SYLLABUS &

SYLLABUS & PROCEEDINGS SUMMARY

AMERICAN PSYCHIATRIC ASSOCIATION

2007 ANNUAL MEETING

SAN DIEGO, CA ✦ MAY 19–24, 2007

PROCEEDINGS SUMMARY

SYLLABUS
AND
SCIENTIFIC PROCEEDINGS

IN SUMMARY FORM

THE ONE HUNDRED AND SIXTIETH
ANNUAL MEETING OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

San Diego, CA

May 19-24, 2007

Published by

$29.95

AMERICAN PSYCHIATRIC ASSOCIATION

1000 Wilson Boulevard, Suite 1825

Arlington, VA 22209

May 2007

This page intentionally left blank

SCIENTIFIC PROGRAM COMMITTEE

ROBERT W. GUYNN, M.D., *Chairperson*, Houston, TX
DAVID A. BARON, D.O., *Vice-Chairperson,* Philadelphia, PA
RENATO D. ALARCON, M.D., Rochester, MN
JOSEPHA A. CHEONG, M.D., Gainesville, FL
KATHRYN M. CONNOR, M.D., Chapel Hill, NC
EDWARD F. FOULKS, M.D., PH.D., New Orleans, LA
DONALD M. HILTY, M.D., Sacramento, CA
STEPHANIE LEMELLE, M.D., New York, NY
JULIO LICINIO, M.D., Los Angeles, CA
CHRISTINE E. MARX, M.D., Durham, NC
ANU MATORIN, M.D., Houston, TX
EDMOND HSIN T. PI, M.D., Los Angeles, CA
ANTHONY J. ROTHSCHILD, M.D., Worcester, MA
KENNETH R. SILK, M.D., Ann Arbor, MI
DEBORAH SPITZ, M.D., Chicago, IL
HARVEY STABINSKY, M.D., J.D., Harrison, NY
LINDA L.M. WORLEY, M.D., Little Rock, AR

Consultants
ROBERT J. BOLAND, M.D., Providence, RI
MARION ZUCKER GOLDSTEIN, M.D., Buffalo, NY
ALEX J. KOPELOWICZ, M.D., Los Angeles, CA
DONNA MANCUSO, M.D., New Orleans, LA
MARY K. MCCARTHY, M.D., Portland, OR
JAMES R. MERIKANGAS, Bethesda, MD
ANAND PANDYA, M.D., New York, NY
JASMINE P. TAYLOR, M.D., Madison, MS

COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING

SANDRA SEXSON, M.D., *Chairperson,* Augusta, GA

COMMITTEE ON CME/LIFELONG LEARNING

DAVID B. MALLOTT, M.D., *Chairperson,* Baltimore, MD
LEAH J. DICKSTEIN, M.D., Louisville, KY
THOMAS A.M. KRAMER, M.D., Chicago, IL
THERESA M. MISKIMEN, M.D., Piscataway, NJ
MARK H. RAPAPORT, M.D., La Jolla, CA
EUGENE J. SCHNEIDER, M.D., Rochester, NY
JEFFREY S. AKMAN, M.D., *Corresponding Member,* Washington, D.C.

COMMITTEE ON COMMERCIAL SUPPORT

SPENCER ETH, M.D., *Chairperson,* New York, NY
PETER B. GRUENBERG, M.D., Beverly Hill, CA
MICHAEL D. JIBSON, M.D., PH.D., Ann Arbor, MI
SCOTT MASTERS, M.D., New York, NY
DAVID M. MCDOWELL, M.D., *Chairperson,* New York, NY
TREVOR R.P. PRICE, M.D., Philadelphia, PA
EDWARD F. FOULKS, M.D., PH.D., New Orleans, LA
DAVID B. MALLOTT, M.D., Baltimore, MD
SANDRA SEXSON, M.D., Augusta, GA

MEDICAL DIRECTOR'S OFFICE

JAMES H. SCULLY, JR., M.D., *Medical Director and CEO*
ROSALIND KEITT, *Chief-of-Staff*

ANNUAL MEETINGS DEPARTMENT

CATHY L. NASH, C.M.P., *Director*
VERNETTA V. COPELAND, *Associate Director*

OFFICE OF SCIENTIFIC PROGRAMS

GARY A. McMILLAN, M.A.L.S., M.S., *Acting Director*
KAREN BOLTON, *Scientific Program Coordinator*
YASHICA L. JOYNER, *Program Assistant*
BYRON PHILLIPS, *Scientific Program Coordinator*
ELIZABETH RUMSEY, *Administrator, CME Courses*
DESTA WALLACE, *Scientific Program Coordinator*

DIVISION OF EDUCATION

DEBORAH J. HALES, M.D., *Director*
KATHLEEN DEBENHAM, M.A., *Director, Department of Continuing MedicalEducation*
LINDA BUENO, R.N., *Associate Director, Commercially-Supported Activities*

FOREWORD

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

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

We wish to express our appreciation to all of the authorsand other session contributors for their cooperation in preparing their materials so far in advance of the meeting. Our special thanks are also extended to Desta Wallace, Karen Bolton, and Byron Phillips in the APA Annual Meetings Department.

Robert W. Guynn, M.D., *Chairperson*
David A. Baron, D.O., *Vice-Chairperson*
Scientific Program Committee

Full Texts

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

TABLE OF CONTENTS

OTHER FORMATS ALPHABETICALLY

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

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

Life members and Life Fellows who were elevated to life status during or prior to May 1976 are exempt from the CME requirement. Members achieving those member classes after May 1976 are subject to the CME requirement. Members who are retired are exempt from the requirement when the APA receives notification of their retirement.

Obtaining an APA CME Certificate

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

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

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

APA Report Form
In addition to category 1 CME activities designated by accredited sponsors, the APA recognizes these additions to category 1 credit as fulfilling the requirement: articles published in peer-reviewed journals (journals included in the Index Medicus) – 10 category 1 credits for each article, 1 article per year; poster preparation for an exhibit at a medical meeting designated for AMA PRA category 1 credit, including published abstract – 5 category 1 credits per poster, 1 presentation per year; teaching, e.g., presentations for activities designated for AMA PRA category 1 credits – 2 credit hours for preparation and presentation of new and original lecture or teaching material designated for category 1 credit by an accredited sponsor, to a maximum of 10 credits per year; medically-related degrees, such as the Master's in Public Health – 25 AMA PRA category 1 credits following award of the advanced degree.

APA members may claim 25 hours of category 1 CME credit for successful completion of Part I and 25 hours for the successful completion of Part II of the examinations of the American Board of Psychiatry and Neurology (ABPN), and the Royal College of Physicians and Surgeons (of Canada). Members may also claim 25 hours for successful completion of the ABPN recertification examination. Members may claim 25 hours for successful completion of the certifying examination in Addiction Psychiatry, Administrative Psychiatry, Child Psychiatry, Forensic Psychiatry, Geriatric Psychiatry, and Psychosomatic Psychiatry.

Members may claim 50 hours of category 1 CME credit for each full year of training in a program that has been approved by the Accreditation Council for Graduate Medical Education (ACGME). Following completion of an ACGME approved residency, APA members are considered to be in compliance with the APA CME requirement. Reporting should begin with three years.

By signing a CME Compliance Postcard, which the APA will send you on request at the end of each three-year reporting cycle, members may demonstrate that they have fulfilled the APA requirement; compliance will be recorded, but a certificate will not be issued.

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

This page intentionally left blank

Pedro Ruiz, M.D.

PRESIDENTIAL ADDRESS

ADDRESSING PATIENT NEEDS: ACCESS, PARITY AND HUMANE CARE

As I reflect on my year as your APA President, my tenure began with several formidable challenges regarding the health of our patients and the well-being of our Association. I firmly believe that it is our social responsibility, as psychiatrists and citizens, to ensure that humane care will not just be a privilege for some, but a right for all human beings. APA advocates on many fronts for universal access to health care and for full and comprehensive parity of psychiatric care, but I knew we needed to build a strong and genuine partnership with patient-oriented and advocacy groups in order to achieve access, parity and humane care for our patients. Our accomplishments include a 2006 Leadership Forum and a newly formed Joint Work Group, forging a stronger and formal, solid coalition with the National Alliance on Mental Illness (NAMI) and Mental Health America (MHA).

Today we have a also stronger and more transparent APA, which can only serve to improve the profession's image and stature. Two interrelated developments underscore this progress. The DSM-V project was already underway for several years, and it was time to select the leadership who will take this very important APA project to a successful completion. At the same time, the field of medicine, including psychiatry, faced serious and ongoing criticisms due to grave ethical violations and irresponsible behavior on the part of various components within the medical field. We, therefore, decided to address the conflict of interest policy, which was in use for this purpose in the APA, and change it into the most transparent and ethically-driven policy that one could humanly design, resulting in a disclosure form that is second to none in the medical field. This process was followed by the appointment of a second APA Board of Trustees Task Force which has screened all of the nominees for the DSM-V Task Force, and is currently screening all of the nominees for the DSM-V Working Groups.

I faced another challenge when I was invited by the U.S. Department of Defense to visit the U.S. Naval Base in Guantanamo Bay, Cuba, together with a group of senior military officers as well as leaders from a variety of professional and medical organizations. I saw physicians, psychiatrists, and other health and mental health personnel, working under the most difficult and challenging circumstances. This led me to appoint another APA Work Group on the health and mental health needs of our men and women in the military, as well as, their family members.

I also worked to strengthen our important ties with the federal institutes (the National Institute on Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism), inviting the Institute directors to address the Board of Trustees and enlisting their participation in this year's Presidential Symposia. Similarly, NAMI, the American Association of Community Psychiatrists, and the American Orthopsychiatry Association continued to partner with our Institute on Psychiatric Services, making last Fall's meeting the most successful in its 58 year history.

As long as there is a mental patient without access to health and mental health care, without full and comprehensive parity of psychiatric care, without receiving proper humane care, and who is still living in the shadows, whether this happens in this country or in any other part of the world, we must heed the call to advocate for them.

This page intentionally left blank

SATURDAY, MAY 19, 12:30 PM - 3:30 PM

INDUSTRY SUPPORTED SYMPOSIUM 1— CLINICAL MANAGEMENT OF ADHD Supported by Shire US, Inc.

No. 1A
CLINICAL MANAGEMENT OF ADHD

Timothy E. Wilens, M.D. *Massachusetts General Hospital, Pediatric Psychopharmacology Research Unit, 55 Fruit Street, Yaw 6900, Boston, MA, 02114*

SUMMARY:

Diagnosing and treating attention-deficit/hyperactivity disorder (ADHD) poses challenges for today's clinician. No one test can confirm a diagnosis. The presence of comorbid conditions can overlap and blur ADHD symptoms. Studies estimate that the disorder affects 4% to 5% of adults and 3% to 7% of school-age children.

ADHD can persist into adulthood, but this is a recent discovery. Characteristics and management of the disorder are different for adults than for children. Misdiagnosis or failure to diagnose can have serious personal and societal consequences, including a variety of mental and somatic illnesses and a greater risk of illiteracy, unemployment, and social maladjustment.

Research and clinical experience are revealing ADHD as a prevalent, often disabling psychiatric disorder that persists throughout life. However, new diagnostic instruments and emerging treatments are providing new tools and options for managing the disorder in patients of all ages. The presentations will update physicians on all aspects of evaluating and treating ADHD. They focus on:

Office-based diagnosis, including taking educational and occupational histories, and using the clinical interview, diagnostic and symptom rating scales, and the psychiatric evaluation as assessment tools.

Treating comorbidity in ADHD (major depression, bipolar disorder, anxiety disorders, personality disorders), which, along with various social and adaptive impairments (antisocial behavior, learning disabilities, and abuse of alcohol, drugs, nicotine, and caffeine), can affect as many as 50%-75% of ADHD sufferers.

Treating ADHD in special groups namely, preschool children and adults including parent training, behavioral interventions, and clinical-trial enrollment for very young children, and psychostimulant and nonstimulant pharmacotherapy, as well as nonpharamacologic interventions, for adults.

Managing ADHD in high-risk patients, including those with hypertension or cardiovascular disease in whom both stimulant and nonstimulant medications may pose health risks as well as patients with comorbid, refractory substance-use disorders.

Effective psychosocial interventions for treating ADHD, including psychoeducation, problem solving, and developing group and individual cognitive-behavioral therapies, as adjunctive treatment or an alternative to pharmacotherapy.

No. 1B
OFFICE-BASED DIAGNOSIS

Keith McBurnett, Ph.D. *University of California, San Francisco, Psychiatry, 401 Parnassus Ave, Room 140, San Francisco, CA, 94143*

SUMMARY:

Until relatively recently, clinicians thought attention-deficit/hyperactivity disorder (ADHD) disappeared with childhood. Recent data suggest, however, that more than half of children with the disorder continue to have significant symptoms throughout life. We now know ADHD persists in about 50% of children with ADHD. Adults with ADHD also suffer functional impairments; they have difficulty finding and keeping a job, for example, or exhibit addictive, antisocial, or destructive behaviors. If undiagnosed and untreated, ADHD can be highly disabling. As such, clinicians must understand adult ADHD and be attuned to its signs and symptoms so that optimal treatment strategies can be implemented.

Approximately 4% to 5% of adults have ADHD, making it one of the most common psychiatric disorders. An accurate diagnosis lays the foundation for the safe and effective treatments now available for disorder management. A diagnosis of adult ADHD is clinically based and hinges on a thorough clinical interview, in conjunction with results from symptom rating scales and supplemental information on the patient's childhood from parents or siblings.

Diagnosing attention-deficit/hyperactivity disorder in adults and children poses several challenges. These challenges include the frequent presence of comorbid psychiatric conditions that can overlap or blur ADHD symptoms. No single physical, mental, or genetic test exists for diagnosing ADHD. Diagnosis requires recognition of adult manifestations of childhood symptoms. Understanding the manifestation of impairments in various life settings is essential; to this end, taking educational and occupational histories is important. Using the clinical interview to assess childhood symptoms of ADHD is an important determinant of whether the patient meets DSM-IV criteria of childhood onset of the disorder.

Despite such challenges, we now have increased knowledge of how children and adults clinically present with ADHD and how childhood symptoms evolve into adult manifestations. Diagnostic and symptom rating scales are valuable tools for assessing ADHD symptoms and making an accurate diagnosis. In this presentation, psychiatric diagnostic evaluation will be reviewed and discussed, highlighting developmental and familial issues that can help lead to diagnosis.

No. 1C
TREATMENT OF ADHD IN SPECIAL GROUPS

Christopher J. Kratochvil, M.D. *University of Nebraska Medical Center, 985584 Nebraska Medical Ctr, Omaha, NE, 68198-5584*

SUMMARY:

Attention-deficit/hyperactivity disorder (ADHD) affects approximately 3% to 7% of school-age children, making it one of the most common psychiatric disorders of childhood. A large body of clinical evidence has emerged over the past 70 years demonstrating the efficacy of stimulant and nonstimulant treatments, as well as a number of alternative second-line agents, in ameliorating the ADHD core symptoms of hyperactivity, impulsivity, and inattention in this age group.

Recently, ADHD has been recognized to occur not only in school-age children and adolescents but across the lifespan, emerging in young preschool children and persisting into adulthood. It is essential that clinicians understand how ADHD symptoms manifest in these less-well-studied age groups and how the therapeutic approach must be tailored to achieve the target treatment goals of each individual.

The symptoms of ADHD can present in children as young as 3 years, with an estimated 2% of 3- to 5-year-olds meeting the diagnostic criteria for ADHD. Preschool children with ADHD are at significant risk for behavioral, academic, social, and family difficulties compared with non-ADHD preschoolers. Diagnosis can be difficult, given the developmentally appropriate hyperactivity and inattention seen in this age group. Comprehensive assessment includes a thorough parental interview, reports from a day-care provider or teacher who interacts with the child in a structured setting, examination of the child's mental status and cognitive functioning, ruling out visual and/or auditory deficits, and determining possible exposure to lead.

Data on the safety and efficacy of pharmacotherapy for ADHD in young children are sparse. However, it is anticipated that recent and ongoing clinical medication trials, such as the Preschool ADHD Treatment Study (PATS), will provide new information on the safety and effectiveness of ADHD therapies in preschool children.Meanwhile, treatment planning for preschoolers should include parent training and behavioral interventions. Ongoing follow-up using age- and gender-normed rating scales is also recommended.

At the other end of the age spectrum, ADHD affects approximately 4% to 5% of adults or as many as 9.4 million individuals, based on US census data. A number of significant studies in adults with ADHD have been conducted over the past decade, providing a solid foundation on which to base treatment strategies. Many pharmacologic agents effective in managing childhood ADHD are also useful in treating adults., However, when developing a treatment plan, the issues and characteristics of ADHD unique to adulthood must be addressed. These include the core symptoms of ADHD as well as associated symptoms, functional impairments, and comorbid conditions. Careful drug selection and adequate dosing can diminish core ADHD symptoms and, over a sustained period of symptom remission, improve functional effectiveness. Currently, two psychostimulants and a nonstimulant are FDA-approved for treatment of adults with ADHD. Extended-release formulations offer the promise of longer therapeutic action, improved compliance due to a simplified dosing schedule, and less abrupt onset and offset of effect. Nonpharmacologic interventions, such as psychoeducation, various psychosocial strategies, and cognitive-behavioral therapy, are also important components of adult ADHD management.

No. 1D
ADDRESSING COMORBIDITY IN ADHD

Paul G. Hammerness, M.D. *Massachusetts General Hospital, Clinical and Research Program in Pediatric Psychopharmacology, 185 Alewife Brook Parkway, Suite 2000, Cambridge, MA, 02138*

SUMMARY:

Adult Attention-Deficit Hyperactivity Disorder is associated with numerous comorbidities and social and adaptive impairments. Studies estimate comorbidity rates to be as high as 50% to 75%, including mood and anxiety disorders, oppositional and antisocial behavior, and learning disabilities. Alcohol abuse and other types of substance abuse are common, and self-medication with excessive doses of nicotine or caffeine can be a clue to the presence of ADHD. In addition, preliminary findings suggest that adult ADHD may be associated with bulimia nervosa, and that objective evidence of breathing-related sleep disorders can be found in some adults with ADHD. Beyond evidence of diagnostic comorbidities, adults with ADHD have been shown to have significant interpersonal and occupational dysfunction.

Careful assessment of the presence of comorbidities is a key component of ADHD evaluation. Clinicians should be aware of the significant cost to the individual and to the community if effective interventions for ADHD and its comorbidities are not applied.

In this presentation, recognizing the clinical spectrum and complex relationship between ADHD and comorbid conditions will be examined. Future approaches to the research and treatment of ADHD will be discussed.

No. 1E
EFFECTIVE PSYCHOTHERAPIES FOR ADULTS WITH ADHD

Mary Solanto, Ph.D. *Mount Sinai School of Medicine, Psychiatry, 1 Gustave Levy Place, Box 1230, New York, NY, 10029*

SUMMARY:

Nonpharmacologic treatment of ADHD, while less well studied than pharmacotherapy, is nevertheless essential to effective management. Studies show that 20% to 50% of adults with ADHD are nonresponders to medication; either their core symptoms are insufficiently reduced or they are unable to tolerate the drugs. But even patients who respond to medication need to learn metacognitive skills_time management, organization, planning, problem-solving, and coping skills_to function effectively. As such, psychosocial treatments are valuable for helping ADHD patients address the developmental, emotional, and behavioral challenges of their disorder, whether or not they are taking medication.

This presentation describes the emerging role of psychosocial treatments in ADHD management. Cognitive-behavioral therapy (CBT) in particular has shown promise in reducing symptoms and improving functioning in ADHD patients, early research suggests. The session will explore the state of the art in scientifically demonstrated psychosocial therapies for ADHD, including existing and emerging research in controlled settings for treating individuals and groups. A strong doctor-patient relationship provides a framework for offering psychoeducation, CBT, self-management skills training, and academic and vocational counseling which are key elements of an effective treatment plan. Patients must also understand that ADHD is a neurologic disorder and it is not their "fault" that they are disorganized and forgetful.

ADHD is typically a lifelong condition that requires continuous care, periodic reevaluation and adjustment of treatment modalities, and assessment of improvement in symptoms, functioning, and overall quality of life. Psychotherapies combined with appropriate ADHD medications in an integrated approach to treatment usually produce the most successful outcomes for patients living with ADHD.

REFERENCES

1. Wender PH. Pharmacotherapy of attention-deficit/hyperactivity disorder in adults. *J Clin Psychiatry.* 1998;59(suppl 7):76-79.
2. Wilens TE, Spencer TJ, Biederman J, et al. A review of the pharmacotherapy of adults with attention-deficit/hyperactivity disorder. J Atten Disord. 2002;5:189-202.
3. Wilens TE, Biederman J, Spencer TJ. Pharmacotherapy of attention deficit hyperactivity disorder in adults. CNS Drugs. 1998;9:347-356.
4. Safren SA, Sprich S, Chulvick S, et al. Psychosocial treatments for adults with attention-deficit/hyperactivity disorder. Psychiatr Clin North Am. 2004;43:831-842.
5. Safren SA, Otto MW, Sprich S. Cognitive-behavorial therapy for ADHD in medication-treated adults with continued symptoms. Behav Res Ther. 2005;43:831-842.
6. Wilens TE, McDermott SP, Biederman J, et al. Cognitive therapy in the treatment of adults with ADHD: A systematic chart review of 26 cases. J Cog Psychotherapy. 1999;13(3):215-226
7. Solanto MV, Marks D J, Mitchell K, et al. Development of a new psychosocial treatment for adults with AD/HD. Submitted for publication.

INDUSTRY SUPPORTED SYMPOSIUM 2—EXPERT DIALOGUE ON ALZHEIMER'S DISEASE: DIAGNOSTIC AND REFERRAL ISSUES, TREATMENT OF THE COGNITIVE DEFICITS, AMELIORATING THE BEHAVIOR COMPLICATIONS, AND COMPREHENSIVE MULTIDISCIPLINARY CARE

Supported by Forest Laboratories, Inc.

No. 2A
EXPERT DIALOGUE ON ALZHEIMER'S DISEASE: DIAGNOSTIC AND REFERRAL ISSUES, TREATMENT OF THE COGNITIVE DEFICITS, AMELIORATING THE BEHAVIOR COMPLICATIONS, AND COMPREHENSIVE MULTIDISCIPLINARY CARE

George T. Grossberg, M.D. *Saint Louis University Medical Center, Psychiatry and Human Behavior, 1221 S Grand Blvd, Saint Louis, MO, 63104-1016*

SUMMARY:

The *Expert Dialogue on Alzheimer's Disease: Diagnostic and Referral Issues, Treatment of Cognitive Deficits, Ameliorating the Behavioral Complications, and Comprehensive Multidisciplinary Care* symposium is a case-based (including videos of patients), interactive, moderated dialogue between senior experts who care for patients with Alzheimer's disease. The symposium will allow for active discussion of participants' questions and encourage participants and experts to share their opinions and recommendations regarding optimal diagnostic and new treatment options in the field. Because studies have shown that contextual learning helps physicians retain new knowledge, the learning activities will help physicians apply the information they retain to clinical practice.

No. 2B
COMPREHENSIVE MULTIDISCIPLINARY CARE

Warachal E. Faison *MUSC/ARCP, Psychiatry, 5900 Core Rd, Suite 203, North Charleston, SC, 29406*

SUMMARY:

This presentation will examine the importance of multidisciplinary care in the treatment of patients with Alzheimer's disease (AD). With the growing elderly population and lack of geriatric health professionals, an increasing number of elderly patients with dementia will be treated by primary care physicians. Multidisciplinary care is critical in the assessment and treatment of patients with dementia as it may lead to earlier diagnosis, delay in onset of behavioral problems, and improved treatment of AD, including behavioral problems. Effective approaches to care will be highlighted.

No. 2C
TREATING COGNITIVE DEFICITS IN PATIENTS WITH ALZHEIMER'S DISEASE

Pierre N. Tariot *Banner Alzheimer's Institute, 901 E Willetta St, Phoenix, AZ, 85006-2727*

No. 2D
AMELIORATING THE BEHAVIORAL COMPLICATIONS IN PATIENTS WITH ALZHEIMER'S DISEASE

Jacobo E. Mintzer, M.D. *Medical University of South Carolina, Psychiatry (ARCP), 5900 Core Ave Ste 203, N Charleston, SC, 29406-6076*

SUMMARY:

Behavioral symptoms such as psychosis, agitation, depression, and apathy are an important component of the Alzheimer's disease symptoms. These symptoms cause significant morbidity to the patient and burden to the caregiver. The presence of these symptoms can be explained using both behavioral/environmental and/or biological models. During this presentation both models will be argued and the data supporting each approach will be discussed. The diagnostic and treatment implications of these approaches will be talked about using an interactive model and clinical vignettes both with the expert panel and audience. The clinical utility of diverse published clinical approaches being advocated by different consensus statements for the treatment of behavioral complications of Alzheimer's will be evaluated. A summary of the interactive discussion will be composed during the symposium and presented on screen to the audience.

No. 2E
DIAGNOSTIC AND REFERRAL ISSUES

William E. Reichman, M.D. *UMDNJ-Robert Wood Johnson Medical School, Psychiatry, 125 Paterson Street, New Brunswick, NJ, 08901*

SUMMARY:

Otpimizing Diagnostic Strategies

Data consistently show that AD is frequently overlooked or misdiagnosed in routine clinical practice. Many obstacles exist that have been difficult to overcome. These include the lack of access to cognitive screening tools in primary care settings that are cost effective, the unavailability of informants to guide history taking, and a lack of recognition of the differences between age associated cognitive losses and disease states such as AD. This presentation will focus on the spectrum of impaired cognition in the elderly, the available tools that are present to identify significant cognitive disability and recommendations for specialty referral.

REFERENCES:

1. Callahan CM, Boustani MA, Unverzagt FW,et al: Effectiveness of collaborative care for older adults with Alzheimer disease in primary care: a randomized controlled trial.: JAMA 2006; 295(18):2148-57.
2. 5. Cummings JL. Use of cholinesterase inhibitors in clinical practice: Evidence based recommendations. Am J Geriatr Psychiatry. 2003;11:131 145.
3. Cohen-Mansfield J, Mintzer JE: Time for Change: the role of nonpharmacological interventions in treating behavior problems in nursing home residents with dementia. Alzheimer Dis Assoc Disor 2005 January/February/March; 19(1):37-40.
4. 1. Hebert LE, Scherr PA, Bienias JL, et al. Alzheimer disease in the US population: Prevalence estimates using the 2000 Census. Arch Neurol. 2003;60:1119 1122.

INDUSTRY SUPPORTED SYMPOSIUM 3—RECOGNITION AND MANAGEMENT OF RESTLESS LEGS SYNDROME (RLS) IN PSYCHIATRIC PRACTICE

Supported by Boehringer Ingelheim Pharmaceuticals, Inc.

EDUCATIONAL OBJECTIVES:

1. to review the epidemiology of Restless Legs Syndrome
2. to discuss the risk factors for Restless Legs Syndrome

No. 3A
UNDERSTANDING RLS:EPIDEMIOLOGY AND CLINCAL FEATURES

Barbara A. Phillips, M.D. *University of Kentucky, Division of Pulmonary, Critical Care and Sleep Medicine, 119 Sycamore Rd, Lexington, KY, 40502*

SUMMARY:

Restless legs syndrome (RLS) is an impairing sensorimotor disorder characterized by an overwhelming urge to move one's legs with paresthesias/dysesthesias, which are worse during periods of inactivity and at night.RLS may be idiopathic or comorbid with a separate medical condition. The prevalence of RLS increases with age, and approximately 2%-4% of the adult population is substantially affected, with women being at greater risk.

RLS has a significant negative impact on quality of life, resulting from chronic sleep deprivation, discomfort during waking hours, and stress.Individuals with RLS typically report symptoms of anxiety and depression, such as fatigue, disturbed sleep, diminished concentration, and psychomotor agitation.

Evidence suggests that patients with RLS are at a higher risk of psychiatric disorders than those with other somatic disorders. Diagnostic interviews with patients with RLS found an increased 12-month and lifetime risk for specific psychiatric disorders, such as panic disorders, generalized anxiety disorders, and major depression, when compared with historical controls.A separate study found that patients with RLS were more likely to have received a prior clinical diagnosis of depression, neurotic disorder, or affective psychosis than the general population.Those with declining renal function have also been observed to have an increased prevalence for RLS. Symptoms also take place during pregnancy and are concurrent with uremia, iron depletion, polyneuropathy, and spinal disorders.

No. 3B
RLS-ASSOCIATED PSYCHIATRIC SYMPTOMS

Hochang Benjamin B. Lee, M.D. *Johns Hopkins University School of Medicine, Department of Psychiatry and Behavioral Sciences, 550 N. Broadway, Suite 308, Baltimore, MD, 21205*

SUMMARY:

Evidence indicates that there is a correlation between restless legs syndrome (RLS) and psychiatric disorders, such as depression and anxiety disorders. Abnormal sleeping patterns are one of the most common complaints from psychiatric patients and these sleep disturbances may be caused by central nervous system abnormalities associated with psychiatric illness as well as by accompanying behavioral disturbances. Results from a survey of patients with RLS have indicated an increased 12-month and lifetime risk for specific psychiatric disorders, such as panic disorders, generalized anxiety disorders, and major depression, when compared with historical controls.

The exact causal relationship between RLS and psychiatric disorders is unknown. Research has suggested that some features of depression might be related to RLS, such as reduced sleep and loss of energy, but not to the full spectrum of a depressive disorder. Abnormalities in dopaminergic transmission and genetic associations between RLS and psychiatric disorders have also been hypothesized as potential causal factors.

Several antidepressants are thought to aggravate RLS, limiting treatment options in these patients. Tricyclic antidepressants and selective serotonin reuptake inhibitors and have been shown to exacerbate periodic leg movements (PLMs). These PLMs are likely the result of enhanced serotonergic availability and secondarily decreased dopaminergic effects.

Although there are shared symptoms between RLS and depressive disorders, such as sleep disturbances, there is no clear relationship between the two illnesses. It is important for psychiatrists to recognize symptoms of RLS, especially in anxious and depressive patients, because certain antidepressants can aggravate RLS. Proper identification of RLS and delineation of treatment strategies dependent on the condition's severity and comorbid conditions is an important step in the process for treating patients who suffer with this disorder.

No. 3C
THE PSYCHIATRIST'S ROLE IN MANAGING RLS

Jed E. Black, M.D. *Stanford Sleep Disorders Clinic, Palo Alto, CA*

SUMMARY:

Overlap of symptom between restless legs syndrome (RLS) and psychiatric disorders complicates appropriate diagnoses of the two disorders. In particular, sleep disturbance, fatigue, activation/agitation, and diminished concentration are commonly seen in RLS as well as mood and anxiety disorders. Patients with RLS commonly report mild to severe discomfort and social isolation, two recognized predictors of depression. Therefore, psychiatrists need to understand that RLS may present with common psychiatric symptoms, e.g., mood disturbance, anhedonia, and anxiety. Conditions that might mimic RLS, such as anxiety/agitation, akathisia, hyperactivity, and peripheral neuropathy, should be excluded.

Diagnosis of RLS is determined by the following 4 criteria: (1) an urge to move the legs, usually accompanied by uncomfortable and unpleasant leg sensations, (2) symptoms are worse when lying or sitting, (3) symptoms are at least partially relieved by movement, and (4) symptoms are worse in the evening or at night. Supportive features of RLS include a family history of the disorder, an initial response to dopaminergic therapy, sleep disturbance, a normal neurological exam, periodic limb movements (>5 per hour of sleep), and iron deficiency. Reduced serum ferritin levels is the most common reason for secondary RLS, even in the absence of decreased hemoglobin.

The DSM-IV diagnostic criteria classify RLS under the category of "Dyssomnia Not Otherwise Specified." Insomnias, hypersomnias, or circadian rhythm disturbances that do not meet criteria for any specific sleep disorder are placed here.

By obtaining a greater understanding of RLS, psychiatrists can improve differential diagnosis of overlapping symptoms and better ensure that treatments are better tailored to a patient's symptoms.

No. 3D
TREATMENT OPTIONS FOR RLS

Jacques Montplaisir, M.D. *University of Montreal - Hôpital Sacre-Coeur of Montreal, Psychiatry, 5400 Blvd Gouin West, Sleep Disorders Center, Montreal, PQ, H4J 1C5, Canada*

SUMMARY:

Not all patients with RLS need medication. Many patients can benefit from appropriate sleep practices and adaptive lifestyle

changes. Patients should allow themselves adequate time for sleep in their daily schedules as well as incorporate consistent, relaxing bedtime routines. Along with suitable sleep hygiene, avoidance of alcohol, caffeine, and nicotine can alleviate periodic leg movements (PLMs). Direct dopamine receptor agonists are considered the most effective treatment for RLS. Depending on the severity of RLS, various other drugs, such as opioids, gabapentin, and benzodiazepines, can also be employed as treatment options.

Thoughtful treatment approaches are necessary for patients with RLS and comorbid psychiatric conditions. The significance of the psychiatric morbidity should dictate which condition is initially treated. RLS may be treated first in instances where the underlying psychiatric symptoms are considered less severe. The Academy of Sleep Medicine currently recommends the use of dopamine receptor agonists as first-line treatment for moderate-to-severe stages of RLS. The use of dopamine agonists has also been associated with a mild antidepressant effect.

REFERENCES:

1. Hening W, Walters AS, Allen RP, et al. Impact, diagnosis, and treatment of restless legs syndrome (RLS) in a primary care population: the REST (RLS epidemiology, symptoms, and treatment) primary care study. Sleep Med. 2004;5:237-246.
2. Picchietti D, Winkelman JW. Restless legs syndrome, periodic limb movements in sleep, and depression. Sleep. 2005;28:891-898.
3. Allen RP: Restless legs syndrome: diagnostic criteria, special considerations, and epidimeology. Sleep Med 2003; 4:101-119.
4. Littner Mr, Kushida C, Anderson WM, et al.: Practice parameters for the dopaminergic treatment of restless legs syndrome and periodic limb movement disorder. Sleep 2004; 27:557-559.

SATURDAY, MAY 19, 6:00 PM - 9:00 PM

INDUSTRY SUPPORTED SYMPOSIUM 4— INSIGHTS FROM STAR*D: ARE OUR PATIENTS' NEEDS BEING MET? Supported by Cyberonics, Cephalon, & Wyeth

No. 4A
INSIGHTS FROM STAR*D: ARE OUR PATIENTS' NEEDS BEING MET?

Maurizio Fava, M.D. *Massachusetts General Hospital, 55 Fruit St, Boston, MA, 02114-2696*

SUMMARY:

Patients who enter treatment for major depressive disorder (MDD) expect symptom remission and return to previous levels of function. However, many patients don't achieve remission with any one treatment, and recovery is a slow process. Therefore, finding effective treatment necessitates a range of 'trial and error' sequential treatment steps, including switching, augmentation, or combination treatments. An unmet need exists for a more tailored approach to achieving remission as precisely as possible. Prior to the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial, there was a dearth of prospective randomized controlled trials in MDD that compared multiple augmentation or switch treatments. In this interactive symposium utilizing an audience response system, we will explore insights from STAR*D which focus on augmentation/combination treatments at the first, second and third treatment steps, and switch treatments at the second, third, and fourth treatment steps.

No. 4B
DO ANTIDEPRESSANTS WORK IN THE REAL WORLD AND FOR WHOM?

Roy H. Perlis, Ph.D. *Mass General Hospital, 15 Parkman St # Acc-815, Mass General Hospital, Boston, MA, 02114-3117*

SUMMARY:

The treatment of depression aims to achieve and sustain symptomatic remission (virtual absence of active depressive symptoms). However, clinicians rarely expect to produce remission with a single agent in any more than a handful of patients. Even with multiple trials of medication, a number of issues contribute to failure to achieve remission, including lack of efficacy, intolerable adverse effects, slow onset of action, drug-drug interactions, comorbid medical illness, and nonadherence. Reported remission rates in large clinical trials vary depending on the setting from 30% to 50%, and even these rates may not translate in real-world practice. Multi-step treatment algorithms have been developed to improve outcomes utilizing augmentation or combination treatments and/or several switches to different treatments. Achieving remission acutely is only part of the picture; the overall goal is to maintain remission over the long-term. In this presentation, we will discuss the short-term and long-term outcomes of depressed outpatients who participated in the real-world Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study. We will also review the sociodemographic and clinical predictors of remission following antidepressant treatment in the context of STAR*D.

No. 4C
SWITCHING ANTIDEPRESSANTS: THE STAR*D EXPERIENCE

Michael E. Thase *WPIC, 3811 Ohara St, Pittsburgh, PA, 15213-2593*

SUMMARY:

Since few patients with major depressive disorder (MDD) achieve remission upon their first antidepressant trial, switching due to lack of efficacy (failure to achieve response) is commonplace. Similarly, drug-drug interactions, comorbid medical illness, or the presence of intolerable side effects may lead to treatment discontinuation and to switching antidepressant agents. The clinician may choose to switch to a different class of antidepressant or to switch within the same class as the failed antidepressant. The evidence base for choosing one over the other is limited, particularly for switching between classes of antidepressants. The Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial examined the real-world effectiveness of switch treatments, beginning at the second step, and continuing through the third, and fourth treatment steps. This presentation will review the STAR*D results of the second, third and fourth step switching of treatments, and then compare the findings to existing literature regarding switching antidepressants. Particular focus will be applied to patients with MDD who have not tolerated or responded to antidepressant treatment, and will explore the possibility that switching antidepressants may bring about remission of symptoms and improve patient outcomes.

No. 4D
POLYPHARMACY TO INCREASE THE CHANCES OF REMISSION

Maurizio Fava *Massachusetts General Hospital, 55 Fruit St, Boston, MA, 02114-2696*

SUMMARY:

Many treatments for depression have established efficacy as single agents in producing response in randomized controlled trials. How-

ever, response without achieving full remission is frequent and associated with continuing disability and poor prognosis compared to those who achieve full remission and remission rates with antidepressant monotherapy are rather modest. This presentation will review the studies that have investigated the use of augmentation or combination strategies at the outset of initial treatment to primarily enhance the chances of remission through synergy and/or a broader spectrum of action. There is some preliminary evidence that this approach could potentially enhance retention and/or increase remission rates since the lack of response with antidepressant monotherapy may lead many depressed patients with little or no benefit to drop out of treatment, precluding the subsequent use of augmentation or combination strategies altogether. In addition, the emergence of certain side-effects (e.g., agitation, insomnia) or the persistence of some initial baseline symptoms (e.g., anxiety, insomnia) may lead to premature discontinuation from monotherapy in the absence of concomitant use of augmenting pharmacological options targeting these symptoms.

No. 4E
AUGMENTATION AND COMBINATION STRATEGIES IN TREATMENT RESISTANT DEPRESSION

Alan F. Schatzberg *Stanford University School of Medicine, Psychiatry & Behavior Science, 400 Quarry Rd, Admin Ofc # 300, Stanford, CA, 94305*

SUMMARY:

Many patients with major depressive disorder (MDD) do not experience a satisfactory clinical benefit from their initial treatment, with less than 30% of patients achieving long-term remission from a first antidepressant trial. The clinician, in treating the remaining 70% (non-remitters and non-responders to the initial treatment), is forced to choose some alternative to the initial failed trial or more commonly, either an augmentation or a combination of pharmacotherapy. Patients who fail trials of monotherapy with an antidepressant enter into various stages of treatment-resistance and are increasingly at risk for chronic long-lasting depressive episodes. As complete symptom remission is the goal of treatment for MDD, the investigators of the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial attempted to determine the most effective augmentation and combination treatment strategies for patients who did not meet this goal with initial treatment. The results of STAR*D will be used in this presentation as a guide for discussing the best augmentation and combination strategies available to the clinician to meet that challenge. Augmentation and combination strategies are also used in the context of treatment of residual symptoms in depression, and this presentation will also review these specific uses of polypharmacy.

No. 4F
THE ROLE OF PSYCHOTHERAPY AS ADJUNCTIVE TREATMENT IN DEPRESSION

Amy H. Farabaugh, Ph.D. *Massachusetts General Hospital, Psychiatry, 50 Staniford St., 4th Floor, Suite 401, Boston, MA, 02114-2696*

SUMMARY:

Major depressive disorder (MDD) can be a severe debilitating disease, and treatment can be frustrating for both the patient and the clinician. The impact of psychotherapy for the treatment of depressive states, particularly in the treatment-resistant population, is unclear. For example, the Adult Primary Care Depression Guidelines recommend psychotherapy, either alone or in combination with antidepressant medication, as first-line treatment for MDD, but the guidelines give little information on the specific type of psychotherapy or length of treatment. In addition, psychotherapy for MDD is often delivered under managed care circumstances and is time-limited, and no evidence base for a "minimum effective time" has been established. In an effort to address these issues, the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial included patients who have historically failed short-term psychotherapy. These patients were able to choose cognitive behavioral therapy as psychotherapy alone or as an adjunct to antidepressant medication with other treatments at the second level. This symposia will review the findings of STAR*D on the impact of psychotherapy on this patient population.

REFERENCES:

1. McIntyre RS, Oâ™Donovan C. The human cost of not achieving full remission in depression. Can J Psychiatry 2004;49(3 Suppl 1):10S-16S.
2. Thase ME. Achieving remission and managing relapse in depression. J Clin Psychiatry. 2003;64 Suppl 18:3-7.
3. Fava M, Rush AJ. Current status of augmentation and combination treatments for major depressive disorder: a literature review and a proposal for a novel approach to improve practice. Psychother Psychosom. 2006;75(3):139-53.
4. Trivedi MH, Rush AJ, Wisniewski SR, et al. Evaluation of outcomes with citalopram for depression using measurement-based care in STAR*D: Implications for clinical practice. Am J Psychiatry 2006;163:28-40.
5. Thase ME, Friedman ES. Is psychotherapy, alone, an effective treatment for melancholia and other severe depressive states? J Affect Disord 1999;54:1-19.

INDUSTRY SUPPORTED SYMPOSIUM 5— INSOMNIA: PRIMARY DIAGNOSIS OR SECONDARY SYMPTOM? Supported by Merck & Co., Inc.

No. 5A
INSOMNIA: PRIMARY DIAGNOSIS OR SECONDARY SYMPTOMS?

David J. Nutt, D.M. *University of Bristol, Psychopharmacology Unit, Henry Wellcome L.I.N.E., Whitson St., Dorothy Hodgkin Building, Room 5.11, Bristol, BS1 3NY, United Kingdom*

SUMMARY:

Insomnia, the most common sleep disorder, is characterized by abnormal wakefulness and or inability to sleep. The complaint of insomnia surrounds many other issues involved with sleep problems. These include difficulties falling asleep, being easily aroused with numerous incidences of spontaneous awakenings or early morning awakenings with the inability to fall back asleep. It is essential to determine whether the condition of insomnia is secondary to another psychiatric or medical condition or exists as a primary diagnosis once all other conditions are ruled out. Despite adequate opportunities to sleep, insomniacs have poor sleep quality that is inadequate or nonrestorative. Approximately, 50% of primary care patients experience insomnia, but only one-third relay this information to their physician and of that number, only 5% seek treatment. Insomnia affects 20-40 % of adults throughout the course of the year with women being 1.3 times more likely to experience insomnia than men. This translates to staggering costs in the management of insomnia. The National Institutes of Health National Center for Sleep Disorder Research estimates $15.9 billion in direct economic costs, which includes outpatient visits, sleep recordings, medications, and charges for treatment.

All to often, patients complain of decreased ability to enjoy social and family relationships, impaired ability to concentrate, and suffer from poor memory. Patients who are diagnosed with insomnia are more than twice than likely as the general population to have a fatigue-related motor vehicle accident. The mortality rates have been estimated to be higher in patients who get less than 5 hours of sleep per night than in the generation population, which make it important to address this issue beyond the realm of secondary occurrences. Traditionally, insomnia was viewed as a symptom secondary to anxiety and depression; however, new data shows that insomnia could also be a precursor to the development of depression. Studies have revealed patients responsive to antidepressant treatment still found insomnia to be the last symptom remaining. Insomnia is currently managed with pharmacological agents such as short and long acting benzodiazepines, benzodiazepine derivatives, nonbenzodiazepine sedative hypnotics, antidepressants, and melatonin. Future treatments such as the $GABA_A$ modulators offer additional insight for clinicians by increasing the understanding of the sleep mechanism. By closely examining how the interactions of current and new agents interplay within the sleep pathways, investigators are increasing their knowledge and understanding in the human sleep mechanism.

In conclusion, a greater emphasis must be made to address the issue of insomnia because of the surreptitious nature of this condition and how it causes substantial morbidity and mortality to individuals. Despite insomnia's high incidence and prevalence, it remains underreported, underdiagnosed, and undertreated. This is, in part, due to the complexity of diagnosing this condition as it may present as either a primary disorder or secondary symptom. These serious consequences make it imperative to address the adverse effects insomnia has on health, longevity and the quality of life.

No. 5B
CLINICAL CROSS-FIRE

Mugdha E. Thakur, M.D. *Duke University Medical Center, Psychiatry & Behavioral Sciences, DUMC BOX 3386, Durham, NC, 27710*

SUMMARY:

Insomnia that occurs in conjunction with a primary medical, psychiatric or environmental condition is referred to as co-morbid insomnia, which had previously been termed secondary insomnia.[17,19,20] Traditionally, management for co-morbid insomnia was primarily directed towards treatment of the primary condition while insomnia was treated separately only if severe or shown not to improve with the treatment of the primary condition. Recent studies in patients with depression, however, suggest that treating both depression and insomnia may lead to more rapid treatment response, and that improved sleep may decrease pain complaints the following day. An important strategy in focusing on persistent sleep abnormalities in depressives is the inclusion of hypnotic agents during a patient's antidepressant regimen. Data from Buysse and colleagues demonstrated that the BZRA, eszopiclone, was shown to improve various parameters of subjective sleep measures such as sleep latency and total sleep time at each treatment week and wake after sleep onset at weeks 1, 3-5, and 7-8. Patients report dramatic improvements in subjective degrees of daytime alertness, sleep quality and depth, ability to concentrate and well-being. Though, it is important to note that eszopiclone was commonly associated with an unpleasant taste. The alpha-delta intrusions in non-REM sleep as seen in waking intrusions into deep sleep, are commonly observed in patients with chronic debilitating condition observed in rheumatoid arthritis, fibromyalgia and heterogeneous pain disorders such as back pain and headaches, and insomnia. It is has been suggested that these so-called intrusions may be the cause of malaise and fatigue commonly seen in depression and aforementioned patients population. Studies in these patient populations with short term treatment with zolpidem (5 to 15 mg) demonstrated no affect on the pain, but was useful for sleep and daytime energy.

Benzodiazepine receptor agonists (BZRAs) and antidepressants tend to be the most commonly prescribed agents, although relatively little data exists on the efficacy of antidepressants for insomnia. While the utility of the BZRAs has been widely demonstrated, they are associated with a variety of side effects, including sedation, physical dependence, and impairment of motor abilities. This discussion will be centered on an interactive case-based learning module displaying a case of co-morbid insomnia with major depressive disorder. The objective is to understand the features of insomnia associated with major depressive episode and treatment approaches. Two sleep specialists will present their individual management plans for the case, followed by feedback from the audience using live audience response system. Current evidence regarding treatment of insomnia in the context of a depressive episode will be discussed.

No. 5C
THE STATE OF INSOMNIA: BARRIERS TO RECOGNITION

Ruth M. Benca, M.D. *University of Wisconsin, Department of Psychiatry, 6001 Research Park Blvd, Madison, WI, 53719*

SUMMARY:

Insomnia, the most common sleep disorder, is characterized by the inability to sleep despite adequate opportunity and/or nonrestorative sleep. The complaint of insomnia most frequently accompanies psychiatric disorders, but is also seen at increased rates in those with medical and primary sleep disorders. Approximately 80% of chronic insomnia is co-morbid to another condition, making it essential to determine whether other conditions or factors that may be contributing to insomnia are present before making a diagnosis of primary insomnia.

Approximately, 67% of primary care patients experience insomnia, but only one-third relay this information to their physician and of that number, only 5% seek treatment; this is likely due at least in part to the failure to recognize the co-morbidities and adverse outcomes associated with insomnia. Furthermore, most physicians are not adequately trained to diagnose and treat insomnia, and they may overestimate risks associated with use of hypnotic medications. Insomnia, whether primary or co-morbid, affects daytime functioning; patients frequently complain of decreased ability to enjoy social and family relationships, impaired ability to concentrate, and poor memory. The mortality rates have been estimated to be higher in patients who get less sleep per night than in the general population, which make it important to address this issue beyond the realm of secondary occurrences.

Traditionally, insomnia was viewed as a symptom secondary to anxiety and depression; however, new data shows that insomnia could also be a precursor to the development of depression, and it the most likely symptom to persist in treated depressives. The persistence of residual symptoms such as insomnia correlates with an increased risk of recurrence and relapse of depression, thus the need of efficacious treatment of residual symptoms. Moreover, the existence residual symptoms is also predictive of severity of psychosocial performance. Not only is insomnia strongly linked with depression from an epidemiological standpoint, but individuals with depression show changes in sleep architecture as measured in sleep laboratory settings, including disturbed sleep continuity, loss of slow-wave sleep and changes in rapid eye-movement sleep patterns that tend to persist during clinical remission. Insomnia patients also show sleep disturbance and loss of slow-wave sleep, suggesting that common mechanisms may be involved. The serious co-morbidities associated with insomnia make it imperative to address the adverse effects insomnia has on health, longevity and the quality of life, as well as

understand the underlying mechanisms for insomnia to develop new and more effective treatments for insomnia and its sequelae.

