Henry A. Nasrallah, M.D.

Speaker: Leslie Citrome, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the diagnostic and conceptual issues of comorbidity in schizophrenia; 2) Perform assessment of common comorbid disorders in schizophrenia; 3) Express understanding of multi-faceted bio-psychosocial pathogenesis in schizophrenia; and 4) Formulate treatment approaches in schizophrenia with comorbid disorders.

SUMMARY:

While clinicians have long recognized and treated comorbid disorders in schizophrenia, the diagnostic concept has only recently been fully endorsed, in the *DSM-5*. Consequently, there has been a lack of systematic research to explore its pathogenesis and treatment. A recent FDA position statement noted that "comorbidity in schizophrenia is more the rule than the exception." While the formal endorsement

has encouraged further research, comorbidity in schizophrenia remains poorly understood and often controversial. This is partly due to the limited understanding of the diverse and complex nature of patients' biopsychosocial pathogenesis and the lack of systematic strategy in management approaches. While the currently available pharmacological treatment has been effective in some comorbid disorders, other conditions often remain ambiguous and unremitting. Evidence indicates that this is partly because these treatment-refractory subgroups of schizophrenia possess complex psychosocial pathogeneses that call for comprehensive pharmacopsychobehavioral treatment interventions. This workshop will present the current biological, as well as psychosocial, factors in the subgroup of treatment-refractory schizophrenia and discuss clinical management. The presenters will discuss their clinical and research experience and review the current epidemiologic, clinical and biological perspectives and discuss treatment options. Each of the three speakers will address a different set of comorbidities as follows: Dr. Citrome will examine the biopsychosocial factors in the pathogenesis of impulsive-aggressive behaviors in high-risk patients with schizophrenia. He will review the current evidence for genetic, neurobiological evidence and the psychosocial environmental factors for impulsive-aggressive behavior and suicidal risks in schizophrenia and discuss the treatment implications. Dr. Citrome will review the current neuropsychological factors in the pathogenesis of substance abuse in patients with schizophrenia. He will review the recent advances in biological and psychosocial factors in the pathogenesis of substance abuse and present optimal clinical management in a schizophrenic patient with substance abuse. Dr. Hwang will review the current neurobiological evidence of psychological factors in the pathogenesis of obsessive-compulsive symptoms in schizophrenia and suggest subtyping strategies. He will present pharmacological and psychobehavioral treatment approaches. Finally, Dr. Nasrallah will review the current psychobiological pathogenesis in schizophrenia with comorbid disorders and discuss pharmacobehavioral intervention for optimal outcome.

A CLINICIAN'S GUIDE TO STRUCTURED ASSESSMENT OF PERSONALITY DISORDER AND FUNCTIONING: THE STRUCTURED INTERVIEW OF PERSONALITY ORGANIZATION-R (STIPO-R)

Chair: Eve Caligor, M.D.

Speakers: Barry L. Stern, Ph.D., Emanuele Preti, Ph.D., John M. Oldham, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Employ the STIPO as an assessment tool in the clinical evaluation of patients with personality disorders; 2) Apply the construct of "level of personality organization" to the classification of personality disorders; 3) Demonstrate familiarity with the research base linking STIPO assessment to clinical outcome; and 4) Understand the link between the STIPO classification of personality disorders and the Levels of Personality Functioning Scale (LPFS) in the Alternative Model for Personality Disorders in Section III of the *DSM-5*.

SUMMARY:

Assessment of personality disorders, personality pathology and personality functioning presents many challenges in clinical practice. The Structured Interview of Personality Organization-Revised (STIPO-R) is a semi-structured interview that guides the clinical evaluation of personality disorders, providing a diagnosis that informs treatment planning and predicts clinical course. STIPO assessment focuses on the domains of self and interpersonal functioning, defenses, moral functioning, and quality of aggression. This workshop will provide participants with an introduction to the STIPO interview, demonstrating its use in clinical practice. We will, in addition, present data illustrating the clinical utility of the STIPO and application of STIPO assessment to the *DSM-5* Level of Personality Functioning Scale (LPFS). This interactive workshop will involve participants in discussion of a videotaped STIPO interview and will provide participants with the opportunity to discuss diagnostic challenges encountered in their own clinical work.

STIGMA OF PSYCHIATRY AMONG ETHNIC MINORITIES AND THE USE OF SOCIAL MEDIA AND THE INTERNET TO REACH UNDERSERVED POPULATIONS

Chair: Wilsa M. S. Charles Malveaux, M.D., M.A.

Speakers: Tiffani Bell, M.D., Jeffrey Borenstein, M.D., Chuan-Mei Lee, M.D., M.A., Racquel E. Reid, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explore the demographics of

different ethnic minority populations in the U.S. and the mental health disparities each faces; 2) Identify the major themes ethnic minority groups discuss when addressing mental health, e.g., attitudes toward diagnosis, treatment and media perception; 3) Describe the means various ethnic minority groups use to connect with other minorities about mental illness, stigma and access to mental health; 4) Understand that social media may be an emerging way of exploring the attitudes of ethnic minority populations towards mental health; and 5) Explore ways psychiatrists can use social media and the Internet to change the dialogue about psychiatry amongst ethnic minorities and break barriers.

SUMMARY:

The question of how social media and the Internet permeate daily life and impact the administration of mental health care in the United States has been of particular interest to researchers inside and outside of medicine in recent years. Increasingly over the past decade, more people have largely obtained their information about psychiatry or psychiatric services from the Internet. Social media, or Internet-based applications centered on user-generated shared content, has revolutionized the way people discuss mental illness, and studies have demonstrated how patients with severe mental illness are portrayed as dangerous. Furthermore, the possibility of media as a conduit for psychological trauma, especially after a national tragedy, has generated concern. Of particular interest is the impact on ethnic minorities of stigma toward mental illness. In many ethnic minority communities, while the reasons behind stigma may vary, there is even more pressure from within minority communities not to seek psychiatric care. Research demonstrates that while certain minority groups are at increased risk for mental health disorders due to acculturative stress and trauma, stigma surrounding psychiatric care has been perpetuated by family members, friends and other individuals in the community with whom patients more easily come into contact via social media. While access to the Internet and social media has grown, there has been little research on the ways individuals with mental illness use social media, nor have there been sufficient studies on how psychiatrists can incorporate these technologies in the education and treatment of their patients and others in need. This workshop first identifies the access of minorities to various forms of social media, how they tend to discuss mental health through these outlets and the common themes regarding

psychiatry and mental illness. It also seeks to identify the stigmas to pursuing mental health perceived by different ethnic minorities and how these views may vary based upon the type of platform used, e.g., Facebook, Tumblr, LinkedIn, MSN Messenger and Twitter. Presenters will draw on cross-disciplinary examples from other areas of study, including sociological, epidemiological, marketing and communications, and will integrate information on how other health professionals use these tools. The workshop will conclude with an educated discussion on specific ways that psychiatrists can effectively use social media and the Internet as a whole to change the dialogue about psychiatry amongst minorities and break down barriers to mental health care.

BEYOND GOOGLING: PSYCHIATRIC MONITORING OF PATIENTS' ELECTRONIC COMMUNICATION

Chair: Paul S. Appelbaum, M.D.

Speaker: Carl Fisher

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand psychiatrists' current attitudes and beliefs about the use of patient-targeted web searches and other forms of Internet-based information gathering in clinical practice; 2) Identify new and potential methods that clinicians might use to monitor and review online patient information; and 3) Discuss the ethical, legal and social implications of these activities.

SUMMARY:

Survey data indicate that a significant number of mental health clinicians regularly search for information about their patients online. However, "Googling" one's patients is only the tip of the iceberg in terms of how psychiatrists might obtain information about their patients from online sources. Social media activity, such as posts on Facebook, Twitter or Instagram, can provide a window into patients' mental state or even reveal risky activity such as self-harm or suicidal statements. Information about "metadata," such as the pattern of online activity, might also have a use; for example, information about the times and frequency of postings (without revealing the actual content of posts) could indicate mania. In some cases, limited review of email activity might even be useful. But there have been almost no discussions about the possibility of psychiatrists obtaining information from this variety of online sources, and in light of the rapid development of technology and

the pervasiveness of such technology in modern life, there is an urgent need to further explore the goals for, advantages of, and risks inherent in such clinical activity. This workshop will address a number of ethical and legal topics relevant to obtaining information about patients from online sources, including patient-targeted Googling; review of patients' activities on social media (Facebook, Twitter, Instagram, etc) or email; dimensions of patient consent: requested by patient vs consensual vs without permission; parallels and differences with traditional uses of collateral information; and special populations (e.g., patients under correctional supervision, minors). The discussion will be focused on the fundamental question of whether there might be some role for consensual tracking of patients' presence online; if so, with what goals, and what might the challenges and risks be? The speakers will present background information and illustrate potential uses of technology and will engage the audience in discussions of hypothetical scenarios that explore the ethics of such practices.

ARE YOU A SITTING DUCK ONLINE? WHAT YOU CAN (AND CAN'T, OR SHOULDN'T) DO TO AVOID, AND TO RESPOND TO, NEGATIVE REVIEWS BY PATIENTS

Chair: Robert Hsiung, M.D.

Speakers: Samantha Adams, Ph.D., Paul S. Appelbaum, M.D., Robert Hsiung, M.D., Laura Roberts, M.D., M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List three websites at which a patient can post a review of a psychiatrist; 2) Give three examples of ethical ways in which a psychiatrist may be able to improve patient satisfaction; and 3) Give one example of a response to a negative review that is likely to be constructive and one example of one that is not likely to be constructive.

SUMMARY:

Online reviews by your patients may affect the vitality of your practice. Review sites enable your prospective patients to take into account the opinions of your current (and past) patients when choosing a psychiatrist. Are you prepared for a negative review? Do you feel anxious? Have you already received a negative review? Do you feel angry? A negative review may be a symptom of trouble in the doctor-patient relationship. By attending to the therapeutic alliance, negative

reviews may be able to be avoided. Once posted, negative reviews may be responded to in ethical (and other) ways. In this workshop, we start by visiting representative review sites. In small groups, participants learn experientially about being attuned and responding to signs of trouble in the doctor-patient relationship. We discuss the ethics of patient satisfaction. What may psychiatrists do—and what ought they not do—to satisfy patients? We conclude with speculation about future directions and discussion.

PSYCHIATRISTS WHO HAVE SURVIVED THE SUICIDE DEATH OF A LOVED ONE: THEIR INSIGHTS

Chair: Michael F. Myers, M.D.

Speakers: Anna Halperin Rosen, M.D., Akshay Lohitsa, M.D., Karen K. Miday, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Become familiar with how the suicide death of a loved one affects individuals, including psychiatrists; 2) Know what bereaved psychiatrists can teach us about this very unique loss; and 3) Learn how we can help grieving psychiatrists when they consult us.

SUMMARY:

According to the Centers for Disease Control and Prevention, there were 41,149 deaths by suicide in the United States in 2013 (the most recent year for which we have data). Recent research-based estimates suggest that for each death by suicide, 115 people are "exposed," and among those, 25 experience a major life disruption. For some survivors, losing a loved member of one's family while growing up may inform their decision to study medicine and perhaps psychiatry. But others may not become a survivor until they are already studying or practicing psychiatry. This workshop is an extension of two previous, well-attended workshops presented at the 2013 and 2015 Annual Meetings. Three psychiatrists who have been bereaved by the suicide death of a family member will enlighten us with their personal and courageous stories. This will include the myriad ways in which their loss has informed their work. Dr. Akshay Lohitsa lost his brother to suicide during his first year of residency. He will use media and anecdotes to illustrate the way illness and suicide impact and change families. Dr. Anna Halperin Rosen lost her brother, Anthony Halperin, a fourth-year medical student, to suicide while she was a second-year resident. Dr. Rosen will

discuss her brother's death and its impact on her development as a psychiatrist. Dr. Karen Miday will discuss the challenge of reconciling the Hippocratic Oath ("First, do no harm") with her physician son's death by suicide in June 2012. She will also talk about the very troubling, and often unspoken, element of shame (especially when substance use is a contributing factor) and the possible diagnosis of "acute suicidal affective disorder" (Joiner). Audience members are invited to engage with the speakers in their quest to understand this very difficult and painful loss.

THE BIOPSYCHOSOCIAL REVOLUTION: ASSESSING PATIENTS IN PSYCHIATRY USING THE DSM-5 CULTURAL FORMULATION INTERVIEW

Chairs: Michael Hann, M.D., M.S., Misty Richards, M.D., M.S.

Speakers: Nina Vasan, M.D., Jeremy D. Kidd, M.D., M.P.H., Ravi DeSilva, M.D., M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the impact of culture on the practice of psychiatry; 2) Learn the basics of the DSM-5 cultural formulation interview; 3) Identify and appreciate culture beyond typically categorized ethnicities, including LGBT, military, etc.; and 4) Encourage the use of a cultural assessment as standard practice during the psychiatric interview.

SUMMARY:

As technological advances lead to an ever-increasingly interconnected and globalized society, the treatment of mental illness and preservation of mental health has become an international and cross-cultural practice. The phenomenology of mental illness, therapeutic alliance between physician and patient and benefits of treatment are profoundly affected by various cultural aspects. Recognizing that new approaches are necessary to treat an increasingly diverse population and that cultural considerations apply to all patients, the DSM-5 includes the Cultural Formulation Interview (CFI). The CFI is a set of questions designed to integrate culture into mental health treatment in order to optimize patient outcomes. It also operates from the viewpoint that culture is multidimensional, individualized and applicable to any clinical encounter regardless of the demographic characteristics of the patient or the clinical setting. The goals of this workshop will be to increase awareness of the impact of culture on the practice of

psychiatry and to describe current research in cross-cultural psychiatry. Culture will be defined from an anthropologic perspective, with an emphasis on aspects of culture beyond race, ethnicity and other traditional demographic categories. Psychiatric leaders involved in the creation of the CFI in the DSM-5 will discuss its development, utility and implementation in regular clinical practice. We have invited Dr. Roberto Lewis-Fernandez and Dr. Neil Aggarwal from the DSM-5 Cross-Cultural Issues Subgroup to participate in this discussion. The DSM-5 CFI will then be presented by APA psychiatric leadership fellows in an interactive fashion to promote its incorporation into regular clinical practice by psychiatrists at any level of training or specialization. This will be followed by live feedback from peers and experts. Finally, participants will be given a summary handout of high-yield "pearls" collected from cultural psychiatry experts.

STANDING UP TO VIOLENCE IN POLICE ENCOUNTERS: THE PLAYERS, THE VICTIMS, THE TRAUMA AND THE SOLUTIONS

Chairs: Elie Aoun, M.D., Racquel E. Reid, M.D.

Speakers: Sandra C. Walker, M.D., Amanda Ruiz, M.D., Jessica Moore, M.D., Matthew L. Dominguez, M.D., M.P.H., Jared K. Taylor, M.D., Lama Bazzi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the recent increase in cases of police violence against unarmed individuals of color and sexual minorities; 2) Recognize the strengths and the weaknesses of Crisis Intervention Training (CIT) as it stands today and identify areas for improving police officer training in dealing with mental illness; 3) Identify the role of mental health professionals in assisting law enforcement officials in recognizing manifestations of mental illness and give officers tools to avoid the use of violence if possible; 4) Understand treatment programs for persons subjected to complex trauma in the context of police-community interactions; and 5) Describe the mental health needs of law enforcement officers as frequent experiencers of trauma.

SUMMARY:

Over the past several years, media attention has highlighted an increase in police violence targeting unarmed individuals of color and sexual minorities, often resulting in violent or fatal outcomes. Multiple reports by the Department of Justice highlight a disproportionate use of force by police officers

toward members of marginalized communities. Many of the alleged suspects were later identified as suffering from a psychiatric illness. Rash stigmatization of people living in urban, inner city areas, coupled with misinterpretation of actions of people who may very well be mentally ill, are some of the proposed explanations for the rise in violent encounters with police. With each of these incidents, the public trust in law enforcement becomes harder to sustain. Reducing the number of deadly use of force incidents among mentally ill individuals must involve the alliance of law enforcement and mental health professionals. Police are increasingly becoming first responders to individuals experiencing behavioral health crises. Traditionally, police encounters with individuals in crisis often escalate to potentially dangerous situations. Knowledge of mental illness is essential to protect the welfare of both the individual as well as the police officer. With jails and prisons increasingly becoming de-facto mental institutions, diverting people from jails to community based mental health services becomes the role of police officers who interact with them first. To date, 46 states have adopted the crisis intervention training (CIT) program to prepare law enforcement officers to manage calls involving the mentally ill. However, such training remains unavailable to most officers. Mental health professionals should be tasked with aiding officers in recognizing signs of mental illness in individuals and helping them learn and utilize de-escalating techniques to prevent the use of violence. Part of addressing flaws in the current system is having a plan to identify victims of violence and connect them to evidence-based services to address trauma. Survivors of violence can often be hard to reach and are embedded within communities where admitting vulnerability or trauma is seen as a sign of weakness. Employing culturally conscious techniques to identify the victims and connect them with resources they find acceptable and useful is tantamount to having a substantial positive impact on the survivors and the communities in which they live. In parallel, police officers themselves deal with traumatic experiences, either directly or indirectly through their colleagues, on an almost daily basis. Screening and treating law enforcement officials for trauma involves special considerations (such as the effect of medication choices on alertness and reaction time, confidentiality, etc.), as the culture of policing does not encourage them to react emotionally to trauma, as strength is equated with stoicism.

A YEAR AFTER WINNING MARRIAGE: THE IMPACT OF OBERGEFELL V. HODGES ON LGBT MENTAL HEALTH

Chair: Robert M. Kertzner, M.D.

Speakers: Stewart L. Adelson, M.D., Mary Barber, M.D., Marshall Forstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the mental health impact of marriage discrimination and its relief addressed by the U.S. Supreme Court in *Obergefell v. Hodges*; 2) Incorporate into psychotherapy with LGBT patients an awareness of evolving norms and a range of opinions about the desirability of marriage; and 3) Identify the impact of this decision on other forms of sexual orientation and gender identity discrimination and related mental health burdens.

SUMMARY:

As we approach the first anniversary of the U.S. Supreme Court decision (*Obergefell v. Hodges*) that upheld a constitutional right to marriage for same-sex couples, mental health professionals can more fully assess the impact of this historic ruling. This workshop will explore clinicians' observations of how the Court's decision affected patients' well-being and will consider ongoing needs for scholarly study of the effects of marriage on LGBT mental health. Issues to be discussed include the relevance of mental health research and advocacy to the Court's ruling, attitudes toward civil marriage among same-sex couples, whether a new stigmatization of being single is occurring among LGBT persons, whether mental health differences between married and never-married adults observed in the general population will be applicable to LGBT persons, the effect of marriage equality on trans people and trans acceptance, and how—or if—this decision affects other forms of discrimination and mental health burden experienced by LGBT persons and their children.

APA COUNCIL ON PSYCHIATRY AND THE LAW: UPDATE

Chair: Steven Hoge, M.D., M.B.A.

Speakers: Richard J. Bonnie, J.D., Marvin S. Swartz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the emerging

issues in proposed legislation regarding physician assistance in dying, such as assessment of competence, identification of unrecognized depression and ethical issues; 2) Understand how federal law affects the entry of individuals into the United States, including the process of entry application, exceptions and the exclusion of individuals based on diagnoses and risk; 3) Understand legal developments in case law regarding the federal parity legislation and its significance for providing psychiatric care; 4) Understand issues related to the transfer of juveniles to the adult criminal justice system and the APA's proposed position statement; and 5) Understand the process by which the Council on Psychiatry and the Law functions within the APA and the development and approval of resource documents and position statements.

SUMMARY:

This workshop will provide members with an overview of the process by which the Council on Psychiatry and Law develops APA policy documents such as position statements and resource documents. The goal of the workshop is to provide members with an update on recent and ongoing issues that the Council is addressing. This workshop will provide participants with an opportunity to provide feedback to the Council regarding a range of important areas. Dr. Hoge will provide an overview of the process. He will also discuss recent developments related to barring individuals with mental disorders from entering the United States. Dr. Swartz will discuss developments in parity litigation as it relates to psychiatric patients' access to care. Professor Bonnie will discuss a proposed position statement on the transfer of juveniles into adult courts for prosecution. We will also discuss emerging legislation on physician assistance with dying and the role of psychiatrists. In each area, the Council will elicit feedback from members regarding the important policy issues. These topic areas may be changed if more important issues arise prior to the Annual Meeting.

THE ART OF THE CURBSIDE CONSULTATION: NICELY DONE

Chair: Lori Raney, M.D.

Speakers: Erik Vanderlip, M.D., M.P.H., Anna Ratzliff, M.D., Ph.D., John Kern, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the major components of the curbside consultation and how the mnemonic Nicely DONE can serve as a reminder for the process; 2) Develop skills to perform a variety of consultations with paired audience members to appreciate the variety of consultation types; and 3) Appreciate the limits of curbside consultation and how to manage difficult consultations.

SUMMARY:

The "curbside" or informal/indirect consultation is a vital part of the psychiatrist's work within the collaborative care model. Working behind the scenes to support the primary care-based team allows immediate implementation of provided suggestions and can help extend psychiatric expertise by educating and subsequently building the capacity of the primary care team to more effectively treat mild to moderate mental illness in this setting. The basic components of an effective curbside consultation include several factors that require understanding and practice to become proficient. This workshop will describe those core functions using the mnemonic Nicely DONE to demonstrate the various aspects: Nicely to remind us of the need to build trust and rapport through our interpersonal connection, D for clarifying the diagnosis, O for offering suggestions, N for providing next steps and E for the educational component of the consultation. After a 30-minute introduction to the mnemonic, the audience will work in triplets to rehearse several consultation scenarios with an observer to see if the five core elements are covered and offer feedback.

DEVELOPING AND RUNNING A SUCCESSFUL RESEARCH TRACK FOR PSYCHIATRY RESIDENTS

Chair: Katharine A. Phillips, M.D.

Speakers: Melissa Arbuckle, M.D., Ph.D., Jane L. Eisen, M.D., Kathryn K. Ridout, M.D., Ph.D., Samuel J. Ridout, M.D., Ph.D., Louisa J. Steinberg, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss key elements of conceptualizing and developing a research track for psychiatry residents; 2) Understand key elements of implementing and running a successful research track, including how to integrate the research track with residency training requirements; and 3) Understand issues related to research training during residency from a resident's perspective.

SUMMARY:

Our field is facing a critical shortage of physician-scientists. Providing residents with intensive research training during their residency—a critical point in their careers—has the potential to increase the number and preparedness of psychiatrists who conduct innovative research in translational, clinical or basic areas. This workshop will address key aspects of conceptualizing and developing a research track as well as how to successfully implement and run a research track. Drs. Phillips, Arbuckle and Eisen will first discuss key aspects of developing and implementing a research track during residency. They have extensive experience as leaders of the resident research tracks at Brown University and Columbia University, both funded by an R25 grant from the National Institute of Mental Health. The three residents, who are participating in Brown University's or Columbia University's R25-funded research track, will provide residents' perspectives. The format will be highly interactive, with substantial time for discussion, as well as questions and answers, between panelists and the audience. The discussion will include challenges of running a research track and solutions. Through this workshop, we aim to offer useful consultation to residency training programs that are interested in developing a research track or currently offer such a track.

RISK MANAGEMENT CONSIDERATIONS WHEN PRESCRIBING CONTROLLED SUBSTANCES

Chair: Kristen M. Lambert, J.D., M.S.W.

Speaker: Moira Wertheimer, J.D., B.S.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Increase awareness of federal and state prescribing regulations and drug diversion programs; 2) Examine the role that prescription drug monitoring programs play when prescribing and identify risk reduction strategies; and 3) Explore the role of telemedicine when prescribing.

SUMMARY:

Death rates from drug overdoses have been steadily rising and now represent the number one cause of death in the United States, surpassing motor vehicle accidents. As a result, there is a national public health initiative to curtail drug deaths and prevent drug diversion through the use of tougher laws and penalties for improper prescribing practices and the implementation of prescription drug monitoring programs in virtually every state. These initiatives,

designed to safeguard the public health and safety while supporting the legitimate use of controlled substances, often results in psychiatrists interacting more frequently with pharmacies, law enforcement and regulatory agencies. This 1.5-hour workshop provided by risk management from the APA-endorsed professional liability program will define some of the risk management and liability exposures that psychiatrists must be aware of when prescribing controlled substances and will explore case examples to further illustrate potential liability exposures faced by psychiatrists when prescribing controlled substances to their patients. Risk mitigation strategies will be presented to help lessen the identified liability exposures.

TREATMENT IN THE IMMEDIATE AFTERMATH OF TRAUMA: FROM THE HOSPITAL TO THE BATTLEFIELD

Chair: Judith Cukor, Ph.D.

Speakers: John W. Barnhill, M.D., Judith Cukor, Ph.D., David A. Nissan, M.D., Amy B. Adler, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the unique challenges and considerations of treatment in the immediate aftermath of trauma; 2) Demonstrate understanding of the unique role of the consultation liaison team in treating physically injured patients following a traumatic event; 3) Identify nonpharmacological interventions employed in the days following a traumatic event; and 4) Exhibit knowledge regarding past and current military practices for acute trauma.

SUMMARY:

Recent emphasis has been placed on providing an evidence base for treatment in the immediate aftermath of trauma, highlighting the paucity of established or recommended practices in the days following a traumatic event. This is especially striking in light of the abundance of research devoted to treatment of post-traumatic stress disorder once it has been diagnosed. Current research also highlights differences in approaches and philosophies regarding intervention in the immediate timeframe following a trauma. This interactive workshop aims to create a dialogue regarding actual practices employed by providers who work on the front lines with trauma patients. Presenters are clinicians and researchers who will describe practices in hospital and military settings. Presentations include the role

of consultation liaison psychiatry in the treatment of patients presenting in the hospital in the immediate aftermath of trauma and a description of psychotherapeutic techniques employed in the intensive care unit in the days following significant burn injury. An overview of military practices for service members in the immediate aftermath of trauma will be provided, and current leadership practices used to prevent post-traumatic stress in the military will be discussed. This interactive session will devote significant time to the facilitation of a conversation with the audience, eliciting perspectives on intervention in the immediate aftermath of trauma.