Despite insomnia's high incidence and prevalence, it remains underreported, under diagnosed, and under treated, indicating a significant unmet need.. The recent report from the Institute of Medicine highlighted the need for public health mandates that focus on campaigns to increase public awareness on the health and economic impact of sleep loss and sleep disorders. These and other IOM recommendations are aimed at advancing sleep medicine and research in terms of developing and validating new guidelines in treatment, disease management strategies and long-term patient care with the goal of achieve treatment parity.

No. 5D
CLINICAL CROSSFIRE

Xavier A. Preud'Homme, M.D. *Duke University Medical Center, Department of Psychiatry, DUMC Box 2908, Durham, NC, 27710*

SUMMARY:

Difficulty initiating and/or maintaining sleep which cannot be attributed to a medical, psychiatric or environmental cause such as medication or drug abuse, is defined as Primary Insomnia. The mechanism of primary insomnia (eg, psychophysiological, idiopathic, cognitive arousal, and faculty conditioning) is unknown, but is thought to be related with a state of hyperarousal. Management of primary insomnia ranges from implementation of sleep hygiene, to pharmacologic intervention such as benzodiazepines and benzodiazepine receptor agonists. Benzodiazepines and newer benzodiazepine receptor agonist potentiates an inhibitory chloride conductance through GABA-gated channels, and thus achieve a sedative-hypnotic effect. In addition, sedating antidepressant as well as a variety of other agents are frequently prescribed with varying results. Moreover, over-the-counter alternatives, such as melatonin, have increasingly been utilized by the general public in the treatment of primary insomnia. Recent studies have shown that behavioral therapy may be just as effective as pharmacotherapy in the treatment of primary insomnia. Reports have shown an increased induction of sleep in healthy volunteers as well as medically ill and geriatric patients who suffer from insomnia. This presentation utilizes an interactive case-based learning module in order to understand diagnosis and management of patients who suffer from primary insomnia from two different perspectives. Two sleep specialists will present their individual management plans for the case, followed by feedback from the audience using live audience response system. Evidence-based management of primary insomnia, including pharmacologic treatments such as benzodiazepine receptor agonists and non-pharmacologic therapies such as cognitive behavioral therapy, will be discussed. By ascertaining the baseline approach of the standards of care towards managing primary insomnia, this forum will compare and contrast treatment strategies in order to develop consensus in current and future trends of management as well as assess parity of care.

No. 5E
PHARMACOLOGICAL PROGRESS IN INSOMNIA

David J. Nutt, D.M. *University of Bristol, Psychopharmacology Unit, Henry Wellcome L.I.N.E., Whitson St., Room 5.11, Bristol, BS1 3NY, United Kingdom*

SUMMARY:

Insomnia is widely encountered in the general practice of medicine, but how psychiatrists and primary care physicians manage this condition is commonly overlooked. Insomnia is managed with pharmacological agents such as short and long acting benzodiazepines and benzodiazepine receptor agonists, antidepressants, cognitive behavioral therapy, and other agents, including atypical antipsychotics, anticonvulsants, melatonin and OTC agents; many of these agents are used off-label and with relatively little data to support their safety or efficacy for this indication. Benzodiazepine agents possess relatively long half-lives, with the exception of triazolam. These agents all reduce latency to sleep onset and were found to demonstrate greater sleep maintenance as seen through increased total sleep time, decreased incidences of awakenings, and reduced waking time after sleep onset. Triazolam has shown a benefit in promoting sleep onset, however, the short half-life reduces its capacity to provide sleep maintenance efficacy. These agents diminish the amount of stage 1 sleep and increase stage 2 sleep, and its suppression of slow-wave sleep and possibly including, rapid eye movement sleep. While efficacious in a short-term treatment regimen, the longer acting, higher dosage benzodiazepines can be associated with various adverse effects such as physical dependence, motor and memory impairment and sedation. While zolpidem is classified as a nonbenzodiazepine, it acts at the benzodiazepine receptor site, which raises concerns of possessing similar benzodiazepine side effects such as dependence. Moreover, current evidence points to nonbenzodiazepine agents as primarily efficacious in sleep onset rather than sleep maintenance.

Melatonin, a hormone produced by the pineal gland is of interest for its wide use as an OTC remedy for insomnia, although the exact nature of its interaction is unknown. Ramelteon, the only FDA-approved hypnotic not classified as a BZRA, is an agonist of type 1,2 melatonin receptors, but is structurally different to melatonin; is not involved in the GABA receptor complexes or other receptors thought to be involved in sleep. Future treatments to insomnia may revolve around selective $GABA_A$ modulators such as gaboxadol, which differs from the traditional $GABA_A$ agonists by enhancing slow wave activity during NREM, promoting deep NREM sleep stages and enhancing overall sleep efficiency. Promising results include no alteration to next-day cognitive performance by $GABA_A$ modulators. Ritanserin, a 5-HT2 antagonist, may alter treatment approaches to sleep insomnia by overhauling our theories on sleep architecture. Idzikowski and colleagues have demonstrated slow wave sleep doubling in duration at the expense of stage 2 sleep. The results of serotonin antagonists altering the sleep architecture without producing insomnia should cause a re-examination of mainstay theories of serotonin's role in sleep control. Future treatments such as the $GABA_A$ modulators and nonpharmacologic therapies such as cognitive behavioral therapy offer additional insight for clinicians by increasing the understanding of the sleep mechanism. A recent report by the Institute of Medicine looks to create awareness to the tens of millions of Americans who have otherwise been susceptible to the harmful effects of insomnia, these initiatives look to reclaim the nation's productivity, healthcare and public safety and provide humane care.

REFERENCES:

1. Asnis GM, Chakraburtty A, DuBoff EA, et al. Zolpidem for persistent insomnia in SSRI-treated depressed patients. J Clin Psychiatry. 1999;60:668-676.
2. Fava M. J Clin Psychiatry. 2004;65 Suppl 16:27-32.
3. Silver MH. Chronic insomnia. N Engl. J Med. 2005;353:803-810.
4. Chesson AL Jr, Anderson WM, Littner M, Davila D, Hartse K, Johnson S, Wise M, Rafecas J. Sleep. 1999 Dec 15;22(8):1128-33.

INDUSTRY SUPPORTED SYMPOSIUM 6—CLINICAL SKILLS TO CLINICAL SCALES: PRACTICAL TOOLS IN THE MANAGEMENT OF PATIENTS WITH SCHIZOPHRENIA
Supported by Pfizer Inc.

No. 6A
INTRODUCTION

John M. Kane, M.D. *The Zucker Hillside Hospital, 7559 263rd St, Glen Oaks, NY, 11004-1150*

SUMMARY:

Psychiatric disorders are among the most common and disabling of all the medical disorders found in society today. For instance, about 2.5% of all healthcare expenditures are for the treatment of schizophrenia, and its annual cost to society has been estimated to be $23 billion.1 The nature of the illness (ie, high rates of unemployment, disorganized thoughts, suspiciousness, etc.) makes it more difficult for patients with schizophrenia to access optimal healthcare and support that would ultimately lead to remission, and facilitate a return to function. Serious comorbid health issues, such as diabetes, cardiovascular disease, and smoking complicate the treatment plan. Accurate assessment of all aspects of the patients' health requires clinicians to have practical tools in their treatment armamentarium that can efficiently and effectively measure and assess functional and medical outcomes. This practical and interactive symposium will incorporate patient video vignettes, audience response systems and Q&A to address issues facing clinicians. The faculty will offer insights regarding effective use of clinical assessments skills and scales, selection of tailored treatment plans, and guidance for incorporating routine assessments of medical health to improve patient outcomes.

No. 6B
MONITORING PHYSICAL HEALTH

Stephen R. Marder, M.D. *Semel Institute at UCLA, Psychiatry, 1030 Lachman Ln, Pacific Plsds, CA, 90272-2224*

SUMMARY:

Patients with schizophrenia have a high rate of serious comorbid medical disorders, which contribute to a 20% reduction in life expectancy compared with the general population. The main cause of morbidity and mortality in patients with schizophrenia is coronary heart disease, whose chief risk factors include cigarette smoking, obesity, dyslipidemia, insulin resistance and diabetes, and hypertension. Studies have found that more than one in five patients with schizophrenia have either hyperglycemia (7%) or frank diabetes (14.5%). The investigators of the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study (N=1460) reported that, at baseline, 11% of participants had diabetes, 14% had hyperlipidemia, and 20% had hypertension. Guidelines for monitoring risk factors have been proposed by a number of groups, including the American Diabetes Association, the American Psychiatric Association, and the Mount Sinai Consensus Group. Antipsychotic medications differ in their effects on cardiac risk factors. As a result, each of these guidelines recommends the careful monitoring of risks and interventions, including changing medications, lifestyle changes, and medical interventions when appropriate. Utilizing patient case studies and an audience response system, this presentation will guide the clinician through the practical, yet necessary, elements of a thorough medical assessment.

No. 6C
MEASURING AND MANAGING AGITATION

Michael H. Allen, M.D. *Colorado Psychiatric Hospital, 4455 E 12th Ave # A011-95, University North Pavillion, Denver, CO, 80220-2415*

SUMMARY:

Many acutely psychotic patients with schizophrenia enter the healthcare system through the emergency department. Greater use of emergency services is associated with male gender, minority race, severe illness, homelessness, and lack of family support. A study of recidivism in the psychiatric emergency room found that younger patients with schizophrenia, particularly those with positive toxicology screenings, are likely to be repeat visitors. Controlling the florid positive symptoms and agitation that often accompany the psychotic episode is paramount. Recent advances in antipsychotic formulations have allowed the clinician to tailor the choice of initial medication to individual patient needs and to allow a smooth transition from IM to oral treatments once the patient's symptoms are stabilized. This presentation will utilize audience response system technology and case presentations to illustrate the complex challenges facing clinicians in the acute setting, such as differential diagnosis, decisions regarding substance abuse and alcohol screens, pharmacotherapy choices, and management actions that facilitate the therapeutic alliance and focus on patient and staff safety.

No. 6D
MEASURING COGNITIVE AND FUNCTIONAL OUTCOMES IN SCHIZOPHRENIA: A PRACTICAL GUIDE FOR CLINICIANS

Rona Hu, M.D. *Stanford School of Medicine, Department of Psychiatry, 401 Quarry Rd, Palo Alto, CA, 94305*

SUMMARY:

Treatment goals in patients with schizophrenia are moving from controlling positive symptoms and maintenance to remission and recovery with some restoration of cognitive and social functioning. Ascertaining a patient's level of cognitive and social functioning may be helpful for the clinician to determine overall goals for recovery to evaluate therapeutic improvements. Several psychotropic agents, especially anticholinergic medications and benzodiazepines, decrease neurocognitive functioning in some patients. Should such side effects remain undetected by clinicians and not be adequately dealt with, patients would be likely to discontinue their medication, deciding the side effects outweigh the benefit of drug treatment. In addition, noncompliance can result from forgetting due to primary or induced (prospective) memory problems, which are frequently observed in psychiatric disorders; however, administering neuropsychological tests to patients with schizophrenia can be challenging. This presentation will focus on teaching clinicians how to use scales and tests to measure cognitive and functional outcomes as well as how to interpret the clinical application of the results.

No. 6E
MEASUREMENT-BASED CLINICAL DECISION-MAKING IN PATIENTS WITH SCHIZOPHRENIA

John M. Kane, M.D. *The Zucker Hillside Hospital, 7559 263rd St, Glen Oaks, NY, 11004-1150*

SUMMARY:

Many factors impact real-world outcomes, and clinicians need to be equipped with the proper clinical tools to evaluate symptom severity, treatment burden, and strategies to optimize treatment efficacy. Although medications may show efficacy for reducing symptoms in tightly controlled clinical trials, the practicing clinician must

translate those data into practice on a daily basis to evaluate clinical effectiveness in individual patients who often may not conform to the clinical characteristics of the typical clinical trial participant. The Positive and Negative Syndrome Scale (PANSS) was developed to assess psychopathology among patients with schizophrenia, with an emphasis on positive and negative symptoms but without neglecting other general psychopathology features. Many remission and recovery models are based on scores of the PANSS. Movement disorders or extrapyramidal side effects are one of the most well recognized components of treatment burden. A number of scales are available to measure emergent or persistent extrapyramidal side effects. These include the Barnes Akathisia Rating Scale, the Simpson-Angus Extrapyramidal Side Effects Scale, and the Abnormal Involuntary Movement Scale. Real-world factors that impact treatment efficacy include optimal dosing range, medication bioavailability, and polypharmacy. This presentation will aim to demonstrate the usefulness of rating scales in clinical practice and employ patient case studies to demonstrate key factors clinicians need to consider in order to get the most out of current treatment.

REFERENCES:

1. Marder SR, et al. Health monitoring of patients with schizophrenia, Physical health monitoring of patients with schizophrenia. Am J Psychiatry 2004 161(8): 1334-1349.
2. 3. Lukens TW, Wolf SJ, Edlow JA, et al. Clinical policy: critical issues in the diagnosis and management of the adult psychiatric patient in the emergency department. Ann Emerg Med 2006;47(1):79-99.
3. Kim MS, Kang SS, Shin KS, Yoo SY, Kim YY, Kwon JS. Neuropscyhological correlates of error negativity and positivity in schizophrenia patients. Psychiatry Clin Neurosci 2006;60(3):303-311.
4. Leucht S, Kane JM, Kissling W, Jamann J, Etschel E, Engel R. What does the PANSS mean? Schizophrenia Research 2005;79(2-3):231-238.

INDUSTRY SUPPORTED SYMPOSIUM 7— THE PREVAILING PREDOMINANT POLE OF BIPOLAR DEPRESSION Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

Objective: Review latest evidence for physiological, biochemical, and anatomical abnormalities associated with bipolar depression, and discuss their possible clinical implications for treatment and prevention.

No. 7A
NEUROBIOLOGY OF BIPOLAR DEPRESSION: IMPLICATIONS FOR TREATMENT

Robert M. Post, M.D. *National Institute of Mental Health, Mood and Anxiety Disorders Program, 10 Center Drive MSC 1272, Bethesda, MD, 30892-1272*

SUMMARY:

Convergent evidence from brain imaging and autopsy studies indicates prefrontal cortical dysfunction in bipolar depression based on neuronal and glial deficits and as measured on an anatomical, biochemical, and physiological basis. Conversely, there is much support for amygdala and ventral striatal hyperactivity leading to relative emotional dysfunction and hyperarousal in the context of deficient cortical modulation and cognitive control. Both genetic and environmental mechanisms may be involved. The single nucleotide polymorphism val-66-val allele of proBDNF is a risk factor for bipolar illness, early onset, or a rapid cycling course; while the val-66-met allele is associated with cognitive dysfunction in normals, bipolars, and schizophrenic patient populations. Environmental stressors can also decrease both hippocampal BDNF and neurogenesis, and these decreases can be attenuated by all antidepressant modalities, and possibly lithium and valproate which may also be neuroprotective. Since many neurobiological abnormalities and cognitive deficits in bipolar illness appear related to either the number of affective episodes or duration of illness, earlier and more effective preventive pharmacological, psychoeducational, and cognitive/behavioral treatments may help prevent or reverse these neuropathophysiological processes as well as ameliorating the substantial morbidity and mortality associated with bipolar depression.

No. 7B
NEW TREATMENT OPTIONS FOR BIPOLAR DEPRESSION

Marcia L. Verduin, M.D. *Medical University of South Carolina, 5 South, 67 President St, Charleston, SC, 29403-5712*

SUMMARY:

Depression represents a significant cause of morbidity for individuals with bipolar disorder, thus, clinicians must have a thorough knowledge of effective treatment strategies for this phase of illness. Evidence-based pharmacologic treatment options for bipolar depression will be reviewed, with an emphasis on lamotrigine (Calabrese et al, 1999), olanzapine-fluoxetine combination (Tohen et al, 2003), and quetiapine (Calabrese et al, 2005). Data regarding the use of other mood stabilizers in bipolar depression will also be reviewed. Additionally, the role of antidepressant agents will be addressed, including the complexities involved in deciding when to initiate and the optimal duration of antidepressant treatment for depressed bipolar individuals. Finally, preliminary data supporting the use of promising new agents (omega-3 fatty acids, modafinil, pramipexole) in bipolar depression will be discussed.

No. 7C
CLINICAL CORRELATES ASSOCIATED WITH TREATMENT-EMERGENT MANIA

Mark A. Frye, M.D. *UCLA, 300 Ucla Medical Plz # 1544, Los Angeles, CA, 90095-8346*

SUMMARY:

Treatment-emergent mania (TEM) is a common clinical concern that can have substantial negative impact on overall mood stability. In addition to antidepressant liability (tricyclics most notably) a number of demographic and clinical risk factors have been variably associated with TEM. These are clinical factors (h/o TEM, subclinical hyperthyroidism, noradrenergic antidepressants, 5HT genetic polymorphisms, mixed depressive symptoms) that can be easily screeneed for in a clinical setting and will be reviewed in this talk. The talk will conclude with a current review of controlled clinical trials where TEM has been assessed.As even one manic episode can be potentially devastating identifying risk factors can be clinically valuable

No. 7D
THE CLINICAL INTERFACE BETWEEN OBESITY AND BIPOLAR DEPRESSION

Susan L. McElroy, M.D. *Univ of CT College of Med, 231 Albert Sabin Way, Cincinnati, OH, 45267-0001*

SUMMARY:

Bipolar depression is often associated with obesity. Indeed, growing research indicates that obesity in patients with bipolar disorder is associated with more severe illness and poorer outcome to lithium-based treatment, often characterized by greater depressive recurrence. This presentation will review available research on the relationship between bipolar disorder and obesity, with a focus on the evaluation and treatment of bipolar depression accompanied by obesity. Emerging correlates of obesity in bipolar depression will be discussed, such as binge eating disorder and the metabolic syndrome. Since bipolar depressed patients may be at greater risk for poorer outcome, specific treatment strategies for this group will be discussed. Such strategies will include using mood stabilizers with lower weight gain profiles; drugs with weight-loss properties (e.g., sibutramine, topiramate, bupropion, and orlistat) in combination with mood stabilizers; behavioral weight management; and cognitive behavior therapy.

No. 7E
CLINICAL CHALLENGES OF DIAGNOSING AND TREATING ADOLESCENTS WITH BIPOLAR DEPRESSION

Kiki D. Chang, M.D. *Stanford University, 401 Quarry Rd, Stanford University, Palo Alto, CA, 94305*

SUMMARY:

Mania in pediatric bipolar disorder (BD) has received far more attention than depression. However, children and adolescents with BD frequently experience depressive symptoms and full depressive episodes, with significant rates of suicidal ideation and attempts. Furthermore, most adults with BD have reported their first mood episode as depression, commonly occurring during childhood. Therefore, closer attention should be paid to the presentation and treatment of bipolar depression in pediatric BD. In this presentation, we will discuss latest data regarding the prevalence and characteristics of depressive symptoms in adolescents with BD. We will then present recent data regarding rates of SSRI-induced mania in this population, including a study at Stanford conducted using rigorous retrospective methodology that included an examination of genetic risk factors for SSRI-induced mania. Finally, we will discuss emerging data regarding the pharmacologic treatment of adolescent bipolar depression, including open studies of lithium, lamotrigine, and quetiapine, and discuss the 2005 expert consensus guidelines regarding this issue.

REFERENCES:

1. Post RM, Speer AM, Hough CJ, Zing G: Neurobiology of bipolar illness: implications for future study and therapeutics. Ann Clin Psychiatry 2003; 15:85-94.
2. Calabrese JR, Keck PE Jr, Macfadden W, Minkwitz M, Ketter TA, Weisler RH, Cutler AJ, McCoy R, Wilson E, Mullen J. A randomized, double-blind, placebo-controlled trial of quetiapine in tx of BP I or II depression. Am J Psych 2005;162:1351-60.
3. Keck PE, Corya SA, Altshuler LL, Ketter TA, McElroy SL, and Tohen M. Analysis of treatment-emergent mania with olanzapie/flouxetine combination in the treatment of bipolar depression. J Clin Psychiatry 2005 66:611-6.
4. McElroy SL, Allison DB, Bray GA, eds. Obesity and Mental Disorders. Taylor & Francis, NY, 2006.
5. Chang KD, Saxena K. Howe MG: Lamotrigine adjunctive or monotherapy in adolescent bipolar depression, in 158th Annual Meeting of the American Psychiatric Association. Atlanta, GA 2005.

SUNDAY, MAY 20, 8:00 AM - 11:00 AM

INDUSTRY SUPPORTED SYMPOSIUM 8—THE ONGOING DEBATE SURROUNDING ATYPICALS: ARE THE BENEFITS WORTH THE RISKS?
Supported by Solvay Pharmaceuticals and Wyeth Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to:

1) Compare and contrast the effectiveness of atypical antipsychotics in terms of symptom control and cognitive functioning in schizophrenia.

2) Examine multiple dimensions that contribute to overall functional outcomes of persons with schizophrenia, including health considerations, medication tolerability, and adherence.

3) Discuss the rationale for drug selection to achieve optimal mental and physical outcomes.

4) Review the risk/benefit ratio of atypicals in early phase schizophrenia.

No. 8A
BALANCING BETWEEN EFFICACY AND SIDE EFFECTS

Samuel J. Keith, M.D. *University of New Mexico, Dept of Psychiatry, 2400 Tucker Rd NE, Albuquerque, NM, 87131-0001*

SUMMARY:

Schizophrenia has been an illness that has been fraught with the expectation of poor outcomes. Patients may respond poorly; they may respond but cannot tolerate the medication; they may respond initially and then deteriorate. Whatever the course, our expectations remain low. Our treatments, however, would appear to be more promising than our results. New medications and new delivery systems continue to become available, each one introduced as an advance over prior treatments. Second generation antipsychotic medications have become the current "gold standard" because of studies which have shown advantages in motor side effects, prevention of relapse and, perhaps, better response in positive and negative symptoms. Yet, the clinician is faced with many choices and many questions when it comes to the treatment of schizophrenia with second generation antipsychotic medications. Is it possible that how the clinician answers these questions may affect the outcome of the illness? The past year has seen a burgeoning of the data available to inform the clinician in these decisions CATIE I and CATIE II. As always, selecting an antipsychotic requires a balancing of efficacy needs and side effect tolerability. There are no effects without side effects. Clinicians have become aware that what medication they select initially may not reflect what the patient will end up taking over the length of the illness. The presentation will explore the importance, relevance and impact of the initial selection, and provide suggested guidelines for making such a choice. Faced with the inevitable consequences both positive and negative from this initial selection, the clinician must be prepared to have fall-back positions in treating psychosis. The presentation will consider further the next steps when a treatment either fails or is intolerable, providing a means to balance efficacy with side effects and means to weigh the relative merits of clinical decisions.

No. 8B
THE EFFECT OF ATYPICALS ON HEALTH OUTCOMES IN LIGHT OF PRE-EXISTING MEDICAL RISKS

Henry A. Nasrallah, M.D. *University of Cincinnati, Psychiatry, 231 Albert Sabin Way, Mail Location 670559, Cincinatti, OH, 45267-0559*

SUMMARY:

In addition to coping with a chronic and disabling brain disease, individuals with schizophrenia tend to suffer from many serious medical morbidities especially cardiovascular disease. Many studies have shown that the average life span in schizophrenia is about 15-20 years shorter than what is observed in the general population.

The risk factors for higher morbidity and mortality in schizophrenia are due in part to an unhealthy lifestyle (smoking, poor diet, and sedentary existence) but is often due to co-existing medical conditions that may be linked with schizophrenia. For example, visceral adiposity, diabetes and hypertension have been observed in schizophrenia even before treatment with psychotropic drugs. Antipsychotic drugs, especially some members of the atypical class, have been associated with the emergence (or exacerbation) of serious metabolic complications. The NIMH-sponsored CATIE study found that 42% of the schizophrenia cohort in the CATIE trial met rigorous criteria for the metabolic syndrome at the time of enrollment into the trial, with an obesity rate (BMI ≥ 30Kg/M2) exceeding 55%. A high proportion of the CATIE schizophrenia subjects with diabetes, hyperlipidemia or hypertension had never received standard medical treatment for their metabolic illness, adding another layer of health risk and disparity of care for this psychiatrically disabled population.

The goals of treatment in schizophrenia to include not only symptomatic control of psychopathology, but also monitoring and addressing the physical health needs of these patients. Psychiatrists must mend the mind while keeping a watchful eye on the body. Best practices in schizophrenia disease management now require standard monitoring of metabolic parameters at baseline and at regular intervals after initiating pharmacotherapy. Physicians must also give careful consideration to matching medically vulnerable patients with an antipsychotic that has a benign side-effect profile for each patient with a specific medical susceptibility. This presentation will discuss evidence-based, individualized treatment approaches for persons with schizophrenia representing a medical strategy to win the battle against psychosis without losing war of life and death.

No. 8C
THE RISK/BENEFIT RATIO OF ATYPICAL ANTIPSYCHOTICS IN EARLY PHASE SCHIZOPHRENIA

Elizabeth Bromley, M.D. *West Los Angeles VA MIRECC & UCLA Health Services Research Center, 11301 Wilshire Blvd, Building 210A, MIRECC, Los Angeles, CA, 90049*

SUMMARY:

A number of large scale clinical trials in younger patients with schizophrenia demonstrate the importance of treatment with antipsychotics to improve short and long-term outcomes. Most of these studies demonstrate specific advantages for second generation versus first generation antipsychotics. However, not all studies show overall advantages (e.g., relapse prevention) for the second generation medications over first generation medications. As a result, clinicians still need to match individual patient's needs when selecting among the atypical antipsychotics. Treatment of early phase schizophrenia raises special considerations.

Numerous studies demonstrate that treatment adherence is particularly poor in early phase schizophrenia. Over one third of patients are non-adherent within the first six months of illness. Early phase patients may be particularly vulnerable to treatment discontinuation as a result of adverse medication side effects such as sedation and extrapyramidal symptoms. New evidence demonstrates that younger patients also appear to be particularly vulnerable to weight gain on atypical antipsychotics. Moreover, the time to treatment response varies widely in first-episode patients, and treatment trials of up to eight weeks may be needed to see full response.

Several large clinical trials and some neurobiological evidence demonstrate that initiating antipsychotic treatment shortly after the onset of psychosis and maintaining treatment adherence improve long term outcomes for young patients with schizophrenia. A growing body of literature shows that periods of psychosis that remain untreated can have detrimental long-term effects. Longer duration of untreated psychosis is associated with more severity of negative symptoms, lower rates of achievement of remission, and lower levels of overall functioning. A shorter duration of untreated psychosis is associated with better response to antipsychotic treatment.

To address the need for treatment compliance in the face of high discontinuation rates in early phase schizophrenia, clinicians should select atypicals that minimize side effects like weight gain, EPS, and sedation. Clinicians should meet patient preferences whenever possible to avoid treatment-emergent side effects that may lead to discontinuation. Depot formulations of antipsychotics may be particularly helpful in early phase patients who are at risk for treatment non-adherence. Increasing evidence shows that targeted psychosocial interventions can be useful in early phase patients to address side effects, prevent weight gain, and facilitate adherence.

No. 8D
NEW MECHANISMS AND INNOVATIVE PHARMACOLOGICAL STRATEGIES

Stephen R. Marder, M.D. *Semel Institute of Neuroscience and Human Behavior at UCLA, Psychiatry, 1030 Lachman Ln, Pacific Plsds, CA, 90272-2224*

SUMMARY:

Recent data from large clinical trials in schizophrenia have demonstrated the limitations of first and second generation (or atypical) antipsychotics. Although the atypical antipsychotics were initially viewed as having clinically relevant advantages for positive and negative symptoms and neurocognitive impairments, both meta-analysis and the findings from large trials such as the NIMH CATIE (Clinical Antipsychotic Trials of Intervention Effectiveness) trial have led some experts to conclude that improvements in these areas will require a focus on other pharmacological and psychosocial strategies. Pharmacological strategies have included the introduction of newer antipsychotics with molecular targets that differentiate them from available agents as well as co-medications that can be added to antipsychotics to target psychopathological dimensions such as negative symptoms and neurocognitive impairments. Treatment development in both of these areas has been facilitated by the NIMH MATRICS (Measurement and Treatment Research to Improve Cognition in Schizophrenia) initiative which has involved collaborations among government (including NIMH and FDA), academia, and industry. Contributions from MATRICS include a consensus battery for measuring outcome in clinical trials of cognition enhancing drugs, guidelines for clinical trials in this area, recommendations for promising clinical targets, and the ongoing development of a new instrument for measuring clinical trials. At the same time that drugs are in development, psychosocial strategies for improving cognition and functional outcomes have achieved promising results. This presentation will review progress in these areas and use actual clinical cases to discuss approaches for improving outcomes.

REFERENCES:
1. 50-20060531-716.
2. Reference: Meyer JM, Nasrallah HA (Editors): Medical Illness and Schizophrenia. APPI, Washington DC, 2003.
3. Perkins DO, et al: Relationship between duration of untreated psychosis and outcome in first-episode schizophrenia: a critical review and meta-analysis. Am J Psychiatry 2005; 162 (10): 1785-804.
4. Marder, S. R. and W. Fenton (2004). "Measurement and Treatment Research to Improve Cognition in Schizophrenia: NIMH MATRICS initiative to support the development of agents for improving cognition in schizophrenia." Schizophr Res 72(1): 5-9.

INDUSTRY SUPPORTED SYMPOSIUM 9— STILL SLEEPY AFTER ALL THESE CURES: HYPERSOMNIA IN PSYCHIATRY Supported by Cephalon, Inc.

No. 9A
STILL SLEEPY AFTER ALL THESE CURES: HYPERSOMNIA IN PSYCHIATRY

Stephen M. Stahl, M.D. *University of California, San Diego, Psychiatry, 5857 Owens Ave Ste 102, Carlsbad, CA, 92008-5507*

SUMMARY:

Hypersomnia, or excessive daytime sleepiness, affects 4-6% of the population.(Dauvilliers and Buguet, 2005) Chronic hypersomnia has numerous etiologies: according to the revised International Classification of Sleep Disorders, the most common are narcolepsy with and without cataplexy, idiopathic hypersomnia with or without long sleep time, recurrent hypersomnia, behaviorally induced insufficient sleep syndrome, hypersomnia due to a medical condition, and hypersomnia due to a drug or substance.(Dauvilliers, 2006) Hypersomnia can be a side effect of antidepressant medication or a residual symptom of depression in nonresponders and partial responders to antidepressant therapy.(Nierenberg et al., 1999) Patients with residual symptoms of hypersomnia are at increased risk of recurrence (Paykel et al., 1995) and relapse from their depression.(Flint and Judd, 1997) The presence of residual symptoms is also associated with worse psychosocial functioning. This program will review the evidence for a link between hypersomnia and depressive or anxiety disorders, the differential diagnosis of hypersomnia in psychiatric disorders, the prevalence and consequences of hypersomnia, the neurobiology of hypersomnia, and treatment strategies.

No. 9B
THE NEUROBIOLOGY OF HYPERSOMNIA

Stephen M. Stahl *University of California San Diego, Psychiatry, 5857 Owens Ave Ste 102, Carlsbad, CA, 92008-5507*

SUMMARY:

The neurotransmitters and pathways that impact sleep and wakefulness are complex and likely involve several different brainstem and basal ganglia systems, in addition to the cortex. Glutamatergic input from the brainstem reticular formation to the tuberomammillary nucleus, as well as to the basal forebrain and posterior hypothalamus, result in critical positive and negative input to the cortex. In addition, direct cortical input from the midbrain raphe nuclei and locus coeruleus has been described. PET studies, as well as fMRI studies from a number of centers, confirm an integral role of the dorsolateral prefrontal cortex (DLPC) and the anterior cingulate gyrus (AC). Key neurotransmitters include norepinephrine (projections from the locus coeruleus to the DLPC), dopamine (projections from the ventral tegmentum to the DLPC), and histamine (projections from the tuberomammillary nucleus to the DLPC). Attention, short-term memory, and other executive functions are clearly affected. Markedly altered intensity of fMRI activation can clearly be demonstrated in the AC and DLPC after 24 hours of sleep deprivation. Treatment with modafinil restores normal activation patterns while improving attention and short-term memory. Most recently, an important cytokine response associated with hypersomnia also has been defined. Proinflammatory cytokines IL-6 and TNF-alpha were found to be elevated in disorders associated with excessive daytime sleepiness, including idiopathic hypersomnia.(Vgontzas and Chrousos, 2002)

No. 9C
THE CLINICAL SPECTRUM OF HYPERSOMNIA

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

SUMMARY:

Hypersomnia refers to the complaint of excessive daytime sleepiness, with or without prolonged sleep duration at night. It is characterized by the tendency to fall asleep in inappropriate places or situations, and is often accompanied by a sense of struggling to stay awake. Hypersomnia is distinguished from fatigue, which is a sense of physical tiredness or weariness, without the tendency to actually fall asleep.

Hypersomnia is an important clinical consideration for several reasons. First, it is a common symptom in the population, affecting 5-10% of adults. Second, it has been linked to a variety of adverse health outcomes, including cardiovascular disease, obesity, and mortality. Third, it characterizes many of the disorders seen and treatments commonly used by psychiatrists. Hypersomnia is a clinical feature of several different sleep-wake disorders that have diverse etiologies. The most common cause of hypersomnia is insufficient nocturnal sleep. This may be caused by voluntary restriction of sleep duration, or by sleep disorders that fragment nocturnal sleep, such as obstructive sleep apnea syndrome and periodic limb movement disorder. Narcolepsy and idiopathic hypersomnia are classic sleep-wake disorders characterized by severe hypersomnia. Circadian rhythm sleep disorders, such as delayed sleep phase syndrome and shift work sleep disorders, result from a mismatch between endogenous circadian sleep-wake rhythms and the individual's desired sleep-wake times; the result is hypersomnia during one part of the day and insomnia at another part of the day. Many medical and neurological conditions can cause hypersomnia; stroke and Parkinson's Disease are among the most common. Hypersomnia also characterizes a number of psychiatric disorders, including major depression. Young adults and those with bipolar disorder are particularly vulnerable to hypersomnic major depressive episodes. Finally, many medications used to treat medical and psychiatric disorders can exacerbate hypersomnia, sometimes in unexpected ways. For instance, SSRI antidepressants in high doses are associated with hypersomnia, either as a direct effect of the medication, or by virtue of disrupting nighttime sleep.

Patients may have more than one cause for hypersomnia. Thus, it is always important to consider various etiologies during clinical evaluation of this problem. One common example is the common comorbidity between sleep apnea and depression, which is expected based on the high prevalence of each disorder. Another example is hypersomnia in patients with bipolar disorder. In addition to direct associations between this disorder and hypersomnia, these patients are at increased risk for obesity, which may be compounded by sedating medications such as antipsychotics and lithium. Obesity, in turn, may predispose them to sleep apnea. Thus, developing a

rational treatment plan for patients with hypersomnia depends on establishing a thoughtful differential diagnosis.

No. 9D
MEASUREMENT OF HYPERSOMNIA

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

SUMMARY:

A comprehensive evaluation of patients who complain of hypersomnia is important because the etiology of their sleep disorder is often not clear. While narcolepsy is a common cause, other potential causes must also be considered. The best way to insure the most appropriate diagnosis, and therefore the most appropriate treatment, is through a careful evaluation that begins with a detailed interview and may also include patient completed questionnaires and a sleep diary. The Brief Fatigue Inventory and Epworth Sleepiness Scales are two *subjective* measures of the degree of fatigue and sleepiness. These scales are widely used and have been validated in a number of clinical studies.(Shen et al., 2006) Both these subjective scales can be administered and properly interpreted in the psychiatrist's office. In contrast, the Multiple Sleep Latency Test (MSLT) and Maintenance of Wakefulness Test (MWT) are *objective* measures of sleepiness and are laboratory-based procedures. The MWT has clinical usefulness in evaluating response to treatment following intervention for conditions associated with excessive sleepinessas in individual patients (Wise 2006) The MSLT can help better characterize the severity, nature, and likely cause, of sleepiness.

No. 9E
STRATEGIES FOR THE MANAGEMENT OF HYPERSOMNIA

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

SUMMARY:

Most patients with sleep disorders can initially be evaluated in an office setting. Successful treatment strategies must identify and treat any associated psychiatric or behavioural disorders but in many cases hypersomnia will persist despite the successful treatment of those disorders, and must be treated as a separate entity.(Ohayon and Roth, 2003) Successful treatment strategies may include attention to sleep hygiene, and to improved nocturnal sleep with the use of sedative hypnotics. Smoking and drinking alcohol just before bed should be eliminated, as these two habits in particular have been shown to exacerbate or perpetuate insomnia.(Jefferson, et al., 2005) Alternative strategies include the selective induction of normal wakefulness without stimulating external vigilance.(Stahl, 2002) Conventional stimulants, as well as newer stimulants such as modafinil, play an important role in the management of hypersomnia unresponsive to these measures. In one study of 18 patients with hypersomnia, sleep attacks and drowsiness were significantly decreased in 83% following treatment with modafinil.(Bastuji and Jouvet, 1988) In another study of 42 subjects with idiopathic hypersomnia, response to stimulants was judged to be good in three-quarters of the patients, though spontaneous improvement of sleepiness was observed in one-quarter.(Bassetti and Aldrich, 1997) In this presentation I will review the clinical evidence in support of these treatment approaches, and provide practical tips on how the psychiatrist can incorporate them into their clinical practice.

No. 9F
PREVALENCE AND CONSEQUENCES OF HYPERSOMNIA

Christoper L. Drake, Ph.D. *Henry Ford Hospital, Sleep Disorders Center, 2799 West Grand Blvd, Detroit, MI, 48202*

SUMMARY:

Hypersomnia, generally defined as excessive daytime sleepiness, is estimated to occur in 10-20% of the population. The consequences of excessive sleepiness include psychomotor impairment, greater risk for accidents, and other aspects of impaired daytime functioning. Although it is a well known symptom of disorders such as narcolepsy, obstructive sleep apnea, and shift-work sleep disorder, it also is a common symptom of several psychiatric conditions. In a study of 215 outpatients treated with an antidepressant, the most common residual symptoms were sleep disturbances (44%) and fatigue (38%).(Nierenberg et al., 1999) The relationship between hypersomnia and risk of relapse in depression is not fully understood and additional research in this area is warranted. However, the symptom of hypersomnia should always alert the clinician to be sure the patient doesn't have a psychiatric disorder.

REFERENCES:

1. Stahl SM: Awakening to the psychopharmacology of sleep and arousal: novel neurotransmitters and wake-promoting drugs. J Clin Psychiatry 63:467-68, 2002.
2. Dauvilliers Y: Differential diagnosis in hypersomnia. Curr Neurol Neurosci Rep 6:156-162, 2006.
3. Richardson GS, Carskadon MA, Flagg W, van den Hoed J, Dement WC, Mitler MM. Excessive daytime sleepiness in man: multiple sleep latency test in narcoleptic and control subjects. . Electroencephalogr Clin Neurophysiol 1978;45: 621-7.
4. Szabadi E: Drugs for sleep disorders: mechanisms and therapeutic prospects Br J Clin Pharmacol 61:761-766, 2006.
5. Ohayon MM: The effects of breathing-related sleep disorders on mood disturbances in the general population. J Clin Psychiatry 64:1195-1200, 2003.

INDUSTRY SUPPORTED SYMPOSIUM 10—DECONSTRUCTING ATTENTION AND COGNITION IN ADHD: NEW UNDERSTANDINGS FOR IMPROVED MANAGEMENT
Supported by McNeil Pediatrics

No. 10A
DECONSTRUCTING ATTENTION AND COGNITION IN ADHD: NEW UNDERSTANDINGS FOR IMPROVED MANAGEMENT

Thomas J. Spencer, M.D. *Massachusetts General Hospital, Pediatric Psychopharmacology Research, 55 Fruit Street, YAW 6900, Boston, MA, 02114*

SUMMARY:

Attention deficit/hyperactivity disorder (ADHD) has been validated by converging phenomenology, neuropsychology, imaging, and genetic data supporting the syndromatic continuity of the disorder from childhood, through adolescence and into adulthood. While being defined by the behavioral symptoms of attention, recent neuropsychological studies have demonstrated important differential findings in adults. Although ADHD manifests itself as symptoms of hyperactivity, impulsivity, and inattention in children, it is the inattentive and executive function deficits which prevail in subjects as

they age. Pharmacologic treatments for ADHD include both stimulant and non-stimulant medications which have been studied in all age groups. In addition, psychosocial interventions for residual symptoms post-medication treatment may play a significant role in reducing symptom severity and quality of life impairments. An overview of the relevant and clinically useful neuropsychological probes and aggregate findings derived from research studies will be presented with implications to clinical practice. In addition, results from recent studies on executive function deficits and cognitive-behavioral therapy will be presented. Imaging studies have begun to help identify the regions of the brain affected by ADHD and the resultant neurocircuitry pathways. These findings may assist the clinician in his or her ability to further enhance treatment regimens for selected adult patients who fail to respond to some medications. With the persistence of inattention occurring throughout the lifespan, a focus on the effects of medications on attention warrants special consideration.

No. 10B
OVERVIEW OF ADHD

Thomas J. Spencer, M.D. *Masschusetts General Hospital, Pediatric Psychopharmacology Research, 55 Fruit Street, YAW6900, Boston, MA, 02114*

SUMMARY:

Attention-deficit/hyperactivity disorder (ADHD) is known to be a prevalent disorder in children and adolescents around the globe (Biederman and Farone, 2004). Although the presentation of symptoms of ADHD has been well characterized in the pediatric population, only recently has ADHD been characterized in adults. Population surveys have estimated the incidence of the disorder to be around 4.1% in those over the age of 18 . (Kessler et al. 2005) Studies have consistently reported that the persistence of ADHD into adulthood is associated with high rates of academic (less years of education, poorer marks, and failed grades) and work failure (poor performance, impairment in task completion, lack of independent skills) and poor relationships with supervisors (Weiss G, Hechtman L, Perlman T, et al. 1979) as well as high rates of psychiatric comorbidity, including substance use disorders and antisocial personality (Weiss G, Hechtman LT, 1986). In addition, there is an increasing array of neurobiologic findings in adults with ADHD (Faraone et al. 2000).

No. 10C
NEUROCIRCUITRY IN ADHD

George Bush , *MA*

SUMMARY:

The tools of neuroscience are providing ever broader glimpses of the underlying pathophysiological mechanisms implicated in Attention-Deficit/Hyperactivity Disorder (ADHD). This presentation will review and integrate results emerging from fMRI, PET, SPECT, EEG, and MEG into neurocognitive models that are continuing to be developed.

No. 10D
PHARMACOLOGICAL TREATMENT OF ADHD: FOCUS ON ATTENTION

Timothy E. Wilens, M.D. *Massachusetts General Hospital, Pediatric Psychopharamacology Research, 55 Fruit Street, YAW6900, Boston, MA, 02114*

SUMMARY:

The pharmacologic management of ADHD includes stimulant and non-stimulant agents proven to treat the hallmark symptoms: hyperactivity; impulsivity; and inattention. Evidence from longitudinal studies shows that while hyperactivity and impulsivity tend to wane with age, inattention can persist throughout the lifespan. There are now numerous studies documenting the safety and efficacy of medications to treat ADHD in children, adolescents, and adults. While all treatment options have evidence that they can improve symptoms of inattention, the different mechanisms of action of the currently available and emerging treatments to treat ADHD may offer clinicians' the ability to tailor medication regimens based on the specific needs of the patients.

No. 10E
NEUROPSYCHOLOGY IN ADHD

Ronna Fried, M.D. *Massachusetts General Hospital and Harvard University, 55 Fruit St., Boston, MA, 02114*

SUMMARY:

ADHD is defined by behavioral characteristics similar to neuropsychological disorders of executive dysfunction. This talk will review the literature on neurocognitive characteristics of ADHD from early childhood through adulthood. The speaker will address the development of the concept of attention and executive function (EF) deficits in ADHD, clinical neuropsychological studies of preteenage children, teenagers and adults with ADHD, gender and the role of psychiatric co-morbidity including the relationship of

learning disabilities to ADHD, heterogeneity of neuropsychological dysfunctions, experimental neuropsychological studies, the relationship of brain structure to function, psychopharmacology of ADHD, and clinical neuropsychological assessment. The group data clearly supports the hypothesis that executive dysfunctions are correlates of ADHD regardless of gender and age, and these EF deficits are exacerbated by co-morbidity with learning disabilities such as dyslexia. However, there is limited data on children under the age of 5, teenagers from age 13-18, and adults with ADHD over the age of 40. Studies of individual classification of people with ADHD compared to healthy, non-psychiatric controls do not support the use of neuropsychological tests for the clinical diagnosis of ADHD, and indicate that not all persons with ADHD have EF deficits. Some persons with ADHD may have deficits in brain reward systems that are relatively independent of EF impairments. Future research should clarify the multiple sources of ADHD impairments, continue to refine neuropsychological tools optimized for assessment, and incorporate longitudinal, developmental designs to understand ADHD across the lifespan.

No. 10F
UNDERSTANDING COGNITIVE AND BEHAVIORAL APPROACHES TO TREATING ADHD IN ADULTS

Steven A. Safren, Ph.D. *Mass General Hospital and Harvard Medical, Psychiatry, 15 Parkman Street, WACC 815, Boston, MA, 02114*

SUMMARY:

Evidenced-based psychosocial treatments for ADHD in adulthood are recently emerging. This is likely due to the recognition that ADHD in adulthood is a valid, prevalent, and interfering neurobiological disorder, affecting between 1 and 5% of adults. Consequently, treatment recommendations call for combining psychopharmacological with psychosocial treatments. Disseminating information about evidenced-based psychosocial approaches to augment the effects of medications for ADHD in adults is of particular and timely importance because "responders" to psychopharmacological treatments typically attain a 50% reduction in symptoms, leaving considerable room for further treatment of residual symptoms. The proposed talk will describe existing studied psychosocial treatments for ADHD

in adulthood, with an emphasis on research findings and clinical applications from controlled and uncontrolled studies. At the time of writing, there have been three uncontrolled studies of psychosocial treatments for ADHD in adults, and three controlled trials. The methodology and outcome of each will be described. Detailed information about the intervention approach from one of the successful controlled trials conducted by the speaker and colleagues at Massachusetts General Hospital will be presented. This approach targets continued symptoms in adults who have been treated with medications, have shown improvements due to medications, but still have clinically significant, interfering, and distressing symptoms. It is a modular treatment approach, involving core modules for improving organizing and planning (psychoeducation, use of a calendar and task list system, problem-solving, and prioritizing), reducing distractibility (learning to gauge one's attention span, record distractions, and break tasks into appropriate lengths of time), and promoting adaptive thinking (learning to identify and restructure negative cognitions that lead to avoidance, procrastination, and other continued symptoms). The approach also contains optional modules for involvement of a spouse/significant other and facing procrastination. Throughout the talk, the speaker will highlight intervention approaches that target attention (reducing distractibility), and organizing and prioritizing important tasks, using both case material and material from ongoing and completed research trials.

REFERENCES:

1. Weiss G, Hechtman L, Milroy T, Perlman T, 1985; Mannuzza S, Gittelman-Klein R, Addalli KA, 1991; Gittelman R, Mannuzza S, Shenker R, Bonagura N, 1985; Biederman J, et al, 2002.
2. Castellanos FX, Sonuga-Barke EJS, Milham MP, Tannock R: Characterizing cognition in ADHD: beyond executive dysfunction. Trends Cogn Sci 2006; 10:117-123.
3. Wilens TE, Dodson W. A clinical perspective of attention-deficit/hyperactivity disorder into adulthood. J Clin Psychiatry. 2004 Oct;65(10):1301-13.
4. Seidman LJ: Neuropsychological function in people with ADHD across the lifespan. Clinical Psychology Review (In press).
5. 31. Safren SA, Otto MW, Sprich S, Perlman CL, Wilens TE, Biederman, J. Cognitive behavioral therapy for ADHD in medication-treated adults with continued symptoms. Behaviour Research and Therapy, 2005; 43: 831-842.

INDUSTRY SUPPORTED SYMPOSIUM 11—LONG-TERM TREATMENT APPROACHES FOR SCHIZOPHRENIA: COMPARING MAINTENANCE AND RECOVERY MODELS

Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES:

After attending this symposium, participants should be better able to:

1) Compare and contrast the maintenance and recovery models, their relative strengths and weaknesses, and their clinical implications.

2) Discuss the role of dose escalation and/or polypharmacy in attaining treatment goals.

3) Outline factors that contribute to medication switching and what outcomes can and cannot be reliably achieved with a change of medication.

No. 11A
OPTIMIZING EXISTING TREATMENT IN STARTEGIES: INDIVIDUALIZING DOSING AND ADJUNCTIVE PHARMACOTHERAPY

Rajiv Tandon, M.D. *Chief of Psychiatry , State of Florida, Department of Children and Families, 1317 Winewood Boulevard, Building 6, Tallahassee, FL, 32399*

SUMMARY:

Mental health systems throughout the United States are attempting to implement models of care for serious mental illness that focus on recovery. In contrast to maintenance strategies which focus on minimizing psychotic symptoms and assuring that patients remain in a stable state, recovery models focus on improving functional outcomes such as work outcomes, social behaviors, and quality of life. The widespread attempts to implement this model have raised important concerns among patients with serious mental illnesses, psychiatrists, and administrators of public mental health systems. These include concerns that resources are being redirected toward unproven management strategies for the illnesses; concerns that expectations have been raised to a level that will lead many patients to experience failures; and a perception that advocates of recovery may minimize the importance of effective psychosocial and pharmacological treatments. This presentation will focus on evidence supporting treatment strategies that can improve functional outcomes and promote recovery. This will include a review of studies combining psychosocial and pharmacological treatments that led to improvements in vocational and social outcomes. In addition, findings supporting the role of neurocognition (including social cognition) and negative symptoms in determining functional outcomes will be presented. Recent studies focusing on psychosocial rehabilitation strategies for improving social and non-social cognition will be reviewed. One of the important principles underlying the recovery model is that treatment approaches should be patient-centered. The concept of shared decision-making in medicine will be reviewed and approaches for implementing this strategy for schizophrenia will be presented.