FEELING BURNED OUT? USING SCIENCE AND WISDOM OF CONTEMPLATIVE PRACTICES TO MANAGE YOUR STRESS AND REDUCE BURNOUT

Chair: Sermsak Lolak, M.D.

Speaker: Sermsak Lolak, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the issue and impact of physician burnout and compassion fatigue; 2) Understand the concepts and techniques of mindfulness practice and compassion cultivation and how these practices can help with the issues of physician burnout and compassion fatigue; and 3) Apply the knowledge and skills from this workshop into real life, both in and outside of work.

SUMMARY:

Physician wellness, compassion fatigue and burnout are among the top challenges affecting physicians, regardless of level of training or practice setting. These issues are now more important than ever given growing distractions, responsibilities and demands both from professional and family areas. Up to one-third of physicians are affected by burnout, which has negative impacts on health, well-being, job satisfaction and productivity, in addition to patient care. Although there have been efforts to promote humanism, empathy and communication training in medicine, it is notable that little attention is paid to formally teaching physicians to cultivate mindfulness and compassion, qualities so central to our profession's identity. Compassion training likely works by promoting functional brain plasticity and affects brain regions responsible for empathy, emotions and executive function. Of particular relevance to medicine is that deliberate compassion training offers a new coping strategy that fosters a

positive affect even when one is confronted with the distress of others, a potential antidote to burnout. This interactive workshop will explore concepts and tools to help decrease burnout and promote compassion with emphasis on scientifically tested contemplative practices informed by wisdom traditions, such as mindfulness and compassion cultivation techniques, although these can be used regardless of practitioners' religious orientation. The first part of the workshop will offer a summary of the literature regarding issues of burnout, empathy and compassion fatigue and its impact, as well as neuroscientific evidence of contemplative practices in reducing burnout and promoting compassion. During the second part of workshop, we will focus on the utility of contemplative practices focusing on mindfulness, compassion and self-compassion techniques as an antidote to burnout. In addition to audience polls, QandA, and individual and small group exercises, there will be an experiential component of guided meditation using mindfulness and compassion cultivation techniques, followed by suggestions of adapting these concepts and practices to everyday life. The presenter, Dr. Lolak is a certified teacher for the compassion cultivation training course (CCT) developed and taught by the Stanford University Center of Compassion and Altruism Research and Education (CCARE). Dr. Lolak is a psychiatrist/psycho-oncologist with special interests in issues of clinician burnout and contemplative practices.

WHAT A PAIN! HOW PILLS, TALKING AND MARIJUANA MAY HELP YOUR PATIENTS WITH CHRONIC PAIN

Chair: Wendy Baer, M.D.

Speakers: Kim Curseen, M.D., Shweta Kapoor, Ph.D., M.B.B.S., Ann Schwartz, M.D., Martha C. Ward, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the role for psychiatry in evaluation and management of opiates for patients with chronic pain; 2) Discuss psychotherapeutic modalities and interventions for patients with pain; 3) Review psychotropic medications used in the treatment of chronic pain and the evidence for their use; 4) Detail the curriculum necessary in resident education to prepare psychiatrists for treating patients with chronic pain; and 5) Understand the potential therapeutic use of marijuana oil in treating pain as well as the legal issues involved in prescribing the oil.

SUMMARY:

Approximately 76 million Americans suffer from chronic pain, accounting for 20% of outpatient visits and 12% of all prescriptions written. Eighty percent of chronic pain patients report that pain disrupts their activities of daily living, and two-thirds indicate that pain has negatively impacted personal relationships. Unsurprisingly, chronic pain also impacts emotional well-being and is closely tied to depression, with higher rates of depression in pain cohorts and pain in depression cohorts than when these diagnoses are examined individually. Given their understanding of psychotropic medications and emotional distress, psychiatrists are uniquely qualified to assist both medical colleagues and patients themselves in the treatment of various pain syndromes. First, our workshop will address the role of psychiatry in prescribing opiates to patients with chronic pain. While many psychiatrists are comfortable with detoxing patients from opiates and managing substance use disorders, many defer opiate prescribing to other medical colleagues. Dr. Wendy Baer will present a case of a patient with chronic cancer pain who needed a holistic approach to management of opiates, antidepressants and hypnotics in the setting of significant relationship stress. Dr. Baer will discuss the benefits of psychiatry managing opiates and will discuss rational prescribing, including the latest evidence on opiate misuse and how to best protect the patient and the physician in the prescription process. Dr. Shweta Kapoor will discuss an evidence-based cognitive behavioral group therapy for chronic pain, including adaptation of the curriculum to individuals with severe and persistent mental illness. Dr. Kapoor will emphasize elements of the curriculum that can be applied during medication management appointments or when meeting with an individual in the inpatient medical setting. Dr. Martha Ward will provide updates in prescribing psychotropic medication to treat pain, including the use of antidepressants and anticonvulsants/mood stabilizers. Dr. Ward will discuss various indications for the use of these medications, with an emphasis on neuropathic and functional pain disorders. Dr. Ann Schwartz will review the current state of the curriculum for psychiatry residents and psychosomatic fellows for management of pain. Recommendations have been made that general psychiatrists should have training and experience in treating pain. The complexities in having a psychiatrist coordinate or take the lead in pain

management will be discussed. The workshop will conclude with a presentation on the therapeutic value of marijuana oil by Dr. Kim Curseen from Emory Supportive Oncology and Palliative Care. Dr. Curseen will discuss the state of the evidence for marijuana as well as the legal and practical challenges in prescribing marijuana.

DYNAMIC THERAPY WITH SELF-DESTRUCTIVE BORDERLINE PATIENTS: AN ALLIANCE-BASED INTERVENTION FOR SUICIDE

Chairs: Eric M. Plakun, M.D., Samar Habl, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Utilize principles of an alliance-based intervention for suicide as part of psychodynamic therapy of self-destructive borderline patients; 2) Understand the symptom of suicide in borderline patients as an event with interpersonal meaning and as an aspect of negative transference; and 3) Understand common factors in treating self-destructive borderline patients derived by an expert consensus panel study of behavioral and dynamic psychotherapies.

SUMMARY:

Psychotherapy with suicidal and self-destructive borderline patients is recognized as a formidable clinical challenge. Several manualized behavioral and psychodynamic therapies have been found efficacious in treatment, but few clinicians achieve mastery of even one of the manualized therapies. This workshop includes review of nine practical principles helpful in establishing and maintaining a therapeutic alliance in the psychodynamic psychotherapy of self-destructive borderline patients. The approach is organized around engaging the patient's negative transference as an element of suicidal and self-destructive behavior. The principles are 1) Differentiate therapy from consultation; 2) Differentiate lethal from non-lethal self-destructive behavior; 3) Include the patient's responsibility to stay alive as part of the therapeutic alliance; 4) Contain and metabolize the countertransference; 5) Engage affect; 6) Nonpunitively interpret the patient's aggression in considering ending the therapy through suicide; 7) Hold the patient responsible for preservation of the therapy; 8) Search for the perceived injury from the therapist that may have precipitated the self-destructive behavior; and 9) Provide an opportunity for repair. These principles are noted to be congruent with six

common factors developed by an expert consensus panel review of behavioral and psychodynamic treatment approaches to suicidal patients with borderline personality disorder. After the presentation, the remaining time will be used for an interactive discussion of case material. Although the workshop organizer will offer cases to initiate discussion, workshop participants will be encouraged to offer case examples from their own practices. The result should be a highly interactive opportunity to discuss this challenging and important clinical problem.

SOCIAL WITHDRAWAL IN MODERN SOCIETY: AN EMERGING CULTURAL CONCEPT OF DISTRESS IN EAST ASIA

Chairs: Takahiro A. Kato, M.D., Ph.D., Alan R. Teo, M.D., M.S.

Speakers: Takahiro A. Kato, M.D., Ph.D., Alan R. Teo, M.D., M.S., Francis Lu, M.D., Shigenobu Kanba, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the multidimensional concept of Japan's hikikomori; 2) List the epidemiologic and clinical features of hikikomori based on empirical international research; 3) Discuss the relationship between hikikomori and contemporary features of culture and society; and 4) Discuss the diagnostic issue of hikikomori and related behavioral abnormalities.

SUMMARY:

Though social isolation has deep roots in many countries, clinical descriptions of social withdrawal in Japan only date to the 1970s. The term "hikikomori" only emerged into prominence in the 1990s as a way to describe this modern form of severe social withdrawal, and since then, hikikomori has been described elsewhere, particularly in other parts of East Asia. We will introduce hikikomori through the language of cultural concepts in the *DSM-5*, examining it as both an idiom of distress and a cultural syndrome. We will describe operationalized research criteria for hikikomori, focusing on dimensions of spending time alone at home, avoidance of social situations and relationships, associated distress or impairment, and duration of symptoms. We will also describe epidemiologic studies on the lifetime prevalence of hikikomori and review the typical clinical course for hikikomori, including treatment, comorbidities and prognosis. In

this workshop, Dr. Kato will introduce the concept of Japan's hikikomori and show some clinical data from his clinical research center. Dr. Teo will describe epidemiologic and clinical data gathered from international settings, particularly East Asia. Prof. Lu and Prof. Kanba will discuss the hikikomori phenomenon based on contemporary perspectives on cultural formulation and cultural psychiatry. Finally, we will welcome discussion with the audience for about 30 minutes.

THE MANAGEMENT OF ACUTE AGITATION ON MEDICAL UNITS AND IN THE INTENSIVE CARE UNIT

Chair: Michael S. Peroski, D.O.

Speakers: Ellen K. R. Breen, M.D., Anique Forrester, M.D., Bhinna Pearl Park, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the evaluation, treatment and diagnostic workup of the acutely agitated patient; 2) Consider the various pharmacological treatment options in the management of acute agitation in both medical units and intensive care units; 3) Consider the various nonpharmacological treatment options for agitated patients in medical units and in intensive care units; 4) Select pharmacological agents to manage agitation based on the unique medical presentation of each patient; and 5) Participate in case-based discussions about managing agitation in these settings.

SUMMARY:

Acutely agitated inpatient medical and intensive care unit patients, if not managed safely, can pose significant risks to patients and to staff. Nonpharmacological and pharmacological treatment options for managing acute agitation will be discussed during this workshop, in particular, the selection of pharmacological agents to treat agitation in medically complex patients. The current state of evidence for the pharmacological management of acute agitation will be discussed. After management of acute agitation that can put patients and staff at risk of harm, it is essential to establish a plausible origin for this agitation and to address underlying medical disorders. We will specifically discuss managing acute agitation with antipsychotics, benzodiazepines, analgesics and novel pharmacological approaches and will specifically discuss management of agitation in the cardiac patient, the patient with delirium and the

patient with possible intoxication. This workshop will, therefore, also focus on the diagnostic workup of the acutely agitated patient. These ideas will be further illustrated through group discussion of select cases.

THE APA: AN NGO OF THE UNITED NATIONS

Chair: Vivian Pender, M.D.

Speaker: Andriy Yur'yev, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the structure of the UN system; 2) List several UN agencies and their functions; and 3) Name the activities that are open to the APA at the UN.

SUMMARY:

In 2014, the American Psychiatric Association (APA) became accredited as a nongovernmental organization (NGO) of the United Nations Economic and Social Council with special consultative status. The APA appointed four member psychiatrists to be Special Advisers to the APA on the UN. The UN is a tripartite system composed of NGOs, member states and UN agencies. NGOs represent and advocate for civil society with the United Nations Secretariat, programs, funds and agencies in consultation with member states. NGOs contribute to a number of activities including information dissemination, awareness raising, education, policy advocacy, joint operational projects, and participation in intergovernmental processes and in the contribution of services and technical expertise. Examples of each of these activities will be presented to demonstrate how psychiatrists can work with the UN. The workshop format will be used to collaborate on future activities with the UN.

PROMOTING OVERALL WELLNESS AND ELIMINATING RISK OF BURNOUT IN TRAINEES (POWER BIT)

Chairs: Deepak Prabhakar, M.D., M.P.H., Cindy Devassy, M.D.

Speaker: Theresa Toledo

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify symptoms of burnout; 2) Identify common factors leading to physician burnout; 3) Promote wellness-oriented strategies; and 4) Become familiar with available resources.

SUMMARY:

Burnout during residency training is a well-known factor potentially inhibiting the professional growth of trainees and exposing them as well as patients to poor outcomes. A composite of work-related exhaustion, detachment and sense of stagnation, burnout has been identified as one of the leading factors associated with physician distress, depression and medical errors. This workshop will be divided into three segments. In the first segment, we will present an overview of physician burnout, associated poor outcomes, a five-factor model contributing to physician burnout and a group exercise designed to create awareness of individual susceptibilities. In the second segment, we will demonstrate common stressful scenarios during residency, present strategies to reduce stress and return to the group exercise to integrate these concepts. In the third segment, we will explore an illustrative example of a mindfulness-based stress reduction strategy, highlight and address common burnout and stress-related cognitive errors, and conclude with a comprehensive list of resources for individuals seeking further assistance.

WRITING A SCHOLARLY ARTICLE: THE AMERICAN JOURNAL OF PSYCHIATRY RESIDENTS' JOURNAL WORKSHOP

Chairs: Rajiv Radhakrishnan, M.D., M.B.B.S., Robert Freedman, M.D.

Speakers: Hun Millard, M.D., Katherine Pier, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify key aspects of writing a scholarly article; 2) Identify common errors in academic writing; and 3) Identify writing opportunities for psychiatric trainees with the *AJP Residents' Journal*.

SUMMARY:

Psychiatric trainees seldom receive formal training on how to write scholarly articles for an academic/scientific journal. They are, however, expected to be able to review scientific literature in an objective manner and acquire the skills required to disseminate scholarly information to their peers. This, therefore, represents a gap in training. *The American Journal of Psychiatry Residents' Journal (AJP Residents' Journal)* offers psychiatric residents and fellows a unique opportunity to be involved in writing, reviewing and editing scholarly articles. As part of this workshop, psychiatric trainees will have

the opportunity to familiarize themselves with guidelines on how to write a scholarly article with a focus on writing in a clear, concise and accurate manner. The workshop will provide examples to help participants identify common errors in writing and offer tips on how to avoid these errors. Participants will also learn about ways in which they can get involved in the *AJP Residents' Journal* and further strengthen their academic writing, reviewing and editing skills.

**NEW DIRECTIONS IN CBT FOR PSYCHOSIS (CBTP):
CBTP IN BUSY CLINICS USING A GUIDED SELF-HELP
APPROACH**

Chair: Farooq Naeem, Ph.D., M.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Have some understanding of the theoretical assumptions underlying traditional cognitive behavioral therapy for psychosis; 2) Become aware of the current focus on stepped care in CBT for psychosis; and 3) Use CBT for psychosis in a clinical setting using guided self-help material.

SUMMARY:

Cognitive behavioral therapy (CBT) for psychosis (CBTp) is now recognized as an effective intervention for schizophrenia in clinical guidelines in most developed countries. CBTp has been tried in a variety of formats and for both individual symptoms as well as for the syndrome of schizophrenia. CBTp has also been tried in a brief format. In spite of these impressive developments, availability of CBTp remains limited. One way to overcome this might be to develop CBT-based guided self-help for psychosis. Self-help programs have been used effectively in the management of psychosis and for the nonpsychotic disorders. There is currently an emphasis on providing CBTp using a stepped care approach. More recently, the Improving Access to Psychological Therapies (IAPT) services in the U.K. are focusing on delivery of low-intensity CBT for psychosis. In this workshop, we will familiarize the participants with the basic theory of CBTp and take them through the practical application of CBTp-based guided self-help material for patients with psychosis. This guided self-help material can be delivered in about 15 to 20 minutes over six to 10 sessions. The guided self-help was found to be effective in a small pilot study. The course will be focused on using the self-help material with experiential exercises and connecting their theoretical basis to direct clinical work. Case

discussion and experiential exercises will be used to facilitate learning. The workshop will be of direct clinical relevance for clinicians who might be unable to use CBTp due to time or other resource issues and will inspire new ways to conceptualize and approach common clinical problems that can be integrated into practice.

**TRANSFORMATION IN NEW YORK STATE: WILL
TOWN AND GOWN REALLY PARTNER? THE DSRIP
EXPERIENCE OF THE BEHAVIORAL HEALTH TEAM AT
NYPH**

Chair: Dianna Dragatsi, M.D.

Speakers: Mary Hanrahan, L.C.S.W., Daniel L Lowy, L.C.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the definition and goals of the Delivery System Reform Incentive Payment (DSRIP) Program and how it could impact behavioral health services in New York State; 2) Understand how a hospital (New York Presbyterian) transformed its behavioral health services to meet DSRIP goals and better partner with community providers and the obstacles to this transformation; 3) Understand how a community agency (Argus) transformed its services to better partner with its local hospital and the current obstacles to this transformation; and 4) Understand how an agency (Washington County Mental Health in Vermont) effectively created community and hospital partnerships.

SUMMARY:

New York State has embarked on a mission to transform delivery of health services through Delivery System Reform Incentive Payment (DSRIP) Program funding. The ultimate DSRIP goal is to reduce hospitalization rates through system transformation, clinical management and population health. The Behavioral Health Team at our hospital, New York Presbyterian, has embraced this mission and has created three projects: primary care integration in mental health clinics, an emergency room triage team and a critical time intervention-like team. The projects aim to improve the overall health of our local population and target treatment for the highest utilizers of emergency and hospital services. In order to achieve this, we have had to develop new partnerships with our community providers. In this workshop, we will describe our projects, the process of our transformation and partnership with

community providers, the obstacles we encountered, and some solutions. In order to highlight this transformation, we will invite a community substance abuse provider, Argus, to describe their experience of partnership with our hospital. We will also invite the Executive Director of Washington County Mental Health in Vermont, Mary Moulton, to present how she successfully created community partnerships and served as a model for our hospital.

THE CIVILIAN SOLDIERS: EXPANDING OUR APPROACH TO MENTAL HEALTH FOR OUR ONE MILLION MILITARY RESERVISTS AND GUARDSMEN

Chair: Philip Michael Yam, M.D.

Speakers: Rita R. Richardson, M.D., Christine A. Winter, D.O., M.B.A., Vincent F. Capaldi II, M.D., M.Sc., Jed P. Mangal, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define the roles, meaning and general demographics of members in the seven military reserve components of the United States; 2) Provide an understanding of reservists' access and use of mental health care as well as challenges unique to this population; and 3) Demonstrate effective strategies in the evaluation, treatment and management of military reserve members.

SUMMARY:

Since the height of the conflicts in Iraq and Afghanistan, the National Guard and military reserve forces of the United States have been heavily mobilized in support or in place of regular active duty units. Despite a similarity in activated and deployed roles to the active duty forces, the guard and reserve members who present for mental health consultations may differ in age, background, comorbidities, and socioeconomic and occupational status. Military life presents risks, challenges and accomplishments unique to any of those who participate, but the reservists and guardsmen return to their lives as usual, which may either be a smooth transition or a trying one. In this interactive workshop, participants will learn who the reservists are and what challenges they face. Through the use of small groups, participants will review case histories of reservists who have sought treatment for mental illnesses and bring to the discussion ideas and learning points for evaluation and treatment. Multiple choice questions and attendee participation

will be utilized to deliberate and exchange concepts in clinical practice.

TWISTS IN THE DOUBLE HELIX: ETHICAL CHALLENGES IN GENETIC TESTING IN PSYCHIATRY

Chair: Paul S. Appelbaum, M.D.

Speaker: Maya Sabatello, Ph.D., LL.B.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review the ethical and social issues that will arise as genetic testing for psychiatric disorders becomes more prevalent; 2) Understand the possible impact on self-image, family relationships, social interactions and stigma; and 3) Encourage participants to consider the parameters that should govern the use of psychiatric genetic testing.

SUMMARY:

This workshop will consider the ethical challenges arising as advances in genetics make their way into psychiatry. These include defining the appropriate scope of prenatal and childhood testing for predisposition to psychiatric disorders, sharing genetic test results with family members who may be at risk, regulation of direct-to-consumer marketing of genetic tests, use of genetic testing prior to adoption and marriage, and the problem of collateral information derived from pharmacogenomic testing. Case examples will be used to highlight the dilemmas, with attendees encouraged to participate in shaping responses.

ASSISTED OUTPATIENT TREATMENT FOR INDIVIDUALS WITH MENTAL ILLNESS REFERRED BY CORRECTIONAL SERVICES: SYNERGY OR REDUNDANCY?

Chair: Scott Soloway, M.D.

Speakers: Jennifer Correale, J.D., Esq., Carolyn D'Aquila, L.C.S.W., M.P.H., Patricia Schwartz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate an understanding of the obstacles to treatment planning for mentally ill, criminal justice-involved individuals; 2) Form an evidence-based opinion regarding the effectiveness of AOT as a method to engage those re-entering the community from jails and prisons; and 3) Differentiate civil and criminal psychiatric outpatient mandates and their intended impact.

SUMMARY:

Since New York State passed court-mandated outpatient treatment in 1999, the Assisted Outpatient Treatment (AOT) Program has been used as a way to assist and leverage individuals with mental illness to engage in mental health treatment in the community. Debates have continued regarding not only the effectiveness of AOT, but also for whom it is most effective. Since its inception, the New York County AOT team has been charged with accepting and reviewing referrals to AOT from city jails (Rikers Island) and from New York State prisons. The subgroup of individuals with severe mental illness who are re-entering the community after incarceration is often the most underserved and disconnected from treatment. As the news media and policymakers pay more attention to recently released prisoners who have committed violent acts in the community, AOT is increasingly being used as one tool to prevent similar episodes in the future. For the first time since 1999, the New York City AOT program is reporting on our experience with and outcomes for the mentally ill and criminal justice-involved individuals in the AOT program. This workshop will inform participants how AOT assesses forensic mentally ill individuals and navigates the complicated criminal justice system to develop appropriate treatment plans. Demographic and outcome data, such as hospitalizations, reincarcerations and adherence to mental health treatment, will be presented with comparisons both to nonforensic AOT individuals and to available outcomes in the literature for non-AOT forensic individuals re-entering into the community. Usefulness of AOT as an adjunct to criminal court mandates for mental health treatment, such as alternatives to incarceration, will also be addressed. We will then discuss de-identified case vignettes to illustrate the challenges, limitations and successes of AOT for this population and to spark discussion with workshop audience participants.

BURNOUT IN RESIDENT PHYSICIANS: WHAT CAN WE DO?

Chair: Mahgul Malik, M.D.

Speaker: Michal Sapieha, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize burnout in colleagues, trainees and self; 2) Demonstrate an understanding of appropriate work environments (including teaching and feedback) that support the

mental health of resident physicians; 3) Demonstrate an understanding of essential resources needed to improve access to a variety of mental health services and programs for resident physicians; and 4) Understand the role of a Balint group in training programs.

SUMMARY:

Physicians experience significant rates of mental illness including burnout, depression, suicide and substance use. They are often exposed to highly stressful environments starting in medical school, in residency training and throughout the rest of their careers. Burnout, a phenomenon consisting of depersonalization, emotional exhaustion and a sense of low personal accomplishment, is prevalent in the resident population with figures ranging from 27 – 75% across different specialties. Burnout can be a perpetuating factor for major depressive disorder, anxiety disorders and other psychiatric disorders. Resident physicians are at a high risk for depression, and physicians in practice have an elevated risk of suicide compared to the general population. Some of this can be attributed to a highly stressful work environment and a stigma in obtaining care. Residency is an extremely challenging time, and residency programs need to focus on early intervention and targeted treatment. Programs may include mental health and substance abuse screening, a mental health crisis line for physicians and support for traumatic experiences. The first part of the workshop will focus on resources targeted at recognizing burnout, including the use of tools, i.e., Maslach's burnout inventory. The workshop will cover appropriate work environments including safety around teaching and feedback. This will be followed by twenty minutes of a small-group breakout session where participants will discuss case-based scenarios regarding appropriate work environments particularly related to effective feedback in training programs. The next part of the workshop will include a brief overview of essential resources employed in various U.S. and Canadian residency programs including mental health and substance abuse screening, a mental health crisis hotline, and supportive debriefing of traumatic experiences that residents deal with in service. Some programs in North America include Balint groups, which are small-group clinical case presentations led by an experienced facilitator that focus on the patient-physician relationship with the goal of enhancing patient care. This will be followed by another small-group breakout session where

participants will discuss the resources in their own programs that they feel are working well, including the role of Balint groups to address some of the challenges encountered. Participants will also discuss obstacles they can face while participating in Balint groups as well as suggestions around incorporating these groups as an important part of residency training.

SEX ED: A PSYCHIATRIC PRIMER ON MANAGING PATIENTS' SEXUAL BEHAVIORS

Chair: Abhishek Jain, M.D.

Speakers: Renee Sorrentino, M.D., Ryan Hall, M.D., Susan Joy Hatters-Friedman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the psychiatrist's possible role in dealing with patient-to-patient and patient-to-staff sexual behaviors; 2) Summarize the potential etiologies of sexually inappropriate behaviors among psychiatric patients; 3) Appreciate specialized sexual offender assessments and treatments; and 4) Consider strategies for managing a patient's sexual behaviors in a general psychiatric or medical setting.