No. 11B
ENHANCING PATIENT OUTCOMES BY IMPROVING MEDICATION TOLERABILITY

Daniel E. Casey, M.D. *Oregon Health and Science University, GH 249 Psychiatry Research, 3181 SW Sam Jackson Park Road, Portland, OR, 97239*

SUMMARY:

Althought switching to another antipsychotic is a common treatment strategy, the clinician is also faced with other viable alternatives..... Maybe, I should keep my patient on this medicine longer and/or increase the dose too? Or maybe I should add another drug?

This presentation will review the available scientific evidence-augmented by case-based senarios-to inform these fundamental decisions for clinicians concerning when not to switch and whether to opt for dose optimization and/or adjunctive strategies. Additionally, this presentation will incorporate emergent information on switching and dosing of antipsychotics in patients who present with first-episode psychosis.

No. 11C
MAINTENANCE AND RECOVERY IN SCHIZOPHRENIA

Peter Weiden *SUNY Health Science Center at Brooklyn, Department of Psychiatry, 450 Clarkson Ave # 1203, Brooklyn, NY, 11203-2056*

SUMMARY:

Newer antipsychotics are rapidly replacing the older, conventional antipsychotics. Surveys of antipsychotic usage suggest that not only are more patients on newer antipsychotics, many patients are switching between newer agents. One survey found that 37 % of patients on taking one atypical will switch to another within a year.

This talk will review the rapid changes over the last few years pertaining to the psychopharmacology of switching antipsychotic medications. The presentation will cover:

(1) The changing pharmacoepidemiology of antipsychotic treatment in schizophrenic disorders in the United States, with special attention to antipsychotic switching rates.

(2) How the newer medications are raising expectations, and in turn, how raised expectations affect switching indications.

(3) The growing literature on switching studies, including studies on switching to currently available atypical antipsychotics, and how the results of the CATIE study can be interpreted within the context of the changing pharmacoepidemiology of antipsychotic prescriptions

More than ever, physicians need to understand both the psychosocial and pharmacologic aspects of using newer medications, as well as distinctions among each of the newer atypical antipsychotics.

No. 11D
THE ROLE OF COGNITIVE BEHAVIORAL THERAPY IN THE TREATMENT OF SCHIZOPHRENIA

Shanaya Rathod, M.D. *Hampshire Partnership NHS Trust, Tulfords Hill Centre, Tadley, Hans, RG26 3HX, United Kingdom*

SUMMARY:

Despite developments and proven efficacy of pharmacotherapy in Schizophrenia, dissatisfaction with medication is high with 75% of patients discontinuing their initially prescribed medication by stopping or changing to another drug (Liberman et al, 2005). Non-adherence with antipsychotic medications in schizophrenia has a significant impact on rate of relapse, prognosis, and resource utilization resulting in high costs for services and society. Poor adherence can be due to various factors which will be discussed in the session. Persons with schizophrenia often deny or are unaware of their mental illness. Illness symptoms may be attributed to life stresses, outside forces or other predicaments, and thus the need for medication may not be recognized. The attitudes and belief systems related to illness, specifically mental illness, contribute towards help seeking behaviour and the degree to which persons follow treatment recommendations.

Cognitive behaviour therapy (CBT) compliments medication management by assisting with understanding and improving compliance with treatment (Rathod et al, 2005) and also the delusional elaboration sometimes associated, or simply faulty assumptions about the function and purpose of medication. CBT for psychosis is based on principles of engagement, collaboration, Socratic questioning, enhancement of coping strategies, education, hypothesis testing, behaviour experiments followed by gentle challenging and search for alternative explanations for patients' experiences. The impact and implications of this therapy in improving adherence will be discussed.

REFERENCES:

1. Marder SR. Integrating pharmacological and psychosocial treatments for schizophrenia. Acta Psychiatr Scand, 2000: 102(407): 87-90.
2. Ren XS, Qian S, Lee AF, Herz L, Miller DR, Kazis LE. Treatment persistence: a comparison among patients with schizophrenia who were initiated on atypical antipsychotic agents. Journal of Clinical Pharmacy and Therapeutics 2006; 31 (1): 57-65 .
3. 2. Andresen R, Oades L, Caputi P. The experience of recovery from schizophrenia: towards an empirically validated stage model. Aust N Z J Psychiatry. 2003;37:586-594.
4. Lieberman, J.A., Stroup, T.S., McEvoy, J.P. et al. (2005) Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia. New England Journal of Medicine 353, 1209-1223.

INDUSTRY SUPPORTED SYMPOSIUM 12—DARK HORIZONS: DEPRESSION AND COGNITIVE IMPAIRMENT
Supported by Forest Laboratories, Inc.

No. 12A
DARK HORIZONS: DEPRESSION AND COGNITIVE IMPAIRMENT

Steven P. Roose *Columbia University - NYS Psychiatric Institute, 1051 Riverside Dr, New York, NY, 10032-1007*

SUMMARY:

We live in an aging society. By 2020, 30% of the population will be over the age of 65 and the most rapidly growing segment of the population is people over the age of 85. Therefore, illnesses that are prevalent in a late-life population will be an ever-increasing public health concern. Two of the most prevalent and devastating disorders in late life are depression and dementia. Traditionally, disorders of cognition and mood in the elderly have been considered separate entities that may frequently co-occur in late-life. Comorbidity was thought to be due to the high prevalence of both disorders in this population rather than reflect an intrinsic relationship between pathological processes, e.g., one illness is a risk factor for the development of the other.

Recently, different types of data strongly suggest that we must revisit the relationship between depression and dementia in late life. For example, epidemiological studies of community dwelling late-life populations strongly suggest that depression is a risk factor for the development of dementia. Studies of patients with depression and cognitive impairment report a high rate of conversion to dementia even if the depression has been adequately treated. Memory and mood disorders can no longer be considered distinct entities in late life. Recent epidemiological, genetic, imaging and patho-physiological studies illuminate the complex, multi-faceted association between these disorders. A more developed, nuanced model of neuro-psychiatric disorders in late life necessarily leads to the possibility of more effective treatment strategies to minimize the impact of these devastating illnesses.

No. 12B
THE EPIDEMIOLIGY AND GENETIC STUDIES OF DEPRESSION AND MEMORY

Richard Mayeux, M.D. *Columbia University - Sergievsky Center, Taub Institute for Research on Alzheimer's Disease, 630 West 168th Street, New York, NY, 10032*

SUMMARY:

The genetic influences on Alzheimer's disease (AD) are complex. Over the last two decades variants in four genes have been firmly implicated in the cause or risk of this disease. Each of these genes is involved in the production, processing or clearance of amyloid, a β-pleated sheet polypeptide derived from a larger protein, the amyloid precursor protein (APP), a ubiquitous transmembrane protein. Mutations in APP, presenilin 1 (PSEN1) and presenilin 2 (PSEN2), have been found in large multi-generational families with an autosomal dominant inheritance beginning as early as the third decade of life. The existence of over 150 different mutations in PSEN1 makes it the most common cause of familial early-onset

disease. These mutations enhance the generation or aggregation of amyloid β peptide which results in amyloid deposition in the form of neuritic plaques in brain implying a pathogenic role.

The ϵ4 allele, a polymorphism of APOE, increases "susceptibility" to AD but is not directly causal. Possession of one APOE-ϵ4 allele is associated with a two- to three-fold increased risk, while having two copies is associated with a five-fold increase. APOE-ϵ4 has a major effect on the age at which AD begins, lowering the age-at-onset in a dose dependent fashion. Because APOE-ϵ4 is a common allelic variant, the population attributable risk associated with APOE-ϵ4 has been estimated at 20%, making it one of the most important risk factors for AD in elderly individuals.

Over the past decade, genetic linkage and association studies have provided evidence for several additional loci producing susceptibility to AD. There is consensus evidence for linkage on chromosomes 10q21-22 and 12p11-12. Additional linkage sites include 6q25-27, 9p21, 19q13 and 21q21-22, but many of these have not been consistent across studies. It has been estimated that there are between five to seven additional genetic variants yet to be identified.

No. 12C
THE BIOLOGY OF DEPRESSION AND DEMENTIA

Gary W. Small *UCLA NPI, 760 Westwood Plz Rm 88-201, Suite 88-201, Los Angeles, CA, 90024-5055*

SUMMARY:

Previous research indicates that depression is a risk factor for the development of dementia and several patho-physiological mechanisms may underlie this association. Recurrent depression is associated with periodic increased levels of cortisol and with hippocampal atrophy. Furthermore, the pathology associated with Alzheimer's disease, specifically amyloid plaques and neurofibrillary tangles, may also disrupt critical neuro-circuitry, which results in depressive phenomenology. Recent findings on the pattern of neuropathological changes in Alzheimer's disease, measured using novel *in vivo* brain imaging methods, will be presented in order to illucidate these possible patho-physiological mechanisms. The functional and structural patho-physiological changes associated with depression and Alzheimer's disease will be reviewed and the case will be made that structural and cellular damage associated with depression or dementia can result in acceleration of the development of both disorders.

No. 12D
VASCULAR DEPRESSION AND VASCULAR DEMENTIA

K. R. Krishnan *Duke University Medical Center, 4584 White Zone, Box 3950, Durham, NC, 27710-0001*

SUMMARY:

The vascular depression hypothesis postulates that sub-clinical ischemic changes in critical areas of the brain, particularly frontal and basal ganglia lesions, create a vulnerability to depression that interacts with genetic, social, psychological and life factors to produce manifest depression in an older-age population. Vascular depression has been associated with striatal frontal dysfunction leading to the syndrome of executive dysfunction, a specific pattern of cognitive deficits. Vascular depression has also been associated with poor treatment response to antidepressant medication in terms of overall lower response rate, longer time to response and higher rate of relapse. The relationship of the vascular depression hypothesis to the well-established phenomena of post-stroke depression will be reviewed, as well as whether this population has a higher propensity to develop vascular dementia over the course of time.

No. 12E
THE COURSE OF TREATMENT OF PATIENTS WITH QUESTIONABLE DEMENTIA

Davangere P. Devanand *Columbia University, 1051 Riverside Dr # 126, New York, NY, 10032-1007*

SUMMARY:

Patients with mild cognitive impairment (MCI) represent a heterogenous group in which some patients convert over time to a clinical diagnosis of probable Alzheimer's disease, and others do not show further cognitive decline. A variety of clinical, neuropsychological, and neurobiological markers have been proposed as early indicators of conversion from MCI to AD. Neuropsychological impairment in tests of episodic memory and executive function, cerebrospinal fluid levels of A-Beta and tau protein, and parietotemporal metabolism deficits using PET are among the more robust predictors that have been identified. The available PET data on two amyloid imaging agents, FDDNP and Pittsburgh compound B, are intriguing but their diagnostic and predictive accuracy are not yet established. In a study of 150 MCI patients and 63 healthy control subjects, specific neuropsychological test scores, odor identification deficits, patient-informant discrepancy in report of function, and MRI hippocampal and entorhinal atrophy were highly significant predictors of conversion to AD over an average of 5 years of follow-up. In the near future, it may be possible to predict MCI conversion to AD with reasonable accuracy, and this will help identify patients who need early treatment, facilitate patient/family planning for their own future, and improve patient selection for clinical trials. To date, the limited data on the use of cognitive enhancers to treat MCI have shown transient effects for the cholinesterase inhibitor donepezil, and no effects for the anti-oxidant vitamin E.

No. 12F
THE COURSE OF TREATMENT OF PATIENTS WITH DEPRESSION AND MILD COGNITIVE IMPAIRMENT

Roy H. Hamilton, M.D. *University of Pennsylvania, Neurology, 1012 Fitzwater St, Philadelphia, PA, 19147-2725*

SUMMARY:

The cognitive deficits associated with depression have traditionally been conceived of as reversible states that resolve after successful treatment of depression. More recently, however, this conceptualization of "pseudo-dementia" has undergone dramatic revision. It is now known that cognitive impairment in the presence of depression is a predictor for the development of dementia, regardless of whether the cognitive impairment normalizes after effective treatment of the depression. In a number of studies of patients with depression and mild cognitive impairment, the rate of dementia after one year of follow-up was 40%, compared to the expected rate of development of dementia in a group of patients with mild cognitive impairment alone that is 13-15% per year. As reviewed previously in this symposium, there are genetic and pathophysiological mechanisms that may underlie the association between depression and mild cognitive impairment. Most importantly, results of new treatment studies designed to delay the devastating effects of these illnesses will be presented.

REFERENCES:

1. St George-Hyslop PH, Petit A. Molecular biology and genetics of Alzheimer's disease. C R Biol. 2005;328(2):119-30.
2. Kepe V: Serotonin 1A receptors in the living brain of Alzheimer's disease patients. Proc Natl Acad Sci USA 2006; 103: 702-707.
3. Krishnan KR: Clinical characteristics of magnetic resonance imaging-defined subcortial ischemic depression. Biol Psychiatry 2004; 55: 390-397.

4. Petersen RC: Current Concepts in Mild Cognitive Impairment. Arch Neurol 2001; 58: 1985-1992.
5. Jorm AF: History of depression as a risk factor for dementia: an updated review. Aust N Z J Psychiatry 2001; 35: 776-781.

SUNDAY, MAY 20, 1:30 PM - 4:30 PM

INDUSTRY SUPPORTED SYMPOSIUM 13—PLANNING FOR SUCCESS IN SCHIZOPHRENIA MANAGEMENT
Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES:

At the end of this session, participants will be able to:

1) Improve their ability to assess a patient's likelihood of treatment adherence.

2) Apply major models of adherence to strategies for remaining on antipsychotic medications for schizophrenia.

3) Incorporate adherence prevalence and risk factor data from studies of patients at various stages of disease, including first-episode and refactory, to the development of practical management strategies for improving treatment adherence among people with schizophrenia in a variety of treatment settings.

3) Develop individualized management plans, including psychosocial interventions, augmentation strategies, depot or long-acting injectable formulations, and side-effect management strategies, to improve patient outcomes.

No. 13B
WHY DO PATIENTS WITH SCHIZOPHRENIA TAKE THEIR MEDICATION? ADHERENCE MODELS FOR FIRST-EPISODE PATIENTS

Peter J. Weiden, M.D. *SUNY Downstate, Department of Psychiatry, 450 Clarkson Ave, Box 1203, Brooklyn, NY, 11203-2056*

SUMMARY:

One of the great challenges in the long-term treatment of schizophrenia is disentangling the major risk factors for medication failure (e.g. nonresponse, relapse) Traditionally, medication nonadherence is considered to be separate from pharmacologic treatment-resistance. Actually, these factors interact with each other. Sometimes these interactions are obvious, other times subtle, but they are always clinically important.

This presentation will first review several models of adherence, looking carefully at why patients take their medication rather than why they stop. The models are 1) intrapsychic, 2) interpersonal, and 3) systems. The presentation will then review new data on long-term adherence and nonadherence among patients with first-episode schizophrenia. These individuals are most likely to do very well with antipsychotic medication, but are also most likely to stop their medication and have the most to lose when they do. The issues that may promote adherence in this patient group include establishing the therapeutic alliance, minimizing distress from side effects, family psychoeducation, and route of medication delivery. Data from these first-episode cohort and intervention studies will then be compared with the previously discussed adherence models. Discussion of selecting specific interventions with specific problems for adherence will be reviewed.

No. 13C
SCHIZOPHRENIA TREATMENT PLANNING: GUIDELINES, MEDICATION ALGORITHMS, PSYCHOSOCIAL STRATEGIES

Dawn I. Velligan, Ph.D. *Univ. of Texas Health Sciences Center, Department of Psychiatry, 7703 Floyd Curl Drive, MS # 7792, San Antonio, TX, 78229-3900*

SUMMARY:

While patients may attend their clinic appointments and fill their prescriptions, research suggests that on average these patients take about half of the medication they are prescribed. Although we continue to develop new antipsychotic and adjunctive treatments with broader efficacy and improved side effect profiles, levels of adherence remain alarmingly low.

The most common method of assessing medication adherence in research and in clinical practice are the self-report of the patient and the impression of the treatment team. Results of several studies indicate that neither patients nor physicians are able to identify how much antipsychotic medication is being taken. Because a physician may attribute persistent psychotic symptoms to problems with the medication rather than problems with adherence, there is a tendency to increase doses, add concomitant medications, prescribe multiple antipsychotics and change medications. In addition, patients may get labeled as being "treatment resistant", when the problem is in fact one of inconsistent adherence to prescribed medication. Furthermore, there are considerable costs to the health care system attributable to polypharmacy and medications that are provided but never taken.

We will discuss a variety of methods to identify problem adherence in patients and describe novel interventions that address the problem. Long-acting injectable medications allow the immediate identification of adherence problems. If the medication is actually making it into the patient, the physician is much more likely to be able to make informed decisions about whether additional medications or dosage adjustments are necessary. Smart pill containers are available that tell patients when to take medication and download adherence information automatically to a secure website, allowing treating professionals to identify problems with adherence and intervene quickly. Environmental and family supports have also been shown to increase adherence to medication. A multi-modal approach to the problem by a multi-disciplinary treatment team able to address patient and environmental/systemic issues is needed.

No. 13D
STRATEGIES FOR ASSESSING AND MANAGING ADHERENCE

Dilip V. Jeste, M.D. *San Diego VA Health Care System, 3350 La Jolla Village Dr, Bldg. 13, 4th Floor, San Diego, CA, 92161-0002*

SUMMARY:

Nonadherence takes many forms. Some clients with schizophrenia take none of their medication and miss all appointments, others are partially adherent, and still others overfill their prescriptions. It then becomes critical to not only assess a patient's adherence status, but to also develop some means of determining the likelihood that a client will be able to comply with therapy, over both the short and long terms.

Factors associated with nonadherence run the gamut from disease-associated and personality traits to institutional and outside support issues. Cognitive function, degree of personal insight, attitudes or responses towards medication, discharge planning, and aftercare have all been suggested as strong predictors of adherence. The challenge, however, is determining which client is likely to comply with treatment, and which is not, and then developing strategies for supporting these individuals.

We will review the latest data on assessment tools, and discuss the findings from clinical trials that focus on patient-centered strategies for improving adherence among this difficult-to-treat population. We will also discuss some practical points that can be applied in daily clinical practice.

No. 13E
CASE PRESENTATIONS OF ADHERENCE DILEMMAS

David Folsom , *M.D.*

REFERENCES:

1. Weiden, P.J.; Kozma, C.; Grogg, A.; and Locklear, J. Partial compliance and risk of rehospitalization among California medicaid patients with schizophrenia. Psychiatr Serv, 55(8):886-91, 2004.
2. Velligan DI, Lam YW, Glahn DC, Barrett JA, Maples NJ, Ereshefsky, L, and Miller, AL. Defining and Assessing Adherence to Oral Antipsychotics: A review of the Literature. Schizophrenia Bulletin. In Press.
3. Dolder CR, Lacro JP, Dunn LB, Jeste DV: Antipsychotic medication adherence: Is there a difference between typical and atypical agents? Am J Psychiatry 2002; 159: 103-108.

INDUSTRY SUPPORTED SYMPOSIUM 14—MAKING EVERY SHEEP COUNT: EVIDENCE-BASED APPROACHES TO TREATING INSOMNIA
Supported by Takeda Pharmaceuticals North America, Inc.

No. 14A
MAKING EVERY SHEEP COUNT: EVIDENCE-BASED APPROACHES TO TREATING INSOMNIA

Daniel J. Buysse, M.D., *Room E-1127, 3811 Ohara St, Pittsburgh, PA, 15213-2593*

SUMMARY:

Insomnia is a common disorder affecting approximately 10-15% of the adult population and costing over $70 billion per year in the US. People with insomnia are at increased risk for work and traffic-related accidents, have increased health care utilization, and impaired quality of life. However, only 5% of patients in primary care settings seek treatment for insomnia, and physicians often have little formal training or experience in sleep medicine. Therefore, education regarding sleep and insomnia is important for both physicians and their patients.

Recent developments in neuroscience have elucidated the processes and neural mechanisms that regulate of sleep and wakefulness. A better understanding of sleep neurobiology can help us to place the clinical complaints of insomnia patients in a broader scientific framework, and can also help us to understand the rationale for various treatments.

Many people with insomnia have co-occurring psychiatric disorders. The relationship between insomnia and psychiatric disorders is often complex, but recent developments have improved our understanding of these relationships. Appropriate recognition and management of insomnia comorbid with psychiatric disorders reduce patient suffering and improve treatment outcomes.

Treatments for insomnia and related disorders include non-pharmacologic and pharmacologic approaches. Behavioral treatments have been shown to be highly efficacious in patients with primary insomnia. Emerging evidence indicates that behavioral treatments are also effective in patients with insomnia and comorbid psychiatric or medical illnesses, and that they can be adapted to usual care settings. Behavioral treatments have also been developed to treat conditions such as the sleep and dream disturbances of post-traumatic stress disorder.

The pharmacologic treatment of insomnia has also undergone rapid development. Benzodiazepine hypnotics have now been supplemented by the introduction of non-benzodiazepine hypnotics including zolpidem, zaleplon, eszopiclone and ramelteon. Zolpidem, zaleplon, and eszopicone are similar to benzodiazepines in their mechanism of action, which involves modulation of GABA activity; ramelteon has a distinct mechanism of action, targeting melatonin receptors. These newer agents are often recommended as first-line treatments for insomnia because of their demonstrated efficacy and reduced likelihood of rebound insomnia or tolerance. These newer agents differ from each other in their specific sleep effects, such as time to sleep onset and sleep maintenance. Educating physicians and patients about these differences and considering patients' preferences may lead to improved clinical outcomes.

This educational activity will highlight the key elements of sleep neurobiology and relate these to the mechanisms, effects, and side effects of insomnia treatments. Experts will discuss comorbidity occurring psychiatric conditions, specifically detailing how the coexistence of insomnia and mental illness may affect treatment and outcomes. Furthermore, this activity will provide an up-to-date understanding of evidence based treatments for the management of insomnia and discuss the importance of patient participation in the selection of treatments.

Doghramji K. The epidemiology and diagnosis of insomnia. *Am J Manag Care*. 2006;12(8 suppl):S214-S220.

No. 14B
THE CLINICAL NEUROSCIENCE OF SLEEP AND INSOMNIA

Daniel J. Buysse, M.D., *Room E-1127, 3811 Ohara St, Pittsburgh, PA, 15213-2593*

SUMMARY:

Sleep and wakefulness are fundamental states of brain function in humans and almost all animals. Identifying the neural substrates of sleep and wakefulness has been challenging because they represent states rather than discrete functions such as speech, movement, or even emotion. However, recent developments in basic and clinical neuroscience have revealed an intricate set of structures and functions that regulate sleep and wake states. Further evidence suggests that sleep disorders including insomnia are related to dysregulation in these structures and functions.

The basic substrate of wakefulness lies in the ascending monoaminergic nuclei of the brainstem, pons, hypothalamus, and basal forebrain. These nuclei innervate the cortex both directly and indirectly via the thalamus. During wakefulness, activity of these wake-promoting regions is reinforced by input from cells in the lateral hypothalamus that use the peptide neurotransmitter orexin (hypcretin). At the beginning of non-rapid eye movement (NREM) sleep, cells in the ventrolateral preoptic area of the hypothalamus become more active, and, though the neurotransmitter GABA, inhibit the arousal centers of the brainstem and hypothalamus. When these arousal centers are inhibited, the cortex and thalamus produce the EEG patterns and behaviors typically associated with sleep. In addition to these centers, sleep and wakefulness are influenced by the circadian system (biological clock), which is regulated by cells in the suprachiasmatic nuclei; and by a wake-dependent, or homeostatic, sleep drive. Finally, input from the prefrontal cortex and limbic system can influence the occurrence and emotional tone associated with sleep and wakefulness.

Specific sleep disorders can be tied to dysregulation of these sleep-wake systems. For instance, destruction of orexin neurons in the lateral hypothalamus causes the human disorder narcolepsy, characterized by sleepiness and unstable sleep-wake states. Abnormal timing of the circadian system leads to delayed or advanced sleep phase disorders. Evidence from functional neuroimaging studies suggests that insomnia is related to reduced inhibition of brainstem-hypothalamic arousal centers, frontal cortex, and limbic system structures during sleep. Likewise, treatments for sleep disorders_both pharmacologic and behavioral--can be understood on the basis of these sleep-wake regulatory systems. Further understanding of basic and clinical neuroscience will lead to further refinements in treatment of sleep and wake disorders.

No. 14C
COMORBIDITY BETWEEN INSOMNIA AND PSYCHIATRIC ILLNESS

Meera Narashimhan, M.D., *University of South Carolina School of Medicine, 19 Running Fox Rd, Columbia, SC, 29223-3018*

SUMMARY:

Approximately 40% of people who suffer from insomnia also have a concurrent psychiatric diagnosis that can influence the course and presentation of insomnia. Anxiety disorders are the most commonly occurring psychiatric disorders; however, the prevalence of major depression and substance abuse is also significantly increased. Some studies, in fact, have reported that insomnia related to a psychiatric disorder is the most frequent diagnosis in patients referred because of insomnia to sleep medicine centers. Conversely, over 2/3 of patients with psychiatric diagnoses complain of insomnia, which is the most prevalent sleep disorder among psychiatric patients. Thus, the overlap often complicates the diagnostic picture of insomnia in patients with mental illness.

Evidence suggests that insomnia, as a part of chronic disease tends to be more severe and persistent than primary insomnia. Insomnia is a better predictor for a new onset or recurrence of depression than any other depressive symptom (e.g., thoughts of or wishes for death, feelings of worthlessness and guilt, weight problems or fatigue). For example, people with insomnia are nearly four times more likely to develop a new depressive disorder than those without sleep disturbance. Furthermore, comorbid insomnia can have a profound negative impact on patients' quality of life and overall functioning, and may be associated with greater healthcare resource utilization. Suicide attempters among people with depression are more likely to have sleep disturbances. In the case of bipolar disorder, insomnia may precipitate or exacerbate episodes of mania. Yet, despite these known outcomes, insomnia has been viewed traditionally as a disorder of minor importance and the comorbidity of the disorders have not been routinely addressed or studied.

More attention has been paid to insomnia and comorbidity occurring mental illness in recent years. The idea that treating insomnia is important for managing patients with mood and anxiety disorders is gaining acceptance, although further data are needed to establish the causal link between sleep disturbance and psychiatric disorders. Recent studies have shown benefits of insomnia treatments and combination treatments for both insomnia complaints as well as depressive symptoms, and the onset of antidepressant response is more rapid when insomnia is treated simultaneously. Patients with psychiatric disorders tend to have chronic insomnia, and newer medications are available which are safe, effective and FDA indicated for long-term use. This activity will discuss the prevalence and epidemiology of co-occurring insomnia and psychiatric disorders and provide a better understanding of the difficulties of diagnosis in these patients as well as describe outcomes and consequences of these disorders in coexistence. Experts will provide clinicians with new data in order for them to better apply evidence-based approaches into clinical practice.

No. 14D
NOVEL PHARMACOLOGICAL TARGETS FOR THE MANAGEMENT OF INSOMNIA

Ruth M. Benca, M.D., Ph.D., *U WI B6/260 Clin Sci Ctr, Department of Psychiatry, 600 Highland Ave, Madison, WI, 53792-0001*

SUMMARY:

Pharmacologic treatment of acute insomnia is generally warranted if insomnia persists beyond one or two nights, or if it occurs frequently. Chronic insomnia can present a therapeutic challenge, and behavioral and pharmacologic modalities are usually needed. Achieving symptom response is more rapid with pharmacologic treatments; however, behavioral methods may be more effective in terms of long-term outcomes. In the past, hypnotic medications used for the management of insomnia have not been assessed for long-term use. However, newer pharmacologic treatment options have been shown to be safe and effective in longer-term treatment and agents with novel mechanisms are being developed. Up until recently, all FDA-approved hypnotics were the benzodiazepine receptor agonists. These medications work by modulating GABA neurotransmission by potentiating GABA's ability to increase conductance of chloride through its channel, resulting in hyperpolarization of neurons. However, BZRAs may produce a number of side effects that can be problematic, particularly for some groups of patients; anterograde amnesia, falls, respiratory depression, disinhibition, daytime drowsiness and cognitive impairments. Adverse effects are thought to be somewhat lessened in the newer non-benzodiazepines in comparison to the older benzodiazepines. Zolpidem was first non-benzodiazepine BZRA hypnotic in the early 1990s. Its hypnotic efficacy is similar to that of benzodiazepine hypnotics; however, zolpidem has been shown to decrease wake time after sleep onset and improve patient reported global sleep measures. Rebound insomnia, memory impairment, dependence, and withdrawal symptoms are uncommon at the recommended doses. Zaleplon is effective for decreasing time to sleep onset in short term trials but has not been proven effective for increasing total sleep time or decreasing the number of awakenings. Eszopiclone, a cyclopyrrolone, is the racemic form of zopiclone and is effective for reducing sleep latency and improving sleep maintenance. It is estimated that 10- 15% of patients who use these hypnotic medications may take them regularly for more than one year although in most cases little safety or efficacy data are available to guide their use beyond two to three months.

With concerns regarding the safety of these types of mediations, a search for newer agents affecting sleep through different mechanisms has been underway. Ramelteon is a recently introduced medication that specifically targets the melatonin (MT1 and MT2) receptors in the brain, which are believed to be critical in the regulation of the body's sleep-wake cycle. Ramelteon has been shown to consistently reduce sleep latency and it has also been found increase total sleep time in some studies. It is well tolerated and approved for long-term use. A number of promising agents are also being developed that target GABA systems and serotonin receptors, which may provide yet other choices for treating insomnia.

As newer agents are being introduced and direct to consumer advertising for these products increases, clinicians need to be able to make evidence-based recommendations for their patients. This activity will discuss the history of insomnia management, the benefits and limitations of currently available treatments. Using up-to-date data, you will see how pharmacotherapy can improve patient outcomes in primary and comorbid insomnia.

No. 14E
INNOVATIVE BEHAVIORAL APPROACHES FOR TREATING INSOMNIA AND COMORBID PSYCHIATRIC ILLNESS

Karl Doghramji, M.D., *Thomas Jefferson University, 1015 Walnut St # 319, Philadelphia, PA, 19107-5005*

SUMMARY:

The efficacy of behavioral/cognitive treatment (CBT) has been well documented for primary insomnia. Comparative studies suggest that they are at least as effective as pharmacological therapies. In contrast to pharmacological therapies, however, they also have lasting benefit.

Specific cognitive behavioral techniques can alleviate different aspects of insomnia. For example, sleep hygiene promotes habits that help sleep; stimulus control strengthens the bed and bedroom environment as sleep stimuli; sleep restriction enforces restricted time in bed to improve sleep depth and consolidation. Other nonpharmacological treatments include relaxation training and circadian rhythm entertainment which reduce arousal and decrease anxiety and reset or reinforce biological rhythms. Cognitive therapy addresses thoughts and beliefs that interfere with sleep and finally, psychotherapy aims to resolve instrapsychic conflict and interpersonal issues related to insomnia. Approaches to increase the portability of behavioral treatments of insomnia into the primary care setting are a subject of research and will be discussed. The rationale, techniques and outline of a behavioral treatment protocol for insomnia comorbid psychiatric and medical conditions will then be presented.

REFERENCES:

1. Buysse DJ, Germain A, Moul D, Nofzinger EA. Insomnia. In: Buysse DJ, ed. Sleep Disorders and Psychiatry. Arlington, VA: American Psychiatric Publishing, Inc.: American Psychiatric Publishing Review of Psychiatry; 2005:29-75.
2. Szelenberg W, Sldatos C. Sleep disorders in psychiatric practice. World Psychiatry. 2005;4:186-190.
3. Morin AK. Strategies for treating chronic insomnia. Am J Manag Care. 2006;12(8 suppl):S30-S45.
4. NIH State-of-the-Science Conference Statement on manifestations and management of Chronic Insomnia in Adults. Available at: http://consenesus.nih.gov/2005/2005insomniaSOS026html.htm. Accessed June 1, 2006.

INDUSTRY SUPPORTED SYMPOSIUM 15—OPTIMIZING OUTCOMES ACROSS THE SPECTRUM OF DEMENTIA
Supported by Eisai, Ind.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to:

1) Realize the importance of preventing AD, the opportunities in doing so, and ways in which to evaluate promising prevention therapies in the shortest possible time.

2) Utilize principles of excess disability and behavioral triggers to assess behaviors, plan meaningful individualized care, and evaluate outcomes.

3) Discuss the need for early and accurate diagnosis across the dementia spectrum.

4) Review therapeutic options for patients with the various stages of Alzheimer's disease.

5) Describe newer strategies to be employed in patients with dementia.

No. 15A
BLENDING SCIENCE AND BEST PRACTICE ACROSS THE DEMENTIA SPECTRUM

Pierre N. Tariot, M.D.

SUMMARY:

Alzheimer's afflicts about 10% of us over the age of 65, and almost half of us over 85. The numbers of people with cognitive impairment preceding dementia are staggering. It is incumbent upon us to blend science with best practice in coping with this public health catastrophe.

Dr. Eric Reiman will survey exciting scientific developments that give us hope that we may be able to prevent Alzheimer's in the foreseeable future with strategies ranging from lifestyle modification to vaccinations, using technologies to conduct efficient proof of concept studies. Dr. Geri Hall will present a simple theoretical framework in which to understand the triggers of behavioral symptoms and effectively manage them. Dr. Roy Yaari will present captivating case examples illustrating practical approaches to the evaluation of patients with cognitive impairment, ranging from a pre-dementia state to early dementia. Given the volume of people who will be suffering these symptoms in the future, it will be useful for the practicing clinician to have tools at hand for systematic evaluation of these patients. Dr. Pierre Tariot will make the transition to management and treatment precepts for people across the whole spectrum of clinical presentation, from normal aging through amnestic mild cognitive impairment to frank Alzheimer's disease. Dr. Jeffrey Cummings will conclude the program with an overview of a future in which we are likely to incorporate traditional medical practices with new diagnostic approaches incorporating genetics, biologics, and blend currently available medications with possibly dramatically different forms of disease modification options.

No. 15B
USE OF PLST MODEL WITH ALZHEIMER'S DISEASE TRAINING

Geri R. Hall, Ph.D.

SUMMARY:

The increasing population of people with Alzheimer's disease and related disorders, the length of the diseases, and the high cost of long term care have shifted the primary responsibility for care to the American family. Assumption of this responsibility imposes significant burdens on caregivers unprepared to manage the complex behavioral presentations that accompany the functional decline.

Most providers and researchers recognize the need for non-pharmacologic management of dementing conditions, using psychoactive medications only when behavioral programs are ineffective. That said, the concept of non-pharmacologic practice is poorly understood. Evidence-based literature generally focuses on single interventions such as music therapy with no unifying framework for integration into a plan of care or evaluation of outcomes.

The Progressively Lowered Stress Threshold (PLST) model is a conceptual framework long used in long term care to simplify care planning and evaluation. Based on concepts of stress, the model identifies six triggers of secondary behavioral symptoms and excessive disability. The model identifies how to modify the routine and environment in highly individualized ways to minimize behavioral triggers.

This talk discusses the model, providing examples of outcomes from a multisite randomized control trial to evaluate differences between caregivers trained in use of the PLST model with those who received traditional Alzheimer's disease training and support. Data were collected on the number and type of secondary behavioral symptoms presented, caregiver interventions, appraisal of effective-

ness of interventions, appraisal of critical events, and general caregiver distress with care recipient behavior. Differences emerged between the two groups.

No. 15C
AN OFFICE-BASED APPROACH TO EARLY AND ACCURATE DIAGNOSIS

Roy Yaari, M.D.

SUMMARY:

Dementia is a clinical state characterized by loss of cognitive function that is not due to an impaired level of arousal. Dementia is a non-specific term encompassing many diseases, the most common of which is Alzheimer's disease. Accurate and early diagnosis is important, not only to distinguish between reversible and irreversible causes, but to potentially maintain patients at a higher level of functioning which may lead to fewer doctor visits and hospitalizations. Other potential benefits of early diagnosis include reduced caregiver burden, delay in nursing home placement, and reduction in the use of psychotropic drugs. The clinical diagnosis is based on identifying elements within the medical history and clinical exam suggestive of dementia. Cognitive testing includes an assessment of orientation, recent and remote memory, language, praxis, visuospatial function, and calculations. Diagnostic tests are necessary in the differential diagnosis of dementia to identify readily treatable metabolic, infectious, or structural causes. Testing depends on the suspected diagnosis, but generally includes a complete blood count, serum electrolytes and liver function tests, thyroid studies, a vitamin B12 level, and structural neuroimaging. Functional neuroimaging, including positron emission tomography are emerging as promising aids in the early diagnosis of dementia.

No. 15D
NORMAL AGING, AMNESTIC MCI OR AD: MANAGING AND TREATING ACROSS THE WHOLE SPECTRUM

Pierre N. Tariot, M.D.

SUMMARY:

Alzheimer's disease is a progressive condition that is unfortunately diagnosed most commonly in the mid-to-later stages of its course, when the characteristic cognitive and functional symptoms associated with the illness have become readily evident to families and physicians. Despite the fact that these patients have already experienced substantial losses in cognition and functioning, substantial benefit can be gained from pharmacotherapeutic options. The cholinesterase inhibitors and the NMDA receptor antagonist memantine have been shown to slow the decline in cognitive dysfunction in patients with moderate-to-severe Alzheimer's, although memantine is currently the only agent approved by the FDA for use in this stage of illness. A single study involving memantine administered in addition to ongoing donepezil suggested an increased cognitive benefit relative to the group receiving a placebo on top of the cholinesterase inhibitor in patients with moderate to severe Alzheimer's, a finding that may relate to the differing mechanisms ascribed to cholinesterase inhibitors and the NMDA receptor antagonist.

Patients with mild Alzheimer's disease can show reduced progression of cognitive dysfunction and functional decline with cholinesterase inhibitors, which are FDA approved for this stage of illness. Results from trials with memantine have been inconsistent in patients at this stage of illness; it is not FDA approved for this purpose. There is emerging evidence suggesting, but not proving, that there may be beneficial effects of anti-dementia agents on behavioral symptoms, both in terms of symptom reduction for people with symptoms present, and possible delayed emergence of symptoms in those not experiencing psychopathology yet. Some pharmacotherapy trials suggest that these agents may prolong time to institutionalization, although the point remains unproven.

There are no FDA approved therapies for treatmen of mild cognitive impairment, although there are suggestive results from some trial conducted with cholinesterase inhibitors. Current treatment guidelines suggest a discusssion with patients and families about the mixed evidence regarding efficacy of this class of agents. At present there are no pharmacologic agents for treatment of age-associated cognitive impairment.

Treatment guidelines tend to emphasize management of medical risk factors for worsening of cognition, as well as optimizing lifestyle variables.

Therapeutic interventions are available for people at any point along the spectrum from age-related cognitive decline to dementia, and evidence is mounting that many of these can confer tangible benefits for people with these frightening and debilitating conditions.

No. 15E
MANAGEMENT OF BEHAVIORAL DISTURBANCES IN ALZHEIMER DISEASE

Jeffrey L. Cummings, M.D.

SUMMARY:

Behavioral changes are common in Alzheimer disease. Patients manifest apathy, agitation, depression, irritability and other neuropsychiatric symptoms. Psychotropics agents may be useful in the management of the behavioral abnormalities, although no agents are specifically approved for this purpose. Antidementia agents also reduce behavioral abnormalities.

REFERENCES:

1. Cummings JL. The neuropsychiatry of Alzheimer's disease and related dementias. Francis an Taylor, London, 2004.
2. Hall, G. and Buckwalter, K. (1987). A conceptual model for planning and evaluating care of the client with Alzhemer's disease. "Archives of Psychiatric Nursing 1:6 399-406."
3. Tariot PN, et al: Memantine in patients with moderate to severe alzheimer's disease already receiving donepezil. JAMA 2004; 192;31-324.
4. Gauthier S, Reisberg B, Zaudig M, et al: Mild cognitive impairment. Lancet 2006; 367:1262-1270.
5. Ferri CP, Prince M, Brayne C, et al. Global prevalence of dementia: a Delphi consensus study. Lancet. 2005; 366:2112-2117.
6. Herbert LE, Scherr PA, Bienias JL, et al. Alzheimer's disease in the US population: prevalence estimates using the 2000 census. Arch Neurol. 2003; 60:1119-1122.
7. World Health Organization. World Health Report 2003–shaping the future. Geneva, Switzerland: World Health Organization, 2003.

INDUSTRY SUPPORTED SYMPOSIUM 16—RETHINKING BIPOLAR DISORDER: IMPLICATIONS OF COMORBIDITIES
Supported by AstraZeneca Pharmaceuticals

No. 16A
RETHINKING BIPOLAR DISORDER: IMPLICATIONS OF COMORBIDITIES

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

SUMMARY:

Bipolar disorder is recognized as a chronic complex condition. Although the disorder is diagnosed based on the occurrence of episodes of abnormal mood elevation, and commonly conceptualized in terms of mood episodes, the majority of patients with bipolar disorder experience high rates of nonaffective psychopathology and a variety of general medical conditions. In fact, rates of several disorders are higher in bipolar disorder than in schizophrenia or unipolar mood disorder. This symposium will explore emerging data in the relationship between bipolar disorder and common comorbidities such as anxiety disorders, psychoactive substance abuse, PTSD, inflammatory disorders, and suicidality with an eye toward reconceptualizing bipolar disorder in terms of the observed multiplex of dysregulation that appears to be its nature. Implications for clinical management will also be discussed.

No. 16B
MEDICAL COMORBIDITIES WITH BIPOLAR DISORDER

Gary S. Sachs, M.D. *50 Staniford Street, 5th Floor, Boston, MA, 02114*

SUMMARY:

Bipolar disorder is a manifestation of brain disease. While the pathologies underlying bipolar disorder remain poorly understood, several lines of evidence link bipolar disorder with general medical conditions. Bipolar patients have been shown to have high rates of organ specific autoantibodies and other cytokine dysregulation. A recent survey found asthma was the only general medical condition more prevalent among subjects screening as positive for bipolar disorder rather than unipolar disorder, however several conditions (asthma, arthritis, hyperlipidemia, hypertension, cardiac disease) were reported more common among the relatives of subjects screening positive for bipolar disorder. These associations may link resilience factors with course of illness. This presentation will review the association between bipolar disorder, inflammatory conditions, and other common general medical conditions. Interventions which focus on risk and resilience factors including anti-inflammatory medications, diet, and exercise will be discussed as potential future innovative treatment strategies as well as implications for current clinical management.

No. 16C
COMORBID SUBSTANCE ABUSE IN BIPOLAR DISORDER

Michael J. Ostacher, M.D. *Massachusetts General Hospital, 50 Staniford St, Boston, MA, 02114-2517*

SUMMARY:

Patients with bipolar disorder are more likely to have a history of substance and alcohol use disorders than are patients with any other psychiatric condition. The lifetime course of illness for these individuals is often marked by earlier onset of mood disorder, lower functioning, higher rates of suicide, non-adherence to treatment, and increased rates of hospitalization. Because symptoms of mania and depression are mimicked by substance intoxication and withdrawal, delays in diagnosis and treatment may result. This lecture will review the epidemiology and course of illness of patients with co-occurring bipolar disorder and substance use disorders, and describe the current best practices for the management of these comorbidities.

No. 16D
SUICIDALITY AS A COMPONENT OF BIPOLAR DISORDER

Lauren Marangell, M.D. *Baylor College of Medicine, One Baylor Plaza, BCM 350, Houston, TX, 77030*

SUMMARY:

Suicide and suicidal behavior are a significant public health problem and at an individual level are devastating to affected individuals and their families. Several studies have documented markedly increased rates of suicide attempts and completions in patients with bipolar disorder. While suicidal behavior is unquestionably determined by a complex combination of risk factors and environmental circumstances, knowledge of the most salient risk factors in this population is necessary of optimal clinical management. This presentation will begin with a review of risk factors for suicidality in bipolar disorder based on both the existing literature and new data from 2 years of follow-up of participants in the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). The presentation will conclude with a critical review of data concerning the relative risks and benefits of pharmacotherapies on suicidality in this population.

No. 16E
POSTTRAUMATIC STRESS DISORDER AND BIPOLAR DISORDER: CRITICAL OVERLAPS AND POSSIBLE LINKS IN PATHOLOGY AND TREATMENT

Lori L. Davis, M.D. *VA Medical Center, 3701 Loop Road East, Tuscaloosa, AL, 35404*

SUMMARY:

The stress-diathesis of mental illness is a possible theoretical model explaining the etiology of mood and anxiety disorders. Significant life stressors, particularly in childhood, may precipitate mental illness, such as bipolar disorder or posttraumatic stress disorder (PTSD), in those who are genetically, biologically, and psychologically vulnerable. The National Comorbidity Survey found that nearly forty-percent of bipolar I patients had a lifetime prevalence PTSD. There is also considerable overlap in the neurobiological and psychological manifestations of bipolar disorder and anxiety disorders, specifically PTSD. However, the systematic research in this comorbid population is scant. This presentation focuses on this neglected area and reviews the evidence for and against an overlap between bipolar and PTSD conditions and their treatments. The clinical relevance and challenges in the treatment of patients with bipolar disorder and concurrent PTSD are carefully explored.

No. 16F
NEUROIMAGING OF DUAL DIAGNOSES

Stephen M. Strakowski, M.D. *University of Cincinnati College of Medicine, 231 Albert Sabin Way, Cincinnati, OH, 45267-0583*

SUMMARY:

The symptoms and signs of bipolar disorder suggest abnormalities within the anterior limbic network (ALN). The ALN is conceptualized as an extended prefrontal-striatal-thalamic iterative network that also incorporates amygdala, 'cognitive' regions of the prefrontal cortex, hypothalamus, and mid-line cerebellum. The ALN has been implicated in emotional processing and injuries within this network may result in secondary manic and mood-cycling syndromes. Neuroimaging studies have permitted the in vivo exploration of the ALN in bipolar disorder. Structural imaging suggested morphometric abnormalities throughout the ALN. Functional imaging extended these

early findings and suggests that dysfunction of the ALN leads patients to compensatory brain activation patterns to manage cognitive tasks. During mood episodes, compensation fails, contributing to symptoms. Additionally, abnormalities in brain systems that manage error processing and impulse control may not only present as symptoms of bipolar disorder, but also underlie the increased risk for impulsive comorbid syndromes (eg, substance use disorders). Specific metabolic abnormalities within the ALN have been proposed to underlie the functional abnormalities observed. The neurophysiology of bipolar disorder and commonly co-occurring syndromes will become better understood as imaging techniques and studies advance.

REFERENCES:

1. Boufidou F, et al: Cytokine production in bipolar affective disorder patients under lithium treatment. J Affect Disord 2004 82:309-313.
2. Fossey MD, et al: Validity and distinction between primary and secondary substance use disorder in patients with bipolar disorder: data from the first 1000 STEP-BD participants. Am J Addict 2006; 15:138-143.
3. Angst F, Stassen HH, Clayton PJ, Angst J: Mortality of patients with mood disorders: Follow-up over 34-38 years. J Affect Disord 2002; 68:167-181.
4. Davis LL, Frazier EC, Williford RB, Newell JM. Long-Term Pharmacotherapy for Posttraumatic Stress Disorder (Review). CNS Drugs 2006;20(5):1-12.
5. Strakowski SM, DelBello MP, Adler CM. The functional neuroanatomy of bipolar disorder: a review of neuroimaging findings. Molecular Psychiatry 2005; 10:105-116.

INDUSTRY SUPPORTED SYMPOSIUM 17—CARING FOR OUR MOST CHALLENGING PATIENTS WITH DEPRESSION: AN INTERACTIVE FORUM ON NOVEL TREATMENTS
Supported by Cyberonics, Inc.

No. 17A
CARING FOR OUR MOST CHALLENGING PATIENTS WITH DEPRESSION: AN INTERACTIVE FORUM ON NOVEL TREATMENTS

Charles B. Nemeroff, M.D. *Emory University School of Medicine, Dept. of Psychiatry and Behavioral Sciences, 101 Woodruff Circle, Suite 4000, Atlanta, GA, 30322-0001*

SUMMARY:

Despite numerous treatment options currently available for the treatment of depression, approximately 2 million people in the United States may experience an inadequate response to treatment (treatment-resistant depression [TRD]) at some point in their lives. The definition of TRD remains a contentious area in the field, defined alternatively as a failure to respond to two or more trials of antidepressant monotherapy to a failure to respond to four or more trials of different antidepressant therapies, including augmentation, combination therapy, and electroconvulsive therapy (ECT). Reports from early randomized clinical trials reveal that among patients treated with antidepressant monotherapy, 15-20% are intolerant of the medications, only about 60-70% demonstrate a response (≥ 50% improvement in depression severity) to initial treatment and multiple therapeutic attempts fail in 5-10%. More recently, it has been reported that as many as one-third of patients experience only a partial response to initial therapy, while nearly one-fifth are considered nonresponders. In addition to the quality-of-life issues for the patient with TRD, the economic cost of TRD is significant. Annual healthcare costs increase significantly for patients with TRD with each successive change in antidepressant medication. Early in treatment (two medication changes), the annual costs are less than $7000 per year. By the eighth medication change, annual costs double to nearly $14,000 per year. There is a well-documented need for better long-term treatments of TRD, as witnessed by multiple efforts to establish treatment algorithms and best treatment steps when first and subsequent treatment measures prove inadequate. The STAR-D study has highlighted the less than optimal remission of real world patients to citalopram monotherapy (REF). There is increasing evidence that somatic interventions, including electroconvulsive therapy (ECT), vagus nerve stimulation (VNS), deep brain stimulation (DBS), magnetic seizure therapy (MST), and repetitive transcranial magnetic stimulation (rTMS) are effective in some patients unresponsive to pharmacotherapy and/or cognitive behavioral therapy. In this interactive symposium, the faculty will use case studies and an audience response system to strengthen clinicians' knowledge and awareness of TRD, to discuss the data on efficacy of novel strategies, to build their confidence in aggressively treating TRD, and to foster practice change.