SUMMARY:

Psychiatric providers may encounter clinical questions regarding the evaluation and treatment of patients' inappropriate sexual behavior, sexual aggression or history of sexual offending. Furthermore, psychiatrists may be looked upon by medical and mental health colleagues or administrators to help understand and address patient-to-patient and patient-to-staff sexually assaultive or inappropriate behavior. In this workshop, we will discuss the psychiatrist's possible role in dealing with patient-to-patient, patient-to-staff and staff-to-patient sexual behaviors, including legal, ethical and administrative considerations. We will inform the general psychiatric provider regarding the potential etiologies (e.g., opportunistic, impulsive, predatory, paraphilic, etc.) of sexually inappropriate behaviors among psychiatric patients. We will review specialized sexual offender assessments and treatments that are not typically conducted in general psychiatric settings. We will discuss management considerations in inpatient and outpatient settings. We will highlight specific legal considerations when dealing with sexual offenders. After presenting this information, we will use an interactive case to

emphasize the salient issues and allow the audience to apply this knowledge.

IN HARM'S WAY: JOB STRESS AND MENTAL HEALTH IN THE MILITARY

Chair: Steven E. Pflanz, M.D.

Speaker: Steven E. Pflanz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the prevalence and causes of work stress in the military; 2) Discuss the impact of work stress on mental health and work performance; and 3) Examine strategies for managing and reducing the adverse impact of job stress.

SUMMARY:

Increasingly, both industry and mental health professionals recognize that work stress is a major factor in determining the mental health of employees. Work stress costs industry over \$300 billion per year in lost productivity, absenteeism, increased health care utilization and disability claims. These costs are incurred similarly by the military. Military psychiatrists and other military mental health professionals are often faced with patients suffering from emotional distress that is attributed to job stress. The stressors of the deployed environment, frequent deployments and combat-related trauma exposure on military personnel are well documented in the literature. Multiple studies have also identified high levels of job stress for military personnel stationed within the United States. The most recent DoD Survey of Health-Related Behaviors found that at least 24% of military personnel reported difficulties secondary to various military-related stressors. Additional research revealed that 29% of military personnel reported suffering from serious job stress. In these populations, the report of work stress was significantly related to multiple measures of impaired work performance and poorer mental health. At work, exposure to either traumatic events or chronic daily stress can produce or exacerbate psychiatric symptoms. In this workshop, the audience will discuss the complex relationship between the military work environment and mental health. We will examine the common sources of military-related job stress, its costs for the military and the mechanisms by which work stress can lead to psychiatric illness. Finally, we will discuss the role of the psychiatrist in treating work stress and

psychiatric illness in working patient populations, especially amongst military personnel. Throughout the workshop, the audience will participate in a lively discussion of job stress and its impacts.

ETHICAL DILEMMAS IN PSYCHIATRIC PRACTICE

Chairs: Richard K. Harding, M.D., Ezra Griffith, M.D.

Speakers: Mark Komrad, M.D., Stephen C. Scheiber, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Provide culturally competent care for diverse populations; 4) Describe the utility of psychotherapeutic and pharmacological treatment options; 5) Integrate knowledge of current psychiatry into discussions with patients; and 6) Identify barriers to care, including health service delivery issues.

SUMMARY:

Abstract not available.

GETTING BACK TO WORK: GUIDANCE FOR CLINICIANS FROM AN EMPLOYER PERSPECTIVE

Chairs: Paul Pendler, Psy.D., R. Scott Benson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Increase their skills in translating their clinical impressions to the more focused aspects necessary to support a disability request from work; 2) Learn to distinguish "psychosocial issues from mental health conditions" and discuss these distinctions with patients; 3) Develop greater capacity to operationalize concepts such as "workplace stress" in order to assess a patient's functional status and document the impairments related to disability; and 4) Enhance their ability to articulate to both patients and the employer when return to work is clinically appropriate.

SUMMARY:

Depression, according to Kessler and colleagues (1999), is "associated with a higher rate of short-term work disability than virtually any other chronic condition." A recent 2015 examination of psychiatric disability found that anxiety arousal, avoidance behavior and depressive mood were all associated

with long-term work disability and absenteeism. Given this continued trend, psychiatrists will continue to be regularly confronted with the delicate balance of providing an accurate diagnostic assessment in reviewing symptoms and also expanding their clinical repertoire to address work functioning and impairments. This exposure begins even during residency, and yet other than traditional forensic assessment training, there are few guidelines to assist psychiatrists with gaining clinical competency about when time off work is medically indicated. The notion of "workplace stress" and overall job strain has become a topic of increasing attention in the literature, with a focus on appreciating the interplay between workplace stress and perceived employee control over workplace demands. Stressful conditions perceived in the workplace then become part of a transactional model that addresses individual resources coupled with workplace conditions. How this type of assessment can augment the traditional psychiatric assessment and treatment will be explored. Working with clinical data on actual cases requesting disability time off work, participants will also learn the employer perspective that emphasizes Warren's (2013) thinking concerning psychosocial issues and Gold's (2013) view of "work capacity" (balance between work supply and work demand) to better assist the clinician in working with their patients when off work. Participants will be introduced to work by Williams (2010) in order to establish their own working qualitative impairment checklist to make clinical recommendations when time off work becomes necessary.

DESIGNER DRUGS, LEGAL HIGHS: IS IT REALLY PLANT FOOD AND BATHING SALTS?

Chair: Roger Duda, M.D.

Speaker: Tyler E. Stratton, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the most popular legal highs and designer drugs currently being abused and understand the different effects users experience from various substances; 2) Describe the recommended treatments in the care of designer drugs users in overdose; 3) Discuss approaches to educate patients on the dangers of designer drugs and legal highs; and 4) Understand where patients source designer drugs and the pipeline bringing designer drugs to patients.

SUMMARY:

Designer drugs have continued to increase in popularity since the first reports of MPTP causing Parkinson's-like symptoms in 1982. Legal highs and designer drugs are seen to be as safer alternatives to traditional "hard drugs" like heroin and cocaine. The more popular designer drugs and legal highs will be discussed. Also, treatment suggestions for overdose on designer drugs will be discussed. The availability of origin of designer drugs will be discussed. Finally, clinicians will be able to understand the dangers, effects and overdose treatment of more popular designer drugs, as well as understand the difficulty in determining the chemical constituents of designer drugs and legal highs.

SMARTPHONES, SENSORS AND MOBILE MENTAL HEALTH: REGULATIONS, RESEARCH AND REAL LIFE

Chair: John Torous, M.D.

Speakers: Gregory G. Harris, M.D., M.P.H., John Torous, M.D., Jung W. Kim, M.D., Shih Yee-Marie Tan Gipson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify important policy and regulatory issues related to mobile mental health technology; 2) Understand how the research literature suggests both potential and pitfalls of technology use in psychiatry; and 3) Address how smartphone technology can be safely and effectively integrated into a clinical environment.

SUMMARY:

Mobile mental health, and especially smartphone and wearable technologies applied toward psychiatric conditions, offers the potential for novel screening, monitoring and adjunctive treatments. However, realizing the potential and transforming such into clinical reality is complex and requires an understanding of the policy issues, research advances and early clinical use cases. In this workshop, we will cover these three issues through interactive demonstrations, clinical case examples and audience participation polls.

WOMEN AT WAR: MEDICAL AND PSYCHOLOGICAL CHALLENGES FOR U.S. FEMALE SERVICE MEMBERS

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Paulette Cazares, M.D., M.P.H.

Speakers: Kate McGraw, Ph.D., Paulette Cazares, M.D., M.P.H., Elspeth C. Ritchie, M.D., M.P.H., Amy

A. Canuso, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know the unique challenges for women in the U.S. military, both in garrison and abroad, in combat; 2) Understand how war affects women, both in combat and on return to home base; 3) Learn how the challenges of pregnancy, lactation and other reproductive and gynecological issues affect military women; and 4) Learn about the challenges for female veterans, including child care and homelessness.

SUMMARY:

The text "Women at War" by Col. (ret) Ritchie and Col. Anne Naclerio was published by Oxford University Press in June 2015. This workshop highlights important themes from that volume. For women, 9/11 ushered in an increasing role in the U.S. military. Technically, only recently have women officially been allowed into combat occupations. However, it is now widely accepted that women have been in combat since long before 9/11. The combat exclusion rule was recently repealed, theoretically allowing women in all combat occupations if they can meet physical fitness standards. Military women also make up a high proportion of medical personnel, who see the consequences of the casualties of war. These include not just wounded soldiers and marines, but enemy combatants and local casualties of bomb blasts and shootings. This presentation will 1) Highlight the medical challenges for women in military service and on deployment, with a focus on reproductive and gynecological systems; 2) Focus on mental health issues for military women; and 3) Translate these issues and challenges into actionable information for clinicians.

RESPONDING TO THE IMPACT OF SUICIDE ON CLINICIANS

Chair: Eric M. Plakun, M.D.

Speaker: Jane G. Tillman, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Enumerate clinician responses to patient suicide; 2) Implement practical steps for responding to patient suicide from the personal, collegial, clinical, educational, administrative and medico-legal perspectives; 3) Design a curriculum to educate and support trainees around their unique

vulnerabilities to the experience of patient suicide; and 4) List recommendations for responding to the family of a patient who commits suicide.

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 direct experience with patient death than clinicians from other environments. Nevertheless, each death by suicide of a psychiatric patient may have a more profound effect on psychiatric personnel than other deaths do on nonpsychiatric physicians because of powerful emotional responses to the act of suicide and the empathic attunement and emotional availability that is part of mental health clinical work. This workshop offers results from an empirical study demonstrating eight common experiences of clinicians who have a patient commit 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 includes ample time for interactive but anonymous discussion with participants about their own experiences with patient suicide—a feature of this workshop that has been valued by participants in the past.

MAY 18, 2016

THE INTERFACE OF ETHICS AND PSYCHIATRY: A COLLABORATIVE CONSULTATION APPROACH

Chair: Nancy N. Potter, Ph.D.

Speaker: Rif S. El-Mallakh, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the interface of ethics and psychiatry; 2) Discuss cases to explore how and when psychiatric ethics consultation is beneficial; and 3) Understand the benefits of working as a team with a philosopher trained in psychiatric ethics.

SUMMARY:

Often, psychiatric ethics is a kind of handmaiden to psychiatry, to be brought to bear on difficult cases or for pedagogical purposes. Many hospitals and clinics have psychiatric ethics consultation services. While this is important for good psychiatric practice, psychiatric ethics can also work at a more intimate level in relation to psychiatrists. This workshop explores the benefits of working as a team with a philosopher trained in psychiatric ethics. With over ten years' experience working together, Dr. El-Mallakh and Professor Potter will discuss the development of their professional relationship, why it is important to both psychiatrists and those who do psychiatric ethics, and present cases for discussion to explore how and when a psychiatric ethics consultation can be beneficial. They will also describe how to develop such a team.

SLIDECAST: HOW TO FASHION YOUR SLIDE PRESENTATION, CAPTIVATE AND RESONATE WITH YOUR AUDIENCE

Chairs: Sunil Khushalani, M.D., Mark Komrad, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the vital importance of investing time and effort on slide presentations; 2) Learn to use some slide presentation guidelines and best practices, including some dos and don'ts of slide presentations; and 3) Apply these ideas to advance their presentation skills from the level of competence to excellence and make their presentations elegant, compelling and inspiring.

SUMMARY:

You have worked hard on the content of your slide presentation. The audience has selected your presentation amidst a whole range of options. Does your slide presentation captivate their attention and keep them engaged? Is the quality of your slides on par with the quality of your content? We have made tremendous strides in psychiatry, and the field has advanced considerably over the last couple of decades. There have been advances even in the world of presentations; if you have seen a TED talk, you have witnessed the power of a great presentation's power to captivate its audience and capture the attention of its viewers from all over the world. Just as in this conference, an audience today has a lot of options to choose from. Your presentation is not only competing with all the other presentations, but also all of the internal distractions

and “smart” mobile devices that almost everyone carries with them today. If your slides are even remotely dull or if there is too much information crammed in your slides, you will quickly lose your audience, who are quick to perceive a mismatch between your knowledge and slide presentation skills. Your slide presentation has the power to not only compel your audience’s attention, but also impart knowledge, change their paradigms and inspire them to take action. Let your slides be a great adjunct to your presentation. In this workshop, we will share dos and don’ts of creating slide presentations, helping you strengthen your message and resonate with your audience so that your content shines and your message creates a lasting impact.

SPEAKING FOR ONE’S SELF: PSYCHIATRIC ADVANCED DIRECTIVES

Chairs: Nubia G. Llubes Rincon, M.D., Abhishek Jain, M.D.

Speaker: John S. Rozel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Summarize potential benefits and drawbacks of psychiatric advance directives; 2) Discuss the ethical and legal aspects of psychiatric advance directives; and 3) Explore future directions in improving the quality and application of psychiatric advance directives.

SUMMARY:

Medical advance directives allow patients to specify their health care decisions for situations in which they would be unable to make those decisions. Psychiatric advance directives are a growing trend, with about two-thirds of states adopting legislation authorizing their use. Psychiatric advance directives can serve as important tools to increase patient self-determination and are consistent with the recovery model. Nevertheless, psychiatric advanced directives can raise ethical and legal considerations, such as circumstances involving involuntary commitment and involuntary treatment concerns, legal questions, and controversies of the practical aspects of involuntary psychiatric treatments. Using audience participation and a case-based approach, this presentation will summarize potential benefits and drawbacks, discuss ethical and legal implications, and explore future directions in improving the quality and application of psychiatric advance directives.