No. 17B
MECHANISM OF ACTION OF VAGUS NERVE STIMULATION (VNS)

Charles B. Nemeroff, M.D. *Emory University School of Medicine, Dept. of Psychiatry and Behavioral Sciences, 101 Woodruff Circle, Suite 4000, Atlanta, GA, 30322-0001*

SUMMARY:

The vagus nerve (cranial nerve X) is a mixed nerve comprised of approximately 80% afferent sensory fibers carrying information to the brain from the head, neck, thorax and abdomen. The only FDA-approved treatment for management of treatment-resistant depression (TRD) is vagus nerve stimulation (VNS). Used first for the treatment of pharmaco-resistent epilepsy, several lines of evidence led researchers to determine whether VNS might have antidepressant effects for patients with TRD. First patients with epilepsy who receive VNS have shown improvement in their depressive symptoms independent of the degree of seizure control attained. A burgeoning literature on the neurobiological effects of VNS suggest that activation of the afferent sensory connections of the vagus produce effects on regions of the brain implicated in the pathogenesis of depression, including the amygdala, locus ceruleus and dorsal raphe nuclei. VNS increases activity in norepinephrine (NE) and serotonin-containing circuits, the neurotransmitter systems most implicated in mood regulation. The available data suggest that VNS activates the locus ceruleus, the main source of central nervous system NE-containing neuronal cell bodies, and dorsal raphe neurons, the main source of 5HT neurons that project to the forebrain. Functional brain imaging studies support the CNS action of VNS. Taken together these mechanisms of action studies are likely to reveal the neurobiological substrates of VNS treatment of TRD.

No. 17C
EFFICACY OF REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (RTMS) AND MAGNETIC SEIZURE THERAPY (MST)

Thomas Schlaepfer, M.D., *University Hospital, Sigmund-Freud Str.25, Bonn, 53105, Germany*

SUMMARY:

Repetitive transcranial magnetic stimulation (rTMS) is a new, experimental technology that holds promise as a treatment of depression. rTMS sends bursts of electomagnetic energy to cortical areas

of the brain thought to be involved in the biology of depression. Superiority to placebo has been indicated in three small blind studies; one recent study compared rTMS with electroconvulsive therapy (ECT) and a second assessed the effectiveness of rTMS started concomitantly with antidepressant medications in patients with non-drug-resistant major depressive disorder. Both studies found that efficacy of rTMS was of benefit based on several different clinical parameters. Magnetic seizure therapy (MST) refers to the intentional induction of a seizure under anesthesia and muscle relaxation for therapeutic purposes using repetitive transcranial magnetic stimulation (rTMS), another experimental therapy using magnetic fields can be more accurately targeted than ECT This method is currently being researched with regards to its antidepressant effects. Recently it has been demonstrated that it is possible to safely and reliably induce seizures in humans. One published clinical trial has evaluated the tolerability of MST versus ECT, using a side-effect rating scale and neuropsychological testing. Scores on a variety of cognitive measures, including disorientation recovery, attention and certain tests of retrograde and anterograde amnesia, were significantly superior after MST versus ECT. The efficacy of MST is currently under investigation in a larger clinical trial; however, efficacy results from two recent case reports look promising.

No. 17D
ASSESSING THE EFFICACY OF VAGUS NERVE STIMULATION (VNS) IN PATIENTS WITH TREATMENT RESISTANT DEPRESSION

Paul Holtzheimer, M.D. *Emory School of Medicine, Dept of Psychiatry and Behavioral Sciences, 1841 Clifton Rd. NE, 4th Floor, Atlanta, GA, 30329*

SUMMARY:

The efficacy of vagus nerve stimulation (VNS) for refractory epilepsy has been well established since its FDA approval in 1997 for this indication. Vagus nerve stimulation is now also FDA-approved for the adjunctive, long-term use in chronic or recurrent major depression in adult patients with an inadequate response to at least four antidepressant treatments. Published open-label data has demonstrated both short- and long-term efficacy for VNS) . The short-term trial showed that more than 30% of patients who received VNS for 10 weeks had at least 50% improvement based on the HAM-D.1 Patients who entered a 9-month extension of this study showed sustained response and remission rates. Short- and long-term results from a placebo-controlled study of VNS in combination with usual standard of care have been described in a group of patients with refractory depression. In the 10-week acute treatment phase, the antidepressant effect of VNS was not confirmed, with response rates similar to controls. 3 However, analysis of the 1-year follow-up data from the cohort of patients receiving adjunct VNS in an open-label fashion demonstrated a significant reduction in the 24-item Hamilton Rating Scale for Depression (HRSD24, $p < .001$). At exit, HRSD24 response rate was 27.2% and remission rate was 15.8%. Scores on the MADRS and CGI-I scales showed similar response rates. A 1-year study of VNS plus treatment as usual versus a comparable group of treatment-resistant patients showed that VNS was associated with greater monthly improvement in depression scores and a significant response rate on the HRSD24 ($p < .011$).

No. 17E
MECHANISM OF ACTION AND EFFICACY OF DEEP BRAIN STIMULATION

Helen Mayberg *Emory University, 101 Woodruff Circle, WMRB, Suite 4313, Atlanta, GA, 30322-0001*

SUMMARY:

While already FDA-approved for treatment of severe Parkinson's disease, deep brain stimulation (DBS) is still in a highly exploratory phase of investigation for treatment of depression and other psychiatric disorders, including treatment-resistant depression (TRD). Based on previous work implicating the subgenual cingulate (Cg25) and its functional connections to specific paralimbic, cortical and subcortical regions in the pathophysiology of depression and antidepressant response mechanisms, the use of chronic, high frequency DBS to modulate Cg25 connectivity in six patients with treatment-resistant depression was tested. Chronic stimulation of white matter tracts adjacent to the subgenual cingulate gyrus was associated with a striking and sustained remission of depression in four of six patients. Antidepressant effects were associated with a marked reduction in local cerebral blood flow as well as changes in downstream limbic and cortical sites, measured using positron emission tomography. These results suggest that disrupting focal pathological activity in limbic-cortical circuits using electrical stimulation of the subgenual cingulate white matter can effectively reverse symptoms in otherwise treatment-resistant depression. Other targets within these circuits are also being tested. Unlike the other neurostimulation techniques that show promise for treating patients with TRD, DBS is an invasive surgical procedure that may limit its use to patients with TRD who have unsuccessfully been treated with several adequate courses of therapy from multiple treatment modalities during the current episode.

REFERENCES:

1. Nemeroff CB, Mayberg HS, Krahl SE, McNamara J, Fraxer A, Henry TR, George MS, Charney DS and Brannen SK. VNS therapy in treatment-resistant depression: clinical evidence and putative neurobiological mechanisms. Neuropsychopharmacol 2006; (in press).
2. 1. Schlaepfer TE, Kosel M, Nemeroff CB: Efficacy of Repetitive Transcranial Magnetic Stimulation (rTMS) in the Treatment of Affective Disorders. Neuropsychopharmacology 2003; 28(2):201-205.
3. 5. George MS, Rush AJ, Marangell LB, et al. A one-year comparison of vagus nerve stimulation with treatment as usual for treatment-resistant depression. Biol Psychiatry 2005;58:364-373.
4. Mayberg HS, Lozano AM, Voon V, et al. Deep brain stimulation for treatment-resistant depression. Neuron 2005;45:651-60.

SUNDAY, MAY 20, 7:00 PM - 10:00 PM

INDUSTRY SUPPORTED SYMPOSIUM 18—HOW COMORBID IS ADHD? RESULTS FROM EPIDEMIOLOGICAL AND CLINICAL STUDIES
Supported by Shire US, Inc.

No. 18A
HOW COMORBID IS ADHD? RESULTS FROM EPIDEMIOLOGICAL AND CLINICAL STUDIES

Joseph Biederman, M.D., *55 Fruit St, Boston, MA, 02114*

SUMMARY:

Attention-deficit hyperactivity disorder (ADHD) is a widely recognized psychiatric condition estimated to affect 5% to 10% of children and 3%-5% of adults. In addition to difficulties in the regulation of attention, motoric activity and impulsivity, ADHD is frequently associated with other psychiatric disorders that occur comorbidly

with ADHD. This symposium will present new data from large clinical and epidemiological samples of adults with and without ADHD highlighting the magnitude of comorbidity in both sexes and review emerging neuroimaging findings addressing specific comorbidities. An interactive audience response system as well as live question and answer session will be included to address the needs of patients with ADHD and comorbid psychiatric disorders.

No. 18B
PATTERNS OF COMORBIDITY IN LONGITUDINAL SAMPLE OF BOYS AND GIRLS WITH ADHD

Joseph Biederman, M.D., *55 Fruit St, Boston, MA, 02114*

SUMMARY:

A large body of literature has documented high levels of comorbidity in ADHD. However, this work is largely based on cross sectional studies of preadolescent boys with ADHD. This presentation will present longitudinal findings from large samples of boys and girls with ADHD followed into adolescent years. This information will provide clinicians and researchers a better understanding of patterns of comorbidities in ADHD in both sexes and examine gender differences in these patterns.

No. 18C
PATTERNS OF COMORBIDITY IN A CLINICAL SAMPLE OF ADULTS WITH ADHD

Thomas J. Spencer, M.D., *Masschusetts General Hospital, Pediatric Psychopharmacology Research, 98 Cranberry Hill Rd, Carlisle, MA, 01741-1005*

SUMMARY:

Diagnosis of attention deficit/hyperactivity disorder (ADHD) is currently based on criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), which lists nine behavioral characteristics for ADHD inattentive type and nine behavioral characteristics for the ADHD hyperactive-impulsive type. When adults meeting full criteria for ADHD are considered, the rate of persistence is estimated to be 15% at age 25 years; however if patients with DSM-IV definition of partial remission of ADHD are included, the rate is much higher--approximately 65%. Comorbid adult onset psychiatric disorders (i.e., depression, bipolar disorder, anxiety disorder), particularly if unrecognized and untreated, further impede the adult patient's ability to function optimally. Accumulating evidence suggests that attention-deficit/hyperactivity disorder (ADHD) can persist into adulthood. Although earlier reports indicated that male and female adults with ADHD have similar psychiatric and cognitive correlates as those identified in youth, this work reflected the very beginning of systematic assessments of adults with ADHD. This symposium will present results from a study done replicate that literature by re-examining gender differences in a large sample of adults with ADHD.

We assessed the effects of ADHD, gender, and their interaction on rates of psychiatric comorbidity and cognitive functioning. Interaction models provided no evidence that gender moderated the association between ADHD and the phenotypic expression of the disorder, the prevalence of lifetime or current comorbid psychiatric disorders, or patterns of cognitive and psychosocial functioning. These results are remarkably consistent with previous findings reported in adults with ADHD as well as with findings well documented in pediatric ADHD. ADHD subjects were associated with cognitive deficits and higher rates of major depression, anxiety, substance use disorders and antisocial personality disorder. ADHD in adults is associated with psychiatric and cognitive impairments in both genders. These results bear striking similarities to findings reported in pediatric samples, supporting the validity of ADHD disorder and stressing the importance of identifying and treating the disorder in adulthood.

No. 18D
PATTERNS OF COMORBIDITY IN A COMMUNITY SAMPLE OF ADULTS WITH ADHD: RESULTS FROM THE NATIONAL COMORBIDITY SURVEY

Ronald C. Kessler, Ph.D., *Harvard Medical School, 180 Longwood Ave Ste 215, Boston, MA, 02115-5821*

SUMMARY:

Despite growing interest in adult attention deficit/hyperactivity disorder (ADHD), its prevalence or risk of comorbid psychopathology is not well studied. A screen for adult ADHD was included in a probability subsample (N=3199) of 18-44-year-old respondents in the National Comorbidity Survey Replication, a nationally representative household survey that used a lay-administered diagnostic interview to assess a wide range of DSM-IV disorders. The estimated prevalence of current adult ADHD was 4.4%. Significant correlates included being male, previously married, unemployed, and non-Hispanic white. Adult ADHD was highly comorbid with many other DSM-IV disorders assessed in the survey and was associated with substantial role impairment. The majority of cases were untreated, although many individuals had obtained treatment for other comorbid mental and substance-related disorders. This session presents these data in detail as well as the associated relevance to recovery and functioning of adult patients with ADHD and comorbid psychopathology.

No. 18E
MORPHOMETRIC FINDINGS IN ADULTS WITH ADHD WITH AND WITHOUT COMORBID BIPOLAR DISORDER

Mike Monuteaux, Sc.D., *Mass General Hospital, 55 Fruit St, Boston, MA, 02114*

SUMMARY:

Although attention deficit-hyperactivity disorder (ADHD) is a common comorbidity in bipolar disorder (BPD), neuroimaging studies of bipolar subjects have not addressed the impact of this comorbidity on neuroanatomical findings. A recent study demonstrated that BPD is associated with abnormalities in limbic regions and orbital frontal cortex areas involved in the regulation of emotion, whereas ADHD is associated with volume differences in cortical and cerebellar areas involved in attention and executive control. These data support the hypothesis that ADHD and BPD contribute in a relatively selective manner to brain volume alterations. This session will review this data in detail and discuss how these findings translate in to addressing the needs of our patients with ADHD comorbid with bipolar disorder.

No. 18F
SPECTROSCOPIC FINDINGS IN CHILDREN WITH ADHD AND COMORBID BPD

Constance Moore, Ph.D., *McLean Hospital, 115 Mill St, Belmont, MA, 02478-1041*

SUMMARY:

It is estimated that children with bipolar disorder have a 70%-90% risk of comorbid attention-deficit/hyperactivity disorder (ADHD) Treatment strategies differ for children with: 1) ADHD, 2) bipolar disorder (BPD), and 3) children with both ADHD and BPD. Most previous positron emission tomography (PET) and single photon

emission tomography (SPECT) studies in children with ADHD have shown altered binding of dopamine markers in the basal ganglia. Other studies have revealed dysfunction of the prefrontal-subcortical system, often with greater involvement of areas of the right hemisphere. Some SPECT studies have identified decreased activity involving the temporal lobe and cerebellum in some children with ADHD, supporting the observation that the dysfunction in ADHD involves not only the frontal-subcortical circuits but also the integration of temporal lobe and cerebellar function in emotion, cognition, and motor planning. Differences in cerebral metabolites are measurable in children with ADHD, bipolar disorder, or comborbid disorders, including creatine plus phoshocreatine, (Cr), myo-inositol containing compounds (Ino), and glutamate plus glutamine (Glx). Myo-inositol-containing compounds may provide information as to the action of antimanic treatments such as lithium, valproate, and carbamazepine. Glutamate and glutamine are measures of glutamatergic neurotransmission and thus may also reflect changes in serotonin and dopamine pathways. This session will review evidence-based spectroscopic findings in children with ADHD and comorbid BPD and investigate the possible neurochemical overlap and distinctions between the two disorders.

REFERENCES:

1. Levy, F et al. Gender differences in ADHD subtype comorbidity. J Am Acad Child Adolesc Psychiatry. 2005;Apr. 44(4):368-76.
2. Wilens TE, Biederman J, Wozniak J, et al. Can adults with attention-deficit/hyperactivity disorder be distinguished from those with comorbid bipolar disorder? Findings from a sample of clinically referred adults. Biol Psychiatry 2003;54(1):1-8.
3. Kessler RC, Adler L, Barkley R, et al. The prevalence and correlates of adult ADHD in the United States: Results from the National Comorbidity Survey Replication. Am J Psychiatry 2006;163:716-723.
4. Castellanos FX, et al. Quantitative brain magnetic resonance imaing in attention-deficit hyperactivity disorder. Arch Gen Psychiatry 1996;53:607-616.
5. Moore CM, et al. Differences in brain chemistry in children and adolescents with attention deficit hyperactivity disorder with and without comorbid bipolar disorder: a proton magnetic resonance spectroscopy study. Am J Psychiatry 2006;163(2):316-318.

INDUSTRY SUPPORTED SYMPOSIUM 19—THE ALCOHOL DEPENDENT PATIENT: IMPROVING OUTCOMES THROUGH ADHERENCE

Supported by Cephalon, Inc. and Alkarmes

No. 19A
PHARMACOTHERAPEUTIC OPTIONS FOR THE MANAGEMENT OF ALCOHOL DEPENDENCE: IMPORTANCE OF ADHERENCE

Robert M. Swift *Providence VA Medical Center, ACOS Research/ Education 151, 830 Chalkstone Ave, Providence, RI, 02908-4734*

SUMMARY:

Alcohol dependence is a chronic disorder associated with significant morbidity and mortality. There are many pharmacologic agents and psychosocial treatments available that have shown promise for improving patient outcomes in alcohol dependence. However, the effectiveness of evidence-based therapies is often limited by poor treatment adherence. Successful treatment for alcohol dependence involves reduced alcohol consumption and increased abstinence. Successful behavioral change requires self-regulation and motivation. There are also many strategies to increase adherence, including utilizing components of psychosocial interventions and prescribing simple dosing regimens, such as once-monthly depot medications.

This presentation will review issues in treatment adherence in patients with alcohol dependence. Evidence-based methods that improve treatment adherence will be discussed. The role of simple pharmacologic regimens, including depot medications, in improving patient adherence will be highlighted. Case studies emphasizing practical approaches for influencing social and environmental factors that impact treatment adherence will be included.

No. 19B
PATIENT ADHERENCE IN THE TREATMENT OF ALCOHOL DEPENDENCE: IMPROVING THE JOURNEY TOWARDS ABSTINENCE

Roger D. Weiss, Ph.D. , *PA*

SUMMARY:

There are many pharmacologic agents and psychosocial interventions with established efficacy for the treatment of alcohol dependence. However, the effectiveness of these treatment regimens is often impaired by treatment attrition and non-adherence. It is well documented that many patients with alcohol dependence irregularly attend clinic visits and cease psychosocial treatment prematurely. With oral pharmacologic agents, it is important that patients do not skip medication doses, and returning for prescription renewals or injections is imperative for both oral and depot medications, respectively.

This presentation will focus on the impact of patient adherence on treatment efficacy of alcohol dependence. Predictors of patient non-adherence and approaches to monitoring adherence as part of the treatment intervention will be described.

No. 19C
PHARMACOTHERAPEUTIC OPTIONS FOR THE MANAGEMENT OF ALCOHOL DEPENDENCE: IMPORTANCE OF ADHERENCE

Robert M. Swift *Providence VA Medical Center, ACOS Research/ Education 151, 830 Chalkstone Ave, Providence, RI, 02908-4734*

SUMMARY:

Alcohol dependence is a common, chronic disorder associated with significant morbidity and mortality. An increased understanding of the neurobiologic basis for alcohol dependence has led to the development of effective pharmcotherapeutic agents. Orally administered agents for the treatment of alcohol dependence include the aldehyde dehydrogenase inhibitor disulfiram, the opioid antagonist naltrexone, and the functional glutamate antagonist acamprosate. However, adherence to daily oral pharmacotherapy can be problematic, limiting the clinical effectiveness of orally administered agents. Monthly intramuscular administration of a long acting formulation of naltrexone has been shown to be well tolerated and significantly reduces the number of heavy drinking days, an important step towards abstinence. This presentation will review the etiology of alcohol dependence and pharmacotherapeutic strategies that may promote adherence and improve patient outcomes.

No. 19D
PATIENT REDINESS: IMPLICATIONS FOR ADHERENCE AND MANAGEMENT OF ALCOHOL DEPENDENCE

Carlo DiClemente, Ph.D. *University of Maryland, Baltimore County, 1000 Hilltop Circle, Baltimore, MD, 21228*

SUMMARY:

There are a multitude of psychosocial interventions and pharmacologic agents available that have shown promise for improving patient outcomes in alcohol dependence. However, the real-world effectiveness of many therapies is limited by poor treatment adherence. Treatment for alcohol dependence involves inherent behavioral change, namely, a reduction in the consumption of alcohol as a step toward complete abstinence. To achieve change, individuals must first become interested or concerned about the need to change, and then convinced that change is in their best interest. The patient must next develop and commit to a plan of action, and then take the actions that are needed to make and sustain the change over time.

Stages of change include precontemplation, contemplation, preparation, action, and maintenance, and successful change requires self-regulation and motivation to progress through the tasks involved in each stage. Within each stage, there are several environmental and individual factors that can either hinder or facilitate a change in behavior. In evaluating treatment efficacy or deciding on a patient's management plan, it is important to consider what stage the individual is in and what factors might contribute to adherence, maintenance, or relapse.

This presentation will review factors that facilitate or hinder treatment adherence and the ability to remain abstinent. Scales for measuring patient motivation for behavioral change will be reviewed and the role of patient readiness for change in the treatment and long-term management of alcohol dependence will be discussed.

No. 19E
IMPLEMENTING ADHERENCE-ENHANCING STRATEGIES IN CLINICAL PRACTICE WITH ALCOHOL-DEPENDENT PATIENTS

Albert J. Arias, M.D. *University of Connecticut Health Center, 263 Farmington Ave MC2103, Farmington, CT, 06030-2103*

SUMMARY:

In treating patients with alcohol dependence, the effectiveness of pharmacologic agents and psychosocial interventions is often compromised by poor treatment adherence. In treatment adherence, several issues come into play, with perhaps the most important being matching patient factors to treatment recommendations. In addition a "menu" of techniques may increase adherence by utilizing components of brief interventions, motivational therapy, contingency management, and community reinforcement.

This presentation will review evidence-based treatment matching for alcohol dependence including use of the American Society of Addiction Medicine Patient Placement Criteria. Practical approaches to enhancing adherence will be discussed for both individual and group treatment settings. Strategies to target to both external and intrinsic barriers to treatment adherence will be reviewed applying a clinical case example.

REFERENCES:

1. Pettinati H, et al: A structured approach to medical management: a psychosocial intervention to support pharmacotherapy in the treatment of alcohol dependence. J Stud Alcohol Suppl. 2005; Jul(15):170-178.
2. Anton R: Combined Pharmacotherapies and Behavioral Interventions for Alcohol Dependence. JAMA. 2006; 295:2003-2017.
3. DiClemente CC, et al: Readiness and Stages of Change in Addiction Treatment. Am J Addict. 2004; 13:103-119.
4. Weiss R: Adherence to pharmacotherapy in patients with alcohol and opioid dependence. Addiction. November 2004; 99 (11): 1382-1392.

INDUSTRY SUPPORTED SYMPOSIUM 20—WEIGHING THE RISKS AND BENEFITS OF ATYPICAL ANTIPSYCHOTICS: CAN WE HAVE OUR CAKE AND EAT IT TOO?
Supported by Bristol-Myers Squibb Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this educational activity, participants should be able to:

1. Review the epidemiological studies demonstrating high rates of morbidity and mortality in schizophrenia and bipolar disorder patients.
2. Discuss the high prevalence of the metabolic syndrome in the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) sample and the low rates of treatment for it.
3. Compare and contrast the metabolic profiles of antipsychotics in the CATIE study.
4. Identify potential patient, provider and system level interventions to improve metabolic outcomes among patients treated with antipsychotic medications.

No. 20A
HIGH MORBIDITY AND MORTALITY IN SCHIZOPHRENIA AND BIPOLAR DISORDER: WHAT, WHY, AND HOW?

Quinton E. Moss, M.D. *University of Cincinnati College of Medicine, Psychiatry, 5573 Woodmansee Way, Hamilton, OH, 45011-5913*

SUMMARY:

Bipolar disorder and schizophrenia have substantial morbidity and mortality and reduced life expectancy compared with the general population. Although suicide remains a major cause of death in both disorders, disproportionately more patients with schizophrenia die from coronary heart disease compared with the general population. Other chronic medical conditions including obesity, dyslipidemia, and diabetes account for greater risk for death in schizophrenia and are highly prevalent in bipolar illness. Both bipolar illness and schizophrenia have higher rates of metabolic syndrome that carries substantial morbidity and risk of death. Cigarette smoking, HIV, and thromoboembolic disease that cause high morbidity and mortality worldwide may be higher in schizophrenia and other psychotic illnesses. Lifestyle, heritability, or effects of standard of care pharmacotherapy may contribute to some of these conditions in both bipolar disorder and schizophrenia. Finally, those with these severe psychiatric illnesses are less likely to receive appropriate medical care with preventive interventions, adhere to recommendations, and remain compliant to medical treatment. The causes of excessive morbidity and mortality in schizophrenia and bipolar illness require intense monitoring and practical interventions.

No. 20B
METABOLIC COMPLICATIONS IN THE CONTEXT OF ANTIPSYCHOTIC EFFECTIVENESS: LESSONS FROM THE CATIE SCHIZOPHRENIA TRIAL

Donald C. Goff, M.D. *Harvard Medical School, Psychiatry, 10 Mount Vernon St, Marblehead, MA, 01945-2314*

SUMMARY:

Along with efficacy and tolerability, safety is considered an important component of long-term effectiveness of pharmacotherapy. The

Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study was a 5-year,multi-center NIMH-funded pragmatic trial comparing the effectiveness of four atypical antipsychotics [olanzapine, risperidone, quetiapine and ziprasidone] with the medium potency first-generation antipsychotic, perphenazine in chronic schizophrenia. The initial report indicated that, at the mean doses used in the trial, olanzapine displayed advantages in overall effectiveness compared to the other agents, but also produced significantly the greatest elevations of measures associated with metabolic complications and had the highest discontinuation rate due to metabolic adverse effects. In Phase II, open-label clozapine was found to the most effective treatment in subjects who did not respond to the antipsychotic administered in phase I. The high prevalence of metabolic syndrome [42%] and estimates of 10-year risk for cardiac disease [significantly elevated for males and females compared to a national control group] for CATIE subjects at baseline will be presented, as will changes in these measures with randomized assignment to various antipsychotics.

Practical approaches to selecting an antipsychotic and monitoring for metabolic side effects, based in part on the results of the CATIE trial, will be outlined and discussed

No. 20C
THE DUAL HEALTH JEOPARDY IN SCHIZOPHRENIA: HIGHLY PREVALENT METABOLIC DISORDERS AND LOW ACCESS TO MEDICAL TREATMENT

Henry A. Nasrallah, M.D. *University of Cincinnati, Medical Center, 231 Albert Sabin Way, PO670559, Cincinatti, OH, 45267-0559*

SUMMARY:

The NIMH-sponsored CATIE schizophrenia trial confirmed that the prevalence of the metabolic syndrome in chronic schizophrenia is twice as high as in the general population (42% Vs 21%). This underscores the high risk of cardiovascular mortality in schizophrenia, but also points to the need to provide persons with schizophrenia; 1) standard medical treatments for metabolic disorders such as diabetes, hyperlipidemia and hypertension, and 2) avoid exacerbating these medical disorders by judiciously matching the vulnerable patient with the antipsychotic least likely to cause weight gain and related health morbidities.

The CATIE data revealed the dual health risks in persons with schizophrenia . On one hand, some atypicals are associated with serious metabolic complications such as weight gain, hyperglycemia, and hypertriglyceridemia. At the same time, the CATIE schizophrenia cohort at enrollment was found to have alarmingly low rates of medical treatment for diabetes (65%), hypertension (38%), or hyperlipidemia (12%).

Based on the above CATIE findings, it is clear that persons with chronic schizophrenia are at a dual jeopardy of comorbid and potential iatrogenic metabolic complications a serious healthcare disparity in receiving treatment for their metabolic disorders . A two-pronged strategy to these challenges is 1) provide appropriate medical treatment for persons with schizophrenia and coexisting metabolic disorders and 2) use metabolically benign antipsychotic agents in this high-risk population.

No. 20D
LESSONS FROM ATPIII, THE ADA, AND THE APA WORKGROUP ON ANTIPSYCHOTICS AND METABOLIC RISK

John W. Newcomer, M.D., *Washington University School of Medicine, Dept of Psychiatry, 660 S Euclid Ave # 8134, Saint Louis, MO, 63110-1010*

SUMMARY:

Individuals with major mental disorders experience increased prevalence of obesity, diabetes, and cardiovascular disease. Available research suggests multiple contributing factors including disease- and treatment-related changes in nutrition and activity, increased prevalence of smoking, and drug-related changes in adiposity and glucose and lipid metabolism. Antipsychotic treatment in particular can significantly contribute to metabolic adverse events that include weight gain, insulin resistance, dyslipidemia, hyperglycemia, and metabolic syndrome, with variable dose-response relationships reported across different medications. Recent consensus efforts within psychiatry have aimed to establish monitoring guidelines for adverse events during antipsychotic treatment, including an APA Workgroup on Antipsychotics and Metabolic Risk. Critical background for such public health prevention efforts include the US Public Health Service (USPHS) Adult Treatment Panel (ATP) III guidelines and American Diabetes Association (ADA) guidelines, which offer validated approaches for monitoring metabolic risk, recognizing higher risk groups, and intervening to lower risk. The APA Workgroup on Antipsychotics and Metabolic Risk offer modest modifications of existing ATPIII and ADA guidelines, including special challenges for Therapeutic Lifestyle Change in patients being treated with antipsychotics and suggestions for whether and when to consider adjustments in psychotropic medications to achieve metabolic risk reduction. Efforts in this area are responsive to a recent Institute of Medicine report regarding the need to reduce disparities in the level of medical care provided to persons with mental disorders.

No. 20E
PATIENT, PROVIDER, AND SYTEM APPROACHES TO REDUCING RISK OF POOR HEALTH IN PATIENTS RECEIVING ANTIPSYCHOTICS

Lisa Dixon, M.D. *University of Maryland School of Medicine, VA Capitol Health Care Network MIRECC, 737 W Lombard St., 520, Baltimore, MD, 21201-1023*

SUMMARY:

The metabolic complications of atypical antipsychotics are particularly challenging for persons with severe mental illness (SMI) because this population has markedly high rates of obesity as well as poor health habits including limited exercise and poor diets. In addition, such patients have increased risks of co-occurring somatic disorders associated with smoking, drug use, and victimization such as respiratory disease, HIV, and hepatitis. These vulnerabilities added to poor quality of somatic health care create great risk of mortality and morbidity and diminished quality of life for persons with SMI. At the same time, antipsychotic drug treatment is almost always essential for control of psychotic symptoms. To help patients and providers navigate this Scylla and Charybdis of illness management, recent research has developed strategies to promote healthful behaviors and illness management within a recovery framework. Intensive psychosocial treatments that provide education and behavioral strategies to promote both exercise and reduced caloric intake and weight loss have shown promise. Peer support may be a valuable component of these approaches. System level changes in health messages and support for lifestyle enhancements as well as access to healthy food are also important. System level approaches must ensure access to primary care that is well integrated into psychiatric management; integrated and supported medical care approaches including case management are promising. Overall, ongoing monitoring and assessment of consumer preferences and empowerment are essential for maintaining clinical stability, medication adherence, and optimal health outcomes

REFERENCES:

1. Meyer JM and Nasrallah HA [Editors] : Medical Illness and Schizophrenia,. Washington, DC, APPI, 2003.
2. Lieberman JA, Stroup TS, McEvoy JP, Swartz MS, Rosenheck RA, Perkins DO, Keefe RS, Davis SM, Davis CE, Lebowitz BD, Severe J, Hsiao JK: Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. N Engl J Med 2005; 353(12):1209-23.
3. Nasrallah HA et al: Low rates of treatment for metabolic disorders in the CATIE Schizophrenia Trial at baseline. Neuropsychopharmacology 2005; 30: S204.
4. Newcomer JW. Second-generation (atypical) antipsychotics and metabolic effects: a comprehensive literature review. CNS Drugs. 2005;19:1-93.
5. 3. Loh C, Meyer JM, Leckband SG. A comprehensive review of behavioral interventions for weight management in schizophrenia. Ann Clin Psychiatry. 2006;18:23-31.

INDUSTRY SUPPORTED SYMPOSIUM 21—STAR*D FINDINGS: IMPLICATIONS FOR PATIENTS, CLINICIANS, AND OTHER STAKEHOLDERS
Supported by Forest Laboratories, Inc.

No. 21A
STAR*D FINDINGS: IMPLICATIONS FOR PATIENTS, CLINICIANS, AND OTHER STAKEHOLDERS

Grayson S. Norquist, M.D., *University of Mississippi Medical Center, Department of Psychiatry, 2500 N State St, Jackson, MS, 39216-4500*

SUMMARY:

The Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial was a large-scale study designed to emulate real-world clinical management of major depressive disorder. STAR*D included a representative population of depressed patients and provided for timely medication dose adjustments and switching, augmentation and combination treatment strategies when remission was not achieved. At the completion of such a large trial and analysis of the findings, it is natural for investigators to reflect and ask, so what? What did we learn? What does this mean to the patient, clinician, and other stakeholders? What next? In this interactive symposium, the presenters will address these questions. Throughout the presentation of the key findings from Level 1, 2, 3, and 4 of STAR*D, the faculty and the audience will be invited to pose questions that will facilitate the translation of the data into real world clinical practice. Audience response polling will provide further insights into clinicians' perspectives on the clinical practice tools available to measure symptoms, side effects, response, remission, and relapse.

No. 21B
CLINICAL METHODS AND PROCEDURES TO ENHANCE ACUTE AND LONG-TERM OUTCOMES

Junius J. Gonzales, M.D., *4920 Sentinel Dr, #301, Bethesda, MD, 20814*

SUMMARY:

The goal of treatment for MDD is long-term, sustained remission. Clinicians require quantifiable tools to determine success or failure of treatment. Effective clinical practice tools used to assess depressive symptoms, side effects, function, response, remission, and relapse must be time-efficient and suitable for systematic measurement of symptoms and functioning over time. In STAR*D, clinicians in both primary care and psychiatric settings used the Quick Inventory of Depressive Symptomatology (QIDS), QIDS Clinician Rating (QIDS-C), and QIDS Self-Report (QIDS-SR) to assess symptom severity, the Frequency, Intensity, and Burden of Side Effects Rating (FIBSER) to assess side effects, and several function measures. How useful are these assessment tools in community practice? In this interactive session, audience polling will be used to provide insights into the gaps between assessment of patients in a clinical study vs. assessments in the community setting. How does that impact the findings of the study? How can clinicians utilize clinical practice tools, including treatment guidelines, to improve patient outcomes?

No. 21C
SELECTING AMONG FIRST-AND SECOND-STEP ACUTE TREATMENTS: LEVEL 1 AND LEVEL 2

Marlene P. Freeman, M.D. *University of Arizona, 1501 N. Campbell Ave., Arizona Health Sciences Center, Tucson, AZ, 85724-5002*

SUMMARY:

Remission, the virtual absence of symptoms, is the short and long-term goal of antidepressant treatment. Yet, remission rates in research-based trials of patients with MDD treated with antidepressant monotherapy are a modest 25-40%. STAR*D was designed to assess effectiveness of treatments in primary care and psychiatric care settings at adequate dose and duration of treatment. When monotherapy failed to achieve remission, patients and clinicians had the option to switch to another treatment, or augment the current medication, with another treatment. In this interactive session, the faculty will address the issues of selecting acute treatments and translate the findings from STAR*D to clinical practice.

No. 21D
TREATMENTS AFTER THE FIRST TWO STEPS INCLUDING FOLLOW-UP: LEVEL 3 AND LEVEL 4

A. John Rush, M.D., *UT Southwestern, 5323 Harry Hines Blvd., E.5.506, Dallas, TX, 75390-9086*

SUMMARY:

When a medication trial does not result in remission, it is considered a treatment failure. Treatment-resistant depression describes depression that does not remit with two or more acute treatment trials. Greater treatment-resistance is ascribed in proportion to the number of trials needed to achieve remission. Moderators contributing to treatment resistance include chronicity of illness, medical and psychiatric comorbidity, and the heterogeneity of the illness. Each additional treatment step that includes switching to a new agent or augmentation of treatment potentially increases the side effect burden for the patient. This interactive session will address the STAR*D findings for patients whose severity of illness required more than two treatment steps in search of remission. This presentation will also discuss the implications of the STAR*D follow-up findings for caring for our patients with MDD over the long-term.

No. 21E
THE ROLE OF OTHER TREATMENT OPTIONS IN THE MANAGEMENT OF DEPRESSION

K. Ranga Krishnan, M.D., *Duke University Medical Center, Box 3950, DUMC, Durham, NC, 27710*

SUMMARY:

Managing patients with complex, chronic MDD to remission may often seem to be as much art as science. Moderators such as chronicity of illness, medical and psychiatric comorbidity, and the heterogeneity of the illness complicate treatment. Chances of attaining remission decrease when more treatment steps are required. Clinicians may be faced with a risk-benefit decision of moving to the next step of treatment options such as MAOIs, atypical antipsychotics, vagal nerve stimulation (VNS), electroconvulsive therapy (ECT), or repetitive transcranial magnetic stimulation (rTMS). This presentation discusses the implications of the STAR*D findings on other treatment options available to clinicians to aid in achieving remission in the most challenging patients with MDD.

REFERENCES:

1. Rush AJ, et al. Self-reported depressive symptom measures: sensitivity to detecting change in a randomized, controlled trial of chronically depressed, nonpsychotic outpatients. Neuropsychopharmacology. 2005 Feb;30)2):405-16.
2. Trivedi MH, Rush AJ, Wisniewski SR, et al. Evaluation of outcomes with citalopram for depression using measurement-based care in STAR*D: Implications for clinical practice. Am J Psychiatry 2006;163:28-40.
3. Trivedi MH, Fava M, Wisniewski SR, et al. Medication augmentation after failure of SSRIs for depression. N Engl J Med 2006;354:1243-52.
4. Keller MB. Issues in treatment resistant depression. J Clin Psychiatry 2005;66(suppl 8):5-12.

MONDAY, MAY 21, 7:00 AM - 8:30 AM

INDUSTRY SUPPORTED SYMPOSIUM 22—LIFTING THE BURDEN OF PSYCHIATRIC ILLNESS: THE MANAGEMENT OF ALLOSTATIC LOAD, METABOLIC SYNDROME, AND CO-OCCURRING DISORDERS
Supported by Solvay-Wyeth

No. 22A
LIFTING THE BURDEN OF PSYCHIATRIC ILLNESS: THE MANAGEMENT OF ALLOSTATIC LOAD, METABOLIC SYNDROME, AND CO-OCCURRING DISORDERS

Mark H. Rapaport, M.D. *Cedars-Sinai Medical Center, Department of Psychiatry, 8730 Alden Dr # C-301, Los Angeles, CA, 90048*

SUMMARY:

One of the greatest challenges facing the partnership between clinicians and patients is the full appreciation of the impact of psychiatric illness and our treatments on patients' physical health. The goals of the symposium are to review with the attendees the complexity of both the mental and physical health challenges that psychiatric patients face. One under-appreciated challenge is that psychiatric syndromes, by their very nature, adversely affect the physical as well as the mental health of our patients. We will summarize existing data about the relationship between psychiatric syndromes and their impact on allostatic load for our patients. A second little-appreciated concern is the potential increase in health burden associated with the use of psychotropic medications. Patients and clinicians must balance the benefits received from pharmacotherapy with potential health risks associated with those medications such as metabolic syndrome and diabetes. The third complex challenge experienced by patients and clinicians is the interactions that occur between psychiatric syndromes and problems with substances of abuse (including alcohol and tobacco). We will highlight some newer data about the biological interplay between co-occurring disorders.

Attempts to remediate this burden of physical illness that compounds psychiatric disorders must rely on a careful evaluation of all potential medical, psychiatric and somatic options. We will use control of weight as a case study of an approach for integrating medical and psychiatric care. The final presentation will review the impact that exercise, massage, and acupuncture may have on ameliorating allostatic burden. Emphasis will be placed on newer research investigating the potential mechanism of action of massage as well as new data suggesting massage may have antidepressant properties. In summary, psychiatric patients face significant challenges due to both the biological impact of brain diseases on the body as well as secondary unintended consequences of our treatment interventions. Recent research suggests that integration of an evidence-based medical approach with alternative somatic therapies may enhance the recovery of our patients.

No. 22B
ISSUES IN THE ASSESSMENT AND MANAGEMENT OF OVERWEIGHT AND OBESITY IN PSYCHIATRIC PATIENTS

Alicia Ruelaz, M.D. *Cedars-Sinai Medical Center, Psychiatry, 8700 Beverly Blvd, 8th Floor, Room 8631, Los Angeles, CA, 90048*

SUMMARY:

Overweight and obesity are increasing in the general population at alarming rates. Psychiatric patients, in particular, are more vulnerable to becoming overweight and encounter greater difficulties when attempting to lose weight. In this portion of the symposium, we will examine what particular physiologic factors lead to obesity in the general population as well as specific physiologic issues found in even the drug-naUïve mentally ill. We will then look at what factors inherent in psychiatric treatments may exacerbate this tendency. An approach to the assessment and proper diagnosis of weight and its co-morbidities, including metabolic syndrome will be presented. Finally, we will explore the treatment options that are available and how they can be modified and utilized by the psychiatrist in order to minimize weight gain and promote weight loss in the psychiatric patient. This will include both pharmacologic and behavioral modifications. Examples from the literature as well as programs at Cedars-Sinai will be presented.

No. 22C
CO-OCCURING DISORDERS: THE COMPLEX INTERPLAY BETWEEN PSYCHIATRIC SYNDROMES, SUBSTANCE USE AND HEALTH

Kathleen T. Brady, M.D. *Medical University of South Carolina, 67 President St, Charleston, SC, 29403-5712*

SUMMARY:

The role of stress in vulnerability to both the initiation and maintenance of substance use disorders has recently received much attention. Animal studies have consistently demonstrated a relationship between stress and addiction which appears to be mediated through corticotropin releasing factor. In clinical settings, definitive demonstration of the relationship between stress and relapse is more difficult, but a growing number of studies utilizing human laboratory procedures demonstrate a relationship between experimentally-induced stress and craving. Substance use disorders commonly co-occur with other psychiatric disorders. The relationship between

stress, allostatic load and substance use is likely to be particularly important in understanding the connection between substance use and psychiatric disorders. The rapid development of technical advances in the neurosciences has led to a better understanding of the molecular biology, neurotransmitter systems, and neural circuitry involved in mental illness and substance use disorders. In this presentation, the neurobiological interface between stress response, substance use, and psychiatric disorders will be explored. Implications for treatment and prevention will be discussed.

No. 22D
PSYCHOTROPIC MEDICATIONS, PSYCHIATRIC ILLNESS AND WEIGHT GAIN

Rohan Ganguli, M.D. *University of Pittsburgh School of Medicine, Psychiatry, 3811 O'Hara St, Pittsburgh, PA, 15213-2593*

SUMMARY:

Persons suffering from chronically mental illness are at a higher risk than others of being overweight (Wallace & Tennant, 1998; Coodin, 2001). Surveys among psychiatrically ill individuals, particularly those with schizophrenia, have shown that the prevalence of obesity in these groups is higher than in the general population (Allison et al., 1999). Although the development of obesity in patients with schizophrenia has recently been attributed in large part to antipsychotic medications (Wetterling, 2001), descriptions from long before the introduction of antipsychotics have described weight gain in schizophrenia. For example Kraepelin (1919) noted that some of his schizophrenic patients gaining enormous amounts of weight over the course of their illness. In fact, it was his opinion that weight gain signified the beginning of remission (Kraepelin, 1919, Jaspers, 1923). Persons suffering from bipolar disorder and chronic depression also have higer rates of obesity than the general population. In addition to antipsychotics, some antidepressants and mood stabilizers are also associated with elevated risk of weight gain and associated metabolic abnormalities.

Physical health risks of excess body weight are numerous and include insulin resistance, diabetes mellitus, hypertriglycidemia, decreased levels of high-density lipoprotein cholesterol, and increased levels of low-density lipoprotein cholesterol. Obesity is associated with gallbladder disease as well as sleep apnea, chronic hypoxia and hypercapnia, degenerative joint disease and certain cancers. Obesity is an independent risk factor for death from coronary heart disease (Pi-Sunyer 1993). Thus it has been proposed that disease and treatment-related metabolic abnormalities may explain the higher risk of premature mortality and morbidity which has been reported in epidemiologic studies of seriously mentally ill populations (Brown et al. 1997; Stark et al., 2003). For example, life expectancy in schizophrenia is 16 to 21 percent shorter than in the general population and mortality is approximately 1.6 to 2.6 percent higher than expected (Newman et al., 1991; Harris et al., 1998).

In this presentation the evidence for the contribution of illness factors, medication and lifestyle, to the development of obesity and other metabolic problems will be reviewed. Physiologic mechanisms underlying these changes and potential remedies will also be discussed.

No. 22E
THE HEART OF THE MATTER: ALLOSTATIC LOAD AND PSYCHIATRIC DISORDERS

Robert Bruce Lydiard, M.D. *University of South Carolina, Psychiatry, SE Health Consultants 1 Poston Rd, Suite 335, Charleston, SC, 29407-3424*

SUMMARY:

Allostatic load is a term which quantifies long-term risk for various medical conditions as a consequence of stress exposure. Stress is defined as 1) perceived threat and 2) perceived inability to control the threat. Stress promotes allostasis, which is a stress-induced range of physiologic responses, including the release of stress mediators (cortisol, catecholamines and pro-inflammatory cytokines, others). Failed shutoff of stress mediator release (allostatic state) leads to deleterious physiological effects (allostatic load) proportional to subsequent stress exposure. As allostatic load increases, the risk for deleterious effects on cardiovascular, metabolic, and immune function increases, as does the risk for atrophy of neurons in critical brain areas.

In this presentation, it will be proposed that anxiety and mood operationally function as stressors, thereby contributing to allostatic load. Relevant data from clinical, epidemiological and longitudinal samples providing support for this hypothesis will be presented and discussed. A model suggesting that psychiatric disorders, like persistent stress, are pro-inflammatory states which may increase allostatic load via this shared mechanism will be described. This model is consistent with clinical observation and some human research which show that concurrent medical and psychiatric disorders can mutually increase the severity of and reduce the likelihood of recovery of both.

The non-random distribution of some medical problems with psychiatric disorders suggests that there may be common elements contributing to both. It is possible that these bi-directional effects are in part mediated by excessive inflammatory activity from both psychiatric and medical conditions. Finally, the available clinical research evidence suggesting that psychotropic agents exert anti-inflammatory effects in psychiatric patients during clinical improvement.

No. 22F
INTEGRATING ALTERNATIVE HEALTH APPROACHES INTO THE CARE OF OUR PATIENTS: EVIDENCE ABOUT THE ACTIONS OF EXERCISE, MASSAGE, AND ACUPUNCTURE

Mark H. Rapaport, M.D. *Cedars-Sinai Medical Center, Department of Psychiatry, 8730 Alden Dr, C-301, Los Angeles, CA, 90048*

SUMMARY:

Exercise and alternative medical therapies are increasing in popularity among the general public. Until recently, there has been limited involvement by the established practitioners and researchers assessing the efficacy of these treatments for individuals with psychiatric syndromes. There now exists an emerging body of literature suggesting that exercise may play an important role in ameliorating symptoms of both depression and anxiety. Exercise may be particularly powerful as part of a comprehensive treatment program for patients with mood and anxiety disorders. There is also an increasing body of evidence suggesting that certain alternative treatments: acupuncture and massage, may have clinically significant beneficial effects. In this presentation, we will review existing data examining the efficacy of a systematic exercise program for patients with psychiatric syndromes. We will critically review data about the efficacy of acupuncture as an adjunct treatment for psychiatric disorders. However, a major focus of this talk will be the presentation of recent findings from our group investigating both the mechanism of action of massage and its potential efficacy as a treatment for major depressive disorder. Details from recent investigations in unipolar disorder will be presented. This presentation of new research about massage will serve as a potential model for systematically exploring the impact of alternative therapies on individuals suffering from psychiatric illness.

REFERENCES:

1. Thakore JH, et al. Int J Obes Relat Metab Disord. 2002;26:137-141.
2. Brady KT, Sinha R. Co-occurring mental and substance use disorders: the neurobiological effects of chronic stress. Am J Psychiatry. 2005 Aug;162(8):1483-93.
3. Strassnig M, Brar JS, Ganguli R*. Nutritional intake in community-dwelling remitted patients suffering from schizophrenia. Schizophrenia Bulletin, 2003, 29: 207-212,.
4. McEwen BS: Mood Disorders and Allostatic Load. Biol Psychiatry 2003;54: 200âƒ207.
5. Moyer CA, Rounds J, Hannum JW: a meta-analysisof massage therapy research. American Psychiatric Press 2004; 130:3-18.

INDUSTRY SUPPORTED SYMPOSIUM 23—HOW DO ATYPICALS AND ANTIPSYCHOTICS WORK?: FROM RECEPTORS TO REALITY
Supported by Bristol-Myers Squibb Company

No. 23A
PHARMACOLOGY OF ATYPICAL ANTIPSYCHOTICS: TRANSLATING MOA INTO CLINICAL PRACTICE

Robert E. Hales, M.D., *University of California Davis, Department of Psychiatry, 2230 Stockton Blvd, Sacramento, CA, 95817-1419*

SUMMARY:

An increasing appreciation of the pathophysiologic mechanisms underlying psychotic disorders has fueled the development of novel pharmacologic agents. Current research studies are now incorporating neuroimaging as a critical tool to guide drug development by further elucidating neuronal pathways associated with psychotic disorders and identifying the physiologic effects of pharmacologic therapies. The broad receptor-binding profiles and pharmacodynamic interactions of some of the atypical antipsychotics have been associated with metabolic abnormalities, hyperprolactinemia and unwanted sedation. When choosing an atypical antipsychotic for the management of a particular disorder, it is important to consider the different pharmacologic profiles of these agents in order to personalize pharmacotherapy based on patient preferences, prior response to treatment, and overall health vulnerabilities. This symposium will review the implications of choice of antipsychotic therapy on functional outcomes, and overall patient health in individuals with psychotic disorders.

No. 23B
MECHANISMS OF ANTIPSYCHOTIC EFFICACY: LINKING PHARMACOLOGY TO PHENOMENOLGY

Shitij Kapur, M.D., *The Clarke Institute, 250 College St, Toronto, ON, M5T 1R8, Canada*

SUMMARY:

The clinical hallmark of schizophrenia is psychosis - an experience marked by ideas of reference, delusions and hallucinations - all subjective experiences and descriptions. Yet, most theories about psychosis (high dopamine, low glutamate etc.) tend to be neurochemical. How can one relate these pharmacological findings to the subjective reality of schizophrenia. That talk will use the 'salience' framework to link pharmacological findings to the subjective experience. It has been proposed that dopamine firing has a role in detection of novel unpredicted rewards (Schultz et al.) and that dopamine release, particularly within the mesolimbic system, has a central role in mediating the "salience" of the environment and its internal representations (Berridge et al.). A dysregulated hyperdopaminergic state (whatever its primary origins) leads to a process of abnormal sense of novelty and abnormal assignment of salience. Delusions are a cognitive effort by the patient to make sense of these aberrantly salient experiences and associations, whereas hallucinations reflect a direct experience of the aberrant salience of internal representations. Antipsychotics, in this framework, exert their anti-"psychotic" effect by "dampening" the motivational salience of these abnormal experiences and associations - and by doing so provide a platform for psychological resolution of symptoms. The framework questions the long held idea that there is a "delayed onset" of antipsychotic activity and shows that one of the effects of the drugs is to create a "detachment" from symptoms. Other predictions of this hypothesis - particularly regarding the possibility of synergy between psychological and pharmacological therapy will be presented.

No. 23C
MANAGING PATIENTS WITH PSCYHOTIC DISORDERS: FROM EFFICACY TO EFFECTIVENESS

John Lauriello, M.D., *906 Tramway Ln Ne, Albuquerque, NM, 87122-1310*

SUMMARY:

Historically, studies of the treatment of psychotic disorders, most notably schizophrenia, have focused on the acute treatment phase, while longer term treatment has been (incorrectly) treated as a simple extension of the acute phase. However, long-term treatment concerns are different from those of acute treatment. Studies of longer term relapse prevention and discontinuation of maintenance treatment have been completed. Most antipsychotics are effective at preventing relapse in randomized, controlled trials, but outcomes from these highly standardized, selective trials give clinicians little guidance for dealing with real-world patients and treatment situations. In most situations and with most patients, regimen tolerability and other treatment variables will determine true long-term effectiveness. Engaging and maintaining the patient's willingness to continue treatment and adherence to the medication regimen is paramount in ensuring positive outcomes. Patients discontinue their antipsychotic for a variety of reasons including overwhelming return of symptoms, side effects and for many a belief they are not (or no longer) ill. Longer term treatment should also consider other measures of outcome besides symptom control. Improving function in a variety of non symptom domain (education, work, relationships) requires the inclusion of the appropriate level of psychosocial and vocational treatment.

No. 23D
NEUROBIOLOGY OF SCHIZOPHRENIA: FROM BASIC SCIENCE TO CLINICAL PRACTICE

Gordon Frankle, M.D. *Columbia University College of Physicians & Surgeons, 563 1st Avenue, New York City, NY, 10016*

SUMMARY:

The use of neuroreceptor imaging techniques has become more widespread over the past decade and these tools are currently being used to study neurological and psychiatric disorders and to inform early-stage drug development. Molecular imaging of receptors, transporters and enzymes, as well as other cellular processes, has grown in recent years to be one of the most active neuroimaging areas. The application of single photon emission tomography (SPECT) and

positron emission tomography (PET) techniques to the study of psychiatric illness has lead to increased understanding of disease processes as well as validated, in vivo, theories of illness etiology. Studies within schizophrenia are largely limited to either the dopamine or serotonin system due in large part to the availability of suitable radiotracers as well as the current theories on the etiology of the illness. Two basic study designs are used when studying schizophrenia using molecular imaging; "clinical studies," compares the findings from imaging studies in those with schizophrenia to normal controls in an attempt to understand the pathophysiology of the illness and "occupancy studies," to enhance the understanding of the mechanism of action of the medications used in treating this illness. This presentation will focus on the findings of molecular imaging studies in schizophrenia, focusing, for the most part, on the serotonin and dopamine systems. Emphasis will be placed on how these findings and techniques are currently being used to inform the development of novel treatments for schizophrenia.

No. 23E
PHARMACOLOGIC PREDICTABILITY OF ANTIPSYCHOTIC-RELATED ADVERSE EFFECTS: AN OPPORTUNITY FOR IMPROVING OUTCOMES

Prakash S. Masand, M.D. *Duke University Medical Center., 1130 Westhills Court, Morrisville, NC, 27560*

SUMMARY:

Antipsychotics are associated with a wide range of adverse effects, including activation and akathisia, extrapyramidal symptoms, sedation, and metabolic and endocrine abnormalities. However, individual agents are generally associated with only some of the events on the list, and these adverse events are highly predictable based on the agent's receptor binding profile. These adverse effects vary widely in terms of severity. Some, such as diabetic ketoacidosis, are often life threatening. Far more common are adverse events that offer longer-term threats to patient health - an example being dyslipidemia - or cause tolerability issues. In addition, while some adverse events are lasting or become worse over time, some, such as akathisia, will generally disappear with time. Many adverse events can be made more tolerable by simply educating the patient about what to expect in terms of effect and duration. In some cases, however, an adverse effect will have a negative effect on patient health or treatment adherence, necessitating a switch to a different medication. This presentation will review the adverse effect profiles of the most common antipsychotic agents and implications of these adverse events for patient outcomes.

REFERENCES:

1. Kapur S. 2003. Psychosis as a state of aberrant salience: A framework linking biology, phenomenology, and pharmacology in schizophrenia. American Journal of Psychiatry 160: 13-23.
2. Lieberman J et al. Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia. NEJM 2005; 353:1209-1223.
3. Frankle WG et al. Serotonin transporter availability in patients with schizophrenia: a positron emission tomography imaging study with [11C]DASB. Biol Psychiatry. 2005;57:1510-1516.
4. Seemuller F, et al. The safety and tolerability of atypical antipsychotics in bipolar disorder. Expert Opin Drug Saf. 2005;4:849-868.

INDUSTRY SUPPORTED SYMPOSIUM 24—TREATING THE SPECTRUM OF BIPOLAR DISORDERS: AN INTERACTIVE CASE DISCUSSION
Supported by AstraZeneca Pharmaceuticals

No. 24A
TREATING THE SPECTRUM OF BIPOLAR DISORDERS: AN INTERACTIVE CASE DISCUSSION

Michael E. Thase, M.D. *University of Pittsburgh Medical Center, Psychiatry, 3811 O'Hara Street, Pittsburgh, PA, 15213-2593*

SUMMARY:

This symposium will consist of four presentations that address treatment of bipolar disorder across the spectrum of the illness. Each presenter will link into an interactive case discussion with the faculty. Dr. Holly Swartz will discuss the role of psychotherapy in bipolar depression. She will focus on bipolar-specific psychotherapy as an adjunct to pharmacotherapy. Empirical evidence shows that adding psychotherapy to pharmacotherapy is more effective than drugs alone. Dr. Michael Thase will examine the pros and cons of antidepressant therapy in bipolar disorder. He will deal with induction of mania or rapid cycling, duration of antidepressant efficacy, and the distinction between type I and type II forms of the disorder. Dr. Roger McIntyre will evaluate treatment options for bipolar depression beyond psychotherapy and conventional antidepressants. His presentation will review the use of anticonvulsants, atypical antipsychotics, dopamine agonists, glutamatergic agents and psychostimulants, and will evaluate combination and integrated treatment approaches. Finally, Dr. Lauren Marangell will discuss the mania component of bipolar disorder and present treatment and prevention strategies. These discussions will be followed by a question-and-answer session. The target audience for this symposium is psychiatrists and other health care professionals who are concerned with bipolar disorder.

No. 24B
PSYCHOTHERAPY AND BIPOLAR DEPRESSION

Holly Swartz, M.D., *Western Psychiatric Institute Clinic, 100 N. Bellefield Avenue, 8th Floor, Pittsburgh, PA, 15213*

SUMMARY:

Bipolar depression drives the preponderance of morbidity and represents the predominant mood state in a majority of patients suffering from this disorder. Despite the clinical importance of this mood state, current pharmacological treatments rarely result in full and complete recoveries. As a result, many individuals continue to experience subsyndromal depressive symptoms and poor psychosocial functioning after the syndromal depression remits. Bipolar-specific psychotherapy, when administered in conjunction with pharmacotherapy, may play an important role both in the treatment of acute bipolar depression and in the long-term management of residual depressive symptoms. Adjunctive psychological therapies for bipolar I disorder, such as psychoeducation, cognitive-behavioral therapy, family-focused therapy, and interpersonal and social rhythm therapy are associated with reductions in overall rates of relapse, but seem to more effective for depression than mania (in contrast to pharmacotherapy alone which seems to be more effective for mania than depression). This presentation will focus on empirical evidence demonstrating the incremental advantages of providing bipolar-specific

psychotherapy in addition to pharmacotherapy for the treatment and prevention of bipolar depression.

No. 24C
ANTIDEPRESSANTS IN BIPOLAR DEPRESSION: A TWO-SIDED STORY

Michael E. Thase, M.D. *University of Pittsburgh Medical Center, Psychiatry, 3811 O'Hara Street, Pittsburgh, PA, 15213-2593*

SUMMARY:

This talk will focus on the treatment of bipolar depression, with specific attention given to the role of antidepressant medications. After decades of neglect, in recent years there has been increasing interest in bipolar depression. There is recognition of the chronicity, morbidity, and disability associated with this phase of illness, as well as a dearth of evidence from the well-controlled treatment studies that are needed to guide the practice of evidence-based scientific medicine. This presentation will highlight the unique nature of the decision to prescribe antidepressants for treatment of bipolar depression, including the risk of inducing mania or rapid cycling, the lack of consensus about the optimal duration of antidepressant efficacy, and the potentially important distinction between the type I and type II forms of the disorder. Contemporary treatment guidelines will be reviewed and critiqued.

No. 24D
BEYOND ANTIDEPRESSANTS: TREATMENT OPTIONS FOR BIPOLAR DEPRESSION

Roger S. McIntyre, M.D. *Toronto Western Hospital, University Health, 399 Bathurst St MP 9-325, Toronto, ON, M5T 2S8, Canada*

SUMMARY:

Bipolar symptoms and episodes dominate the course of bipolar disorder. Depressive symptoms are at least as disabling as manic or hypomanic symptoms at corresponding severity levels. Over the past decade, a newly established database indicates that the depressive phase of bipolar disorder is highly associated with obesity and other somatic health issues in the bipolar population. Moreover, deliberate self-harm and suicidality differentially affect the depressive phase of bipolar disorder further underscoring the need for timely detection and appropriate treatment. Conventional mood stabilizers and unimodal antidepressants are frequently prescribed for the acute and prophylactic management of bipolar depression. This prescription pattern continues despite the proof of efficacy for many of these treatments and the hazard of hypo/manic switching and cycle acceleration with antidepressant therapy. Nevertheless, several novel treatments such as third-generation anticonvulsants, atypical antipsychotics, dopamine agonists, novel glutamatergic agents and psychostimulants are either established or under investigation for bipolar depression. Psychosocial interventions, such as cognitive behavioural therapy and psychoeducational initiatives have also been established as effective, particularly in the depressive phase of the illness. This presentation will review key concepts and principles in the diagnosis and management of bipolar depression as well as a concise review of treatment data.

No. 24E
TREATING AND PREVENTING MANIA

Lauren B. Marangell, M.D. *Baylor College of Medicine, 6655 Travis St # 560, Houston, TX, 77030-1312*

SUMMARY:

Pharmacologic treatment options for acute mania have expanded and now include lithium, valproate, carbamazepine, and the atypical antipsychotics, both alone and in combination. This presentation will review the randomized controlled trial data and clinical practice guidelines pertaining to the use of these medications for the treatment of mania. Clinical considerations for medication choices, including side effects and illness severity, will be systematically presented. The presentation will conclude with a discussion of longer-term treatment to prevent future manic episodes.

REFERENCES:

1. Scott J: Psychotherapy for bipolar disorders: efficacy and effectiveness. J Psychopharmacol 2006; 20(suppl 2):46-50.
2. Thase ME: Bipolar depression: issues in diagnosis and treatment. Harvard Rev Psychiatry 2005; 13:257-271.
3. Suppes T, et al: The Texas Implementation of Medication Algorithms: Update to the Algorithms for Treatment of Bipolar I Disorder. J Clin Psychiatry 2005; 66:870-886.
4. Calebrese JR, et al: A US perspective of the CANMAT bipolar guidelines. Bipolar Disord 2005 ;7(suppl 3):70-72.

MONDAY, MAY 21, 7:00 PM - 10:00 PM

INDUSTRY SUPPORTED SYMPOSIUM 25—IMPROVING OUTCOMES IN SCHIZOPHRENIA: PRODROME TO REMISSION
Supported by Janssen Pharmaceutica and Research Foundation

No. 25A
IMPROVING OUTCOMES IN SCHIZOPHRENIA: PRODROME TO REMISSION

Christoph U. Correll, M.D., *The Zucker Hillside Hospital, Albert Einstein College of Medicine, 7559 263rd St, Glen Oaks, NY, 11004-1150*

SUMMARY:

The onset of schizophrenia, whether insidious or acute, is marked with difficulties for patients, families, and clinicians. The severity of symptoms may be denied, and the medical nature of behavioral disturbance may be misunderstood. The afflicted person often keeps symptoms hidden from family and friends, may remove themselves emotionally and geographically from social support networks, and often confound psychosis onset with substance abuse. The gradual development of psychosis, combined with misunderstanding of symptoms, creates a substantial time window between symptom onset and initiation of diagnosis and treatment.

Since long-term outcomes have been poor in schizophrenia recent attempts have been made to identify and intervene in patients much earlier in their illness than previously attempted. It is almost axiomatic in medicine that treatment effectiveness is greatest when initiated early in a pathologic process. Antipsychotic drug treatment in schizophrenia may be symptomatic therapy rather than altering an underlying pathologic process, but clinical prudence supports the early intervention with antipsychotic drugs. An additional hypothesis is influential: that psychosis is "toxic" in some sense, and the length of psychosis experience alters the future course of the illness and the individual's responsiveness to treatment. A longer duration of untreated psychosis may be actually associated with a poorer treatment response.

Additionally, structural brain abnormalities are known to be present in people with schizophrenia. Longitudinal studies have found that certain abnormalities in people with schizophrenia are progressive over time and related to the illness course and treatment outcome of patients with first episode, chronic and childhood onset schizophrenia. Although schizophrenia may arise from a neurodevelopmental diathesis, structural changes over time suggest that the pathophysiology of schizophrenia may be progressive after the onset of illness. There has recently been much speculation regarding the role of medication in contributing to schizophrenia-associated pathomorphologic changes as well as mitigating such changes. Preclinical studies and emerging clinical data have suggested the possibility of specific atypical antipsychotic drugs having pharmacologic properties that could produce neurotrophic, neurogenetic, or neuroprotective effects and possibly lead to improvement in the illness in the longer-term.

Also, in recent years, partial recovery and remission have become increasingly prominent targets for treatment outcomes of people with schizophrenia. This is due in part to new understanding of the etiology and course of schizophrenia, new treatments, and increased interest in improving outcomes among patients, families, advocates and professionals. The current lack of clear, clinically relevant outcomes for comparing treatment modalities has helped to drive recent interest in this area. Thus, in line with this thinking, newer treatment attempts have been focused increasingly on treatment effectiveness and functional outcomes. Newer medications on the horizon may have better treatment effectiveness and tolerability in order to improve these long-term outcomes. This activity ties together recent evidence for interventions in the early phases of schizophrenia to advances in therapeutic choices and goals for longer-term therapy. The experts will discuss schizophrenia treatment options from the prodromal phase to the current concept of remission.

No. 25B
EARLY INTERVENTION IN THE PSYCHOTIC PRODROME: HAS ITS TIME COME?

Christoph U. Correll, M.D. *The Zucker Hillside Hospital, Albert Einstein College of Medicine, 116 Cypress St, Floral Park, NY, 11001-3425*

SUMMARY:

Since treatment of psychotic disorders is often associated with a chronic relapsing course and poor functional outcome, interventions during the prodromal, i.e., sub-psychotic, stages have become a recent focus of research. Studies showing a relationship between longer duration of untreated psychosis and potentially progressive gray matter loss during the transition from a pre-psychotic to a psychotic illness phase have further fuelled hopes that early interventions taking place before the onset of full, syndromatic psychosis could delay, if not abort the progression of the disorder.

The theoretical and practical foundation for prodromal identification and intervention strategies in people considered at risk for a psychotic disorder will be reviewed. Prodromal symptom criteria widely used in research will be presented. In addition, completed and ongoing initiatives aiming to identify and intervene in people who are considered at high risk for psychotic disorders will be presented. Further, issues of non-specificity of the available criteria, strategies for sample enrichment, and risk-benefit and ethical considerations will be highlighted. Finally, implications of currently available data for future research and clinical practice will be discussed in detail.

High risk studies in subjects considered to be prodromal for psychotic disorders have found conversion rates that range between 20% and 40% over one to two years of follow-up. Base rates of true risk for psychosis are obscured in many of these studies by uncontrolled treatment effects and relatively short follow-up durations. Several studies around the world evaluating the effectiveness of pharmacological and non-pharmacological strategies in high-risk groups, alone or in combination, have been conducted, others are underway. Published pharmacological studies are restricted almost exclusively to antipsychotics as a potentially preventive treatment. To date, evidence indicates that early intervention programs have the potential to reduce prodromal symptom severity and short-term functional disability. In addition, interventions may, at least to some degree, delay the onset of full-blown psychosis. Whether psychotic symptoms are just suppressed or whether the disease process itself can be modified by early interventions is still a matter of debate. Similarly, it is unclear if and how much early interventions in high risk programs can alter the course of a psychotic disorder once it has developed and what the relationship is between prodromal symptom response and ultimate syndromal and functional outcome.

Available data suggest that early intervention programs can reduce prodromal symptom severity and short-term deterioration. Further research is needed, however, to determine if psychotic illness expression and functional decline can ultimately be prevented. Moreover, more studies are needed comparing the effectiveness of antipsychotics with non-antipsychotic medications since it is unclear if the same mechanisms underlie successful preventive or symptomatic interventions. Finally, it needs to be clarified how transferable research results are to clinical practice.

No. 25C
THE COURSE OF BRAIN ABNORMAILITIES IN SCHIZOPHRENIA: CAN WE SLOW DISEASE PROGRESSION?

Rene Kahn, M.D., *University of Utrecht Medical School, PO Box 85500, Utrecht, 3508 GA, Netherlands*

SUMMARY:

Structural brain imaging studies have shown that multiple subtle brain abnormalities are consistently found in schizophrenia patients. These pathomorphologic findings have been most commonly demonstrated as brain volume differences involving the ventricular system and cortical and subcortical gray matter regions in patients compared with matched healthy volunteers. Additionally, decreased temporal lobe and amygdala volumes have been noted in people with schizophrenia. This data, however, has been mostly reported from studies performed in chronic schizophrenia patients and little work to date has focused on providing clear information on specific neurobiologic abnormalities early in the course of illness and how these may change over time. If modifications could be made early in the illness to stop the progression of deterioration or improve deficits currently this would represent a significant advance for treatment and outcomes in schizophrenia.

Recent longitudinal studies have found that MRI volume changes in people with first episode schizophrenia are indeed progressive over time and it has been suggested that the most significant deterioration may occur early in the course of illness. Also, while not always consistently reported, the longer duration of untreated psychosis may result in higher temporal gray matter reductions seen in first episode patients. Therefore, neurovulnerability and potential neuroprotection early in the course of psychosis is an important therapeutic avenue in which exploration is needed. This is of high interest as neuroimaging data provide some evidence of volume loss, particularly in the hippocampal region during the transition to psychosis. Brain MRI studies have provided support to show the degeneration of glial cells, loss of neuropil and increased membrane turnover in the early stages of schizophrenia. These changes at the onset of psychosis may provide the cellular substrate for synaptic and dendritic changes resulting from local atrophy and disconnectivity, thus leading to longer term and more evident neurobiologic abnormalities as have been reported.

There has recently been much speculation regarding the role of medication in contributing to schizophrenia-associated pathomorphologic changes as well as mitigating such changes. Evidence is accumulating that conventional antipsychotic utilization and higher doses may in fact lead to decreases in total brain and ventricular volume as well as gray matter loss. These neurobiologic changes, most alarmingly, are associated with poorer functional and cognitive outcomes in people with schizophrenia. However, preclinical studies and emerging clinical data have suggested the possibility of specific atypical antipsychotic drugs having pharmacologic properties that could produce neurotrophic, neurogenetic, or neuroprotective effects.

This activity will describe brain abnormalities present in patients with schizophrenia and how the early course of the illness and symptoms may be affected by these abnormalities. Additionally, the expert will discuss current data on pharmacologic treatments that may modify the course of brain abnormalities and how this applies to clinical outcomes.

No. 25D
IMPROVING RATES OF RESPONSE AND REMISSION IN SCHIZOPHRENIA: HOW DO WE GET WHERE WE NEED TO BE?

John M. Kane, M.D., *The Zucker Hillside Hospital, 7559 263rd St, Glen Oaks, NY, 11004-1150*

SUMMARY:

When treating patients with schizophrenia, response to an initial course of a specific antipsychotic medication is often unsuccessful, either because of insufficient efficacy and/or insufficient tolerability. Yet clinicians are often unsure as to what to do next. A variety of augmentation and switching strategies are frequently employed, but the evidence supporting these strategies is weak or inconsistent. Developing better predictors of response (either therapeutic or adverse) is an important goal. The use of pharmacogenomics is beginning to emerge as a potentially useful strategy.

In terms of remission, a longer-term goal, appropriate medication and disease management is critical. Non-adherence in medication-taking is an all-too-frequent factor in causing preventable relapse and diminishing the chances of achieving and sustaining remission.

This presentation will review recent data on predictors of acute response and strategies to enhance response. In addition, we will provide an overview of remission rates with a variety of different treatment strategies.

REFERENCES:

1. Kampman O, Lappala P, Vaananen J, et al. Indicators of medication compliance in first episode psychosis. Psychiatry Res. 2002;110:39-48.
2. Lieberman JA, Malaspina D, Jarskog LF. Preventing clinical deterioration in the course of schizophrenia: the potential for Neuroprotection. CNS Spectr. 2006;(11 suppl):1-13.
3. Leucht S, Busch R, Hamann J, Kissling W, Kane J. Early-onset hypothesis of antipsychotic drug action: a hypothesis tested, confirmed and extended. Biol Psychiatry. 2005;57(12):1543-1549.

INDUSTRY SUPPORTED SYMPOSIUM 26—NAVIGATING THE COMPLEX MAZE OF BIPOLAR DISORDER
Supported by Pfizer Inc. and Organon Inc.

No. 26A
NAVIGATING THE COMPLEX MAZE OF BIPOLAR DISORDER

Prakash S. Masand, M.D. *Duke University Medical Center, 110 Swift Ave Ste 1, Durham, NC, 27705-4800*

SUMMARY:

Bipolar disorder is a life-long illness, characterized by frequent, recurrent episodes and significant morbidity and mortality. A rapid and accurate diagnosis is necessary for prompt implementation of appropriate treatment, but many patients are misdiagnosed, and it may be years before they receive appropriate treatment. Once the diagnosis is made, medication must be chosen that can control symptoms in the short-term and prevent relapse in the long-term. Many patients with bipolar disorder have psychiatric and medical comorbidities which further complicate treatment: comorbid psychiatric diagnoses may require additional treatment, while medical comorbidities, the most common of which in this population involve overweight and metabolic complications, may limit medication choices and/or necessitate further polypharmacy. The Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD), an ongoing large-scale longitudinal study of sequential treatment strategies for bipolar disorder that includes both standard and randomized treatment groups, is providing valuable information on comorbidities, disease course, and the relative efficacy of different treatment strategies, which will enhance the ability of the clinician to make evidence-based treatment decisions for their patients with bipolar disorder, thus improving patient care.

No. 26B
MANAGING THE BIPOLAR PATIENT WITH MEDICAL COMORBIDITIES

Andrea Fagiolini, M.D. *University of Pittsburgh School of Medicine, 3811 O'Hara Street, Pittsburgh, PA, 15213*

SUMMARY:

Obesity and its complications, which include diabetes, dyslipidemia, and hypercholesteremia, are even more common among bipolar patients than among the general population. Furthermore, these medical comorbidities are associated with poor mental health outcomes, such as an increased rate of suicide attempts, and shorter time to recurrence. While atypical antipsychotics have established efficacy in treating mania and preventing relapse in patients with bipolar disorder, many of these agents are obesogenic, as well as being associated with other adverse effects, such as hyperprolactinemia. These adverse events not only damage health, but are poorly tolerated by the patient and erode patient quality of life. It is now evident that the subjective tolerability advantage of atypical antipsychotic therapy may be mitigated by the weight gain and metabolic effects that occur with specific individual agents and may have a serious impact on morbidity, mortality, and quality of life. This presentation will review the adverse event profiles of available atypical antipsychotics and factors clinicians should consider when choosing an agent that will promote patient mental and physical health.

No. 26C
TAILORING ANTIPSYCHOTIC TREATMENT TO THE COMPLEX PATIENT WITH BIPOLAR DISORDER

Paul E. Keck, Jr., M.D., *University of Cincinnati College of Medicine, 8395 Old Stable Rd, Cincinnati, OH, 45243-1441*

SUMMARY:

The consequences of failing to diagnose bipolar disorder can be substantial. Bipolar disorder, when left untreated, is associated with severe clinical symptoms and a very high rate of suicide. Diagnosing this disorder can be complicated because patients with bipolar disorder often present with depression and may be reluctant to report previous manic or hypomanic episodes, which may lead to the misdiagnosis of unipolar depression. As a result, initiating treatment with

antidepressants alone is not efficacious for bipolar disorder and may exacerbate hypomania, mania, or cycling.

In addition, various other psychiatric disorders, such as anxiety disorders, alcohol-use disorders are among the most commonly co-occurring conditions affecting patients with with bipolar disorder. As with depression, the presence of co-occurring anxiety disorders has important prognostic and treatment implications.

The co-occurrence of alcohol-use disorders is negatively associated with outcome in the treatment of bipolar disorder. Certain studies show that the relative age at onset of alcohol-use and bipolar disorders is associated with differences in the course of both conditions. And it appears that gender-specific relationships between alcoholism and bipolar disorder play a role as well.

More controversial and relatively unexamined is the co-occurrence of bipolar and eating disorders, though of major clinical and public health importance.

This presentation will review the various psychiatric conditions that may co-exist with bipolar disorder and not only complicate diagnosis, but also treatment outcomes.

No. 26D
BRINGING RESEARCH TO THE CLINICIAN: LESSONS FROM STEP-BD

Gary S. Sachs, M.D. *10 Garland Rd, Lincoln, MA, 01773-1800*

SUMMARY:

The Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) is a large-scale longitudinal study of sequential treatment strategies for bipolar disorder that includes both standard and randomized treatment groups. While ongoing, this study has already revealed deficits in treatment, such as a lack of appropriate treatment for patients with comorbidities, and produced multiple findings in regards to population demographics, disease course, and treatment efficacy. Key pieces of information which are especially important to the clinician who treats patients with bipolar disorder include the high rate of relapse, the high rate of treatment nonresponse, and the need for polypharmacy to manage many patient's symptoms. This presentation will discuss key findings from STEP BD and ways clinicians can use these findings to improve patient outcomes.

No. 26E
DIAGNOSTIC PITFALLS IN PATIENTS WITH BIPOLAR DISORDER

Prakash S. Masand, M.D. *Duke University Medical Center, 110 Swift Ave Ste 1, Durham, NC, 27705-4800*

SUMMARY:

Bipolar disorder is a devastating condition that affects approximately 3% of the population. Diagnosis of bipolar disorder is often confounded by the lack of insight patients have into their manic episodes and the similarities between the presenting symptoms and other psychiatric disorders. If a patient presents during a manic episode, diagnosis is relatively simple, but the clinician is far more likely to encounter a patient undergoing a mixed or depressive episode, resulting in a misdiagnosis of depression or agitated depression, and inappropriate treatment. Many patients are not diagnosed until years after their first episode and receive no or inappropriate treatment in the interim. Thorough history-taking and clinician vigilance, can, however, reduce the likelihood of misdiagnosis and improve patient care. This presentation will review common pitfalls in the diagnosis of patients with bipolar disorder and strategies for distinguishing bipolar disorder from depression and agitated depression.

REFERENCES:

1. Fagiolini A, et al. Metabolic syndrome in bipolar disorder: findings from the Bipolar Disorder Center for Pennsylvanians. Bipolar Disord. 2005;7:424-430.
2. Keck PE, et al. Pharmacologic treatment considerations in co-occurring bipolar and anxiety disorders. J Clin Psychiatry. 2006;67 Suppl 1:8-15.
3. Perlis RH, et al. Predictors of recurrence in bipolar disorder: primary outcomes from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). Am J Psychiatry. 2006 Feb;163(2):217-24.
4. Calabrese JR et al. J Clin Psychiatry. 2004;65:1499-1504.

INDUSTRY SUPPORTED SYMPOSIUM 27—WHEN ENDOCRINOLOGY AND PSYCHIATRY COLLIDE: WHAT THE CLINICIAN NEEDS TO KNOW ABOUT ANTIPSYCHOTIC-INDUCED ENDOCRINE DISTURBANCES

Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

1. To understand the pathophysiology of type 2 diabetes and the metabolic syndrome.
2. To learn the diagnostic criteria for diabetes and the metabolic syndrome
3. To review current treatment strategies for both conditions

No. 27A
DIABETIS AND THE METABOLIC SYNDROME: FROM SOUP TO NUTS

Ram Cooppan, M.B.Ch.B. *One Joslin Place, Boston, MA, 02215*

SUMMARY:

Diabetes mellitus is increasing globally and will affect more than 300 million people by 2025. Most of this will be type 2 diabetes caused by genetic and environmental factors that result in insulin resistance and beta cell dysfunction. The rise in type 2 diabetes parallels the increase in obesity and a sedentary lifestyle and is occurring in younger age persons. Treating the earlier stage of Impaired Glucose Tolerance with life style changes and weight loss can prevent progression to type2 diabetes by 58%. Many therapies that can address the underlying physiology are now available and can result in excellent glucose control.

The major complication of type 2 diabetes is cardiovascular disease that results from the interaction of visceral obesity, insulin resistance with glucose intolerance, hypertension, dyslipidemia and a pro thrombotic state and pro inflammatory state. This cluster of risk factors has been called the metabolic syndrome and there is considerable discussion on the diagnostic criteria. One thing is clear that the definition of visceral obesity varies in different ethnic groups. Therapy is to treat the risk factors aggressively to goals from outcome studies. In addition attention has to be paid to other therapies with the potential to exacerbate the risk factors.

No. 27B
ANTIPSYCHOTICS, DIABETES, AND THE METABOLIC SYNDROME: WHAT IS THE STRENGTH OF THESE RELATIONSHIPS?

John W. Newcomer, M.D., *Washington University School of Medicine, Dept of Psychiatry, 660 S Euclid Ave # 8134, Saint Louis, MO, 63110-1010*

SUMMARY:

Individuals with major mental disorders have an increased prevalence of obesity, diabetes, dyslipidemia, hypertension and cardiovascular disease. Multiple factors contribute to these problems, including disease- and treatment-related changes in nutrition and activity, increased prevalence of smoking, and treatment-related changes in adiposity and glucose and lipid metabolism. Antipsychotic treatment in particular can significantly contribute to metabolic adverse events that include weight gain, insulin resistance, dyslipidemia, hyperglycemia and metabolic syndrome. Evidence spans the results of large observational studies and controlled experimental studies including randomized clinical trials such as CATIE. Recent consensus efforts within psychiatry have aimed to establish monitoring guidelines for adverse events during antipsychotic treatment, including an APA Workgroup on Antipsychotics and Metabolic Risk. US Public Health Service Adult Treatment Panel (ATP) III guidelines and American Diabetes Association (ADA) guidelines for risk reduction in the general population offer validated approaches for monitoring metabolic risk, recognizing higher risk groups, and intervening to lower risk. Efforts at risk reduction in this area are responsive to a recent Institute of Medicine report regarding the need to reduce disparities in the level of medical care provided to persons with mental disorders.

No. 27C
PROLACTIN ELEVATION AND ANTIPSYCHOTIC THERAPY: WHAT TO TELL PATIENTS ABOUT RISKS TO BONE AND SEXUAL FUNCTIONING

Meera Narasimhan, M.D., *University of South Carolina School of Medicine, 3555 Harden Street Extension, Columbia, SC, 29203*

SUMMARY:

Antipsychotic induced hyperprolactinemia, a neglected domain in psychiatry is underresearched and presents a serious challenge to clinical practice warranting immediate attention. Complex effects of first and second generation antipsychotics and their uncertain interactions with human growth and sexual development given their widespread use in children and adolescents, backed by limited long-term data poses a clinical and ethical dilemma to practitioners. Disruption of the hypothalamo pituitary gondal axis and its deleterious effects on sexual function mediated by antipsychotic-induced increases in serum prolactin levels and the its consequences on bone mineral density is a poorly understood phenomenon with far reaching implications on the subjective well being of our clients across their life span.

Absence of evidence based trials and lack of monitoring guidelines to address these serious risks has often resulted in switching to antispychotics with lower liability to provide symptomatic relief. Differential effects of second generation antipsychotics as elucidated by clinical trials and neuroimaging data has shed some light on the biological underpinnings of these adverse events. These evolving concerns highlight the unmet need to customize treatments to best suit the symptom presentation of each individual patient.

No. 27D
GUIDELINES FOR THE MANAGEMENT OF METABOLIC AND ENDOCIRING SIDE EFFECTS: CONFUSION OR CONSENSUS?

Peter F. Buckley, M.D. *163 McBride Rd, Augusta, GA, 30907-1682*

SUMMARY:

Set against a spectre of increasing medicolegal adversity, clinicians are presented with invariably confusing-and often even conflicting-information on the relationship between endocrine disturbances and antipsychotic medications. Moreover, in the absence of a clear appraisal of this risk and faced with several guidelines, clinicians are encouraged to undertake close monitoring for metabolic disturbances during antipsychotic therapy. Available evidence suggests a lag between the awareness of clinicians regarding metabolic side effects and the implementation of monitoring practices. There are also meaningful differences between the current guidelines. The forthcoming recommendations from the APA Task Force representing the most comprehensive appraisal of the risks-and management thereof-of metabolic disturbances. Current practice favors switching antipsychotics over other interventions- it is presently unknown whether preemptive use of statins or related agents might mitigate the development of metabolic syndrome. There is also an accruing literature on the application of dietary and lifestyle behavioral programs (designed for obese nonpsychiatric populations) to manage obesity in psychiatric outpatients. These approaches are promising, although they need to be tailored to take into account the cognitive impairments and limited resources of patients with schizophrenia. This presentation will provide a synthesis of current management approaches (including emergent evidence on the impact of lifestyle modification approaches)on the care of patients with mental illness who develop these metabolic complications and it will also address expectations for clinical documentation.

No. 27E
INCREASING GLOBAL BURDEN OF CARDIOVASCULAR DISEASE IN GENERAL POPULATIONS AND PATIENTS WITH SCHIZOPHRENIA

Charles H. Hennekens, M.D., *University of Miami Medicine, 2800 South Ocean Boulevard, Boca Raton, FL, 33432*

SUMMARY:

Cardiovascular disease (CVD), which includes coronary heart disease (CHD), cerebrovascular and peripheral vascular diseases, is the leading cause of mortality in the United States and most developed countries, accounting for about 50% of all deaths. In patients with schizophrenia life expectancy is 20% shorter than average translating to a reduction from about 76 to 61 years for US patients. Unfortunately, patients with schizophrenia have increased risk factors for CVD with a relative risk of about 1.5 compared to the general population. In addition, patients with schizophrenia have a markedly increased relative risk of suicide (of about 10.0). CVD, as a more common cause of death, is responsible for more of the excess premature mortality in patients with schizophrenia than suicide, accounting for 50% of deaths versus 1%. The major modifiable determinants include obesity and its consequences, namely, dyslipidemia, hypertension, and insulin resistance leading to diabetes as well as cigarette smoking. This situation is analogous to that of smoking with CVD and lung cancer where the relative risk is far lower for CVD (about 2.0) than lung cancer (about 20.0). With the prevalence of CVD, smoking cessation would avoid more premature deaths from CVD than from lung cancer. Strategies to reduce the disparity in mortality between patients with schizophrenia and the general population should include aggressive management of risk factors for CVD as well as primary prevention efforts.

REFERENCES:

1. 1. Inzucchi SE. Oral antihyperglycemic therapy for type2 diabetes. Scientific Review. JAMA 2002;287:360-372.
2. Newcomer JW: Second-generation (atypical) antipsychotics and metabolic effects: A comprehensive literature review. CNS Drugs 2005, 19(1):1-93.
3. Masand PS, Culpepper L, Henderson D, Lee S, Littrell K, Newcomer JW, Rasgon N. Metabolic and endocrine disturbances in psychiatric disorders: a multidisciplinary approach to appropriate atypical antipsychotic utilization. CNS Spectr. 2005 Oct;10 (10).

4. De Hert M, Van Eych D, De Nayer A. Metabolic abnormalities associated with second generation antipsychotics: fact or fiction? Development of guidelines for screening and monitoring. International Clinical Psychopharmacology 2006; 21 (2): 11-15.

INDUSTRY SUPPORTED SYMPOSIUM 28—IMPROVING DEPRESSION TREATMENTS: BRIDGING THE GAP BETWEEN RESEARCH AND CLINICAL PRACTICE
Supported by Eli Lilly and Company

No. 28A
IMPROVING DEPRESSION TREATMENTS: BRIDGING THE GAP BETWEEN CLINICAL TRIALS AND COMMUNITY PRACTICE

Jonathan E. Alpert, M.D. *Massachusetts General Hospital, 50 Staniford St Fl 4, Boston, MA, 02114-2517*

SUMMARY:

Improving Depression Treatments: Bridging the Gap Between Clinical Trials and Community Practice

Clinicians treating depressed patients face the twin challenges of staying current with the research literature and evaluating the degree to which the literature relates to their clinical practices. Randomized controlled trials provide the necessary foundation for the empirically based management of depression. However, clinical trials often lack ecological validity by virtue of study design, setting and subjects. Indeed, most randomized depression treatment trials have excluded patients older than 75 years old as well as patients with significant medical or psychiatric comorbidity. Remarkably few randomized, prospective trials have focused on maintenance treatment of depression. There is a similar paucity of data on the acute treatment of depression in women during the transition to menopause. The focus of this symposium is on recent promising efforts to bridge the gap between research trials and the management of depression in clinical practice. Dr. Alpert will introduce the key topics and themes. Dr. Mark Zimmerman will provide a unique perspective, based on his experience with the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project, on the incorporation of assessment tools during the treatment of depressed patients and on the structure and focus of follow-up care. Dr. Timothy Petersen will review findings from the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial, and implications for the management of difficult to treat depression in community practice settings. Dr. Hadine Joffe will present findings relevant to women's health and particularly related to the evaluation and management of depression among patients entering menopause. Dr. Chip Reynolds will present a review of strategies to achieve optimal therapeutic outcomes during acute and maintenance treatment in old-age depression. Finally, Dr. Gregory Simon will present an overview of epidemiology and treatment considerations when working with depressed patients with chronic medical conditions together with a discussion of the effectiveness of quality improvement programs aimed at raising the bar on depression treatment in this large patient population. Finally, a panel discussion will further highlight evolving knowledge about the optimal evaluation and management of depressed patients in real-world practice including those patients who have been traditionally underrepresented in depression treatment trials.

No. 28B
FOLLOW-UP CARE AFTER INITIATING ANTIDEPRESSANT TREATMENT: AN EMPIRICALLY INFORMED APPROACH

Mark Zimmerman, M.D., *Rhode Island Hospital, Dept of Psych, 235 Plain St Ste 501, Providence, RI, 02905-3243*

SUMMARY:

Most research on the treatment of depression focuses on establishing the efficacy of therapeutic modalities. Little research examines issues in the management of depression such when and how often to schedule follow-up visits after initiating antidepressant treatment and how to monitor the course of treatment. This presentation will address three issues in the management of depression in clinical practice: what message to give to patients regarding the onset of action of antidepressant medication, when should patients be scheduled for follow-up care after initiating antidepressant medication, and how can quantitative measures of depression severity be incorporated into clinical care without burden or disrupting routine practice.

Contemporary textbooks indicate that antidepressants take several weeks to work. Consequently, patients are often told that medication needs to "build up in their system" and usually takes a month to work. However, the results of a recent meta-analysis indicate that the onset of antidepressant action is in the first week of treatment, and that "true drug effect" (i.e., efficacy greater than placebo) is greatest in the first two weeks of treatment. This suggests that the message given to patients should be changed, and that patients should be told that patients often notice improvement in their symptoms in the first week or two after starting treatment.

Perhaps related to beliefs that the onset of action of antidepressants is delayed, many clinicians schedule the first follow-up visit after initiating antidepressant medication 3 to 4 weeks later. We speculated that it is therapeutic to assess patients depression status, and to evaluate the impact of follow-up assessments, we conducted a meta-analysis of 41 double-blind, placebo-controlled antidepressant trials published over the last 2 decades. Because some clinical trials require subjects to present on a weekly basis while others allow subjects to skip a week (eg, scheduling follow-up visits at Weeks 1, 2, 3, 4, and 6, but *not* Week 5), we were able to evaluate the impact that an extra follow-up assessment had on reduction in depression severity rating scores. We hypothesized that a greater reduction in depression severity rating scores would occur in cohorts receiving extra follow-up assessments. We found that follow-up assessments in antidepressant treatment trials incur a significant therapeutic effect for subjects receiving both antidepressant and placebo treatment. Because follow-up visits themselves are therapeutic we recommend that patients be seen within two weeks of initiating treatment, and at least twice during the first month of treatment.

When following patients clinicians can take a global, impressionistic approach towards evaluating outcome, or they can quantify patients' status. During the past decade, as part of the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project we have developed and validated several new self-report and clinician-rated measures of depression that are feasible to incorporate into clinical practice. The advantages of this approach towards assessing outcome will be discussed.

No. 28C
ACHIEVING AND MAINTAINING OPTIMAL THERAPEUTIC OUTCOMES IN OLD-AGE DEPRESSION

Charles F. Reynolds III, M.D. *University of Pittsburgh, Psychiatry, 216 Tennyson Ave, Pittsburgh, PA, 15213-1416*

SUMMARY:

Major depression in old age is common, disabling, and frequently lethal. It is the main treatable risk factor for suicide in late life. The hallmark of depression in old age is its syndromal complexity, born of its coexistence with chronic medical disorders, cognitive impairment, anxiety, and disability. Most older Americans with depression, if they receive any treatment at all, do so in the general medical sector (not in the specialty mental health sector). Their treatment is likely to be of low intensity and short duration, with infrequent follow-up, lack of dosage adjustment to ensure appropriate exposure to antidepressant pharmacotherapy, and sub-optimal treatment adherence. Inadequate treatment confers a bad prognosis for achieving remission, maintaining recovery, and preventing sequelae of late-life depression.

This presentation will review the evidence base for the treatment of major depression in old age, including both pharmacotherapy and depression-specific psychotherapy. We will show data that even in first episodes of illness, patients are better off remaining on maintenance pharmacotherapy for at least two years, in order to prolong recovery and prevent recurrences. This is often a difficult lesson for older patients, their carers, and their physicians; yet it reflects the propensity of the illness to become recurrent and chronic-- and, hence, the need for chronic disease management strategies integrated into the patient's general treatment plan for co-existing conditions like diabetes or hypertension.

Evidence-based practice for old-age depression can, fortunately, be implemented successfully in primary care settings, as demonstrated by the IMPACT, PROSPECT, and RESPECT studies, via depression care managers supervised at a distance by geriatric psychiatrists. This is a point of critical public health importance for mental health services delivery, given the severe and growing shortage of psychiatrists with added qualifications in old-age psychiatry. However, unfortunately, reimbursement policies have yet to catch up with the science.

Finally, we will discuss hypothesized moderators of treatment response variability, that is, patient characteristics associated with partial response and high liability to early recurrence. These hypothesized moderators include anxiety, chronic medical illness burden, and cognitive impairments (especially executive dysfunctions), all of which reflect the syndromal complexity of major depression in old age and all of which need to be addressed in treatment planning.

No. 28D
OPTIMIZING CARE FOR DEPRESSION DURING THE MENOPAUSE TRANSITION: THE INTERFACE BETWEEN PSYCHIATRY AND GYNECOLOGY

Hadine Joffe, M.D. *Massachusetts General Hospital, Psychiatry, 185 Cambridge St, Suite 2000, Boston, MA, 02114-2790*

SUMMARY:

Women are at increased risk for depression during the menopause transition, and those with hot flashes are at particularly high risk for experiencing a menopause-associated depression. Following the publication of the Women's Health Initiative study, rates of hormone therapy use have decreased significantly. As a result, there are more women with untreated menopause symptoms, such as hot flashes. The perimenopause is a period of increased for a first lifetime episode of depression and for recurrence of depression. Hot flashes are associated with depression and those with hot flashes are more likely to develop a depression episode. Clinicians treating women with depression during midlife should be aware of the possibility that the hormonal changes that underlie the menopause transition may be a factor leading to the increased risk for depression and they should inquire about the presence of menopausal symptoms such as hot flashes and night sweats.

Hot flashes and night sweats (also called vasomotor symptoms) are the primary symptom of the menopause transition. For some, vasomotor symptoms can have a profound impact on quality-of-life because of daytime interference and/or disruption of sleep because of nocturnal symptoms. Hormonal therapy is the most effective and established treatment of hot flashes and menopause-associated sleep problems. However, many women are unable or unwilling to use estrogen. A growing body of evidence supports the use of serotonergic antidepressants (SSRI and SNRI) as alternative treatments for hot flashes in menopausal women.

Clinicians treating depression in peri- and early postmenopausal women should take in account other menopausal symptoms. Studies using SSRI and SNRI to treat depression in this population show that these serotonergic agents also treat hot flashes in depressed women. Such studies suggest that serotonin-based antidepressants may be important options for treating a number of different menopausal symptoms, leading to improvement of overall well-being.

No. 28E
CONSIDERATIONS IN THE TREATMENT OF DEPRESSED PATIENTS WITH CHRONIC MEDICAL CONDITIONS

Gregory E. Simon, M.D. *Group Health Cooperative, Center for Health Studies, 1730 Minor Ave., #1600, Seattle, WA, 98101*

SUMMARY:

Among people with chronic medical conditions, depressive disorders are especially common and are associated with a large burden of mental and physical suffering, disability, reduced treatment adherence, and increased health services costs. Even when depressive disorders are recognized, they may be mistakenly viewed as natural or inevitable consequences of medical illness. Treatment is often inadequate in duration or intensity. This presentation will review evidence regarding: the epidemiology of depression among people with common chronic medical conditions; the validity of depression diagnostic criteria in people with chronic medical illness; the association between depression and functional impairment, lost work productivity, somatic symptoms, poorer self-care, and increased health services costs; the quality of treatment typically provided to people with comorbid depression and general medical conditions; the efficacy and effectiveness of depression treatments (both antidepressant medication and structured, depression-specific psychotherapy) in people with chronic medical illness; and the economic benefits of improved depression treatment. Finally, we will discuss the implications of this evidence for the changing role of psychiatrists in the health care system.

No. 28F
THE SEQUENCED TREATMENT ALTERNATIVES TO RELIEVE DEPRESSION (STAR*D) STUDY: LESSONS LEARNED

Timothy Petersen, M.D. *Massachusetts General Hospital, 55 Fruit Street, Bulfinch 449, Boston, MA, 02114*

SUMMARY:

The Sequenced Treatment Alternative to Relieve Depression (STAR*D) study used a prospective design to determine the comparative effectiveness of different next-step treatment options for outpatients with Major Depressive Disorder (MDD) when remission was not attained with an initial selective serotonin reuptake inhibitor (SSRI), citalopram (CIT). This study was carried out in real-world primary care and specialty settings, with a specific effort to increase the generalizability of its findings. In addition, STAR*D utilized a novel approach, which we called the "equipoise stratified" design,

that allowed flexibility in the randomization process, so that both study participants and clinicians had some say as to which treatment options a given study participant was randomized to. Clinical outcomes of STAR*D were very broad and included symptoms, function, side effect burden, quality of life, and participant satisfaction. These outcomes were evaluated by independent assessors masked to treatment assignments or by an IVR system. This presentation will review the findings of STAR*D with respect to the short-term outcome of Levels 1 through 4 of this large, multicenter study, and will also discuss the clinical and practical implications of these findings. These results can hopefully guide our treatment decisions in the real word with respect to the treatment of MDD.