COMBAT-RELATED PTSD, HOMICIDE AND ATTEMPTED SUICIDE-BY-COP

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Keith A. Caruso, M.D.

Speakers: Elspeth C. Ritchie, M.D., M.P.H., Keith A. Caruso, M.D., Kevin D. Moore, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the effects of combat-related PTSD on homicide and suicide-by-cop; 2) Peer review of one of the presenters’ case formulation that included the defendant’s PTSD, Bipolar Disorder, attempted suicide-by-cop and intentional dissimulation of that phenomenon; and 3) Learn how combat-related PTSD may or may not help in mitigation.

SUMMARY:

The objectives of this workshop include reviewing the role of combat-related PTSD in homicide and peer reviewing one of the presenter’s case formulations that included the defendant’s PTSD, bipolar disorder, attempted suicide by cop and intentional dissimulation of that phenomenon. Andrew Brannan was a 100% psychiatrically disabled decorated Vietnam combat veteran previously diagnosed with PTSD and bipolar disorder. Following the January 1998 homicide of Deputy Kyle Dinkheller in Laurens County, Georgia, Brannan’s case wound its way through the Georgia courts until his execution in January 2015. The presentation will include a three-and-a-half-minute patrol car video that captured what began as an apparent attempted suicide by cop and derailed into homicide. Brannan’s psychiatric history and that of his legal proceedings up to his execution will be discussed at length, giving the audience an opportunity to evaluate the case related to issues of insanity, mens rea, and mitigating and aggravating factors. This case was widely reported in the national media, raising concerns about the adequacy of his defense and moral issues about executing a veteran with known mental illness. Additional issues of attempted suicide by cop and intentional dissimulation will also be addressed.

COLLEGE MENTAL HEALTH PRACTICE: ADJUSTING FOR SEASONALITY, SETTING AND SCOPE OF SERVICES

Chair: Marshall L. Garrick, M.D.

Speaker: Amy Poon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Develop strategies for addressing the impact of seasonality on college mental health practice; 2) Analyze the impact of setting on college mental health practice; and 3) Clarify the appropriate scope of services for a specific college mental health practice.

SUMMARY:

Distinguishing characteristics of college mental health practice relate to the great impact of seasonal changes, the diverse range of settings and variation in scope of services. This workshop is designed to utilize collegial interaction and collective experience to address clinical practice issues in the context of the three noted factors. Some of the content for this workshop will include topics from the journal article "The Calendar, Complementarity, and Pacing in the College Mental Health Setting" (currently published online and to be assigned to an issue of *Academic Psychiatry*). Practice issues are to be summarized by the presenters, and the audience members at large will have an opportunity to ask questions or make comments. One example issue involves the question of how to manage patient flow in the context of marked seasonal variation in workload. Another issue includes how to address medical leave policies for students typically needing such consideration late in the semester or quarter. A third topic might involve how to utilize a short-term psychotherapy model when many patients need longer-term therapy. The relative emphasis on given topics would be affected by the relevance of subject matter to the attendees. An underlying goal of the workshop would be to help psychiatrists and other mental health professionals who work in diverse college mental health settings experience a greater degree of commonality amongst themselves.

BUILD A SKILL: INTERACTIVE SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT) TRAINING TO ENHANCE CLINICAL PRACTICE

Chair: Shilpa Srinivasan, M.D.

Speakers: Suzanne M. Hardeman, N.P., Matt Orr, Ph.D., Shilpa Srinivasan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the components, goals

and rationale of SBIRT; 2) Understand the rationale and use of screening to include substance use limits and associated health risks; 3) Understand and demonstrate the application of MI skills to conduct a brief negotiated interview; and 4) Understand criteria for referral to treatment, types of treatment and common treatment referral mistakes.

SUMMARY:

Background: Substance use poses high morbidity, mortality and economic burden and adversely affects treatment compliance in both medical and psychiatric care. Approximately 30% of adults use alcohol at unhealthy levels, and 6 – 10% misuse legal and illegal drugs. Only one in six people report discussing their substance use with a health care provider. Training in substance use assessment and management among health care professionals is insufficient compared to other preventable illnesses despite initiatives to support such training. Training for health care providers who are already in practice is underemphasized and not readily available. SBIRT (screening, brief intervention and referral to treatment) is a comprehensive, integrated, evidence-based public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing them. Screening quickly assesses the severity of substance use and identifies the appropriate level of response. Brief intervention utilizes motivational interviewing (MI) techniques to encourage and support insight and awareness into substance use and motivation toward behavioral change. Referral to treatment focuses on providing recommendations for and access to specialty care for those identified as needing more extensive treatment. Because it can be taught in a relatively short session and delivered within the time constraints of any busy practice setting, the SBIRT approach is an ideal skill for every health care practitioner. **Methods:** During this 90-minute workshop, an interprofessional panel will present an overview of SBIRT and its components (40 minutes). Demonstration videos will be included to illustrate the components of screening and brief intervention. In the next 40 minutes, the skills necessary for delivering SBIRT will be demonstrated and practiced using interactive, small-group activities. Screening tools and pocket cards used for patient education will be provided to each participant. The remaining 10 minutes will be used for participant QandA. **Objective:** During this session, participants will gain practical skills and understand the components,

goals and rationale of SBIRT; the rationale and use of screening, including substance use limits and associated health risks; the application of MI skills to conduct a brief negotiated interview; and the criteria for referral to treatment, types of treatment and common treatment referral mistakes. **Conclusion:** Meeting patient care needs by addressing substance use in clinical practice is imperative for health professionals. SBIRT is a practical and highly versatile intervention that provides an effective mechanism to identify patients at risk for substance-related health conditions, encourage reduction in use and prompt treatment in patients with substance use disorders. As a skill, SBIRT can empower health professionals to provide effective patient care.

EXPLORATIONS OF MEDICAL STUDENTS' CHOICE OF PSYCHIATRY AS A CAREER

Chairs: Leonard M. Gralnik, M.D., Ph.D., Mitchell J. Cohen, M.D.

Speakers: Matthew N. Goldenberg, M.D., M.Sc., Sergio Hernandez, M.D., Peter J. Holland, M.D., John Spollen, M.D., Thomas L. Schwartz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify important factors that medical students endorse as reasons for choosing psychiatry as a career; 2) Understand opportunities for change in the medical school curriculum that will help recruit students into the field of psychiatry; and 3) Identify impediments in the medical school curriculum and environment that discourage students from choosing psychiatry as a career.

SUMMARY:

Psychiatric disorders are among the leading contributors to the global burden of disease. There is a shortage of psychiatrists available to treat these disorders, and the shortage is expected to increase. Only about 4% of medical students in the United States choose to pursue psychiatric residency training. Some medical schools have a significantly higher percentage of medical students choosing psychiatry as a career. It is important to identify factors that encourage students to choose psychiatry, as well as factors that dissuade them from this choice. Previous reports have focused on surveys of medical school faculty to evaluate these factors. We present results of surveys of medical students and residents who have chosen to pursue psychiatry as a career. Exploration of these results, in particular comparing results among schools that

have differing percentages of students choosing psychiatry as a career, will shed light on this important question. We also present data from the Association of American Medical Colleges (AAMC) Graduation Questionnaire (GQ) and the corresponding Matriculating Student Questionnaire (MSQ) that examines the stability of the specialty choice of psychiatry as students progress through medical school. Data from the AAMC that examine levels of student debt and psychiatry clerkship length as possible predictors of recruitment of students into the field of psychiatry will also be presented. All workshop participants will be invited to share their experiences regarding medical students in their institutions choosing psychiatry as a career. Particular attention will be paid to participants' perceptions about factors that encourage students to choose psychiatry while also touching upon factors that may drive students away from psychiatry as a career choice. Participants will be encouraged to discuss their perceptions in light of their understanding of the relevant literature. Participants will also be given the opportunity to share their thoughts about the presenters' findings regarding medical student and resident perceptions about reasons for choosing or not choosing psychiatry as a career. Lessons learned from the workshop will be communicated to members of the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) to help improve recruitment of students into the field of psychiatry.

ADDRESSING THE COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN

Chair: Shama Patel, M.D.

Speakers: Eraka Bath, M.D., Yolanda P. Graham, M.D., Jordan Greenbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the role of the mental health professional in addressing the commercial sexual exploitation of children; 2) Discuss trauma-informed treatment approaches and challenges; 3) Review the juvenile justice system's response to the commercial sexual exploitation of children, including promising practices from the field; and 4) Identify different models of medical and psychiatric intervention and prevention based on different levels of care.

SUMMARY:

Commercial sexual exploitation of youth is arguably one of the most egregious human rights violations of our time. Estimates suggest that, annually, there are close to 300,000 youth in the United States who are victims of sex trafficking and commercial exploitation. Sex trafficking is common in cities all across the United States, particularly where there are high concentrations of runaway and homeless youth, youth in the foster care system, minors being charged for prostitution and areas with major transportation hubs. Mental health professionals are uniquely poised to identify, intervene and advocate for victims of trafficking, as they may be one of the few limited contacts victims have while still in captivity. Due to the clandestine nature of the crime, raising health care providers' ability to identify and care for commercially sexually exploited youth is essential. This workshop will review psychiatric treatment approaches and trauma-informed models of care for this vulnerable population. This workshop moves from an overview of commercial sexual exploitation of youth and clinical indicators of trafficking to approaches for treatment and intervention. Specifically, participants will review trauma-informed treatment approaches, methods to improve identification, and strategies for addressing inherent challenges. Furthermore, this workshop will offer effective models of prevention and intervention currently in place to address the psychiatric, legal and medical aspects of this issue.

CREATING A LEADERSHIP DEVELOPMENT PROGRAM TO PREPARE YOUR DEPARTMENT/ORGANIZATION TO SUCCESSFULLY NAVIGATE TURNOVER OF KEY LEADERSHIP POSITIONS

Chair: Kari M. Wolf, M.D.

Speaker: Jane Ripperger-Suhler, M.D., M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define succession planning and its importance in academic medicine and health care; 2) Describe the value of a systematic faculty leadership development plan; 3) Compare and contrast models of leadership development inside and outside of health care; and 4) Construct a systematic plan to develop leaders within your own department/organization.

SUMMARY:

The American Management Association 2011 survey identified that 71% of senior leaders "rendered

leadership succession more important than ever before." However, Allison Vaillancourt, Vice President for HR and Institutional Effectiveness at the University of Arizona, recently explained the dearth of succession planning in academia by stating, "Succession planning strikes many people [in higher education] as slotting and favoritism. We just have a huge commitment to the competitive process for positions." With 55% of psychiatrists over the age of 55 (making us the second oldest group of physicians), we know that much of our most experienced educators will be turning over in the coming years. How do we prepare departments to smoothly transition our educational leadership roles to newer (often fresh out of training) members of the department? Historically, educators have stayed in place for decades. When we trained, the faculty had been there for years and would be there far into the future. Today, we live in a time of unprecedented upheaval in health care and academic medicine turnover as people become frustrated, incentives change, new regulations emerge, life brings unexpected twists and turns, and our workforce ages. As a result, we need to prepare for a health care and educational environment organized and implemented by the next generation of leaders. How do we systematically prepare junior physicians for this role? What are the key ingredients that led to our own success as leaders? What are the competencies that will lead to success in this changing environment? What can we learn from the business community who has long embraced the concept of succession planning? This presentation will define succession planning; review its role in the business community, health care and academia; and discuss barriers to successful succession planning. We will highlight the "call to arms," necessitating that we think about succession planning so the legacy of outstanding education can continue in the collective departments represented in the audience as all of us consider transitions to new roles. We will review an example of the systematic way that succession planning has evolved in our own rapidly growing department, highlighting the importance of incorporating both "didactic" educational opportunities for faculty as well as key experiential opportunities to build specific skills. Finally, we will brainstorm how these lessons can be applied in the varied departments and organizations represented in the audience and the benefits that we can expect to accrue. Teaching modalities will include presentation, large-group discussion and small-group discussion using liberating structures.

VITALSIGN6: PARTNERING WITH PRIMARY CARE PROVIDERS IN USING INNOVATIVE SOFTWARE TO IMPLEMENT UNIVERSAL DEPRESSION SCREENING AND MEASUREMENT-BASED CARE

Chairs: Manish K. Jha, M.B.B.S., Madhukar Trivedi, M.D.

Speakers: Madhukar Trivedi, M.D., Manish K. Jha, M.B.B.S., Katherine Sanchez, Ph.D., L.C.S.W., Tracy Greer, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the opportunity to partner with primary care providers to improve detection and treatment of depression, especially in minority and underserved populations through universal screening; 2) Understand the elements of measurement-based care (MBC) and how it can be used to attain functional recovery; 3) Understand the design of an innovative point-of-care software program to administer self-report instruments and its seamless implementation in busy clinics; and 4) Establish a plan to implement MBC in their practice and seek opportunities to collaborate with primary care providers.