REFERENCES:

1. Posternak, M.A., & Zimmerman, M. Is there a delay in the antidepressant effect? A meta-analysis. Journal of Clinical Psychiatry, 2005, 66, 148-158.
2. Reynolds CF et al: Maintenance Treatment of Major Depression in Old Age. NEJM 2006; 354: 1130-1138; and 1189-1190 (editorial).
3. Joffe H, Soares CN, Cohen LS. Assessment and treatment of hot flushes and menopausal mood disturbance. Psychiatr Clin North Am. 2003 Sep;26(3):563-80.
4. Lewis L. Recognizing and meeting the needs of patients with mood disorders and comorbid medical illness: a consensus conference of the Depression and Bipolar Support Alliance. Biol Psychiatry 2003; 54:181.
5. Fava M et al; Background and rationale for the sequenced treatment alternatives to relieve depression (STAR*D) study. Psychiatr Clin North Am. 2003 Jun;26(2):457-94,.

TUESDAY, MAY 22, 7:00 PM - 10:00 PM

INDUSTRY SUPPORTED SYMPOSIUM 29—CIGARETTE SMOKING, SMOKING CESSATION, AND PSYCHIATRIC ILLNESS Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should:

1) Appreciate the multiple sources of medical risk for the depressed patient.

2) Appreciate the difficulty and risks associated with smoking cessation for the patient with a history of depression.

3) Appreciate the depressed smokers can successfully stop smoking, but that this may require additional sustained medications.

No. 29A
WHAT MAKES SMOKING CESSATION UNIQUE IN PATIENTS WITH A HISTORY OF DEPRESSION

Alexander H. Glassman, M.D. *Columbia University, Psychiatry, 1051 Riverside Dr Unit 116, New York, NY, 10032-1007*

SUMMARY:

Medically healthy, depressed patients are 65% more likely to develop coronary artery disease and carry a similar increased risk of stroke. This increased risk exists even when controlling for cardiac risk factors including smoking. Unfortunately, depressed patients are also at increased risk of becoming addicted to cigarettes and when the two risks are combined, the depressed patient is more than twice as likely to suffer the adverse consequences of vascular disease, not to mention the usual risk of emphysema and lung cancer. Cigarette smoking is an enormous health risk for the depressed patient and yet is frequently ignored. Patients frequently minimize this risk because they know how difficult cessation can be. Depressed patients, especially recurrent depression, are more likely to fail. Evidence shows that withdrawal symptoms from nicotine are more severe in smokers with a history of depression and if the depressed smoker is fortunate enough to succeed at cessation there is a six fold greater risk of relapse to a new episode of major depression. Twin studies indicate that there are shared genes that increase the risk for both smoking and depression. It is important for psychiatrists to recognize these risks and to a just treatment accordingly. Nicotine undoubtedly has antidepressant qualities in some individuals and sustained cessation often requires increased antidepressant treatment. Interestingly, although bupropion is both a proven antidepressant and an aid to smoking cessation, it does not prevent depressive relapses in abstinent smokers with a history of MDD. There is anecdotal evidence that nicotine patches can augment antidepressant drug treatment. Whether alpha-4, beta-2 partial agonists will reduce the risk of depressive relapse is unknown and needs to be tested.

No. 29B
PHARMACOLOGICAL TREATMENT OF NICOTINE DEPENDENCE IN SCHIZOPHRENIA: THE DEVIL IS IN THE DETAILS

Tony P. George, M.D. *Yale University, Psychiatry, 34 Park Street, New Haven, CT, 06519*

SUMMARY:

The objective of this presentation is to review medication treatments for nicotine dependence in schizophrenic patients, and factors associated with treatment failure or success. These patients show high rates of cigarette smoking, very high blood nicotine levels, and higher quit failure rates compared to non-psychiatric smokers. Uncontrolled studies with nicotine replacement therapies indicate that these products are safe these patients and are associated with moderate short-term smoking abstinence rates of 10-40%. However, efficacy studies comparing NRTs to placebo have not been conducted. Recently, three placebo-controlled studies of sustained-release (SR) bupropion in schizophrenic smokers suggested short-term efficacy. Moreover, treatment with bupropion SR was well tolerated with little evidence for alteration in positive symptoms, and possibly reductions in negative symptoms. The role of extended treatment with NRTs and bupropion will be explored. A recently completed trial from the Yale comparing combination nicotine patch and bupropion SR to patch and placebo bupropion indicated that the combination triples the chance of quitting compared to patch alone. Long-term (6 month) follow-up outcome is also improved compared to patch or bupropion monotherapy. The presentation will also summarize the role of patient factors which may modulate cessation outcomes including level of nicotine dependence, treatment with atypical versus typical antipsychotic drugs, genetic polymorphisms in prefrontal cortex (PFC) catecholamine metabolism and the presence and severity of PFC-dependent neurocognitive deficits. Finally, the role of novel approaches such as nicotinic partial agonists (e.g. varenciline), allosteric modulators (e.g. galantamine), and PFC dopamine enhancers (e.g. atomoxetine) are discussed. While schizophrenic smoking is clearly a "hard target", increasing our understanding of the neurobehavioral basis of schizophrenia and nicotine dependence is leading to more rationale approaches to smoking cessation.

No. 29C
ANIMAL MODELING AND INTEGRATIVE NEUROCIRCUITY OF ADDICTION VULNERABILITY IN MENTAL ILLNESS

R. AndrewChambers, M.D. *Indiana University School of Medicine, Psychiatry, 791 Union Dr, IPR, Indianapolis, IN, 46202-2873*

SUMMARY:

Dual diagnosis is a problem of tremendous depth and scope where substance use disorders and mental illness are frequently co-morbid across a diversity of drug types and psychiatric diagnoses. Combining animal models of psychiatric disorders with preclinical addiction paradigms provides insights into the fundamental brain mechanisms underlying the common themes and heterogeneous presentations of dual diagnosis disorders. Investigations using neurodevelopmental and adult-onset lesion models of mental illness, suggest the unitary nature of mental illness and addiction vulnerability both on the neurocircuit and clinical-behavioral levels. Future investigations on animal models of dual diagnosis will better characterize the neural networks commonly involved in psychiatric syndromes and the addiction process, and serve as platforms for developing more effective, parsimonious, and preventative treatments for addictions and psychiatric illnesses as stand alone or co-morbid conditions.

No. 29D
PHARMACOTHERAPIES FOR SMOKING CESSATION

Cheryl A. Oncken, M.D. *University of Connecticut Health Center, Department of Medicine, 263 Farmington Avenue, Farmington, CT, 06030*

SUMMARY:

Cigarette smoking is a significant public health concern. Although 70% of smokers would like to quit, and 46% make a quit attempt each year, less than five percent are abstinent one year later. Pharmacotherapy is a recommended treatment for most smokers. Randomized placebo-controlled trials have shown overwhelming evidence that pharmacotherapy substantially improves smoking cessation rates relative to placebo in community samples. However, in spite of proven efficacy, relapse is common and long-term abstinence the exception. This presentation will review the rationale and evidence supporting first and second line pharmacotherapies recommended by treatment guidelines for smoking cessation (e.g., nicotine replacement therapies, bupropion SR, clonidine, and nortriptyline) and the usefulness of extending usual treatment. duration. In addition, the strength and weaknesses of the recently published NDI trials of varenicline, the first of a new class of partial nicotinic agonists for smoking cessation, will be discussed. Rationale and clinical trial data for other potential emerging treatments for smoking will also be reviewed (e.g., nicotine vaccine, monoamine oxidase inhibitors, and rimonabant).

No. 29E
REWARD SYSTEMS UNDERLYING MOTIVATION AND ADDICTION

Peter W. Kalivas, Ph.D., *Medical University of South Carolina, Physiology and Neuroscience, 173 Ashley Ave, Charleston,, SC, 29425*

SUMMARY:

Relapse to drug taking is a cardinal feature of addiction to drugs of abuse, and is a point in the cycle of addiction where pharmacotherapies may be most useful. Recent understanding from neuroimaging addicts and animal models of relapse reveals that the glutamatergic projection from the prefrontal cortex to the nucleus accumbens is a final common pathway in the circuitry mediating craving and drug-seeking. Animal studies reveal that withdrawal from chronic drug administration produces changes in proteins that regulate glutamate transmission in this pathway, and these alterations in protein function are postulated to underlie relapse. By targeting some of these proteins in animal models of addiction it is possible to demonstrate a critical role in drug seeking. Some proteins found important in this regard are metabotropic glutamate receptors, the cystine-glutamate exchanger, Homer, AGS3 and actin. By understanding how glutamate synapses adapt to chronic drug treatment, and developing pharmacotherapies to normalize these adaptations, it is possible to ameliorate drug seeking in animal models of addiction.

REFERENCES:

1. Glassman AH, Covey LS, Stetner F, Rivelli S. Smoking cessation and the course of major.
2. George, T.P. et al. Biol. Psychiatry 2002; 52: 53-61.
3. Chambers, RA, Krystal, JH, Self, DW: A neurobiological basis for substance abuse comorbidity in schizophrenia. Biol Psychiatry 2001; 50:2: 71-83.
4. Fiore MC, Bailey WC, Cohen SJ et al, Treating Tobacco Use and Dependence. Clinical Practice Guidleine. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000.
5. Kalivas, PW, N Volkow. 2005. The neural basis of addiction: A pathology of motivation and choice. Am J Psychiatry, 162: 1403-1413.

INDUSTRY SUPPORTED SYMPOSIUM 30—AM I A PSYCHIATRIST... OR AN ENDOCRINOLOGIST? COPING WITH METABOLIC DISTURBANCES DURING THE TREATMENT OF SCHIZOPHRENIA
Supported by Pfizer & Solvay-Wyeth

No. 30A
ANTIPSYCHOTICS AND METABOLIC RISK: WHAT'S THE PROBLEM AND WHAT'S THE SOLUTION?

Dan Haupt, M.D., *Washington University School of Medicine, 660 South Euclid Avenue, St. Louis, MO, 63110-1002*

SUMMARY:

Individuals with major mental disorders have an increased prevalence of obesity, diabetes, dyslipidemia, hypertension and cardiovascular disease. Multiple factors contribute to these problems, including disease- and treatment-related changes in nutrition and activity, increased prevalence of smoking, and treatment-related changes in adiposity and glucose and lipid metabolism. Antipsychotic treatment in particular can significantly contribute to metabolic adverse events that include weight gain, insulin resistance, dyslipidemia, hyperglycemia and metabolic syndrome. Evidence spans the results of large observational studies and controlled experimental studies including randomized clinical trials such as CATIE. Recent consensus efforts within psychiatry have aimed to establish monitoring guidelines for adverse events during antipsychotic treatment, including an APA Workgroup on Antipsychotics and Metabolic Risk. US Public Health Service Adult Treatment Panel (ATP) III guidelines and American Diabetes Association (ADA) guidelines for risk reduction in the general population offer validated approaches for monitoring metabolic risk, recognizing higher risk groups, and intervening to lower risk. Efforts at risk reduction in this area are responsive to a recent Institute of Medicine report regarding the need to reduce disparities in the level of medical care provided to persons with mental disorders.

No. 30B
ANTIPSYCHOTIC -INDUCED HYPERPROLACTINEMIA: A NEGLECTED ISSUE IN PSYCHIATRY

Robert Conley , M.D., *Chief, Treatment Research, Maryland Psychiatric Research Center, Baltimore, MD*

SUMMARY:

Antipsychotic induced hyperprolactinemia, a neglected domain in psychiatry is under researched and presents a serious challenge to clinical practice warranting immediate attention. Complex effects of first and second generation antipsychotics and their uncertain interactions with human growth and sexual development given their widespread use in children and adolescents, backed by limited long-term data poses a clinical and ethical dilemma to practitioners. Disruption of the hypothalamo pituitary gondal axis and its deleterious effects on sexual function mediated by antipsychotic-induced increases in serum prolactin levels and the its consequences on bone mineral density is a poorly understood phenomenon with far reaching implications on the subjective well being of our clients across their life span. Absence of evidence based trials and lack of monitoring guidelines to address these serious risks has often resulted in switching to antipsychotics with lower liability to provide symptomatic relief. Differential effects of second generation antipsychotics as elucidated by clinical trials and neuroimaging data has shed some light on the biological underpinnings of these adverse events. These evolving concerns highlight the unmet need to customize treatments to best suit the symptom presentation of each individual patient.

No. 30C
GUIDLINES FOR THE THE MANAGEMENT OF METABOLIC AND ENDOCRINE SIDE EFFECTS: CONFUSION AND CONSENSUS

Peter F. Buckley, M.D., , *Department of Psychiatry, Medical College of Georgia, Augusta, Georgia*

SUMMARY:

Set against a specter of increasing medicolegal adversity, clinicians are presented with invariably confusing-and often even conflicting-information on the relationship between endocrine disturbances and antipsychotic medications. Moreover, in the absence of a clear appraisal of this risk and faced with several guidelines, clinicians are encouraged to undertake close monitoring for metabolic disturbances during antipsychotic therapy. Available evidence suggests a lag between the awareness of clinicians regarding metabolic side effects and the implementation of monitoring practices. There are also meaningful differences between the current guidelines. The forthcoming recommendations from the APA Task Force representing the most comprehensive appraisal of the risks-and management thereof-of metabolic disturbances. Current practice favors switching antipsychotics over other interventions- it is presently unknown whether preemptive use of statins or related agents might mitigate the development of metabolic syndrome. There is also an accruing literature on the application of dietary and lifestyle behavioral programs (designed for obese nonpsychiatric populations) to manage obesity in psychiatric outpatients. These approaches are promising, although they need to be tailored to take into account the cognitive impairments and limited resources of patients with schizophrenia. This presentation will provide a synthesis of current management approaches (including emergent evidence on the impact of lifestyle modification approaches) on the care of patients with mental illness who develop these metabolic complications and it will also address expectations for clinical documentation.

No. 30D
CONSUMER PERSPECTIVE ON TOLERABILITY AND SAFETY OF ANTIPSYCHOTIC MEDICATIONS

Fredric J. Frese, Ph.D., *Assistant Professor of Psychology in Clinical Psychiatry, Northeastern Ohio Universities College of Medicine, Rootstown, Ohio*

SUMMARY:

As complex as decision making regarding antipsychotic therapy has become for clinicians, their patients are faced with the ultimate choice as to which treatment best fits their needs. Adverse effect profile of medications plays powerfully into this decision making process. We are also all-too-aware that adverse effects are powerful determinants of medication noncompliance during treatment. An important appreciation is that all adverse effects are not equal in the eyes of patients. Tolerability and safety are overlapping constructs here. Antipsychotic-induced obesity and metabolic disturbances are key adverse effects that patients must now take into account with treatment. Dr. Frese provides a consumer perspective on the complexity of decision making and he offers guidance to clinicians on how best to represent this dilemma to their patient.

No. 30E
THE INCREASING GLOBAL BURDEN OF CARDIOVASCULAR DISEASE IN GENERAL POPULATIONS AND IN PATIENTS WITH SCHIZOPHRENIA

Charles H. Hennekens, M.D., *University of Miami School of Medicine, University of Miami School of Medicine, Miami, FL*

INDUSTRY SUPPORTED SYMPOSIUM 31—MONOAMINE OXIDIZE INHIBITORS TODAY: A 21ST CENTURY VIEW ON THE TREATMENT OF DEPRESSION
Supported by Bristol-Myers Squibb Company and Otsuka American

No. 31A
MONAMINE OXIDASE INHIBITORS TODAY: A 21ST CENTURY VIEW ON THE TREATMENT OF DEPRESSION

Philip R. Muskin, M.D. *Columbia University, Consultation-Liaison Psychiatry, 622 W. 168th Street, Mailbox #427, New York, NY, 10032*

SUMMARY:

This symposium will provide a view on how to use data from research from the perspective of a clinician. We will review data regarding treatment of depression and atypical depression, review treatment with monoamine oxidase inhibitors (MAOI's), provide perspective on MAOI diets, and explore how the neuroscience of mood disorders may lead to novel treatment approaches in the future.

Sharon L. Alspector, MD will present the basics of evidence-based medicine for psychiatrists in a talk entitled *Everything you wanted to know about evidence based psychiatry, but were afraid to ask.* Most clinicians have no training in research methodology or biostatistics and are ill-equipped to read the literature. Using a case-based approach she will demonstrate how understanding some basic principles, e.g., intent-to-treat, odds ratios, and confidence intervals will enable clinicians to use the literature as a guide to patient treatment.

Philip R. Muskin, MD will review the history, mechanism of action, and myths about monoamine oxidase inhibitors in *The MAOI's Revisited: The Facts and the Myths.* Many psychiatrists consider MAOI's as especially effective antidepressants, burdened with side effects and food/medication interactions limiting their widespread use. What is the evidence for use of MAOI's in depression, atypical depression and anxiety disorders? Is the route of administration of MAOI's meaningful in terms of safety and clinical effect?

Kenneth L. Shulman, MD will examine myths regarding the dietary restrictions associated with MAOI's in a talk entitled *Diet and MAOI's: Where we went wrong and where we need to go.* Much of the information informing MAOI diets derived from misunderstanding of diets and inaccurate measures of food tyramine content. Dr. Shulman will present the research investigating accurate tyramine food concentrations. Once "forbidden" foods turn out to have little tyramine. A modern MAOI diet will enable patients and clinicians to use MAOI's with realistic dietary restrictions.

Charles B. Nemeroff, MD, speaking on *Treatment of Mood Disorders in the 21st* Century: The Best of Applied Neuroscience, will complete the symposium with an overview of what the future holds for potential medications. How do the findings from the research on the biology of mood disorders impact on the development of new treatments? He will address the concept of the route of medication administration in terms of therapeutic and adverse effects.

The symposium will feature participant interaction during each presentation and will conclude with a panel discussion and general question and answer period.

No. 31B
EVERYTHING YOU ALWAYS WANTED TO KNOW ABOUT EVIDENCE-BASED PSYCHAITRY (BUT WERE AFRAID TO ASK)

Sharon L. Alspector Mozian, M.D. *Columbia University, Department of Psychiatry, 2141 34th Avenue, Apt 15C, Long Island City, NY, 11106-4356*

SUMMARY:

Background:

Evidence-based clinical practice has become the 21st century standard for all medical specialties. The majority of psychiatrists have no training in reading the literature in a manner that meaningfully informs clinical practice. Clinical trials make up the bulk of the "evidence" in psychiatry. In order to use this information with patients, psychiatrists must obtain the skills to understand what such publications reveal/conceal. Without these skills, they find the psychiatric literature inaccessible and immaterial to their daily clinical activities. Personal experience, or pharmaceutical company "detail" information, guides treatment decisions. This has the potential to lead to data misinterpretation and suboptimal patient care.

Presentation:

We will present a common clinical scenario in concert with a relevant published article one might find in a literature search about the clinical problem: a 30 year old woman, naUïve to psychiatric treatment, presents with symptoms consistent with atypical depression. How can "evidence" guide the approach to treatment for this patient, and is there data to select what medication will best treat her depression and also be well tolerated? We will review a randomized placebo-controlled comparison of fluoxetine and imipramine in the acute treatment of atypical depression (McGrath, et al. AJP 2000; 157:3 344-50). This review will demonstrate core concepts of evidence based practice. The first part of the presentation will focus on criteria for assessing validity of the article including a discussion of the concepts of randomization, blinding, and intention-to-treat analysis. The second part of the presentation will focus on understanding the results in a clinically meaningful way. Emphasis will be placed on calculating the number needed to treat and the importance of understanding the 95% confidence interval. The final part of the presentation will focus on applicability of this data to the care of this patient. Highlighting how the locations of tables, figures, and text that guide our critical appraisal will demonstrate efficient "mining" of the data.

Conclusions:

Efficient use of the psychiatric literature in the effective treatment of their patients is available to all clinicians, regardless of research or statistical background.

No. 31C
TREATMENT OF DEPRESSION IN THE 21ST CENTURE: THE BEST OF APPLIED NEUROSCIENCE

Charles B. Nemeroff, M.D. *Emory University School of Medicine, Dept. of Psychiary and Behavioral Sciences, 101 Woodruff Cir, Suite 4000, Atlanta, GA, 30322-0001*

SUMMARY:

Over the past several years, remarkable advances have been made both in our understanding of the central nervous system (CNS) and in the pathophysiology of the major psychiatric disorders, resulting in major breakthroughs in our capacity to treat these devastating illnesses. Since the seminal work of Ramon Y Cajal and Golgi at the turn of the century, new techniques such as fluorescence histochemistry have evolved into immunohistochemical and more recently /in situ /hybridization. These techniques have permitted, for the first time, the elucidation of chemically defined neural circuits. Such advances in the mapping of neural systems and the visualization of monoaminergic and peptidergic neurons and their receptors in tissue sections have provided the tools for the burgeoning field of neurochemical pathology of psychiatric disorders. Data provided from such studies has served as the basis for the development of novel pharmacological approaches to the treatment of affective and anxiety disorders, as well as schizophrenia. This review focuses on major neural systems implicated in the pathophysiology of depression, including monoamines and neuropeptides. Development of novel agents are described, including selective serotonin receptor agonists, CRF receptor antagonists, and the use of an antisense strategy. Novel methods of predicting antidepressant treatment response for individual patients are described, ranging from genomics to functional brain imaging. Novel methods of drug delivery are also described.

No. 31D
DIET AND MAOI'S - WHERE WE WENT WRONG AND WHERE WE NEED TO GO?

Kenneth I. Shulman, M.D, *Sunnybrook Health Science Ctr, Department of Psychiatry, 2075 Bayview Ave, Toronto, ON, M4N 3M5, Canada*

SUMMARY:

Background The need to restrict tyramine-containing foods in association with the use of irreversible monoamine oxidase inhibitors (MAOI's) was recognized at a time of increasing medico-legal sensitivity. This led to excessively restrictive diets based on anecdotal and sometimes inaccurate data. In turn, this created a major obstacle to the use of MAOI's and established an atmosphere of confusion and uncertainty about the risk of hypertensive crises.

Objectives This talk will review the systematic attempts to provide a simplified and safe MAOI diet based on evidence from the literature and careful tyramine analyses. The presentation will review the pharmacology of tyramine-containing foods and MAOI's to provide current, state-of-the-art, dietary recommendations. A number of

myths about the tyramine content of many foods have been dispelled, including the long-held concern about red wines and specifically Chianti wines. Tyramine levels for relevant groups will be reviewed. A balance of safety and practicality calls for a simple diet focusing primarily on restriction of aged cheeses, tap/draft beer, marmite, soy sauce and soy bean condiments and air-dried meats. Web-based information with on-going surveillance and review may ensure continuous quality improvement for the MAOI diet. In light of the continued use of traditional MAOI's for atypical, refractory and geriatric depressions, as well as the recent FDA approval of the selegiline patch, dietary issues based on tyramine sensitivity factor (TSF) remain an important consideration in the modern clinical armamentarium for the treatment of mood disorders with MAOI's.

REFERENCES:

1. Guyatt G and Rennie D Users' Guides to the Medical Literature Essential of Evidence-Based Clinical Practice Chicago IL: AMA Press 2002.
2. Nemeroff CB. Psychopharmacology of affective disorders in the 21st century. Biol Psychiat 1998; 44:517-525.
3. Shulman KI, Walker SE. Refining the MAOI diet: tyramine content of pizzas and soy products. J Clin Psychiatry 1990; 60(3); 191-193.
4. Oreland L, Callingham BA: Monoamine Oxidase Inhibitors. Journal of Neural Transmission 1987, Supplement 23.

No. 31E
MAOIS REVISTED: FACTS AND MYTHS

Philip R. Muskin, M.D. *Columbia University, Consultation-Liaison Psychiatry, 1700 York Avenue, Apt. 1-L, New York, NY, 10128-7815*

SUMMARY:

Monamine oxidase inhibitors (MAOI's) are the first antidepressants. In the early 1950's, iproniazid caused euphoria and improvement of mood in patients with tuberculosis. Animal experiments demonstrated antidepressant effects leading to the discovery that MAOI's inhibit enzymes that deaminate dopamine, norepinephrine, and serotonin. Iproniazaid was the first MAOI antidepressant. Hepatotoxicty and adverse cardiovascular events resulting from unrealized interactions with certain medications and tyramine containing foods (''cheese reaction'') limited the widespread use of the drug. Second-generation MAOI's are chemically distinct from iproniazid and are not hepatotoxic, but pharmacodynamic effects with other medications and foods remain a limitation. MAO has two forms: ''A'' which primarily acts on dopamine, norepinephrine and serotonin; ''B'' which primarily acts on phenethylamine and tyramine (in the striatum ''A'' is responsible for the majority of dopamine oxidative metabolism). Inhibition of MAO-B in the GI tract prevents the metabolism of tyramine in food, resulting in absorption of larger than normal amounts of tyramine. Large amounts of absorbed tyramine can cause the release of substantial quantities of norepinephrine, resulting in a hypertensive crisis. Inhibition of gut/liver MAO-B is unrelated to the therapeutic effects of MAOI's which depend upon inhibition of brain MAO-A.

Objective This talk will focus on the mechanism of action of MAOI's, their potential side effects, drug/food interactions, and therapeutic effects. The food/drug interactions were quite rare but limited the use of MAOI's. This is unfortunate as they are efficacious in a variety of anxiety disorders, depression, and were thought to be a better treatment for atypical depression than other medications. The limited use of MAOI's has resulted in a situation where many psychiatrists have no experience in treating patients with these drugs. The talk will review the therapeutic uses of MAOI's, focusing on depression and atypical depression, and review the limitations in the use of MAOI's.

Conclusion MAOI's are an important class of medication that has fallen into disuse secondary to dietary restrictions and drug interactions. Modern diets, which are less restrictive than in the past, may lead to increased use of MAOI's. Psychiatrists need to understand how MAOI's work in order to differentiate the CNS effects that can be therapeutic (neurotransmitter) or adverse (drug interaction), from the peripheral adverse effects (food interaction). This understanding may lead to greater use of the MAOI's for patients who do not respond to or do not tolerate the SSRI and SNRI medications.

INDUSTRY SUPPORTED SYMPOSIUM 32—UNDERSTANDING THE COMPLEXITY OF BIPOLAR MIXED EPISODES
Supported by Eli Lilly and Company

No. 32A
UNDERSTANDING THE COMPLEXITY OF BIPOLAR MIXED EPISODES

Susan L. McElroy, M.D., *University of Cincinnati Medical School, 231 Albert Sabin Way, ML 0559 Cincinnati, OH 45267-0559*

SUMMARY:

Bipolar mixed episodes represent one of the most difficult clinical challenges in the course of bipolar disorder. Mixed episodes can present with equal admixtures of depressive or manic symptoms, but one component frequently predominates. Mixed episodes are more common than previously thought, particularly in young people. Mania with dysphoric features has been reported in 5% to 70% of different samples, and mixed hypomania is common in patients with symptoms of hypomania and particularly common in women. Depressive mixed episodes, where depression is more predominant but with many features of a hypomania or mania being present, are increasingly being recognized. Patients with mixed episodes are often severely ill, and their illness is associated with more profound manic and general psychopathology, more agitation, anxiety, psychotic, and catatonic symptoms. These patients typically also have higher rates of comorbidity, a higher risk of suicide, and a poorer outcome than patients with pure manic episodes. Bipolar mixed episodes are often more difficult to treat than either pure mania or depression. Treatment with antidepressants can worsen the course of mixed states (particularly, intra-episodic mood lability), and misdiagnosis can result in negative clinical outcomes. Treatment of mixed episodes by simultaneous treatment of depression and mania is ineffective. Overall, there are few double-blind, placebo-controlled studies specifically designed to assess treatment of mixed episodes. Typically, these patients comprise a subgroup of the patient cohorts in clinical trials. Acute mixed episodes do not respond favorably to lithium. Olanzapine and valproate are drugs of first choice. Carbamazepine may play a role in the prevention of mixed episodes. Lamotrigine may be useful in treating mixed episodes with predominantly depressive symptoms. Atypical antipsychotics can play a particularly key role in the long term management of bipolar mixed episodes. The choice of agent should be based on efficacy as well as tolerability.

No. 32B
DIAGNOSTIC DILEMMAS OF MIXED STATES IN BIPOLAR DISORDER

Mark A. Frye *300 Ucla Medical Plz # 1544, Los Angeles, CA, 90095-8346*

SUMMARY:

Accurate diagnosis of bipolar disorder is essential for effective treatment, and misdiagnosis of mixed states remains a source of poor treatment outcome, functional impairment, and prolonged disability. Surveys suggest that patients with bipolar disorder are often misdiagnosed on initial presentation, most often with major depressive disorder. The distinction between mixed states and agitated depression has long been a source of controversy in the literature. Among the phases of bipolar disorder, depression is associated with the highest suicide risk, followed by mixed states and presence of psychotic symptoms. Suicidal ideation during mixed states has been correlated with the severity of depressive symptoms. Bipolar disorder may be confused with unipolar depression, because patients with bipolar disorder are usually symptomatic with depression rather than mania and patients may deny manic symptoms because they are ego syntonic. Bipolar disorder may also be misdiagnosed as schizophrenia, since both disorders can present with psychotic symptoms. An incomplete patient history, lack of patient insight, and the presence of psychiatric comorbidity, such as anxiety or substance use disorders, may contribute to misdiagnosis. Inaccurate diagnoses can potentially have negative clinical implications, and inappropriate therapy may destabilize the course and outcome of the disease. An accurate diagnosis of bipolar disorder can be assisted by asking about symptoms of mania or hypomania in every patient presenting with symptoms of depression, recognizing mixed states in which manic and depressive symptoms occur simultaneously, and identifying the features of bipolar depression that distinguish it from unipolar depression. Careful screening for current and past symptoms of mania or hypomania, as well as close clinical follow-up can reduce misdiagnosis. Depressed patients with atypical bipolar features that resemble anxiety or agitation may be suffering from mixed states. In DSM IV mixed states of mania and depression are characterized by a minimum of 1 week of both mania and depression. Many clinicians see the spectrum of mixed states in their practice including agitated depression, anxious depression, or dysphoric mania. Symptoms of bipolar disorder are present each day and often include agitation, insomnia, psychosis, changes in appetite, suicidal ideation, and marked functional impairment. The effect of substances such as antidepressants should be excluded as the cause of such manifestations. The diagnosis of bipolar disorder can be complex, resulting in a delay between first presentation and initiation of appropriate therapy. The presence of mixed states has implications for the diagnosis of bipolarity in patients previously diagnosed as unipolar, for antidepressant use (which may worsen such states), and for the selection of appropriate mood stabilizers (ie, lithium vs anticonvulsants) in known bipolar patients.

No. 32C
COMORBIDITY AND CONSEQUENCES OF BIPOLAR MIXED EPISODES

Joseph F. Goldberg, M.D., *Silver Hill Hospital, 208 Valley Road, New Canaan, CT, 06840*

SUMMARY:

Clinicians frequently misidentify mixed presentations of mania (or hypomania) with depression as constituting pure manic or depressive phases of bipolar illness. The accurate detection of co-occurring manic and depressive features is often confounded by substantially elevated rates of drug and alcohol abuse or dependence in mixed states. While causal relationships between mixed mania and substance misuse are often difficult to establish, longitudinal outcome studies suggest that mixed states and substance misuse independently contribute to increased morbidity and functional impairment in bipolar disorder. Moreover, as compared to pure manic or depressed phases of illness, mixed states entail substantially longer times until recovery, as well as greater risks for recurrent suicidal behaviors.

The prevalence of anxiety disorders in bipolar patients is between 40% to 90% in the NCS study and Stanley Foundation Bipolar Research Network. Females, Bipolar II patients, and those with mixed states and an earlier age of onset are more likely to have comorbid anxiety. These patients are poor responders to lithium and have a worse out come.

This presentation will summarize existing information from longitudinal studies about comorbid psychopathology including anxiety disorders and substance abuse in bipolar mixed episodes. New data from the NIMH STEP-BD program will be presented on the high rates of comorbidity in patients with bipolar mixed episodes.

No. 32D
THE ACUTE TREATMENT OF THE PATIENT WITH MIXED BIPOLAR EPISODES

Roger S. McIntyre, M.D. *Toronto Western Hospital, University Health, 399 Bathurst St - ECW-3D-003, Toronto, ON, M5T 2S8, Canada*

SUMMARY:

For bipolar patients experiencing a manic or mixed episode, the primary goal of treatment is to control symptoms and allow a return to normal psychosocial functioning. The rapid control of agitation, aggression, and impulsivity is particularly important for patient safety. Mixed mania, rapid cycling-type patients with bipolar disorder do not respond well to lithium therapy. Antipsychotic agents long have been used for patients with bipolar disorder during both the acute and maintenance phases of treatment. Conventional antipsychotics are effective, but may induce late dyskinesia, weight gain, sedation, sexual dysfunction, and depression. These adverse effects often lead to non-compliance. Because of the more benign side effect profile of atypical antipsychotics, they are now preferred over typical antipsychotics such as haloperidol and chlorpromazine. The newer atypical antipsychotics include olanzapine, risperidone, quetiapine, ziprasidone, and aripiprazole. These drugs have been approved for treatment of bipolar mania and, with the exception of quetiapine, for mixed episodes. They may be used either alone or in combination with lithium or valproate. Olanzapine was the first atypical to be approved for treatment of bipolar mania and mixed episodes. In 2004, olanzapine was also approved for bipolar maintenance treatment, and the combination of olanzapine and fluoxetine is also approved for treatment of bipolar depression. In addition, olanzapine may have specific prophylactic mood-stabilizing properties. Olanzapine, alone or in combination with divalproate or lithium, has been adequately evaluated in randomized clinical trials involving mixed-state patients; risperidone and quetiapine have not. Although the tolerability profiles of atypicals as a class are superior to those of conventional antipsychotics, there are differences among the atypical agents in their propensity to cause certain adverse events such as extrapyramidal symptoms and weight gain, particularly in the long-term. Resistance to the use of olanzapine has centered around the problem of weight gain and the attendant risk of type 2 diabetes and the metabolic syndrome. Vigorous management of this potential problem (ie, monitoring of weight, waist circumference, lipids, and glucose) is required. Olanzapine and aripiprazole are the only atypical antipsychotics indicated for the long-term treatment of bipolar disorder. The choice of antipsychotic treatment for different subgroups of patients with bipolar depression, including those with comorbid anxiety, may vary. Issues for investigation of optimal antipsychotic treatment of bipolar mixed episode patients include recognition of the core features of this subtype of bipolar illness and the threshold symptoms for treatment. Further data on monotherapy vs combination therapy and acute vs long-term management are also required. When choosing drugs for the treatment of mania, and especially for patients with mixed states, efficacy against manic and depressive symptoms both short and long term as well as safety and tolerability should be considered.

No. 32E
IMPROVING LONG TERM OUTCOMES IN PATIENTS WITH BIPOLAR MIXED EPISODES

Susan L. McElroy, M.D., *University of Cincinnati Medical School, 231 Albert Sabin Way, ML 0559 Cincinnati, OH 45267-0559*

SUMMARY:

Mixed episodes comprise up to 40% of acute bipolar hospital admissions, but there are few double-blind, placebo-controlled studies specifically designed to treat patients with bipolar mixed episodes. Because the presentation of mixed episodes is complex and they are difficult to treat, current treatment recommendations target only select aspects of these episodes. While most of the care received by bipolar patients occurs during the maintenance phase, relatively little empirical data is available to guide long-term treatment decisions. Recently, considerable progress in the short-term treatment of mania with agents such as anticonvulsants and atypical antipsychotic agents has been made, but long-term treatment trials (other than with lithium) are rare. Because of complex clinical variation over-time, olanzapine and aripiprazole long-term outcomes data in bipolar disorders demands precise research design and statistical challenges that remain largely unmet. Data available on maintenance treatment with standard antidepressant medications indicate that they are destabilizing for some bipolar patients, particularly following a mixed episode. Atypical antipsychotics are promising options for maintenance treatment, but have not been evaluated sufficiently in double-blind trials. Olanzapine and aripiprazole have FDA approval for the long-term treatment of bipolar disorder but data in mixed episodes is limited. Although preliminary data indicate that atypical antipsychotics will be a promising addition to currently available maintenance treatments, their potential in long-term management remains to be fully explored. Atypical antipsychotics appear to have broadly similar efficacy against manic symptoms of bipolar disorder, but important differences in their tolerability profiles will likely to be of particular relevance during long-term treatment. Long-term side effects including weight gain, metabolic disturbances and sexual dysfunction have to be considered along with efficacy. A supportive role for psychosocial therapies of mixed episodes has been suggested, but here, too, there is a scarcity of published studies. Despite the prevalence and severity of bipolar mixed episodes, a well-developed scientific database informing long-term treatment choices is virtually non-existent. The limited and sometimes contradictory information on maintenance treatment clearly demonstrates a need for further research. Decisions regarding pharmacotherapy should be made on a case-by-case basis, since broad recommendations based on available evidence cannot be adequately made at this time. More quality research is needed to delineate effective treatment strategies. Double-blind controlled studies with atypical antipsychotics in the long-term treatment of mixed episode bipolar disorder will be critical to determine the effectiveness of these agents as maintenance therapy.

REFERENCES:

1. Strakowski SM, McElroy SL, Keck PE Jr, West SA. Suicidality among patients with mixed and manic bipolar disorder. Am J Psychiatry. 1996;153:674'676.
2. Goldberg JF, Garno JL, Leon AC, Kocsis JH, Portera L. Association of recurrent suicidal ideation with nonremission from acute mixed mania. Am J Psychiatry. 1998;155:1753-1755.
3. Vieta E. The treatment of mixed states and the risk of switching to depression. Eur Psychiatry. 2005;20:96-100.
4. Krüger S, Young LT, Bräunig P. Pharmacotherapy of bipolar mixed states. Bipolar Disord. 2005;7:205'215.

WEDNESDAY, MAY 23, 7:00 PM - 10:00 PM

INDUSTRY SUPPORTED SYMPOSIUM 33—FIBROMYALGIA: NEW INSIGHTS INTO THE PATHOPHYSIOLOGY AND TREATMENT
Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

1) To identify the neurobiological factors that predispose an individual to develop fibromyalgia and other related pain syndromes
2) To identify the hallmark physiological features of fibromyalgia and other "central" pain syndromes

No. 33A
THE PATHOPHYSIOLOGY OF PAIN IN FIBROMYALGIA AND RELATED SYNDROMES

Daniel J. Clauw, M.D. *University of Michigan, Internal Medicine, 24 Frank Lloyd Wright Drive, Ann Arbor, MI, 48106*

SUMMARY:

Research into Fibromyalgia (FM) has taught us a great deal about the confluence of neurobiological, psychological and behavioral factors that contribute to this syndrome. The hallmark of this syndrome as well as a host of regional somatic and visceral pain syndromes (e.g. irritable bowel syndrome, temporomandibular disorder, tension headache, idiopathic low back pain) is augmented central processing of pain. Individuals with these syndromes exhibit both hyperalgesia (increased painfulness or normally painful stimuli) as well as allodynia (pain in response to normally non-painful stimuli) throughout their body. This augmented central pain processing by self-report has been corroborated by a variety of functional neuroimaging techniques, as well as evoked potentials and other objective measures.

Although previously we had assumed that these changes in central pain processing *caused* these disorders, there is accumulating evidence that baseline differences in the function of the autonomic nervous system, the hypothalamic pituitary adrenal axes, and pain processing systems in large part represent *diatheses* that predispose individuals to subsequently develop chronic regional or widespread pain. FM has a strong familial predisposition, with >8 odds ratio suggested for first-degree relatives. A variety of genetic polymorphisms, especially involving monoamine synthesis or transport, have been identified as being more common in FM and related syndromes. In addition to these polymorphisms that have already been identified, other physiologic predisposing factors that likely have a genetic underpinning include those that lead to low baseline function of the autonomic and hypothalamic pituitary axes, as well as a low baseline pain threshold (tenderness) of an individual. Baseline psychological and cognitive factors also are predictive of the development of acute pain, and especially the transition from acute to chronic pain. Superimposed upon these diatheses, these chronic regional and widespread pain syndromes can then be "triggered" by a variety of "stressors", including acute or chronic "peripheral" pain (i.e. due to damage or inflammation of tissues), certain infections (such as Lyme and EBV infections), physical trauma, and even being deployed to war. It is likely that these "stressors" trigger chronic regional and widespread pain syndromes both because of direct underlying neurobiological changes (e.g. neuroplasticity resulting from central sensitization) as well as because of cognitive and behavioral responses to acute symptoms (e.g. exercise and activity cessation, sleep disruption, increased distress, distorted cognitions).

A more complete understanding of these complex neurobiological, behavioral, and cognitive factors that lead to symptom expression leads to a more rational treatment of these patients.

No. 33B
THE ROLE OF DISORDERED SLEEP IN FIBROMYALGIA

Lesley M. Arnold, M.D. *6240 Cedar Crossing Ln, Cincinnati, OH, 45230-3781*

SUMMARY:

Over 90% of patients with fibromyalgia report poor quality of sleep, which is often perceived to be light and unrefreshing, irrespective of its duration. Sleep laboratory assessments demonstrate disordered sleep physiology that is thought to be the basis of the unrefreshing sleep experience. This sleep abnormality consists of inappropriate intrusion of alpha waves (normally seen during wakefulness or REM sleep) into deep sleep (characterized by delta waves). Alpha-delta sleep intrusion is thought to contribute to the musculoskeletal pain and fatigue of fibromyalgia. Serotonin and Substance P are postulated to mediate the qualitative abnormality of sleep in patients with fibromyalgia. However, the sleep abnormality is not specific to fibromyalgia and is found in other disorders, including other chronic pain syndromes. This presentation will review the current understanding of the possible cause-effect relationship between pain and sleep and will review options to manage sleep disorders in fibromyalgia patients, including use of non-benzodiazepine sedatives, tricyclic agents, alpha 2 delta ligands, and cognitive behavioral therapy.

No. 33C
NEW DEVELOPMENTS IN THE PHARMACOLOGICAL TREATMENT OF FIBROMYALGIA

Leslie J. Crofford, M.D. *University of Kentucky, Internal Medicine, J-509 Kentucky Clinic, Lexington, KY, 40536-0284*

SUMMARY:

Substantial progress has been made in identifying pharmacological treatments for fibromyalgia. New, large clinical trials in fibromyalgia have provided evidence of the efficacy of several different medications. Several studies have shown that alpha 2 delta ligands, which bind to the alpha 2 delta subunit of voltage-gated calcium channels, resulting in decreased calcium influx at nerve terminals and subsequent reduction in the release of several neurotransmitters thought to play a role in pain processing, improve pain, fatigue, sleep, function, and global well-being in patients with fibromyalgia. Selective serotonin and norepinephrine reuptake inhibitors, which are thought to enhance serotonin and norepinephrine neurotransmission in the descending pain inhibitory pathways, have been found to improve pain, other symptom domains, function, quality of life, and global well-being in fibromyalgia patients. Recent evidence suggests that opiates may contribute to hyperalgesia if used chronically, and opiates have not been found to be effective for the long-term management of fibromyalgia. The short-acting non-benzodiazepine sedatives improved sleep in patients with fibromyalgia but did not improve pain. Small, preliminary studies of 5-HT_3 antagonists, NMDA-antagonists, and a dopamine 3 receptor agonist show promise in the treatment of fibromyalgia. An evidence-based algorithm for the pharmacological treatment of fibromyalgia will be presented.

No. 33D
EXERCISE AS A TREATMENT FOR FIBROMYALGIA

Dina Dadabhoy, M.D. *University of Michigan, Internal Medicine, 24 Frank Lloyd Wright Drive, P.O Box 385, Lobby M, Ann Arbor, MI, 48106*

SUMMARY:

Exercise is an active area of research in fibromyalgia treatment. Several recent exercise trials have explored the efficacy of different levels of exercise intensity and forms of exercise. Among exercise interventions, the evidence is most supportive of aerobic exercise for fibromyalgia treatment. Patients who can tolerate a high level of aerobic exercise intensity experience an improvement in cardiovascular fitness, pain pressure thresholds, global well being, and self-reported function. However, aerobic exercise does not consistently improve major symptom domains associated with fibromyalgia, including pain, fatigue, sleep disturbance, or psychological symptoms. Many patients, in fact, do not tolerate high intensity exercise and report increased pain. Although optimal intensity, duration, and frequency of exercise have not been clearly established, studies do suggest an alternative low to moderate intensity, graded aerobic exercise may lead to improvements in global assessment, tender points, and quality of life. Specifically, a gradual increase in exercise to reach a goal of 30 to 60 minutes of low-moderate intensity aerobic exercise at least 2-3 times a week for more than 10 weeks is associated with positive short-term benefits. Despite the evidence supporting an exercise intervention, adherence to exercise is a problem for many patients with fibromyalgia. Several factors, including disability, stress, depression, low confidence in the ability to exercise, barriers to exercise, and lack of social support, contribute to the poor adherence to exercise.

REFERENCES:

1. Dadabhoy D, Clauw DJ: Fibromyalgia: progress in diagnosis and treatment. Curr Pain Headache Report 2005; 9(6):399-404.
2. Moldofsky H: Management of sleep disorders in fibromyalgia. Rheum Dis Clin North Am 2002;28:353-365.
3. Arnold LM. Systemic Therapies for Chronic Pain. In: Wallace DJ, Clauw DJ, eds.
4. Busch A, Schachter CL, Peloso PM, Bombardier C: Exercise for treating fibromyalgia syndrome. Cochrane Database Syst Rev 2002 (3): CD003786.

MONDAY, MAY 21, 11:00 AM - 12:30 PM

SCIENTIFIC AND CLINICAL REPORT SESSION 1—PRESIDENT'S THEME: "ADDRESSING PATIENT NEEDS: ACCESS, PARITY, AND HUMANE CARE"

No. 1
THE DISCOURSE OF HEALTH CARE ECONOMICS

David A. Rothstein, M.D. *Swedish Covenant Hospital, Psychiatry, 2851 West Bryn Mawr, Chicago, IL, 60659*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1.) understand the concept of a discourse; (2.) recognize how this concept can be applied to understanding factors in health care economics; (3.) recognize the rhetorical modes and tropes of the discourse of health care economics, how the discourse limits what can be considered, excludes important options, and can be used to corrupt the doctor patient relationship; and (4.) be better able to transcend the limitations of the discourse.

SUMMARY:

Objective: In order to better address patient needs of access, parity, and humane care, we must clarify the significant factors which impair adequate financing of systems for delivering comprehensive psychiatric care. Method: The concept of "discourse" is applied to examine significant threats to the doctor patient relationship represented by government interference and the inappropriate application of mainstream market economic theory to health care. This paper looks back at the public debate over former President Clinton's "health care reform," and the changes which followed its failure. Results: Restrictions in healthcare spending have adversely affected the provision of medical care, in psychiatry even more than other medical specialties. The discourse of health care economics is a subset of the discourse of mainstream economics, with its rhetorical modes, tropes, conceptual categories, and logical operations, which, in a circular manner, result from and reinforce popular perceptions and foregone conclusions. This limits what can be considered, and, like repression on the individual level, can exclude important ideas and concepts. Like colonial discourse, which served to "justify" and promote the actions of colonial powers, the discourse of health care economics can be used to "justify" and promote the "colonization" of health care by political and corporate interests. Conclusions: This paper documents features of the discourse and suggests some of the ideas excluded by the discourse, so that we may be better able to fulfill our role as healers and meet our patients' needs.

REFERENCES:

1. Rothstein DA: Input-Output Model for Health Care Economics. Chicago Medicine 1984; 87:594-607; Rothstein DA: Economic Conquest and the End of the Cold War. International Society of Political Psychology Meeting, Krakow, Poland, 1997.
2. Rothstein, DA: with Rosenzweig ND, co-chair, and Leontief W, et al.: Input-Output Economics and the Health Care Sector, APA Meeting, Dallas, Texas, 1985; Bloche MG, Ed: The Privatization of Health Care Reform: New York, Oxford Univ Press, 2003.

No. 2
MEDICARE PART D PRESCRIPTION DRUG BENEFITS: IMPACT ON MEDICATION ACCESS AND CONTINUITY AMONG DUAL ELIGIBLE PATIENTS WITH PSYCHIATRIC CONDITIONS

Presenters: Joyce C. West *APIRE PRN, 1000 Wilson Boulevard, Arlington, VA, 22209*, Joshua E. Wilk, Irvin L. Muszynski, Donald S. Rae, William E. Narrow, Darrel A. Regier

EDUCATIONAL OBJECTIVES:

1) At conclusion of this presentation, participants will understand the extent and nature of medication access and continuity problems associated with Medicare Part D experienced among a large national sample of dual eligible patients with mental and addictive illnesses treated by psychiatrists.

2) Participants will be able to identify PDP features and practices most strongly correlated with enhanced medication access and continuity and compare/contrast to those PDP features and practices associated with medication access and continuity problems.