SUMMARY:

Major depressive disorder (MDD) is both underdiagnosed and undertreated, especially in minority and low-income populations. Barriers to depression treatment include persistent stigma, a shortage of behavioral health services and resultant suboptimal use of antidepressant medications. Primary care settings are often the gateway to identifying undiagnosed or untreated mental health disorders, particularly for people with comorbid physical health conditions. Minority populations, in particular, are more likely to receive mental health care in primary care settings. Partnering with primary care providers and providing them with tools to efficiently and effectively diagnose and manage depression will improve access to care and might lead to better outcomes. This workshop will be divided in two halves. In the first half, participants will learn about our process of 1) Developing partnerships with clinics that primarily serve low-income minority populations and 2) Implementing universal screening and measurement-based care (MBC) in these busy practices. They will receive training in standardized MBC tools to assess depression symptom severity, antidepressant treatment side-effects and treatment adherence to

facilitate remission of depressive symptoms with minimal side-effect burden and consistent treatment adherence. Talking points that can be used to describe the benefits of MBC to clinicians in primary care settings will be provided. Participants will also learn about the difference between remission and functional recovery as a treatment target and how to incorporate self-report assessments of functional recovery in routine clinical practice. In the second half, participants will be divided in four groups. Using multiple mobile training devices (iPad tablets) per group, workshop faculty members will demonstrate the point-of-care, web-based software program we have developed to screen all patients in each participating clinic for depression, monitor symptoms over time for those patients who screen positive, and guide the clinical provider in treatment planning and medical decision making. In these small groups, participants will be led through a discussion of the challenges associated with the implementation of evidence-based interventions in their settings or communities, the practice redesign involved in adoption of these interventions, the barriers to translation to the “real world” and how they plan to implement MBC in their practice.

THE TRANSCULTURAL COMPETENT PSYCHIATRIST: CHARACTERISTICS, CHALLENGES AND ABILITIES

Chair: Hamid Peseschkian, M.D., D.M.Sc.

Speakers: Hamid Peseschkian, M.D., D.M.Sc., Afrim A. Blyta, M.D., Jusuf S. Ulaj, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand basic principles of the therapeutic relationship in transcultural settings; 2) Identify personal characteristics and traits of psychiatrists in order to be effective in transcultural settings; and 3) Identify potential traps in transcultural first interviews.

SUMMARY:

With the increase of culturally diverse societies in the United States and all over the world, we are more and more in need of culturally competent mental health workers. Especially in psychiatry and psychotherapy, where every therapeutic relationship is unique and shaped by individual cultures, knowledge about other cultures is not sufficient. Based on the presenters’ 20-year-long experience in working with mental health patients in both individualistic and collective societies (in Western Europe, the Balkans, the Middle East, Russia and

China), the importance of developing a transcultural competency that enables mental health workers to work with patients from any culture, compared to a vague multicultural knowledge that focuses only on the main minorities of one's country, is identified. In a highly interactive format, the participants will broaden and deepen their knowledge and skills about effective and necessary personality traits of a psychiatrist in transcultural settings. The workshop will specially focus on a transcultural semi-structured first interview from the perspective of Positive Psychotherapy, a humanistic psychodynamic approach to psychiatry and psychotherapy. Common pitfalls in the therapeutic relationship are examined, with case materials from both presenters and participants. With the participants, the presenters will identify some helpful interventions and techniques that can be applied in the clinical practices of psychiatrists and other mental health professionals.

LGBT IN THE MILITARY

Chairs: Christopher H. Warner, M.D., Carl Castro, Ph.D.

Speakers: Jeremy Goldbach, Ph.D., Ian W. Holloway, Ph.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the implications of allowing LGBT service members to serve openly and without fear of reprisal in the military; 2) Discuss the possible health and well-being disparities that exist within the military as a result of the DADT policy and how these disparities could significantly impact mission readiness; and 3) Recognize possible policy changes that need to be implemented to fully integrate LGBT service members into the military.

SUMMARY:

Including both guard and reserve, nearly 65,000 (or 2.8%) of military personnel identify as lesbian, gay, bisexual or transgender (LGBT). Until the repeal of Don't Ask, Don't Tell (DADT), LGBT service members could not disclose their sexual orientation ("come out"), as punishment and discharge was common. This negative treatment of LGBT service members is well-embedded in military culture even prior to the passing of DADT in 1993; 19,000 service members were discharged between 1980 and 1993, while just 13,000 were discharged between 1993 and 2009. In the general population, LGBT people experience stress related to their sexual orientation and gender

expression known as minority stress, which suggests that societal oppression and chronic victimization lead to significant distress for LGBT people and result in poorer health and mental health outcomes. LGBT individuals have a greater likelihood of reporting child maltreatment; interpersonal violence; intimate partner violence; sexual assault; child abuse or neglect; hate crimes; rejection from family, friends and religious communities; and unexpected death (including suicide). As a result, LGBT people are at heightened risk of mental health problems, including high rates of depressive symptoms and suicide, anxiety, post-traumatic stress disorder, and substance use and abuse. Further, sexual minorities may fear disclosure because of real and perceived impact on their ability to maintain a supportive social network, creating opportunities for further social isolation. The experiences of LGBT service members may be distinctly different from their non-LGBT military counterparts yet remain unexplored. LGBT service members may experience heightened harassment related to the "hypermasculinity" of military service. Burks also presents a compelling conceptual framework that suggests DADT may have uniquely "served to increase LGBT victimization, decrease victim reports and help seeking, and prevent sexual orientation military research" (p. 604). In short, the system of the past 30 years has amplified victimization while minimizing research that informs the military on best practices to support this high-need population. Further The Department of Defense has suggested that the current system of care is "insufficient to meet the needs of today's forces and their beneficiaries, and will not be sufficient to meet their needs in the future." While now allowed to serve openly, a better understanding of the experiences of LGBT service members as well as their unique social service needs is necessary. In this workshop, experts from the military and nonmilitary communities will discuss the implications of allowing LGBT service members to serve openly and without fear of reprisal, the health and well-being disparities that exist within the military and how they impact readiness, and the changes needed to fully integrate LGBT service members into the military.

PSYCHOLOGY PRESCRIPTION PRIVILEGES: THE ILLINOIS EXPERIENCE

Chair: Daniel Yohanna, M.D.

Speakers: Peter Fore, M.D., Linda F. Gruenberg, D.O., Sidney Weissman, M.D., James G. MacKenzie, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Become familiar with the history and approaches used to obtain psychology prescription privileges across the country; 2) Learn about other non-physician prescribers in the United States and if there is a need for more; 3) Learn about current requirements for prescribing medications by non-physicians and what would make for safe training; and 4) Learn about best approaches to educate legislators and the public about psychology prescription privileges.

SUMMARY:

Psychology prescriptive authority, known as RxP, has become law in three states: New Mexico, Louisiana and now Illinois. This workshop will consist of a panel of Illinois psychiatrists and their long experience with psychology prescription privileges and legislation. With one in five Americans experiencing a mental health disorder and the majority of patients being in primary care, the panel will first discuss if there is a need for more psychotropic prescribers and if so how best to meet this need. There is a long history of psychologists attempting to obtain prescribing privileges in a number of states through legislation. The panel will discuss the history of RxP in order for the participants to appreciate the details of this effort and how it may affect them in their own states. Politically, the strategy psychologists have taken has been varied and sophisticated. The panel will also discuss safe prescribing education and training. We believe that legislation passed in Illinois brings us closer to a curriculum and experience that can add to the mental health system and the benefit of patients in a safe manner. Finally, we will discuss the writing of legislation and rules and the pitfalls that may be encountered.

WORKING WITH AFRICAN IMMIGRANT ADOLESCENTS AND YOUNG ADULTS: FROM THE EXPERTS

Chairs: Tolu Olupona, M.D., Evaristo Akerele, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Increase understanding of unique issues related to working with the young African immigrant population in America; 2) Improve psychiatric evaluation skills when working with this population; 3) Identify treatment options in managing young African immigrants presenting to

mental health settings; and 4) Participate in a case-based discussion that illustrates the challenges of working with African immigrant adolescents and young adults.

SUMMARY:

According to most U.S. censuses, over 1.6 million African-born immigrants live in the U.S., representing a recent wave of African immigration to the U.S., which increased in the 1980s and remains ongoing. These immigrant communities are heterogeneous in their cultures, tribes, religion and languages. Increasingly, adolescents and young adults from these communities are presenting to mental health clinics with various psychopathologies. Given its unique and diverse mores and customs, working with this population is presenting new challenges for clinicians not familiar with this group. Using a case-based history, this interactive workshop will review evaluation, diagnostic and treatment options in working with adolescents and young adults from this population.

WHAT WE'VE LEARNED FROM GENETIC OBESITY SYNDROMES: ARE OVERWEIGHT/OBESITY, ANOREXIA NERVOSA, BULIMIA NERVOSA AND BINGE EATING DISORDER SO DISSIMILAR?

Chair: Janice Forster, M.D.

Speakers: Janice Forster, M.D., Nicolette Weisensel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the hypothalamic mechanisms controlling energy balance; 2) Learn about genetic obesity syndromes and their underlying neurobiology; 3) Understand the neurobiology of anorexia nervosa, bulimia nervosa and binge eating disorder; 4) Understand the contribution of psychological and behavioral factors to overweight/obesity and other the eating disorders; and 5) Compare and contrast the role of eating behavior, psychological traits, reward drive, neurochemistry and environment across all these eating disorders.

SUMMARY:

Rates of overweight/obesity are epidemic. Although there are environmental and lifestyle causes for this epidemic, there is evidence for familial and ethnic propensity in 40 – 50% of cases with European ancestry through the action of the fat mass obesity-related gene (FTO). In addition, there are genetic

obesity syndromes that are rare diseases, either polygenic or monogenic in occurrence, that have recognizable phenotypes. Studying the neurobiological underpinnings of these rare diseases has informed our understanding of the hypothalamic mechanisms contributing to energy imbalance that result in obesity and other eating disorders. Although body mass index (BMI) appears to be a useful tool to identify overweight/obesity and other eating disorders (bulimia nervosa, binge eating and anorexia nervosa), it does not predict underlying neurobiology. All of these eating disorders have commonalities in domains such as reward drive; eating behavior; neurochemistry; and psychological factors of inhibition, dyscontrol and emotionality. For the most part, all of these conditions are chronic, difficult to treat and carry high morbidity. Aspects of eating behavior, such as sensitization and habituation, have been studied in overweight/obesity and not only determine the bias toward nutrient selection associated with food ingestion, but also to the reward drive and addictions. These phenomena are signaled by specific neurotransmitters in the brain and have been observed using imaging techniques. Additional studies have elucidated the role of cortical inhibition in the mindful modulation of subcortical, hedonic drive. All of these studies have advanced our understanding of ways in which clinicians can help patients change their approach to eating behavior, regardless of the diagnosis. In this workshop, Dr. Forster will review the regulation of eating behavior and feedback mechanisms balancing energy intake with specific focus on leptin, ghrelin and other neuropeptides involved in hypothalamic signaling. The characteristics of the most common genetic obesity syndromes will be described, including age of onset, genetic etiology, behavioral phenotype and underlying neurobiological mechanisms leading to obesity. Dr. Weisensel will present the neurobiological underpinnings of binge eating disorder, bulimia nervosa and anorexia nervosa, including a discussion of genetics, fMRI and neurochemical factors. Unusual cases of comorbidity of genetic obesity with eating disorder will also be discussed. As a group exercise with open discussion, the phenomenology and neurobiology of genetic obesity, common overweight/obesity, binge eating disorder, anorexia nervosa and bulimia nervosa will be compared and contrasted. At the conclusion of this presentation, the participant will understand common factors of neurobiology, psychological traits and environmental factors in predisposing,

precipitating and perpetuating behavior across all eating disorders, regardless of BMI.

SERVING THE HOUSEHOLD AND THE HOMELESS: BEHAVIORAL HEALTH-PRIMARY CARE INTEGRATION IN TWO HEALTH CARE MODELS FOCUSED ON SOCIAL DETERMINANTS OF HEALTH

Chair: Eduardo Camps-Romero, M.D.

Speakers: Frederick Anderson, M.D., Mohammad Asim Nisar, M.D., Carissa Caban-Aleman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe how integrated behavioral health-primary care applies to a household-centered model of care and a homeless health care center; 2) Identify how to introduce economic, environmental, family and legal determinants of health in psychiatric evaluation and treatment planning; 3) Leverage ICD10 codes within a medical record and in an integrated care registry to encourage identification and subsequent treatment planning in regards to the social determinants of health; 4) Devise methods to incorporate social determinants of health in health professions training about integrated care; and 5) In small groups, role-play the psychiatrist's role in an interdisciplinary team by simulating cases that illustrate how the social determinants of health inform the care of the patient and household.

SUMMARY:

Integrated care is gaining broad evidence of effectiveness in traditional outpatient settings and is widely adopted nationally. However, less known is whether it yields the same results outside established clinics and working with poor, underserved populations. The Herbert Wertheim College of Medicine (HWCOC) in Miami, FL, aims to train socially responsible doctors while improving the health of our community. HWCOC's curriculum includes Neighborhood HELP™, a unique longitudinal service-learning program where outreach workers and medical, social work, nursing and law students and faculty provide care and address social determinants in underserved households and comprehensive mobile health clinics in Miami-Dade's underserved neighborhoods. Our faculty and students also provide clinical services and respectively train at Camillus Health Concern, the only federally qualified health center exclusively providing health care for the homeless in Miami and working in conjunction with one of the main housing

programs in downtown Miami: Camillus House. Camillus has a colocated model of care and is piloting the implementation of a unified integrated care model into its primary care services. Access to integrated behavioral health services remains a challenge in both programs even after addition of dedicated psychiatrists and licensed therapists. Different strategies were introduced in both of these programs to provide household and person-centered care. In this workshop, we will describe the process of care integration in our nontraditional clinical environments, including 1) Psychiatrists' and therapists' evolving role in the programs; 2) Creating an integrated care clinic system through building culturally competent, unified and interdisciplinary teams that provide whole-person care; 3) Merging the educational and clinical missions for the behavioral health teams; 4) Tailoring the medical record and patient registry to include mental health outcome measures, key biomarkers for disorders that respond to behavioral health interventions (hypertension, obesity, diabetes and smoking) and social determinants of health; and 5) Utilizing ICD-10 codes to reflect the contribution of social determinants of health in patient outcomes. We will illustrate these approaches by presenting our timeline, examples of medical records and patient registry templates, including social determinants of health, and an outline of the educational program we developed.

TRANSFORMATION OF MENTAL HEALTH CARE FOR U.S. SOLDIERS AND FAMILIES DURING THE IRAQ AND AFGHANISTAN WARS: WHERE SCIENCE AND POLITICS INTERSECT

Chair: Christopher H. Warner, M.D.

Speakers: Millard Brown, M.D., Christopher Ivany, M.D., Charles Hoge, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Outline the key advances made in military behavioral health care over the past 15 years and their impact on future military policies and procedures; 2) Recognize the similarities and key differences between U.S. and foreign military service behavioral health care; and 3) Identify potential challenges facing military behavioral health care in the coming decade and recommend potential interventions to improve the system of care.

SUMMARY:

The cumulative strain of 14 years of war on service members, veterans and their families, together with continuing global terrorist threats and the unique stresses of military service, are likely to be felt for years to come. Scientific as well as political factors have influenced how the military has addressed the mental health needs resulting from these wars. Two important differences between mental health care delivered during the Iraq and Afghanistan wars and prior wars has been the degree to which research has directly informed clinical care and the consolidated management of services. The U.S. Army Medical Command implemented programmatic changes to ensure delivery of high-quality standardized mental health services, including centralized workload management; consolidation of psychiatry, psychology, psychiatric nursing and social work services under integrated behavioral health departments; creation of satellite mental health clinics embedded within brigade work areas; incorporation of mental health providers into primary care; routine mental health screening throughout soldiers' careers; standardization of clinical outcome measures; and improved services for family members. This transformation has been accompanied by reduction in psychiatric hospitalizations and improved continuity of care. Although measurable improvements in stigma perceptions have also been documented, challenges remain, including continued underutilization of services by those most in need, problems with treatment of substance use disorders, overuse of opioid medications, concerns with the structure of care for chronic postwar (including post-concussion) symptoms, and ongoing questions concerning the causes of historically high suicide rates, efficacy of resilience training initiatives and research priorities.

FOREIGN BODY INGESTORS: MANAGEMENT CHALLENGES FOR CONSULTATION LIAISON PSYCHIATRISTS

Chair: Elias Khawam, M.D.

Speakers: Syma Dar, M.D., Margo Funk, M.D., M.A., Karen E. Salerno, M.S.W., Lara W. Feldman, D.O., Christopher Sola, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review and discuss cases of self-injurious behavior (SIB) that challenge the CL clinician; 2) Review the literature regarding SIB management on the Consult Service; and 3) Develop

practical skills in dealing with difficult patient scenarios involving SIB.

SUMMARY:

Management of patients with foreign body ingestion is challenging for both psychiatrists and our medical colleagues. Consultation psychiatrists are often tasked with evaluating, treating and assessing suicidal intent of those patients. Early career psychiatrists in particular may feel the strain of producing an effective assessment and treatment plan while balancing the expectations of their medical colleagues, social work and nursing caregivers. The speakers of this workshop include an early career psychiatrist, junior and senior faculty, and a psychiatric social worker. We will share a qualitative survey of various specialists and disciplines in our hospital health system that have dealt with SIB patients. **WORKSHOP FORMAT:** 1) Dr. Khawam will moderate the workshop and help facilitate the audience's personal experiences and challenges in treating foreign body ingestors. A pre-workshop survey will be collected. 2) Drs. Dar, Funk and Khawam will each present a challenging case, pose key management questions and then proceed to a time-limited small-group discussion. The discussion will focus on transference/countertransference issues, role of the CL consultant, and processing patient and primary service expectations. At the conclusion of each case, the answers of the small groups will be collected and shared with all workshop attendees. 3) Dr. Khawam and Dr. Dar will review the existing literature on foreign body ingestion as well as paradigms that can be incorporated as practical management skills. 4) Dr. Khawam will review the results from the survey that was sent to various medical subspecialties and nursing caregivers who have dealt with foreign body ingestors. 5) Ms. Karen Salerno, a social worker on the consultation-liaison team, will discuss the social worker's role in working with patients who ingest foreign bodies. She will review key components of psychosocial history with this patient population as well as community resources that may assist in the coordination of care for this complex patient population. 6) The final portion of the workshop will be two clinical scenarios where the speaker and the audience participants will role-play the CL consultant, the primary service taking care of foreign body ingestor patients. The goal of this exercise is to employ management techniques learned in the workshop in a collegial environment. 7) The

workshop will conclude with a QandA, closing remarks and collection of the post-workshop survey.

DON'T TELL ME TO CALM DOWN! IDENTIFYING TRIGGERS AND NONPHARMACOLOGICAL MANAGEMENT OF CHILD AND ADOLESCENT PATIENTS AT RISK FOR AGITATION

Chairs: Chase Samsel, M.D., Ronke L. Babalola, M.D., M.P.H.

Speaker: Sally Nelson, M.Ed., R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn to identify triggers that precipitate agitation in the child and adolescent population; 2) Identify nonpharmacological interventions that are appropriate to prevent and/or manage agitation; and 3) Discover specific techniques to use prior to, during and after agitation in the autism spectrum population.

SUMMARY:

There are limited publications regarding the issue of education for residents and fellows working with children and adolescents who may become agitated. Hospitals nationally have mandates and intentions to manage the increase in agitation and violence among patients and families without uniform guidelines or training. Both the Joint Commission for Accreditation of Hospitals and the Centers for Medicare and Medicaid Services have mandated that hospitals move toward a restraint-free environment. There is increased focus on managing patients without the use of medication or physical restraints. Many psychiatric trainees receive little or no practical education on identifying early stages of agitation and nonpharmacological interventions. Identifying and avoiding individual patient triggers can prevent an escalation of behaviors. Providing training and practice has been shown to decrease anxiety and increase the level of confidence in managing levels of agitation without the use of medication. Among the most challenging situations are those involving patients with autism spectrum disorder (ASD), who may have behavioral dysregulation when their normal routine and structure is disrupted. This workshop will provide conceptual frameworks and tools for prevention and management of agitation in the hospital or clinic setting for patients with and without ASD.

ACCELERATED RESOLUTION THERAPY: A "MAGIC BULLET" FOR PTSD?

Chairs: Wendi Waits, M.D., Megan Marumoto, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe how accelerated resolution therapy differs from traditional evidence-based therapies for PTSD; 2) Appreciate the strengths and limitations of research published to date on accelerated resolution therapy; 3) Explain the ways in which bench research may explain the clinical outcomes seen with ART patients; and 4) Gain first-hand experience using eye movements to address unpleasant sensations and emotions.

SUMMARY:

Founded by Laney Rosenzweig in 2008, accelerated resolution therapy (ART) is an eye movement therapy administered in a structured protocol format to help patients achieve rapid resolution of distressing symptoms, especially those related to trauma. Despite being a relatively new addition to the therapist's toolkit of trauma treatments, ART contains all of the psychotherapy elements carrying an A-level recommendation in the 2010 DoD-VA clinical practice guidelines for PTSD, including (visual) narration, exposure, stress inoculation, cognitive restructuring and psychoeducation. Published clinical evidence on ART suggests that most patients experience clinically significant improvement after just one session and can typically achieve remission of post-traumatic stress disorder (PTSD) in five or fewer sessions. In the largest study published to date, subjects with PTSD achieved remission in an average of 3.7 ART sessions and had a 94% completion rate. ART bears some similarities to other trauma therapies, such as eye movement desensitization disorder (EMDR) and prolonged exposure (PE), but it is more directive and simpler to administer. The overall objective in an ART session is for the patient to rescript a traumatic memory through the use of eye movements, making their images as positive as possible so that they are no longer distressed when recalling them. The ART protocol also helps patients break up their traumatic scenes into manageable chunks, processing out physical sensations as they arise. After the patient is sufficiently desensitized to their scene, they are instructed to rescript it however they like while performing eye movements. Rescripting of the scene shortly after desensitization appears to be critical to ART's sustained effect and is supported by bench research. Verbal or written narration is not required, giving ART a unique advantage in treating patients

who can't or don't feel comfortable sharing the details of their trauma. ART empowers the patient with creating their own rescripted scenes and solutions to their problems. The therapist serves as a facilitator to the creative process, often finding the sessions extremely rewarding and even fun. This workshop will orient participants to ART, review published and ongoing ART research, review the basic science research supporting ART's effectiveness and examine some clinical cases. Additionally, the presenters will share some practice management tips and lessons learned based on their experience implementing ART at a large community-based hospital and in private practice.

RESEARCH LITERACY IN PSYCHIATRY: HOW TO CRITICALLY APPRAISE THE SCIENTIFIC LITERATURE

Chair: Diana E. Clarke, Ph.D., M.Sc.

Speakers: Diana E. Clarke, Ph.D., M.Sc., Farifteh F. Duffy, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the basic study designs, concepts and statistics used in psychiatric research; 2) Identify why it is important to the individual psychiatrist to be able to understand scientific literature and interpret study concepts, designs and statistics; 3) Discuss and critically appraise the scientific literature; and 4) Identify gaps in literature in a practical sense to have greater access to evidence-based care and informed clinical decisions.

SUMMARY:

The overall goal of this workshop is to educate participants on what it means to critically appraise the scientific literature. Throughout the workshop, participants will be introduced to the basic concepts, study designs and statistics in psychiatric research that will enable them to read and understand the scientific literature and appreciate the importance of being able to critically appraise the literature. Time will be allotted for participants to read a scientific article for discussion. The workshop then will utilize a "journal club"-style interactive format in which methodological and statistical issues will be introduced and discussed on a section-by-section basis as they pertain to the scientific article. After the introduction of methodological and statistical issues related to each section, participants will be given a few minutes to read that respective section of the article. Participants will then discuss the

article, view it with a critical eye, and analyze and apply concepts learned. In summary, participants will learn how to appraise the scientific literature in a critical, thorough and systematic manner. Not only will this workshop help participants stay abreast of changes in the field and identify gaps in the literature, in a practical sense, it will enable greater access to evidence-based care and inform clinical decisions.

ENGAGING THE UNENGAGED PATIENTS WITH SEVERE MENTAL ILLNESSES: COMMUNITY-BASED CROSS-CULTURAL EXPERIENCES FROM INDIA AND CANADA

Chairs: Nitin Gupta, M.D., Amresh Shrivastava, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand and appreciate delivery of community care in a Western, developed country like Canada; 2) Understand and appreciate delivery of community care in a non-Western, developing country like India; 3) Compare and contrast the community model of care in developed and developing country set-ups; and 4) Discuss how these models of community care can be adapted to the specific country-based models as per identified local needs.

SUMMARY:

Community care in India is delivered in a vastly different manner than in Western countries like Canada. However, models from the developed world can be adopted to suit the local Indian culture, subject to testing for appropriateness. Home-based treatment (HBT) is one such model available in the West for quite some time, and there were limited attempts of its use in India in the last three decades with some success. Combined with the fact that there is a huge treatment gap in urban settings and community care is predominantly directed toward rural settings, there was a need to develop HBT as a service for tri-city of Chandigarh (a city in North India) and test its acceptability. This workshop shall discuss the common models of community care being used in Canada, which shall be exemplified with case vignettes. Additionally, the development and implementation of the HBT service in Chandigarh, India, will be initially described, along with the standard operating procedure (SOP) for the service. The case vignettes shall be applied to this Indian model, and discussion shall focus on the cross-cultural aspects of delivery of community care

and the need for adaptation as per local needs and cultural phenomena.