SUMMARY:

Objective: This study provides national data on medication access and continuity problems experienced during the first four months of the Medicare Part D Prescription Drug Benefit among a national sample of Medicare and Medicaid "dual eligible" psychiatric patients. Method: 5,800 psychiatrists were randomly selected from the AMA Physicians Masterfile. 62% responded to the survey, reporting clinically detailed data on one systematically selected patient and on features and experiences of their caseload. Results: Approximately half the patients had at least one problem with medication access or continuity reported by their psychiatrist since January 1, 2006; while 10% were reported to have improved medication access or continuity. 22% of patients discontinued or temporarily stopped their medication because of prescription drug plan coverage, management or administrative issues; 18% were previously stable on their medications but had to switch to a different medication than clinically desired because medication refills were not covered or approved. 27% of the psychiatric patients with medication access problems were reported to have experienced a significant adverse clinical event, with 17% having an ER visit. Patients with prior authorization, preferred drug or formulary lists, "step therapy" or "fail first protocols," requirements to switch to generics, limits on the number or dosing of medications, or protocols for transitioning patients on stable medication regimens to preferred medications were significantly more likely to experience a medication access or continuity problem ($p < .001$) and have a significant adverse clinical event as a result ($p < .001$). Conclusions: These findings indicate significant medication access and continuity problems during the initial implementation of Medicare Part D. Although the administrative functioning associated with the transition to PDPs is expected to improve considerably, CMS policies enacted to ensure access to protected classes of psychopharmacologic medications to safeguard this population do not appear to be functioning as intended.

REFERENCES:

1. Donohue J: Mental health in the Medicare Part D drug benefit: a new regulatory model? Health Affairs 2006: 25: 707-719.
2. Pear R: Medicare woes take high toll on mentally ill. The New York Times. 2006b Jan 21.

No. 3
DEALING WITH DISASTER MENTAL HEALTH

Presenters: Russell F. Franco D'Souza, Sr., M.D. *Northern area Mental Health, Melbourne, Austr, Department of Clinical Rials & Bipolar Program, Northern Hospital, 185 Coopers Street, Epping,*

Melbourne, 3073, Australia, Pedro Ruiz, Jr., M.D., Kenneth Kirkby II, M.D., Bruce Singh II, M.D., Jack S. McIntyre, M.D.

EDUCATIONAL OBJECTIVES:

An understanding of recent Natural and Human caused Disasters

The consequences of disaster on mental health from the recent disasters in Asia and USA

The socio cultural influence on the after math of disasters on mental health disorders and reselience promotion from recent evidence

The importance of collaboration with appropriate traditional resource such as faith heelers, clergy and similar as an opportunity in terms of care, provision of meaning and general community support.

Rebuilding by building capacity and mental health promotion leasons learn

SUMMARY:

Objective: Catastrophes generally challenge the human's capacity to transcend shock and the impact of loss and grief. To study the experiences of the dealing with the recent disasters as the Tsunami in Asia, the Katrina disaster of US, the Earth quake disaster of Kashmir and the war in Srilanka Method: The World Health Organisation recommends 'psychological' first aid - a mix of empathy, support, and counselling and provision of basic physical needs that can be done by volunteers with just a little training. It is the long term issues where things can become more complex. As the victims of this catastrophe try to re-establish the pattern of their lives, this, together with inert psychological vulnerability that many might be carrying will need additional benefits of mental health interventions, that might help restore symptom recovery but importantly also enable the much needed functional recovery.

Pannel speakers who have been involved with disaster intervention related to the above Disaster in collaboration with the local mental health professonals will report from evidence the challenges and interventions that were successfull and unsuccessful in supporting the mental health requirments of the affected populations Results: The most prelevant disorders in the general population are major depression, generalised anxiety, somatization disorder and post traumatic stress disorder.

The most vulnerable groups are women, children and those who are unable to receive treatment and culture specific issues.

Evidence of contraversies. from western mental health concept, experience and interventions and the appropriateness of the application of these interventions to reduce the burden of conflict and natural disaster in resource poor countries.

Another recognisable issue is the place of religion, spirituality and rituals in enhancing resilience, coping and rebuilding through acceptance and finding some meaning even in their suffering and loss. Conclusions: Mental health promotion - to address this situation. of massive needs and very limited professional resources and innovative approaches are useful to address these need.

These range from training alternative professionals, use of community resources such as teachers, appropriate faith healers and volunteers to empower the population.

In all the efforts to rebuild there is a temptation to implement short-term measures to alleviate such suffering. This, then, must be accompanied for each such situation with a long-term plan to rebuild essential mental health services at the primary, secondary and tertiary levels thus ensuring the approach of "building capability" This will mean not only empowerment of the people but a population that will be positively prepared for future disasters and emergencies.

REFERENCES:

1. D'Souza R, Singh B, Mental Health Challenge in Srilanka from working with in the disaster area, World Psychiatry Vol. 4 No:. 2: 68 June 2005.
2. Ghosh N, Mohit A, Murphy S Mental Health Promotion in Post Conflict Countries Journal of the Royal Society for the Promotion of Health Nov 2004, Vol 1 124 No. 6.

SCIENTIFIC AND CLINICAL REPORT SESSION 2—COMPULSIVE AND ADDICTIVE BEHAVIORS

No. 4
ASSOCIATION OF CANNABIS USE WITH PRODROMAL FEATURES OF PSYCHOSIS AND BEHAVIORAL PROBLEMS IN ADOLESCENTS

Presenters: Juha M. Veijola, M.D. *University of Oulu, Psychiatry, P O Box 5000, Peltolantie 5, Oulu, 90014, Finland*, Pirjo H. Maki, M.D., sari Tormanen, Irma Moilanen, M.D., erika lauronen, M.D., anja taanila, M.A., Jouko Miettunen, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be aware of the complexity of problems associated with substance abuse.

SUMMARY:

Objective: Cannabis use has been found to associate with psychosis and behavioral problems in countries with a relatively common use of cannabis. We studied the association between prodromal features of psychosis and behavioral problems and cannabis use in adolescents in a country with low levels of cannabis use.

Method: Members of the Northern Finland 1986 Birth Cohort were asked to participate in a field study at the age of 15-16 years. Participants (N = 6,330; 3,059 boys) completed screen for prodromal features of psychosis (PROD-screen) and Youth Self-Report (YSR) together with information of their cannabis use. In odds ratios (ORs) gender, family type, social class, smoking, use of other drugs and parental substance use disorder are used as covariates. Results: Subjects who had tried cannabis reported more sympoms both in PROD-screen and in YSR subscales. Of subjects who reported at least three prodromal features 206 (10.2%) had tried cannabis, compared with 171 (3.7%) among other subjects (adjusted OR 2.2; 95% CI 1.7-2.9). Of YSR scales, strongest association was in rule-breaking behavior subscale (OR 4.2; 3.2-5.6) and in thought problems (OR 2.3; 1.7-3.0). Conclusions: Cannabis use associated with prodromal features of psychosis and behavioral problems in this large Finnish general population based sample of adolescents with low level of cannabis use. We intend to follow-up these adolescents to assess the evolution of psychosis syndromes and continued exposure to cannabis. This will further illuminate the association between cannabis and psychosis after controlling for the prodromal features reported in adolescence.

REFERENCES:

1. Achenbach TM (1991) Manual for the ASEBA School-Age Forms & Profiles. Burlington, VT: University of Vermont, Research Center for Children, Youth & Families. USA.
2. Verhulst FC, Prince J, Vervuurt-Poot C, de Jong J (1989) Mental health in Dutch adolescents: self-reported competencies and problems for ages 11-18. Acta Psychiatrica Scandinavica, Supplementum 356:1-48.

No. 5
PATERNAL ALCOHOLISM PREDICTS ALCOHOL DEPENDENCE BUT NOT RECOVERY AFTER 40 YEARS

Presenters: Joachim Knop, M.D. *University of Copenhagen, Institute of Preventive Medicine, Kommunehospitalet DK-1399 Copenhagen*

K, Copenhagen, DK-1399, Denmark, Elizabeth C. Penick, Ph.D., Elizabeth J. Nickel, M.A., Per Jensen, M.D., Ann M. Manzardo, Ph.D., Sarnoff Mednick, Ph.D., William F. Gabrielli, Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the end of this presentation, participants should be able to evaluate the importance of paternal alcoholism in the development and in the recovery from alcoholism in male offspring

SUMMARY:

Objective: This longitudinal, high-risk study determined whether alcoholism in the father predicted the onset and long-term course of alcohol abuse and alcohol dependence in their sons. Method: Subjects were selected from a Danish birth cohort (N = 9125, born 1959 - 61) that included 223 sons of treated alcoholic fathers (high risk = HR) and 106 matched sons of fathers not treated for alcoholism (low risk = LR). These subjects have been studied systematically over the last 40 years. Most recently, they were evaluated at age 40 (N= 202) by a psychiatrist who used structured interviews and DSM-III-R criteria to diagnose an Alcohol Use Disorder that either was or was not in remission at the time of the examination. Results: HR subjects were more likely than LR subjects to develop alcohol dependence over the 40 years (31% vs. 16%, p<.03)). However, HR subjects were not more likely to develop alcohol abuse (17% vs. 15%). More subjects with alcohol abuse were in remission at age 40 compared to those with alcohol dependence. Risk status did not predict the recovery from either alcohol dependence or alcohol abuse. Antisocial behaviors in childhood were most predictive of alcohol dependent subjects who failed to recover . Conclusions: This high-risk study showed that sons of alcoholics were significantly more likely to develop alcohol dependence, but not alcohol abuse as adults. Remission from alcohol dependence was not associated with paternal risk, suggesting that familial influences play a stronger role in the development of alcoholism than in its recovery. Premorbid antisocial traits were strongly associated with the failure to remit from alcoholism.

REFERENCES:

1. Vaillant G: A 60-Year Followup of Alcoholic Men. Addiction 2003;98:1043-51.
2. Goodwin DW, Knop J, Jensen P, Gabrielli WF, Schulsinger F, Penick EC: Thirty-Year Followup of Men at High Risk for Alcoholism. Annals New York Academy of Sciences 1994; 708;.

No. 6
SELF-LOATHING AND PERFECTIONISM: LINKING EATING DISORDERS AND COMPULSIVE EXERCISE

Presenters: Alayne Yates, M.D. *University of Hawaii, Psychiatry, 242 Opihikao Way, Honolulu, HI, 96825,* Jason Andrus, M.D., John H. Draeger, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to:

1. Understand the unique contribution of perfectionism to eating disorders and compulsive athleticism
2. Appreciate how measurement of perfectionism, self-loathing, performance concern and body dissatisfaction support this construct
3. Explore how developmental, socio-cultural, and genetic forces modify trait perfectionism

SUMMARY:

Objective: Perfectionism is common among compulsive exercisers (CE) and eating disordered patients (ED). Obsessive-compulsive personality traits (including perfectionism) are significantly greater in persons with ED who exercise excessively. This presentation focuses on measurement of perfectionism in problematic diet and exercise behaviors and explores how genetic, developmental, and sociocultural forces may influence these behaviors. Method: Instruments used to study 107 Honolulu marathoners included the: 1) self-loathing subscale (SLSS) of the Exercise Orientation Questionaire ; 2) EDI-2 scales, including Drive for Thinness (DT); 3) Commitment to Exercise Scale (CES), pathological/addictive exercise versus normative exercise; 4) Profile of Mood States (POMS), used extensively with athletes; and 5) Multidimensional Perfectionism Scale (MPS) measuring doubts about actions, concern over mistakes, parental criticism, parental expectations, high personal standards, and organization (healthy perfectionism). Results:).

The first five factors of the MPS were correlated with SLSS scores at the p <.01 level, while organization was inversely correlated. Organization was also inversely correlated with the diagnosis of anorexia. Total MPS score correlated with the addictive portion of the CES (p<0.01). A simultaneous regression analysis was conducted with CES and MPS total scores entered as independent variables and SLSS as the dependent variable. Only the total MPS score was a significant predictor variable (Beta=.692, t(86)=8.025, p<.001), accounting for 53% of the variance of SLSS.

POMS measures mood in the sport and exercise environment. Factors include tension, depression, anger, vigor, fatigue, and confusion, as well as a global measure of mood. There was no association between SLSS and the positive factor, vigor. In addition, eight of the POMS items were found to correlate with SLSS, including "worn out", "unhappy", "confused", "hopeless", "unable to concentrate", "fatigued", and "discouraged."

The SLSS is a useful measure of perfectionism in athletes and, based on our earlier research, indicates risk for ED. The SLSS consists of only 4 items based on statements about exercise. It doesn't produce false negatives in athletes who wish to appear healthy. Further investigation is needed to appreciate the basis and remarkable versatility of the 4 item, exercise based SLSS. Conclusions: Perfectionism is a largely genetically determined trait that helps individuals set goals, maintain direction and stay on course, Perfectionistic individuals may, however, experience self-criticism, dysphoria, and an inability to change direction even when clearly indicated. When this occurs, the perfectionism becomes maladaptive and may be referred to as neurotic perfectionism. SLSS and other instruments may be used in prospective studies to define the role of perfectionism in child development and factors that promote the conjunction with neuroticism.

REFERENCES:

1. Halmi, K et al.: Perfectionism in Anorexia Nervosa: Variation by Clinical Subtype, Obsessionality, and Pathological Eating Behavior Am J Psychiatry, 2000; 157: 1799-1805.
2. Davis C, Brewer H, Ratusny D *f*Behavioral Frequency and Psychological Commitment: Necessary Concepts in the Study of Excessive Exercising§ Journal of Behavioral Medicine 1993; 16(6): 611-628.

SCIENTIFIC AND CLINICAL REPORT SESSION 3—OCD

No. 7
CAPSULOTOMY IN REFRACTORY OCD: LONG-TERM OUTCOME IN 25 PATIENTS

Christian Rück, M.D. *Karolinska Institutet, Clinical Neurosciences, Sect Psychiatry, Psychiatry, Karolinska Hospital, Stockholm, 17176, Sweden*

EDUCATIONAL OBJECTIVES:

This presentation's aim is to increase the participants understanding of neurosurgery for mental disorder, particularly in OCD. It will discuss important etical and safety aspects as well as showing recent outcome data and their relation to the surgical lesions site and size.

SUMMARY:

Objective: To evaluate the long-term efficacy and safety of capsulotomy in OCD and its relationsship to the placement and size of the surgical lesion. Method: Non-controlled long-term follow-up of a referred sample of 25 consecutive OCD patients having undergone capsulotomy since 1988. Main Outcome Measure: Yale-Brown Obsessive-Compulsive Rating Scale (Y-BOCS). Other outcome measurements include anxiety and depression scales and measurements of impairment and global functioning. Neuropsychological testing and MRI data were included. Results: Mean Y-BOCS was 34 preoperatively and dropped to 18 at long-term follow-up ($p<0.0001$). Two neurosurgical complications related to radiosurgery were reported. A mean weight gain of 6 kg was reported in the first postoperative year. Two patients were severely disinhibited postoperatively. Ten patients were considered to suffer from significant problems in the area of executive functioning, apathy or disinhibition. Only 2 patients achieved remission from OCD without substantial side effects, Conclusions: Capsulotomy is effective in reducing OCD symptoms but carries a significant risk of substantial side effects.

REFERENCES:

1. Rück C, Andréewitch S, Flyckt K, Edman G, Nyman H, Meyerson BA, Lippitz BE, Hindmarsh T, Svanborg P, Mindus P, Åsberg M: Capsulotomy for refractory anxiety disorders: long-term follow-up of 26 patients. Am J Psychiatry 2003; 160(3):513-21.
2. Rück C, Svanborg P, Meyerson BA: Lesion topography in capsulotomy for refractory anxiety--is the right side the right side? Stereotact Funct Neurosurg 2005; 83(4):172-9.

No. 8
TRICHOTILLOMANIA IN YOUTH: A NATURALISTIC OUTCOME STUDY

Presenters: Catherine L. Mancini, M.D. *McMaster University Medical Center, Psychiatry & Behavioural Neurosciences, 1200 Main Street West, Hamilton, ON, L8N 3Z5, Canada*, Michael A. Van Ameringen, M.D., Beth Patterson, B.S.N., Roseann Milad, B.S.C.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to:

1. Understand the clinical presentation and characteristics of youth with trichotillomania.

2. Examine the relationship of trichotillomania with obsessive compulsive spectrum disorders.

3. Understand the potential use and benefits of pharmacological interventions in the treatment of youth with trichotillomania.

SUMMARY:

Objective: Little is known about the treatment outcome of youth with trichotillomania (TTM) despite the fact that the average age of onset is 13 years. This study investigated the outcome of the naturalistic treatment of youth with TTM in an anxiety disorders clinic sample. Method: A retrospective chart review was conducted on 14 patients between the ages of 9 and 17, with trichotillomania, treated in a naturalistic fashion in an Anxiety Disorders Clinic. Patients were evaluated using the Anxiety Disorders Interview Schedule for DSM-IV or the Structured Clinical Interview for DSM-IV. Demographic and clinical variables were identified including comorbid diagnoses, current and previous treatment as well as treatment response. Results: Using the Clinical Global Improvement Scale (CGI), 64% of the patients were improved with 3 patients having a CGI of 2 (moderate improvement), 3 with a CGI of 3 (significant improvement) and 3 with a CGI of 4 (complete cessation of hair pulling). Eight of the fourteen patients were initially treated with a serotonin reuptake inhibitor alone with 28% receiving moderate to significant improvement in hair pulling. Five patients were treated with antipsychotic medication alone and experienced moderate to significant improvement with one patient experiencing a complete cessation of hair pulling. Three of twelve patients received antipsychotic medication with an SSRI or anticonvulsant with 2 out of 3 receiving significant improvement to complete cessation of hair pulling. The other patient received a mild reduction in hair pulling (CGI=1). Conclusions: In this study of youth with trichotillomania, those receiving antipsychotic medication with or without SSRI were more likely to receive moderate to significant improvement in their symptoms than those receiving SSRI treatment alone. Six of 7 who received antipsychotic medication, with or without SSRI, achieved significant to complete cessation of their trichotillomania symptoms. Placebo-controlled trials are needed to further investigate this treatment.

REFERENCES:

1. Christenson GA, Crow SJ: The characterization and treatment of trichotillomania. J Clin Psychiatry 1996; 57:42-49.
2. Tay Y, Levy M, Metry D: Trichotillomania in childhood: Case series and review. Pediatrics 2004; 113:494-498.

No. 9
OCD IN PSYCHIATRIC OUTPATIENTS: PREVALENCE, COMORBIDITY, AND DEMOGRAPHIC AND CLINICAL CHARACTERISTICS

Presenters: Charlotte A.L. Rocker, B.S. *Rhode Island Hospital, Outpatient Psychiatry, 235 Plain Street, Suite 501, Providence, RI, 02905*, Mark Zimmerman, M.D., Iwona Chelminski, Ph.D., Diane D. Young, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be aware of the frequency of OCD in psychiatric outpatients, and the association between OCD and demographic, clinical, and psychosocial variables.

SUMMARY:

Objective: Most research of psychiatric patients with obsessive-compulsive disorder (OCD) is based on patients presenting to a specialty clinic. Few studies have examined OCD patients who present for treatment in a general outpatient practice. In the present report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) Project, we examined the prevalence of OCD in a large sample of psychiatric outpatients and compared patients with and without a diagnosis of OCD on demographic, clinical, and psychosocial characteristics. Method: 2300 subjects presenting to the Rhode Island Hospital outpatient practice for an intake appointment were interviewed by trained diagnosticians using the Structured Clinical Interview for DSM-IV (SCID). Independent sample t-tests were conducted to compare groups on continuous variables, while chi-square analyses were used to compare groups on categorical variables. Results: Of the 2300 patients, 170 (7.4%) received a current diagnosis of OCD. Only 18.8% (n= 32) of the patients diagnosed with OCD received it as their principal diagnosis. Of the remaining 138 patients diagnosed with OCD as an additional disorder, 75.0% (n=102) wanted treatment to address their symptoms. Compared to patients without a diagnosis of OCD, patients with current OCD were younger (33.1 years v. 38.6 years, $t=6.44$, $p<.001$), scored lower on the Global Assessment of Functioning (GAF) scale (43.5 v.53.8, $t=6.39$, $p<.001$), and were more likely to have missed work due to

psychopathology (62.7% v. 54.1%, chi-square=4.74, p<.05) and to have current suicidal tendencies (59.4% v. 43.8%, chi-square=15.91, p<.001). Patients with OCD also had a higher rate of current comorbid Axis I diagnoses (2.79 v. 1.98, t=-5.60, p<.001) than did patients without OCD. Conclusions: Although OCD was not usually the principal reason for seeking treatment, it was associated with increasing severity of pathology and functional impairment, and most patients with OCD wanted treatment to address their OCD symptoms.

REFERENCES:

1. Pinto A, Mancebo MC, Eisen JL, Pagano ME, Rasmussen SA: The Brown Longitudinal Obsessive Compulsive Study: Clinical Features and Symptoms of the Sample at Intake. J Clin Psychiatry 2006; 67:703-711.
2. Poyurovksy M, Kriss V, et al: Comparison of Clinical Characteristics and Comorbidity in Schizophrenia Patients With and Without Obsessive-Compulsive Disorder: Schizophrenic and OCD Symptoms in Schizophrenia. J Clin Psychiatry 2003; 64:1300-1307.

SCIENTIFIC AND CLINICAL REPORT SESSION 4—METABOLIC DISORDERS AND PSYCHOSIS

No. 10
SECOND-GENERATION ANTIPSYCHOTICS AND DIABETES MELLITUS: RISK, NUMBER NEEDED TO HARM, AND CLINICAL IMPACT

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand and interpret the observational pharmacoepidemiological studies comparing antipsychotics on the outcome of diabetes mellitus.

SUMMARY:

Objective: Type 2 diabetes mellitus has been reported during antipsychotic treatment. The objective of this report is to quantify the potential risk of treatment-emergent diabetes mellitus among patients receiving antipsychotic medications. Method: Data Sources - Medline and Psychinfo databases using the key words "antipsychotic" (including individual drug names), "diabetes", and "risk" or "incidence" for all English-language articles published between 1966 and 2005, inclusive. Study Selection - A total of 25 observational pharmacoepidemiological studies were found comparing antipsychotics on the outcome of diabetes mellitus. Risk calculations were performed using data obtained from the pharmacoepidemiological studies that met the following criteria: 1) cohort design, 2) determination of pre-existing diabetes, 3) inclusion of antipsychotic monotherapy as an exposure variable, and 4) comparison with exposure to first-generation antipsychotics. Sufficient information was provided in 15 of the reports to be able to estimate attributable risk. Data Extraction - The quantification of the risk factors for diabetes mellitus is usually presented as risk ratios. These ratios inform us about the increased (or decreased) likelihood of developing diabetes with exposure to the risk factor versus not being exposed. For example if the relative risk is 3.0, then the likelihood is three times as great. However, this metric does not inform us on how common this risk factor is in contributing to the risk of diabetes seen in day-to-day practice. For this reason we focused on attributable risk and Number Needed to Harm (NNH) when examining the potential risk of new-onset diabetes with the use of antipsychotic medication. Results: Risk of treatment-emergent diabetes mellitus is reported in 25 conflicting retrospective studies utilizing drug prescription databases. Analyses that provide the relative incidence of diabetes mellitus during treatment with individual antipsychotics reveals the attributable risk for individual second-generation antipsychotics relative to first-generation antipsychotics ranging from 53 more to 46 fewer cases per 1000 patients. Similarly the NNH to encounter 1 case of diabetes was not consistently in the favor of first-generation antipsychotics. Effect sizes comparing potential risk between second-generation antipsychotics and first-generation antipsychotics as measured by NNH were generally small, ranging in absolute magnitude of 19 to 333 for clozapine, 22 to 3333 for risperidone, 21 to 747 for olanzapine, and 24 to 500 for quetiapine (the smaller the NNH, the bigger the difference between the second-generation antipsychotic and the first-generation antipsychotic comparator). Seldom are the differences statistically significant (the 95% confidence interval for the NNH usually includes infinity, and that for the attributable risk usually includes zero, denoting lack of statistical significance), and the confidence intervals themselves are relatively wide (denoting lack of precision of the estimate). Results for the studies where the length of follow-up post-exposure was one-year or more were not any more consistent in their outcomes. Conclusions: The avoidance of diabetes as an outcome cannot be predictably achieved by choice of antipsychotic. Risk Management for new onset diabetes requires the assessment of established risk factors such as family history, advancing age, non-white ethnicity, diet, central obesity, and level of physical activity.

REFERENCES:

1. Citrome L. The increase in risk of diabetes mellitus from exposure to second-generation antipsychotic agents. Drugs Today 2004;40:445-464.
2. Citrome L, Jaffe A. Relationship of atypical antipsychotics with development of diabetes mellitus. Ann Pharmacother 2003;37:1849-1857.

No. 11
METABOLIC RISKS OF PSYCHOSIS IN SWEDEN

Presenters: Urban Ösby, M.D. *Karolinska Institutet, Molecular medicine and surgery, Solparksvägen 3, Solna, S-169 54, Sweden*, Sören Akselson, M.D., Anna Löthman, M.D., Helena Ring, M.D., Signy Reynisdottir, M.D., Martin Schalling, M.D., Claes-Göran Östensson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the importance of assessing the metabolic risks for patients with long-term psychosis, in order to improve outcome by treating or preferrably preventing the increased metabolic risks.

SUMMARY:

Objective: This is a population-based prospective cohort study, where metabolic risk factors are assessed longitudinally among psychosis patients. The study investigates metabolic risk factors such as weight gain and obesity, impaired blood glucose and lipid levels; metabolic risks related to adverse effects of psychiatric medication, versus adverse life style factors such as smoking and alcohol use; and the effects of prospective risks assessments on patient metabolic risks over time. Method: The study recruits patients diagnosed with schizophrenia and other long-term psychotic disorders from specialized psychosis outpatient departments. A prospective high risk population sample for diabetes will serve as a reference group. Patients are assessed with a psychiatric questionnaire with information on diagnosis, level of functioning (GAF and CGI), duration of illness, duration of treatment, present medications including somatic medications and history of use of antipsychotics, antidepressants and mood stabilizers. Somatic health is assessed with a questionnaire about

CHD, diabetes and hypertonia as well as smoking habits and alcohol intake. Patients are also asked about CHD, diabetes and hypertonia among first-degree relatives. Health-related quality of life is assessed using a questionnaire (EQ5D). Blood pressure, weight, height and waist circumference is measured. A basic clinical laboratory assessment of blood levels of blood status, ASAT, GT, creatinin, blood glucose, TSH, Chol, TG, LDL-chol, and HDL-chol is made. Samples are taken for later DNA, plasma and serum analyses. Patients are followed-up for three years. Drug-naUïve first-episode patients are assessed before start of medication and after 1, 2, 3, 6 and 9 months of treatment, and thereafter included in the ordinary follow-up. Results: Findings from the first 500 patients show the highly elevated metabolic risks. Of the patients included, 61% have schizophrenia, 5% schizoaffective disorder, and another 5% delusional disorder. 11% have psychosis NOS and 5% bipolar disorder. BMI is 28.3 for men and 28.4 for women. Waist circumference is 104.9 cm for men and 95.4cm for women. 75% of male patients and 70% of female patients are either overweight or obese, with 30% of both men and women being obese. 50% have gained 10 kg or more in weight from start of antipsychotic medication, and another 30% have gained 5-10 kg. 38% have pathologic fasting glucose levels, with 14% having known or suspected diabetes, and 24% fasting glucose intolerance. 38% are smokers, and another 21% previous smokers. 23% are medicating with risperidone, 21% with olanzapine, and 11% with clozapine. 80% of the patients are on one antipsychotic drug, while 20% are on two or more drugs. 14% of the patients are medicating with lithium, 27% with SSRIs, and 4% with TCAs. Conclusions: Patients with psychiatric disorders are a high-risk group for metabolic disorders. In addition to risks conferred by genetic and lifestyle factors, there are important iatrogenic components, caused by adverse effects from antipsychotic medication. To improve outcome, it is important to diagnose and treat metabolic risks among patients in psychiatric treatment. Increased understanding of the underlying causes can improve treatment options, quality of life and social function.

REFERENCES:

1. Ösby U, et al: Mortality and causes of death in schizophrenia in Stockholm county, Sweden. Schizophr Res. 2000 Sep 29;45(1-2):21-8.
2. Ösby U, et al: Time trends in schizophrenia mortality in Stockholm county, Sweden: cohort study.BMJ. 2000 Aug 19-26;321(7259):483-4.

No. 12
EFFECT OF BODY WEIGHT AND METABOLIC COMPLICATIONS ON HEALTH RELATED QUALITY OF LIFE IN SWEDISH OUTPATIENTS WITH SCHIZOPHRENIA.

Presenters: Signy Reynisdottir, M.Div. *Karolinska University Hospital, Center for Obesity Treatment, Norrtulls Sjukhus, Norrtullsg 14, Stockholm, 11345, Sweden*, Anna Pejlare, Soren Akselson, Deanne Mannelid, Helena Ring, Birgitta Lindelius, Urban P. Osby

EDUCATIONAL OBJECTIVES:

The presentation will give additional insight to the importance of developing routines for prevention and treatment of obesity in patients with long-term psychotic illness.

SUMMARY:

Objective: Weight gain and obesity-related health problems cause increased morbidity in patients with psychotic disorders. Previous data indicate reduced self-reported quality of life in patients with schizophrenia and population surveys indicate reduced quality of life in obesity. The purpose of this study was to examine the combined impact of obesity and schizophrenia on health related quality of life (HRQL). Method: The study was performed as part of a prospective cross-sectional study of metabolic risk factors in Swedish patients with psychotic illness. Body weight and height were measured and BMI (body mass index) calculated. All subjects filled in questionnaires including EQ5D, a validated HRQL instrument including 5 dimensions of daily life. Socioeconomic data, information about other medical conditions and present medication was also collected. The results were compared to a population based survey with self-reported body height, weight and EQ5D from 29.000 subjects. Results: Data from 400 consecutive patients included in the study: 70% of the females and 74 % of the males have a BMI > 25 kg/m2 and 35% are obese, compared with 35% (female) and 50% (male) overweight and 10% obese in the population sample. Increasing body weight was associated with reduced self-reported quality of life in both groups. Patients with psychotic illness reported more problems in all 5 dimensions of daily life. The negative effect of the mental disorder on HRQL was more pronounced in males than females. A high level of education and current employment had a positive effect. Conclusions: The study confirms previous data on the high prevalence of obesity in this patient population. The negative effect of obesity is additive to the negative effect of the mental disorder on self-reported health-related quality of life suggesting that preventive measures against excessive weight gain should be integrated in the care of patients with long-term psychotic illness.

REFERENCES:

1. Nasrallah H: Low rates of treatment for hypertension, dyslipidemia and diabetes in schizophrenia. Schizophr Res. 2006 Sep;86(1-3):15-22.
2. Jia H: The impact of obesity on health-related quality-of-life in the general adult US population. J Public Health 2005; 27(2):156-64.

SCIENTIFIC AND CLINICAL REPORT SESSION 5—LEGAL ISSUES IN PSYCHIATRY

No. 13
UNDERSTANDING FILICIDE

Sara G. West, M.D. *University Hospitals of Cleveland, Psychiatry, 2608 Canterbury Road, Cleveland Heights, OH, 44118-4335*

EDUCATIONAL OBJECTIVES:

1. To clarify the terms used to describe the murder of one's own children
2. To review various classification systems used to categorize the motives behind filicidal acts
3. To apply these definitions and categories to case examples

SUMMARY:

Objective: Filicide is a horrific crime that stirs up many strong emotions. In an effort to maintain objectivity in evaluating and/or treating the perpetrators and to foster a better understanding of the nature of these crimes, a number of classification systems have been developed to delineate the motivation for killing one's own children. Method: A Medline search of articles published between the years of 1964 and 2004 was performed using the key terms "filicide," "infanticide" and "neonaticide." The abstracts of these articles were reviewed to determine if they offered a system that could be used to classify the motives behind filicide. In those articles providing classification systems, the data pertaining to the formation of the system was reviewed as well. The various classification systems were then applied to four case studies found in the literature. Results: The literature search resulted in the discovery of seven modern and three historical classification systems that helped to define the motives of parents who kill their children in industrialized nations.

Furthermore, the data on which these systems were based provided demographic information about the perpetrators and logistical information concerning the crimes. When the classifications systems were applied to case studies, there was significant overlap in the categorization of the crimes. Conclusions: Since the beginning of civilization, parents have killed their children for a variety of reasons. Over the last 80 years, however, there have been major strides taken to identify the motives behind filicide. The creation of multiple classification systems, in which there exists great overlap, provides a greater understanding of acts of filicide and those who commit these shocking crimes.

REFERENCES:

1. Resnick PJ. Child murder by parents: a psychiatric review of filicide. Am J Psychiatry 1970; 126: 325-334.
2. Guileyardo JM, Prahlow JA, Barnard JJ. Familial filicide and filicide classification. Am J Forensic Med Pathol 1999; 20(3): 286-92.

No. 14
TESTIMONIES OF APA AND ANA PRESIDENTS IN THE HARRY THAW "BRAIN STORM" DEFENSE: TEMPORARY INSANITY ONE HUNDRED YEARS AGO IN 1907

Emil R. Pinta, M.D. *The Ohio State University, Psychiatry, 7652 Ashworth Street, Columbus, OH, 43235-1702*

EDUCATIONAL OBJECTIVES:

1) To obtain an understanding of forensic testimony and concepts of insanity one hundred years ago. 2) To obtain a historical perspective of the temporary insanity defense and its application today. 3) To realize the foundations of current diagnoses in terminologies used at the beginning of the twentieth century.

SUMMARY:

Objective: To demonstrate use of the temporary insanity defense and expert testimony in the twentieth-century's first "celebrity trial." Method: In June 1906, Harry K. Thaw, son of a railroad multimillionaire, shot and killed noted architect Stanford White during the performance of a Broadway musical. The trial that began in January 1907 utilized a temporary insanity defense while drawing on the "unwritten law." It involved testimonies from some of the nation's top experts--including four future presidents of the APA (C. Pilgrim, C. MacDonald, C. Wagner and W. White) and a past (G. Hammond) and future (S. Jelliffe) president of the American Neurological Association. All but one (MacDonald) testified for the defense. One explanation was that Thaw experienced a "brain storm" at the time of the shooting, i.e. an "explosive condition of the mind" that caused a sudden, temporary defect of reasoning.

Among this illustrious group, William AlansonWhite and Smith Ely Jelliffe are probably best remembered by psychiatrists today. The elections of White and Jelliffe as presidents of the APA and ANA in 1924 and 1929 reflected the acceptance of the psychoanalytic movement into mainstream psychiatry and neurology.

At the time, Graeme M. Hammond was probably the best known of the defense experts. He had been a professor at the New York Post-Graduate Medical School since 1896, and was elected president of the ANA in 1898.

The prosecution had its cadre of experts that also included a future president of the APA, Carlos F. MacDonald, elected in 1913.

Charles G. Wagner was the first of the well-known alienists to take the stand for the defense. He was elected president of the APA in 1916. Wagner agreed with the "brain storm" diagnosis of temporary insanity offered by Britton D. Evans, superintendent of the Morris Plains New Jersey Asylum. White, Jelliffe, and Charles W. Pilgrim, (elected president of the APA in 1910) all agreed that Thaw was not responsible for himself at the time of the shooting, but was now sane. However, they were unable to make a diagnosis. Hammond described "temporary mania," "psychokinesia" and said both were equivalent to "brain storm."

The standard for criminal responsibility was McNaughtan criteria. However, the strategy of the defense relied less upon the finer points of law and diagnosis and more upon gaining sympathy for the defendant by emphasizing the right of a husband to avenge dishonor for himself and his wife. By exposing jurors to a "battle of the experts" and legal arguments, the defense hoped to raise doubt regarding his sanity and to reshape in jurors' minds the relationship between insanity and justifiable homicide. Results: The strategy for the defense was moderately successful because the jury remained deadlocked and did not return a murder verdict. Thaw was found not guilty by reason of insanity in a second trial. Conclusions: Similar strategies for the insanity plea are relevant today.

REFERENCES:

1. Umphrey MM: Dialogics of legal meaning: spectacular trials, the unwritten law and narratives of criminal responsibility. Law Society Rev 1999; 33:393-423.
2. Mackenzie FA: The Trial of Harry Thaw. London, Geoffrey Bles, 1928. reprint Holmes Beach FL, Gaunt, 2000.

No. 15
CORRECTIONAL MENTAL HEALTH CARE IN A LARGE, URBAN JAIL: CHALLENGES AND OPPORTUNITIES

Presenters: Amina Abdulla, M.D. *MHMRA, Harris County Jail, 11427 Ashford Willow, Sugar land, TX, 77478*, Michael Searls, M.D., Robert Simon, Jr., M.Psy., Sondra Markle, R.N., John Godejahaun, R.N.

EDUCATIONAL OBJECTIVES:

To recognize the unique complexity of a large, urban correctional facility (Harris County Jail) where incoming detainees present with a variety of mental health illnesses. This presentation will outline the provision of care in the facility allowing the participant to recognize the importance of the problems facing the detainee population and should be aware of the need for augmented community resources.

SUMMARY:

Objective: The purpose of this presentation is to outline the current mechanisms of provision of care to the detainee population, to present the challenges inherent to a short-term, acute jail setting, and to demonstrate the need for more effective community approaches to mental health care. Method: Each incoming detainee receives an intake screening evaluation to identify medical and/or mental health need. Review of the results of that screening will be presented to give the audience an appreciation for the disease burden entering the jail facility and to give perspective as to the need for community resources. Given the challenge of community mental health treatment, the jail often becomes a primary source for mental health care delivery. Results: The ever-growing jail detainee population is additionally fueled by the arrest of mentally ill homeless individuals along with difficulties obtaining state mental hospital beds for jail detainees. Conclusions: The presentation concludes with increasing the importance of community based treatment programs for mentally ill patients and avoiding branding them as criminals.

REFERENCES:

1. Solomon P, Draine, J, Meyerson, A: Jail Recidivism and Receipt of Community Mental Health Services. Hospital Community Psychiatry, 45:793-797, Aug 1994.
2. Treisman GJ, Angelino AF, Hutton HE: Psychiatric Issues in the Management of Patients with HIV Infection. Journal of the American Medical Association, 286: 2857-2864, Dec 2001.

SCIENTIFIC AND CLINICAL REPORT SESSION 6—ANXIETY DISORDERS

No. 16
TREATMENT OUTCOME OF PANIC DISORDER AND AGORAPHOBIA IN A NATURALISTIC CLINICAL SETTING

John K. Lam-Po-Tang, M.B.B.S. *The Paddington Practice, 326 South Dowling Street, Paddington, 2021, Australia*

EDUCATIONAL OBJECTIVES:

To understand that empirically-validated treatments fro Panic Disorder and Agoraphobia may be implemented in routine clinical practice. To understand that validated structured assessment tools may be integrated into routine clinical practice.

SUMMARY:

Objective: Cognitive-behavioural therapy (CBT) programmes have been developed in the last three decades, with multiple clinical trials demonstrating efficacy in research settings (American Psychiatric Association, 1998). Knowledge about the effectiveness of such treatments in routine clinical settings is less well-established (Wade et al, 1998).

The aim of the study was to determine the outcome of an empirically-validated CBT programme for Panic Disorder or Panic Disorder with Agoraphobia in a naturalistic clinical setting, using validated outcome measurements.

Method: Patients were treated using CBT in an outpatient private practice setting if they fulfilled DSM-IV criteria for either of these disorders; the presence of comorbid psychiatric or physical disorders did not preclude treatment. Standardised outcome measures were implemented at the commencement and conclusion of treatment, and effect sizes were calculated for each measure. Measures used were the Agoraphobic Cognitions Questionnaire, Body Sensations Questionnaire, Mobility Inventory and frequency of panic attacks. The use of both antidepressant medications and benzodiazepines was recorded at the start and finish of treatment. Results: Eighty-one patients were treated over the study period. The mean age of the sample was 34.8 years. The proportion of females in the sample was 43%. Individuals were treated for an average of six sessions over an average period of 99 days. Results from outcome measures demonstrated statistically significant improvement following treatment with CBT in the sample; there was no statistically significant difference in reported usage of either antidepressant medication or benzodiazepines over the treatment period. The effect sizes achieved over the treatment period ranged from 0.5 to 1.2 standard deviations. Conclusions: The results of the study indicate that an empirically-validated CBT programme for Panic Disorder and Panic Disorder with Agoraphobia may be transported into a routine clinical setting and produce acceptable effect sizes.

REFERENCES:

1. American Psychiatric Association: Practice guideline for the treatment of patients with panic disorder. American Journal of Psychiatry 1998; 155 (5 supplement): 1 â 34.
2. Wade WA, Treat TA, Stuart GL. Transporting an empirically supported treatment for panic disorder to a service clinic setting: A benchmarking strategy. Journal of Consulting and Clinical Psychology 1998; 66: 231 â 239.

No. 17
PANIC DISORDER WITH SOCIAL ANXIETY DISORDER COMORBIDITY: DIFFERENCE OF RESPONSE TO LOW VERSUS HIGH DOSES OF CLONAZEPAM

Presenters: Antonio E. Nardi, M.D. *Federal University of Rio de Janeiro, Institute of Psychiatry, R Visconde de Piraja 407, 702, Rio de Janeiro, 22410003, Brazil*, Alexandre M. Valença, M.D., Isabella Nascimento, M.D., Fabiana L. Lopes, M.D., Rafael C. Freire, Valfrido L. de-Melo-Neto, M.D., Marco A. Mezzasalma, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the importance of the diagnosis of panic disorder and social anxiety disorder comorbidity. They will be able to identify that these patients respond to panic attacks with lower doses of clonazepam than to social anxiety symptoms.

SUMMARY:

Objective: To explore the dose-response relationship of clonazepam in patients with panic disorder (PD) and social anxiety disorder (SAD) comorbidity (DSM-IV). Method: 44 PD patients with SAD comorbidity were assigned to a comparison of the effects of 2mg or 6mg of clonazepam, and were followed up for 12 weeks. The main instrument used to measure the number of panic attacks was the Sheehan Panic and Anticipatory Anxiety Scale. The primary outcome measure for SAD symptoms was the mean change from baseline in the Liebowitz Social Anxiety Scale (LSAS). Results: After 12 weeks of treatment, panic attacks were reduced 71.4% from baseline in the 2mg group (n=21) compared to a 73.9% reduction in the 6mg group (n=23). Thirteen patients (56.5%) of the higher dose group, 12 patients (57.1%) of the lower dose group were completely free of panic attacks. There was no difference in efficacy between the clonazepam groups in the PD symptoms. All scores for LSAS and self-rated visual analogue scales for social anxiety symptoms showed differences between the treatments. The 6mg dose was more efficacious in the LSAS scores, showing a significant difference in relation to the lower dose group. Of 44 safety-available subjects, 11 (25.0%) withdrew from the study, 7 (15.9%) due to adverse events and 4 (9.1%) due to insufficient clinical response. Discontinuations for clonazepam 2mg group and 6mg group were 23.8% (n=5) and 26.1% (n=6) respectively. Conclusions: Clonazepam was found effective in the treatment of PD and SAD comorbidity. Although the antipanic effect of the lower dose of clonazepam was clearly demonstrated, a higher dose seems to be required for the treatment of concomitant SAD.

REFERENCES:

1. Davidson JR, Potts N, Richichi E, Krishnan R, Ford SM, Smith R, Wilson WH: Treatment of social phobia with clonazepam and placebo. J Clin Psychopharmacol 1993;13:423-428.
2. Nardi AE, Perna G: Clonazepam in the treatment of psychiatric disorders: an update. Int Clin Psychopharmacol 2006; 21:131-142.

No. 18
THE RELATIONSHIP BETWEEN FUNCTIONAL OUTCOMES AND TREATMENT OF ANXIOUS AND PAINFUL SOMATIC SYMPTOMS IN PATIENTS WITH GENERALIZED ANXIETY DISORDER

Presenters: David V. Sheehan, M.D. *University of South Florida, Psychiatry, 3515 East Fletcher Avenue, Tampa, FL, 33613-4706*, Adam Meyers, Apurva Prakash, Michael J. Robinson, Ralph W. Swindle, James Russell, Craig H. Mallinckrodt

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the relationship between changes in global functioning and the treatment of anxious symptoms (psychic and somatic) as well as painful somatic symptoms in patients with generalized anxiety disorder.

SUMMARY:

Objective: Functional role impairment, including diminished work productivity and social relationships, as well as poorer well-being

and life satisfaction have been well-documented in patients with generalized anxiety disorder (GAD).[1,2] This report examines the relationship between global functional impairment and the treatment of anxious symptoms and painful somatic symptoms (PSS) in patients with GAD. Method: Data from two double-blind, placebo-controlled trials in adult outpatients meeting DSM-IV criteria for GAD were pooled. In the first trial (9-week fixed-dose treatment period), patients were randomized to duloxetine 60 mg QD (n=168), duloxetine 120 mg QD (n=170), or placebo (n=175). In the second trial (10-week flexible-dose treatment period) patients were randomized to receive 60-120 mg QD of duloxetine (n=168) or placebo (n=159). In both trials, the Hamilton Anxiety Rating Scale (HAMA) was used to measure anxious symptoms; the Sheehan Disability Scale (SDS) was used to assess global functional impairment; and the Visual Analog Scale for Overall Pain (VAS) was used to measure severity of PSS. Pearson partial correlations were used to assess the magnitude and significance of the associations between global functional impairment and psychic anxiety or PSS. Path analysis was used to assess the relative contributions of changes in psychic and somatic anxiety and PSS on improved functional outcomes. Results: At baseline, the association between global functioning and anxiety (controlling for PSS) was .42, whereas the association between global functioning and PSS (controlling for anxiety) was .25 (each $p<.05$). At endpoint, the correlation between changes in global functioning and anxiety (controlling for PSS) was .59, whereas the correlation between changes in global functioning and PSS (controlling for anxiety) was .29 (each $p<.05$). Path analysis revealed that 36% of the total improvement in global functioning due to duloxetine treatment was independent of improvement in HAMA psychic and somatic anxiety subscale scores or VAS score. This represents a direct treatment effect of duloxetine on improvement in global functioning. Improvement in psychic anxiety indirectly accounted for 48% of the total treatment effect on improvement of global functioning, whereas 7% and 9% of the improvement in global functioning was indirectly accounted for by improvements in somatic anxiety and overall pain respectively. Conclusions: In patients with GAD, most of the treatment effect of duloxetine in improvement of global functioning was mediated through indirect improvement in psychic anxiety with smaller contributions through improvement in somatic anxiety and PSS, while about 1/3 of the improvement was associated with undefined effects of duloxetine treatment.

REFERENCES:

1. Mendlowicz MV, Stein MB. Quality of life in individuals with anxiety disorders. Am J of Psychiatry 2000; 157(5):669-82.
2. Rickels K, Zaninelli R, McCafferty J, Bellew K, Iyengar M, Sheehan D. Paroxetine treatment of generalized anxiety disorder: A double-blind, placebo-controlled study. Am J Psychiatry 2003; 160(4):749-756.

SCIENTIFIC AND CLINICAL REPORT SESSION 7—ATTENTION SPECTRUM DISORDERS

No. 19
CIRCADIAN RHYTHM DISTURBANCES IN ADHD

Presenters: George Alan Keepers, M.D. *Oregon Health Science Univ., Psychiatry, 3181 SW Sam Jackson Park Rd, Portland, OR, 97239-3098*, Robert D. Levitan, M.D., Kyle P. Johnson, M.D., Alfred J. Lewy, M.D.

EDUCATIONAL OBJECTIVES:

1. At the conclusion of this workshop the participant should be able to recognize the presence of delayed sleep phase syndrome and other circadian rhythm disturbances in attention deficit hyperactivity disorder.

2. At the conclusion of this workshop the participant should be able to recognize rapidly varying circadian rhythms in patients with attention deficit disorder and understand the implications for treatment of sleep disturbance.

3. At the conclusion of this workshop the participant should be able to understand the contribution of sleep disorders to the exacerbation of the symptoms of attention deficit disorder.

4. At the conclusion of this workshop the participant should be able to utilize medications and melatonin to effectively treat sleep disorder in patients with attention deficit disorder.

SUMMARY:

Introduction. ADHD affects 4-7% of the school-age population and persists into adulthood. Evidence suggests significant sleep, circadian rhythm and seasonal disturbances in sleep and mood in ADHD.

Objectives. In studies we have conducted we hypothesize ADHD patients will show unstable circadian rhythms, phase delays and seasonal variations in sleep quality, mood and ADHD symptoms compared to controls.

Methods. Study 1. Adolescents with ADHD and controls are admitted each season for 4 overnight stays. DLMO and DLMOff are determined from serum melatonin profiles. Actiwatches measure activity levels to determine sleep onset, times of awakening, total sleep time, and sleep efficiency. Initially, the KSADS, ADHD RSI-Vare collected. Seasonally a Children's Morning-Eveningness Preferences Scale, and ADHD RSIV are collected.

Study 2. Adults with ADHD were evaluated for SAD using the SIGH-SAD and for morningness-eveningness (MEQ) using the the Horne-Osterberg scale. ADHD symptoms were measured with the Brown Adult ADD scale, CAARS and CPT. Subjects were classified as SAD or non-SAD and by MEQ. Correlations between MEQ, CPT performance and ADHD scales were determined.

Results. Study 1. ADHD subjects had significant delays in DLMO which correlated with delayed sleep onset. Actigraphy data for subjects demonstrate that significantly delayed sleep onset, reduced sleep and poor sleep efficiency. Melatonin profiles showed a high degree of variability in DLMO. ADHD was improved (ADHD-RS RCI $p<.05$) at the summer solstice.

Study 2. Forty percent of subjects had evening chronotypes differing from the normal population. MEQ was correlated with CPT ($p<.01$) and with the Brown ADD effort subscale ($p<.004$).

Discussion. These data are evidence for sleep disruption, phase delays, unstable circadian rhythms, and seasonal effects on circadian rhythm stability, mood and symptomatology in ADHD. This workshop will review the literature on this topic, present research results, discuss clinical implications and encourage questions and contributions from the audience.

REFERENCES:

1. Mick, E., Biederman, J., Jetton, J. and Faraone, S: Sleep disturbances associated with attention deficit hyperactivity disorder: the impact of psychiatric comorbidity and pharmacotherapy. J. of Child and Adolescent Psychopharm 2000; 10:233-231.
2. Corkum, P., Tannock, R. and Moldofsky, H: Sleep disturbances in children with attention-deficit/hyperactivity disorder. Journal of the American Academy of Child and Adolescent Psychiatry 1998; 37:637-646.

No. 20
IS COMORBID ADULT ADHD PREVALENT IN PSYCHIATRIC OUTPATIENTS?

John A. Gergen, M.D. *250 pantops mtn rd, #5107, charlottesville, VA, 22911*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to:

Discuss the prevalence of an Adult Attention Deficit Disorder (AADD) as a comorbidity of another psychiatric illness.

Identify diagnostic strategies which could identify AADD when present as a comorbid condition.

Become aware that the presence of comorbid AADD and its associated Altered Attention Traits may have perpetuated and may now confound the treatment of the primary psychiactric disorder.

SUMMARY:

Objective: Prospectively determine the prevalence of an adult attention deficit disorder (AADD) as a comorbidity of other psychiatric problems (1, 2); confirm the clinical characteristics of the primary psychiatric difficulties; and further explore the role of altered attention traits (AAT) as a contributor to perpetuating and treatment confounding features of the primary psychiatric problem. A prior retrospective study of 127 adult outpatients revealed a prevalence of 18% with a confirmed diagnosis of AADD while interpolated estimates projected a prevalence of 35%. AAT is a cluster of behavioral characteristics affecting memory, social functioning, cognitive performance and energy states found in persons with AADD but no comorbidities, persons who have successfully adapted to the challenges of AADD and persons who appear to be the genetic source for ADHD in their children. Method: 237 consecutive adult outpatients presenting with recurrent or persistent psychiatric difficulties were evaluated for the presence of AAT while cconcurrently meeting diagnostic standards identified by the Self-Report Scale-V1.1 from the NYU School of Medicine and the General Adult Symptom Checklist from Amen . Results: The confirmed AADD prevalence was 27% while an additional 16% were considered as possible but unconfirmed. The primary psychiatric diagnoses in individuals with AADD fell in the bipolar spectrum with onset before age 21. AAT remained a valid and useful screening instrument. Conclusions: AADD is likely to be a prevalent comorbidity in psychiatric patients experiencing a mood or anxiety disorder beginning before age 21. The presence of AADD/AAT may significantly contribute to the perpetuating of a primary psychiatric problem and may confound its treatment. The prevalence of AADD/ADD comorbidity may also be an unrecognized variable in other studies of psychiatric difficulties including those in the bipolar spectrum, substance abuse and anxiety categories where there has been an early onset and strong genetic linkage.

REFERENCES:

1. Nierenberg AA, Miyahara S, et al : Clinical and diagnostic implications of lifetime attention-deficit/hyperactivity disorder in adults with bipolar disorder: data from the first 1000 STEP-BD participants. Biol. Psychiatry, 2005; 57(11); 1467-1473.
2. Weiss M, Hechtman L: A randomized double-blind trial of paroxetine and/or dextroamphetamine and problem-focused therapy for attention-deficit/hyperactivity disorder in adults. J. Clinical Psychiatry 2006; 67(4): 611-619.

No. 21

EXTENDED DURATION OF ACTION OF SPD465, A 16-HOUR MIXED AMPHETAMINE SALTS FORMULATION, IN THE TREATMENT OF ADULTS WITH ADHD

Presenters: Thomas J. Spencer, M.D. *Mass General Hospital, 55 Fruit Street, YAW6900, Boston, MA, 02114*, Lenard A. Adler, M.D., Richard H. Weisler, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to:

1) Recognize the benefits of a stimulant medication with a duration of action up to 16 hours in the treatment of ADHD in adults.

2) Demonstrate the favorable safety and tolerability associated with a medication that provides extended control, up to 16 hours, of ADHD symptoms in adults.

SUMMARY:

Objective: This dose-optimization study evaluated efficacy and safety of SPD465, an oral, once-daily, extended-release, single-entity amphetamine product with a 14- to 16-hour duration of action in adults with ADHD. Method: Long-acting stimulants that provide symptom control up to at least 12 hours are the preferred treatment for attention-deficit/hyperactivity disorder (ADHD). Although this duration of action may suffice for children with ADHD, many adults require up to 16 hours of ADHD symptom control. This 7-week, phase III, randomized, double-blind, placebo-controlled, parallel-group, multicenter study enrolled subjects 18-55 years old with a diagnosis of ADHD. Subjects received SPD465 12.5-75 mg/d once daily or placebo. The primary outcome measure was baseline-to-endpoint change in the Attention Deficit Hyperactivity Disorder Rating Scale-4th Edition (ADHD-RS-IV). Among other secondary outcome measures, the Time-Sensitive ADHD Symptom Scale (TASS) - a twice-daily self-reported ADHD symptom severity scale - evaluated the extended duration of action of SPD465. Safety was evaluated by comparing adverse events (AEs), vital signs, labs, and electrocardiograms (ECGs) in each treatment group. Results: The study enrolled 280 participants; 274 participants underwent randomization (137 in each treatment group). Improvements in the ADHD-RS-IV total score mean change from baseline to endpoint were significantly greater with SPD465 than with placebo (-14.3±12.06 vs. -6.3±11.20; $P<0.0001$). Similar significant improvements also occurred in secondary outcome measures. TASS total scores were statistically significantly different on drug compared to placebo at both the 5±2 hours postdose (-16.1±12.15 vs. -12.2±10.95; $P=0.0003$) and 13-16 hours postdose timepoints (-16.1±12.15 vs. -12.9±11.00; $P=0.0018$). The most common AEs in SPD465 subjects were insomnia, dry mouth, and decreased appetite, and were predominantly mild to moderate. Conclusions: SPD465 significantly improved ADHD symptoms in adults compared with placebo and was well tolerated. The duration of action, up to 16 hours, of SPD465 may have benefit in adults with ADHD who need full-day symptom control.

REFERENCES:

1. Wilens T, Dodson W: A clinical perspective of attention-deficit/hyperactivity.
2. Adler L, Cohen J: Diagnosis and evaluation of adults with attention-.

SCIENTIFIC AND CLINICAL REPORT SESSION 8—CHILD AND ADOLESCENT PSYCHIATRY

No. 22

QUALITY OF CARE FOR CHILDREN AND ADOLESCENTS: ACCESS TO PSYCHOTHERAPY

Presenters: Farifteh F. Duffy, Ph.D. *APIRE PRN, 1000 Wilson Boulevard, Suite 1825, Arlington, VA, 22209*, Joyce C. West, Ph.D., Donald S. Rae, William E. Narrow, M.D., Darrel A. Regier, M.D.

EDUCATIONAL OBJECTIVES:

Increase awareness of trends in use of psychotherapy for the treatment of psychiatric disorders in children and adolescents.

SUMMARY:

Objective: To examine rates and patterns of conformance with evidence-based treatment recommendations for the provision of psychotherapy among children and adolescents treated by psychiatrists in a broad range of clinical settings. Method: National data on 393 children and adolescents from the 1997 and 1999 *American Psychiatric Practice Research Network Study of Psychiatric Patients and Treatments* were used and weighted estimates are provided. Results: Findings indicate that nearly 40% of children and adolescents were not provided guideline recommended psychotherapeutic care from any provider within 30 days of the index visit to the treating psychiatrist. Highest rates of psychotherapy were observed among those diagnosed with schizophrenia (76%). Factors associated with not receiving guideline-concordant psychotherapeutic care include: having a managed care health plan, no reported psychosocial problems, and being treated in 1997. Conclusions: Despite evidence-based and expert-consensus-based support for provision of psychotherapy as a component of treatment for children and adolescents, 2 out of every 5 youth in psychiatric care did not receive psychotherapy in a 30 day period. Healthcare financing and management policies need to facilitate greater access for this treatment modality. The current findings give needed direction for payers, health plans, practitioners, parents and other constituents who seek to improve access and quality, and promote wider use of evidence-based practices in mental health services systems for children and adolescents.

REFERENCES:

1. American Academy of Child and Adolescent Psychiatry. Practice parameters for the assessment and treatment of children and adolescents with depressive disorders. J Am Acad Child Adolesc Psychiatry; 37(10 Supplement):63S-83S; 1998.
2. American Academy of Child and Adolescent Psychiatry. Practice parameters for the assessment and treatment of children and adolescents with schizophrenia. J Am Acad Child Adolesc Psychiatry; 40(7 Supplement):4S-23S; 2001.

No. 23
ADOLESCENT DEPRESSION AND ITS RELATIONSHIP TO SCHOOL DROPOUTS AND ACCIDENTS ON UNIVERSITY CAMPUS

Presenters: Chih-Wei Yang, M.D. *E-DA Hosiptal, Department of Psychiatry, No I, Yi-Da Road, Jiau-Shu Tsuen,, Yan-Chau Shiang, Kaohsiung country, 824, Taiwan Republic of China*, Yi-Hsin Yang, Ph.D., Mei-Chu Yen Jean, M.D., Tai-Jui Chen, M.D., Li-Min Su, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the condition and prevalence of adolescent depression and recognize the association of adolescent depression and school dropouts in university campus.

SUMMARY:

Objective: Adolescent depression is a widespread problem with extensive psychosocial consequences. The objective of this prospective study was to investigate adolescent depression and its relationship to school dropouts and accidents after 6 months follow up in a university campus. Method: A total of 2,056 freshmen students age 17-19 in a university in south Taiwan participated in this study. They were asked to complete the Center for Epidemiologic Studies Depression Scale (CES-D) during the entrance physical examination in September, 2004. After 6 months the records of school dropouts and accidents near campus were colleted from the Department of Student Affairs. Results: The mean age of our subjects was 18.7 years, and 59.1% were males. The percentage of moderate to severe depression scores of CES-D in male and female adolescents were 22.6% and 30.5%. Female adolescents had more depression problems in frequency and severity ($p<0.001$). Adolescents who had severe depression (CES-D scores from 31 to 60) were at higher risk of school dropouts (OR=14.49, 95% CI 3.20-65.67). The association of depression and accidents was not obvious. Conclusions: The results of this study showed that adolescent depression at the time they entered the school was associated with school dropouts in the first six months. Psychoeducation and intervention programs aimed at reducing depression were important in university campus.

REFERENCES:

1. Egger HL, Costello EJ, Angold A: School refusal and psychiatric disorders: a community study. J Am Acad Child Adolesc Psychiatry 2003; 42: 797-807.
2. Thompson EA, Eggert LL: Using the suicide risk screen to identify suicidal adolescents among potential high school dropouts. J Am Acad Child Adolesc Psychiatry 1999; 38: 1506-14.

No. 24
INSULIN RESISTANCE IN ADOLESCENT SUBJECTS AT RISK FOR PSYCHOSIS

Presenters: Hannu J. Koponen, M.D. *University of Oulu, Psychiatry, P.O.Box 5000, Oulu, FIN-90014, Finland*, Pirjo H. Maki, M.D., Irma Moilanen, M.D., anja taanila, M.A., jaana laitinen, M.A., tuija tammelin, M.A., Juha M. Veijola

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be aware of possible health risks in the offsprings of their psychotic patients. t

SUMMARY:

Objective: It is unclear if there is a potential genetic vulnerability to develop metabolic syndrome in subjects with psychosis. We were able to study the signs of metabolic syndrome in subjects at risk for psychosis in their adolescence. Method: The Northern Finland 1986 Birth Cohort is a longitudinal one-year birth cohort study from an unselected population (N=9,362). When adolescents were 15-16 year-old they were asked to participate in a comprehensive field study. The procedure included fasting blood sample of lipids, glucose and insulin, and measures of blood pressure and waist circumference. Subjects also completed a questionnaire concerning their level of physical activity and daily dieting habits. Among participants of the field study there were 117 subjects (51 boys) at risk for psychosis, ie mother or father appearing in the Finnish Hospital Discharge Register between 1972-2000 for any psychosis. Comparison group was altogether 6,470 participants (3,197 boys) without risk for psychosis. Results: In boys at risk for psychosis the level on insulin was increased as compared to those without risk for psychosis (mean level 12.5 mmol/L vs. 10.9 mmol/L). There were no other significant differences in the measures of metabolic syndome between the two groups in boys or girls. Subjects at risk for psychosis (both boys and girls) had somewhat lower level of physical activity and poorer dieting habits compared to those without risk for psychosis. Conclusions: Increased level of insulin may be the first sign of metabolic syndrome; our finding in boys suggests that there could be a a potential genetic vulnerability to develop metabolic syndrome in subjects with familial risk for psychosis. On the other hand the lower level of physical activity and poorer dieting habits may as well explain the finding

REFERENCES:

1. Henderson DC. Schizophrenia and comorbid metabolic disorders. J Clin Psychiatry. 2005;66 Suppl 6:11-20.
2. Casey DE Metabolic issues and cardiovascular disease in patients with psychiatric disorders.

REFERENCES:

1. Breslau N, Davis GC, Andreski P: Migraine, psychiatric disorders, and suicide attempts: an epidemiologic study of young adults. Psychiatry Res 1991; 37:11-23.
2. Breslau N: Migraine, suicidal ideation, and suicide attempts. Neurology 1992; 42:392-395.

SCIENTIFIC AND CLINICAL REPORT SESSION 9—PSYCHIATRIC IMPACT OF MEDICAL CONDITIONS

No. 25
SEVERE HEADACHES AND THE RISK OF SUBSEQUENT SUICIDAL THOUGHTS OR BEHAVIORS

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation attendees will be able to describe the associations between severe headaches, psychiatric illnesses, and development of suicidal thoughts or behaviors.

SUMMARY:

Objective: To assess whether severe headaches are associated with increased risk of suicidal thoughts or behaviors independent of depression and other psychiatric illnesses. Method: The sample contained 6,832 community-dwelling adults who reported no previous suicidal thoughts or behaviors during an initial interview, and had a one-year follow-up interview. Severe headaches and psychiatric diagnoses were recorded during the initial interview, and four self-reported suicidal thoughts/behaviors were recorded at follow-up: thinking about death, wanting to die, thinking about committing suicide, and attempting suicide. Logistic regression analyses were used to examine the association between severe headaches and development of suicidal thoughts/behaviors. Results: At the initial interview 11.4% of respondents reported severe headaches; 10.8% developed one or more suicidal thoughts/behaviors during the follow-up. Severe headaches were associated with a 39% increased odds of developing one or more suicidal thoughts/behaviors, adjusting for psychiatric diagnoses and demographic characteristics. When this analysis was repeated for the three thoughts or behaviors about one's own death (i.e., excluding general thoughts about death), severe headaches were associated with a greater (48%) increased odds of developing one or more suicidal thoughts/behaviors. Examined individually, major depressive disorder (relative risk=1.71; 95% confidence interval=1.00-2.94), anxiety symptoms (1.96; 1.42-2.71), drug abuse/dependence (2.87; 1.98-4.16), and alcohol abuse/dependence (1.33; 1.09-1.62) were each associated with increased odds of suicidal thoughts/behaviors. The only psychiatric diagnosis that confounded the association between headaches and suicidal thoughts/behaviors was anxiety symptoms: major depression, alcohol or drug abuse/dependence, panic disorder, and schizophrenia/schizoaffective disorder were not confounders. Conclusions: Similar to one previous study, the association between severe headaches and suicidal thoughts/behaviors was not explained by depression and other mental illnesses, although some diagnoses were associated with increased odds of developing suicidal thoughts/behaviors. These results suggest that individuals with severe headaches should be screened for suicidal thoughts/behaviors, whether or not a psychiatric condition is present.

No. 26
MODAFINIL IMPROVES BEHAVIORAL ALERTNESS IN PATIENTS WITH RESIDUAL EXCESSIVE SLEEPINESS FOLLOWING NASAL CONTINUOUS POSITIVE AIRWAY PRESSURE (NCPAP)-TREATED OBSTRUCTIVE SLEEP APNEA (OSA)

Presenters: David F. Dinges, Ph.D. *University of Pennsylvania, Department of Psychiatry, 423 Gaurdian Drive, 1013 Blockey Hall, Philadephia, PA, 19104*, Max Hirshkowitz, Ph.D., Sanjay Arora, Ph.D., Jed E. Black

EDUCATIONAL OBJECTIVES:

Modafinil significantly improves wakefulness in nCPAP-treated patients with OSA and residual excessive sleepiness. This analysis determined the effect of modafinil on behavioral alertness in this patient population.

SUMMARY:

Objective: Modafinil significantly improves wakefulness in nCPAP-treated patients with OSA and residual excessive sleepiness. This analysis determined the effect of modafinil on behavioral alertness in this patient population. Method: In this multicenter, double-blind, placebo-controlled study, patients with OSA treated with nCPAP therapy who had residual excessive sleepiness were randomized to once-daily modafinil (200 or 400 mg) or placebo for 12 weeks. Behavioral alertness was assessed in patients by performance on the Psychomotor Vigilance Task (PVT), which provided outcomes for speed of reaction times (RT), the ability to sustain attention without lapses, the stability of alertness, and the number of response errors as an index of impulsivity. Results: Modafinil significantly decreased patients' reaction times compared with placebo, as reflected in a mean change in RT from baseline of -14.4 msec for modafinil and +1.3 msec for placebo ($P<.0001$). Modafinil significantly improved patients' ability to sustain attention without lapses, as shown by the change from baseline in mean number of lapses for modafinil versus placebo (-1.8 vs -0.24, respectively; $P=.0006$). Wake state stability was improved by modafinil as measured by the change in mean standard deviation of correct RTs for modafinil versus placebo (-30.4 vs +45.5, respectively; $P=.0001$). There was no difference between modafinil and placebo in the percentage of incorrect RTs. The most common adverse events reported by patients were headache (modafinil, 26%; placebo, 12%), infection (modafinil, 14%; placebo, 21%), and nausea (modafinil, 11%; placebo, 2%). Conclusions: Modafinil is well tolerated and improves behavioral alertness, without an increase in impulsivity, in nCPAP-treated patients with residual excessive sleepiness associated with OSA.

REFERENCES:

1. 1. Dinges, DF, Weaver, TE: Effects of modafinil on sustained attention performance and quality of life in OSA patients with residual sleepiness while being treated with nCPAP. Sleep Medicine 2003; 4:375-384.
2. 2. Black JE, Hirshkowitz M: Modafinil for treatment of residual excessive sleepiness in nasal continuous positive airway pressure-treated obstructive sleep apnea/hypopnea syndrome. Sleep 2005; 28:464-471.

No. 27

THE EFFECT OF SILDENAFIL ON ERECTILE FUNCTION AND DEPRESSION: META-ANALYSIS OF RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED STUDIES IN MEN WITH ED AND TREATED OR UNTREATED DEPRESSION

Presenters: Joseph Cappelleri *Pfizer, Inc., Eastern Point Road, MS 8260-253, Groton, CT, 06340-8030*, H. George Nurnberg, Richard L. Siegel

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to recognize that patients with depression and erectile dysfunction (ED), either related to or independent of antidepressants, improve erectile function and depression with sildenafil treatment. Standardized effect size improvements of >1.0 and 0.4 to 0.8 occurred in both ED and depression, respectively, with successful sildenafil treatment of ED.

SUMMARY:

Objective: To systematically measure the efficacy of sildenafil treatment of erectile dysfunction (ED) and improved depression in a heterogeneous group of men with ED and treated or untreated depression. Method: Review of literature (Current Contents, EMBASE, Cochrane, HealthSTAR, MEDLINE), presentations, and FDA registry for double-blind, placebo-controlled (DBPC) trials from 1997–2005 that involved sildenafil treatment of ED accompanied by primary or secondary depression disorder with or without serotonergic-antidepressant (SRI-AD) treatment. Data extraction of each study included study design, diagnosis, age, patient population, numbers randomized, dosing regimen, inclusion criteria, ED etiology, ED duration, depression duration, treatment duration, EF domain and depression severity scores. Erectile function [(Erectile Function (EF) domain of the International Index of Erectile Function [IIEF]) and depression severity (HAM-D, MADRS, CES-D) were considered as primary measures of interest. Treatment differences were analyzed using fixed- and random-effects models. Meta-analysis compared active depression associated (DA) (n=524) with non-depression associated (NDA) ED (n=3029) from 10 original DBPC sildenafil studies in which men with ED and SRI-ADs were excluded. Results: The search revealed 4 suitable high quality (Jadad=5) studies (n=524).

EF domain: Results from the fixed- and random-effects models were similar. Compared with placebo, sildenafil significantly and substantially improved EF domain scores by 7.9(95%CI,6.63–9.26;P<0.001) in DA patients compared with 8.4 (95%CI,7.50–9.31;P<0.001) in NDA patients. Corresponding standardized effect-sizes were 1.03(95%CI,0.7–1.29;P<0.001) and 1.08(95%CI,1.0,1.20;P<0.001) for DA and NDA, respectively. Heterogeneity of treatment effect was significant (P=0.036); about half observed was real (I^2=51.5%). The placebo/sildenafil effect size (ES) ratio=0.31.

Depression: Compared with placebo, sildenafil was associated with improvement in depression scores of −1.36(95%CI,−2.03 to −0.68;P<0.001) in DA and −1.97(95%CI,−4.28 to 0.34;P<0.09) in NDA patients. Corresponding standardized sildenafil effect sizes were 0.38(95%CI,−0.56 to 0.20;P<0.001) and 0.44(95%CI,−0.95 to 0.08;P=0.094), respectively. Heterogeneity of treatment effect existed across studies (P<0.001; I^2=87.6%). The placebo/sildenafil ES ratio=0.33.

ED responders: Positive ED treatment response associated with depression score improvement of −2.84(95%CI,−3.55 to −2.13;P<0.001) in the fixed- and −3.68(95%CI,−7.40 to 0.046;P= 0.05) in the random-effects model. Corresponding treatment effect sizes were −0.81(95%CI,−1.01 to −0.60;P<0.001) and −0.84(95%CI,−1.61 to −0.06;P=0.034). Heterogeneity of treatment effect existed across studies (P<0.001;I^2=93%). The ED nonresponder/responder ES-ratio=0.002. Conclusions: Sildenafil treatment efficacy for men with ED and depression (with or without SRI-AD) was high, robust, specific, and as consistent in this heterogeneous subpopulation as in ED without active depression. Results suggest associated depression improvement of moderate effect size with effective sildenafil treatment of ED, and larger depression effect size improvements for ED responders, independent of assigned treatment, which suggests mood effects are more likely non-specific ED response related.

REFERENCES:

1. Nurnberg HG, et al. Am J Psychiatry. 2001;158(11):1926-1928.
2. Nurnberg HG, et al. JAMA. 2003;289(1):56-64.

TUESDAY, MAY 22, 11:00 AM - 12:30 PM

SCIENTIFIC AND CLINICAL REPORT SESSION 10—MEDICAL AND METABOLIC CONSEQUENCES OF PSYCHIATRIC TREATMENT

No. 28

METABOLIC ABNORMALITIES IN PSYCHIATRIC INPATIENTS

Presenters: John W. Goethe, M.D. *Institute of Living, Burlingame Center for Psychiatric Research and Education, 200 Retreat Avenue, Hartford, CT, 06106*, Bonnie L. Szarek, R.N., Charles F. Caley, Pharm.D.

EDUCATIONAL OBJECTIVES:

Attendees will be able to (1) list at least two clinical variables associated with abnormalities in metabolic measures, (2) discuss the association between psychiatric medications and metabolic syndrome.

SUMMARY:

Objective: To (1) determine the prevalence of metabolic abnormalities by diagnostic group and (2) identify the associated clinical and demographic variables. Method: Waist circumference (WC), BMI, FBS, lipid values, medications, diagnoses and demographics were recorded for consecutively-admitted adult psychiatric inpatients between 4/1/2005 and 3/31/2006 (n=2075). The sample was 59.8% white, 16.0% black, 20.2% Latino; mean age was 38.9 years (18 to 64). The most common diagnoses were major depressive disorder (MDD) (44.0%), bipolar (18.6%), schizoaffective (SA) (15.6%), and schizophrenia (SZ) (12.3%). Patients were categorized as positive/negative on each of the ATP criteria for metabolic syndrome. Demographic, diagnostic and treatment variables were examined using chi-square and logistic regression. Results: For the sample as a whole, 67.7% had at least one abnormal metabolic measure. As expected, age > 40 was associated with increased odds of meeting at least one criterion, but this association was dramatic only for patients with SA (OR=3.190). SA patients of any age were more likely to meet the WC criterion (62.5% vs approximately 30-40% for other diagnoses, p <.001; OR=1.891); SA patients taking an atypical antipsychotic (AAP) were five times more likely to meet this criterion (OR=5.066). AAP use was not otherwise associated with any abnormal metabolic measure. Bipolar and MDD patients > age 40 were at much greater risk for hypertension (OR=11.313 and 13.274, respectively, vs ORs of < 5 for SZ and SA). Receiving an antidepressant increased the risk for dyslipidemia in patients with SZ (OR=1.887), SA (OR= 1.621) and MDD (OR=2.292). Conclusions: The recent focus on metabolic syndrome in psychiatric patients has been largely limited

to patients with schizophrenia receiving AAPs. This study suggests that the risk of metabolic abnormalities is high in a wide range of psychiatric patients.

REFERENCES:

1. Am Diabetes Assn., APA, Am Assn. of Clinical Endocrinologists, North American Association for the Study of Obesity: Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes. J Clin Psychiatry 2004; 65:267-272.
2. Casey DE, Haupt DW, Newcomer JW, et al: Antipsychotic-induced weight gain and metabolic abnormalities: Implications for increased mortality in patients with schizophrenia. J Clin Psychiatry 2004; 65(Suppl 7):4-18.

No. 29
NEUROLEPTIC MALIGNANT SYNDROME INDUCED BY LOW DOSE ARIPIPRAZOLE IN FIRST EPISODE PSYCHOSIS

Presenters: Harun Evcimen, M.D. *Drexel University College of Medicine, Psychiatry, 1427 vine street, philadelphia, PA, 19102*, Yesne Alici-Evcimen, M.D., Irakli Mania, M.D., Maju Mathews, M.D.

EDUCATIONAL OBJECTIVES:

Our educational objective is to alert psychiatrists to the risk of *neuroleptic malignant syndrome* induced by atypical antipsychotics. At the end of our presentation, clinicians would be able to appreciate the importance of considering and recognizing this potentially *life-threatening* condition in patients treated with atypical antipsychotics.

SUMMARY:

Objective: Neuroleptic Malignant syndrome (NMS) is a life-threatening, develops on exposure to antipsychotic medications. The incidence ranges between 0.02-2.44% (1), with the majority of cases occurring in individuals between the ages of 18 and 59 years (2). The underlying mechanism has been unclear; however, it is believed to be related to rapid dopamine (D2) blockade by antipsychotics. 66 % of patients have been reported to have the onset of NMS symptoms within 2 weeks of the start of antipsychotics (3). The classic triad involves the autonomic nervous system, the extrapyramidal system, and cognitive changes.

NMS is less frequently seen with atypical antipsychotics than conventional antipsychotics (4). Aripiprazole is a partial agonist with high affinity at dopamine D2- and 5-HT1A-receptors, and antagonism at Serotonin-5HT2A-receptors (4). Method: We describe a patient with first episode psychosis who developed NMS on low dose aripiprazole. Results: Ms. M, a 57-year-old Caucasian female, on involuntary admission with a first episode psychotic disorder. She was given aripiprazole 10 mg/day without concurrent medications. Physical and neurological exam were normal. On day 2, she started complaining of stiffness around her neck. She was found to have muscular rigidity and bradykinesia. Since the extrapyramidal symptoms (EPS) improved with benztropine, aripiprazole was continued. On day 4, she developed shuffling gait, resting tremor, masked face, cogwheel rigidity and drooling. She became mute, stopped eating, drinking on her own and was noted to be confused. Her temperature was 101.5F and her white cell count was 16,000. Blood pressure ranged between 110/75 and 150/100 mmHg. Her pulse was 108 bpm. CK levels were normal. Although some improvement observed with 2 mg lorazepam, she continued to be catatonic, and was transferred to the medical unit. No other etiology could be found to explain her findings. The patient made an uneventful recovery in motor function and self care within days of discontinuation of aripiprazole and starting lorazepam 3 mg/ day. A residual state of confusion and slight drooling persisted for several weeks. Conclusions: Aripiprazole is a functional dopamine agonist in hypodopaminergic states as occurs in NMS (5). The Physicians' Desk Reference documents two "possible" cases of NMS induced by aripiprazole in a premarketing clinical database, and we found only one report of NMS recently published occurring with aripiprazole (6). Our case differs from the other cases (7, 8, 9,) in that, the patient developed NMS diagnosed at low doses of aripiprazole in a first episode psychotic disorder. It is believed that the lower doses of antipsychotic medication decreases the incidence of NMS. However, the answer remains unclear in the absence of controlled data comparing the incidence of NMS and dosing strategies. Although it is well known that atypical antipsychotics produce lower rates of EPS inadequate control of EPS has been proposed as a risk factor for NMS (10). In conclusion, our case report suggests that clinicians should be aware of the risk of NMS with atypical antipsychotics at low doses and carefully monitor patients especially when EPS develops.

REFERENCES:

1. 1. Ananth J, Parameswaran S, Gunatilake S, Burgoyne K, Sidhorn G. Neuroleptic malignant syndrome and atypical antipsychotic drugs. J Clin Psychiatry 2004;65:464-70.
2. 2. Borovicka MC, Bond LC, Gaughan KM. Ziprasidone and Lithium induced neuroleptic malignant syndrome. Ann Pharmacotherapy 2006 Jan;40(1):139-42.

No. 30
METABOLIC ABNORMALITIES IN PATIENTS WITH MAJOR DEPRESSIVE DISORDER

Presenters: Karen Blank, M.D. *Institute of Living, Memory Disorders Center, 200 Retreat Ave, Research Builiding 6th floor, Hartford, CT, 06106*, Bonnie L. Szarek, R.N., John W. Goethe, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should to able to:

To recognize and obtain the essential metabolic parameters that may be abnormal in adult patients with major depression.

To recognize and monitor patients who may pose higher risks of developing metabolic abnormalities during treatment of major depression.

To monitor for the development of metabolic syndrome in patients with depression across the adult life span.

SUMMARY:

Objective: Abnormalities in certain metabolic measures (MMs) may increase the risk for cerebrovascular disease, a condition associated with both depression and dementia. This study examined patients with MDD to determine (1) the prevalence of metabolic abnormalities and (2) their association with age and treatment variables. Method: The sample was all inpatient discharges (4/1/03-3/31/06) ≥ age 35 with a diagnosis of MDD n= 1718. Recorded MM included: BMI, waist circumference (WC), triglycerides, glucose, diabetes diagnosis (DM) and hypertension diagnosis (HTN). Independent variables included demographic and clinical features and length of stay (LOS). Associations were determined using stepwise logistic regression.

Results: Results: As expected, patients ≥ 65 were more likely to have ≥ 1 abnormal MM (OR =2.334), but the prevalence of metabolic dysfunction was high in patients < 65 as well (68.1% vs. 81.4%). Older patients had an increased risk for glucose > 110 (OR=1.787), triglycerides ≥ 150 (controlling for statin use) (OR=1.417,) and HTN (OR=2.638). However, the proportion of patients meeting the WC criterion did not vary by age group. Receiving an atypical antipsychotic was not associated with any MM after controlling for other variables. Also unexpected was that asthma was associated with increased risk on the WC (OR=1.995), DM (OR= 1.732), and glucose (OR=1.815) measures.

Conclusions: Conclusions: Risk factors (metabolic syndrome and others) are common in depressed patients and the prevalence of

abnormal MMs is high in both geriatric and younger patients with MDD. Further research is needed to determine the relationships among MM, MDD, the medications used to treat depression, and risk for cognitive impairment. .

REFERENCES:

1. Barnes DE, Alexopoulos GS, Lopez OL, WIlliamson JD, Yaffee K: Depressive symptoms, vascular disease, and mild cognitive impairment: Findings from the cardiovascular health study. Arch Gen Psychiatr 2006; 63:273-279.
2. Kales, HC, Maxiner DF, Mellow AM. Cerebrovascular disease and late-life depression. Am J Geriatr Psychiatry 2005;13: 88-98,.

SCIENTIFIC AND CLINICAL REPORT SESSION 11—ACCESS, AVAILABILITY, AND UTILIZATION OF PSYCHIATRIC SERVICES

No. 31
RECURRENT PSYCHIATRIC HOSPITALIZATION

Presenters: Christine Dunn, M.A. .., *New Haven, CT, 22222*, William H. Sledge

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant should 1) be able to list the causes for recurrent psychiatric hospitalization, 2) recognize and list the patient factors that contribute to recurrent psychiatric hospitalization, 3) define the service system issues that co-occurr with psychiatric hospitalization

SUMMARY:

Objective: The purpose of this study was to determine if an interagency treatment planning process, the High User Treatment Planning Group (HUTPG), could be effective in engaging patients in their treatment and to determine what differences distinguished those who were recurrently readmitted to the hospital in contrast to those who were not.

In our review of the literature, we noted that the consensus definition for ''recidivism'' seems to be someone who is admitted to a psychiatric inpatient service three or more times within an eighteen month period (Casper & Pastva, 1990; Kent et al., 1995). Findings have included patient oriented explanations such as psychopathology (Casper & Donaldson, 1990), especially substance abuse (Kent et al., 1995) and psychosis (Geller, 1986). Treatment and medication non-compliance has also been a recurrent factor in recidivism (Grossman, et al, 1993; Carpenter, et al, 1985).

Method: All available patients (N=91) admitted to the Yale-New Haven Psychiatric Hospital during the study period (Sept 12, 2005 through July 14, 2006) who had three or more admissions within eighteen months (N=118) were approached for participation in the research which included an assessment at admission and follow-up monthly for three months after discharge. Of these 91, 33 consented (36%). There was no difference along the lines of gender, principal diagnosis, payer, age, or previous history between those who agreed and those who did not agree to be in the research.

We also carried out a retrospective chart review of 69 patients who were identified as recidivist patients from September, 2005 to July 1, 2006 and we matched them with the next admitted, non-recidivist patients during the same time. Eventually, we will have 75 patients in each category. Results: The chart review of recidivist (N=69) and non-recidivist (N=47) patients revealed demographic and diagnostic differences (more schizophreniform diagnoses among recidivist patients). Twenty one (21) pf the 33 (64%) who were recruited to participate in the follow-up study were re-admitted within 6 months after the index hospitalization. There was no difference between those that had the HUTPG and those who did not in terms of readmission experience. Of the 33 patients who enrolled in the prospective study, we found that if there were problems with housing, shelter, food, or security at the one month follow-up, the patient was more likely to be re-admitted by 6 months than those who did not have difficulties in these domains in the first month follow up. These findings were significant at p<.05 level or better.

A major clinical finding was that the recidivist patients were extremely reluctant to be involved with treatment, comply with medications, and work with their families, as well as enroll in the research. Consequently, the patients that we have may or may not be representative of the class in general. Conclusions: New approaches for collaborative engagement are needed in order to reduce the re-hospitalization experience for those who are prone to return. We believe that a major promising perspective is a recovery-oriented approach to engagement with care.

REFERENCES:

1. Casper, E. S., & Pastva, G. (1990). Admission histories, patterns and subgroups of the heavy users of a state psychiatric hospital. Psychiatric Quarterly, 61(2), 121-134.
2. Carpenter, M. D., Mulligan, J. C., Bader, C. A., & Meinzer, A. E. (1985). Multiple admissions to an urban psychiatric center: a comparison study. Hospital and Community Psychiatry, 36(12), 1305-1308.

No. 32
REDUCING THE MEDICAL AND FINANCIAL BURDEN OF DEPRESSIVE ILLNESS: A PLAN FOR IMPROVING HEALTH CARE SERVICES

Lawrence W. Adler, M.D. *University of Maryland School of Medicine, Psychiatry, 7310- Ritchie Highway, 512, Glen Burnie, MD, 21061-5555*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should (1) recognize that major depression constitutes a leading cause of disability in the United States; (2) have knowledge of the epidemiologic studies detailing depression as risk factor for diabetes, stroke, hypertension, ischemic heart disease, and dementia; (3) have knowledge of epidemiologic data demonstrating the inefficiency of current diagnosis and treatment of depression; (4) have knowledge of the financial burden of depression and (5) understand the proposed re-alignment of health care services proposed by the presenter to address these problems.

SUMMARY:

Objective:

The objectives of this presentation is to review the prevalence of, and medical and economic burdens of major depressive disorder (MDD) in the U.S., and the adequacy of treatment provided by the current healthcare delivery system. A paradigm change in delivery of services is proposed to address the current deficiencies.

Method:

(1) Review of NIMH disability data using Disability-Adjusted Life Years (DALYs) and Years Lived with Disability (YLD) as metrics.

(2) Review of psychiatric epidemiology studies: the Ecologic Catchment Area Study (ECA), the National Co-Morbidity Study (NCS), the National Co-Morbidity Study-Replication (NCS-R), and the National Epidemiologic Survey of Alcoholism and Related Conditions (NESARC). Current and lifetime prevalences are presented.

(3) Review of The National Health and Nutrition Examination Surveys (NHANES) and the Atherosclerotic Risk in Community

Studies to ascertain risks of medical co-morbidities conferred by MDD history

(4) Data from the U.S. Department of Health and Human Services, from studies by Analysis Group, Inc., and from the combined NCS and Mid-Life Development in the United States Survey (MIDUS) cohorts are utilized to estimate financial burden.

(5) Efficacy of anti-depressant treatment is estimated from pharmaceutical databases, and expressed as Number Needed to Treat (NNT) as the metric.

(6) Adherence to Health Plan Employer Data Set (HEDIS) process measures is derived from the 2004 National Committee for Quality Assurance (NCQA) report.

Results:

(1) MDD was the fourth leading case of DALYs and the leading cause of YLD in 1996.

(2) The prevalence of current MDD ranged from 3.0% to 8.6%; lifetime prevalence ranged from 5.2% to 16.2%.

(3) MDD was a statistically significant risk factor for: fatal ischemic heart disease (RR=1.5); stroke (RR=1.73); for type II diabetes (RH=1.63). In each statistic 95% CL excluded 1.0.

(4) In 2000, total yearly financial burden of depression was estimated at $83.1 billion.

(5) The NNT for a patient to respond to an antidepressant in pharmaceutical trials varied from 5 to 9.

(6) Adherence to 3 HEDIS indicators was best in commercial plans, but varied from 20% to 61% adherence at best.

Conclusions:

MDD is a highly prevalent and disabling chronic medical illness. It is underdiagnosed and inadequately treated. It is a risk factor for disabling medical illnesses, but co-ordination of medical and psychiatric services is sub-optimal. The financial burden is high, straining limited medical and financial resources.

A delivery system with the following attributes is proposed:

(1) vertical integration to assure co-ordinated care and continuity of care, and use of computerized medical records

(2) focus on prevention, health promotion, and patient and family education

(3) utilization of validated diagnostic instruments such as the M.I.N.I. to permit ascertainment of sub-syndromal and syndromal MDD

(4) utilization of a simple, valid, standardized outcome measure, such as Patient Global Improvement scale

(5) partnership of NIMH, academic and private clinical research centers, and pharmaceutical companies in real- world effectivness trials (such as STAR*D)

REFERENCES:

1. Richardson M, Shiu-Torton SS: Mental Health Services. In Introduction to Health Services, edited by Williams SJ, Torrens PR, New York, Delmar, 2002, pp280-307.
2. Kessler, RC, Berglun P, Demler O, Jin R, Koretz D, Merikangas KR, Rush AJ, Waters EE, Wang PS: The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). JAMA 2003; 289:2095-3015.

No. 33
PSYCHIATRIC HOSPITAL BED NUMBERS AND ECONOMIC FACTORS IN THE XIX AND XX CENTURIES - NEW ANALYSES

Presenters: Alfonso Ceccherini-Nelli, M.D. *53 Honey End Lane Clinic, 53 Honey End Lane, Reading, RG30 4EL, United Kingdom*, Stefan Priebe, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand a) the significance of macroeconomic factors in predicting hospital bed numbers in psychiatry and b) the relevance of new statistical methods to identify the predictive associations.

SUMMARY:

Objective: **Psychiatric institutionalisation in the XIX century and the opposite phenomenon of deinstitutionalisation, one century later, has been explained mostly using medical and sociological paradigms. An economic explanation, although plausible, has not been supported by sufficient empirical data. This study aimed to test the hypothesis that macro-economic factors predict changes of hospital bed numbers in the 19th and 20th century.** Method: **Time series analytical techniques were utilised to study the relationship between rates of hospital psychiatric bed occupancy and selected economic variables from 5 data sets, i.e. North Carolina (US) and Berkshire (England) in the late 19th century,** and US, United Kingdom, and Italy during the last decades of the 20th century. Consumer Price Index, Real Gross Domestic Product per capita, money supply, central bank discount rate, and rate of unemployment were tested as predictors of psychiatric hospital bed numbers and co-integration rather than conventional correlation coefficients were established to test the hypothesis. Results: **For both data sets in the 19th century,** pair-wise and multivariate Johansen's cointegration tests indicate the existence of a statistically significant long-run equilibrium relationship among psychiatric hospital beds and all examined economic variables. Also in data sets for the 20th century, cointegration tests confirm a long run relationship among rates of hospital psychiatric beds and economic factors. Increase of Consumer Price predicted a decrease of hospital beds (and vice versa) in all data sets and was the best predictor of changes in psychiatric bed numbers. Conclusions: There appears to be a long-run equilibrium relationship among economic factors, in particular the Consumer Price Index, and psychiatric hospital bed numbers. Cointegration tests can be a useful method to explore such relationships.

REFERENCES:

1. Priebe S, Badesconyi A, Fioritti A, et al.: Reinstitutionalisation in mental health care: comparison of data on service provision from six European countries. BMJ 2005; 330: 123-6.
2. Brenner MH: Mental Illness and the Economy. Cambridge, Harvard University Press, 1973.

SCIENTIFIC AND CLINICAL REPORT SESSION 12—INTERNATIONAL STUDIES IN SCHIZOPHRENIA

No. 34
BRAIN MORPHOLOGY IN SCHIZOPHRENIA WITHIN THE NORTHERN FINLAND 1966 BIRTH COHORT

Presenters: Matti K. Isohanni, M.D. *University of Oulu, Psychiatry, P.O. Box 5000, Peltolantie 17, PP1, Oulu, 90014, Finland*, Päivikki Tanskanen, M.D., Jouko Miettunen, Ph.D., Graham Murray, M.D., Peter B. Jones, M.D., Ed T. Bullmore, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that developmental pathways in schizophrenia differ compared to subjects without psychosis, and to understand what is currently known on the anatomical systems behind these differences.

SUMMARY:

Objective: The Northern Finland Birth Cohort 1966 Study aims to explore the evolution of morbidity, both somatic and psychiatric, troughout the life course.

Method: We have performed follow-ups since pregnancy, most recently at age 33-35, including sMRI.

Results: We have identified in schizophrenia (contrasted to non-psychotic controls) subtle volume changes in hippocampus mainly not mediated by genetic or obstetric risks. Global gray matter, white matter, total brain volume did not differ between the groups, but CSF did. Significant deficits of gray matter volume in the schizophrenia group were found in specific brain regions: fronto-thalamic, superior and medical temporal regions (including parahippocampal gyrus), the insula, and cingulate cortex.

Conclusions: We have identified evidence of structural deviances and dysfunction in a distributed network involving a fronto-cerebellar system in schizophrenia, and we demonstrated that the normal relationship between infant development and adult brain structure is disturbed. This disruption of anatomical system previdesa mechanistic link between the developmental deviances prior to schizphrenia, and adult cognitive abnormalitiesand psychotic features.

REFERENCES:

1. Ridler K, Veijola JM, Tanskanen P, Miettunen J. et al: Frontoclebellar systems are associated with infant motor and adult executive functions in healthy adults but in schizophrenia. PNAS (in press).
2. Tanskanen P, Veijola J, Piippo U, Haapea M, Miettunen J, Pyhtinen J, Bullmore E, Jones P, Isohanni M: Hippocampus and amygdala volumes in schizophrenia and other psychoses in the Northern Finland 1966 Birth Cohort. Sch Res 2005; 75: 283-294.

No. 35
THE ADHES PROJECT IN ISRAEL: NEW INSIGHTS IN ADHERENCE IN SCHIZOPHRENIA

Presenters: Yoram Barak, M.D. *Abarbanel Mental Health Center, Psychogeriatrics, 15 KKL Street, Bat-Yam, 59100, Israel,* Dov Aizenberg, M.D., Avi Bleich, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation participants should be able to recognize that the ability of physicians to recognize nonadherence is poor. Using a brief questionnaire will enable identifying specific barriers amongst their schizophrenia patients.

SUMMARY:

Objective: The concept of adherence captures the dynamic and complex changes required to maintain optimal health in people with chronic diseases. The WHO has recently published its international project on adherence to long-term therapies emphasizing the critical effects of non-adherence. Lack of adherence to medications for schizophrenia after discharge from hospitalization is the single most significant risk factor for relapse. Data from psychiatrists is needed to provide a basis towards awareness and for positive change. The ADHES project was initiated by Janssen-Cilag in 11 European countries in order to evaluate psychiatrists' positions towards adherence in schizophrenia, to elicit specific local obstacles and to enable future interventions for improvement. Method: A nationwide survey of board-certified psychiatrists was undertaken employing a 14-questions questionnaire. Each respondent was asked to report on adherence variables for 10 schizophrenia patients in his care. Current and lifetime adherence was evaluated as well as intentional and unintentional failures. Results: A total of 326 psychiatrists (31.3 % of all psychiatrists in the country) agreed to participate in the survey reflecting their evaluations of 3,260 schizophrenia patients. The majority of participants (73 %) reported practicing in public and academic setting and most had noted that using the questionnaire increased their awareness of adherence issues. During the last month in 43 % of patients the treating psychiatrist suspected non-adherence to medications. Amongst the most commonly endorsed failures in adherence were due to: lack of insight (51 %), side-effects (43.5 %), cognitive impairment (35.7 %) and substance abuse (16.8 %). The great majority of psychiatrists (86 %) thought that psychoeducation promotes adherence. Conclusions: From a public health and service delivery perspective, treatment nonadherence in schizophrenia undermines the possibility of social remission and rehabilitation. The Israel-ADHES project promotes awareness amongst physicians treating schizophrenias patients and emphasizes the main barriers to adherence from the psychiatrists' perspective.

This study was performed in collaboration with JC Health Ltd.

REFERENCES:

1. Osterberg L, Blaschke T: Adherence to medication. N Engl J Med 2005;353:487-497.
2. Ascher-Svanum H, Faries DE, Zhu B, Ernst FR, Swartz MS, Swanson JW: Medication adherence and long-term functional outcomes in the treatment of schizophrenia in usual care. J Clin Psychiatry 2006;67:453-460.

No. 36
SCHIZOPHRENIA IN THE OFFSPRING OF ANTENATALLY DEPRESSED MOTHERS AND FAMILIAL RISK- FOLLOW-UP OF THE NORTHERN FINLAND 1966 BIRTH COHORT

Presenters: Pirjo H. Maki, M.D. *University of Oulu, Psychiatry, P O Box 5000, Peltolantie 5, Oulu, 90014, Finland,* Juha M. Veijola, M.D., Jouko Miettunen, Ph.D., Jari Jokelainen, M.S.C., Paula Rantakallio, M.D., Peter B. Jones, M.D., Matti K. Isohanni, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand, that antenatal depression is common. Anyhow, it may not increase the risk for schizophrenia in the offspring without Familial Risk for psychosis.

SUMMARY:

Objective: Maternal depression is common during antenatal period. We studied the association between mothers' antenatal depressed mood and schizophrenia in their adult offspring with special consideration to Familial Risk for psychosis. Method: In the Northern Finland 1966 Birth Cohort mothers of 12 058 babies were asked at mid-gestation at the antenatal clinic if they felt depressed. This general population birth cohort of the children was followed up for 31 years being record-linked with the FHDR covering the years 1982-97. Mothers and fathers appearing on the FHDR between 1972-2000 for any psychosis (i.e. ICD-8 290-299, DSM-III-R diagnoses 290-299, and ICD-10 F 20-29) were identified. Results: Of the mothers of the offspring, 14 % felt depressed during pregnancy. The cumulative incidence of hospital-treated schizophrenia was 1.3% among the offspring of depressed mothers and 0.9% among the descendants of non-depressed mothers (RR 1.5; 95%CI 0.9-2.4). The elevated level of maternal depressed mood in pregnancy among schizophrenia patients was connected to Familial Risk of psychosis. Conclusions: Mothers' depressed mood in pregnancy per se is unlikely to increase the risk for schizophrenia in the offspring, but seems to be connected to Familial Risk for psychosis in the close relatives of schizophrenia patients.

Acknowledgements: This work was supported by grants from the Signe and Ane Gyllenberg Foundation

REFERENCES:

1. Rantakallio P: Groups at risk in low birth weight infants and perinatal mortality. Acta Paediatr Scand 1969; 193:1-71.
2. Mäki P: Parental separation at birth and maternal depressed mood in pregnancy - associations with schizophrenia and criminality

in the offspring. Acta Universitatis Ouluensis Medica D 740, Oulu Univ. Press 2003. http://herkules.oulu.fi/isbn9514270800.

SCIENTIFIC AND CLINICAL REPORT SESSION 13—THEORETICAL AND RESEARCH APPROACHES IN THE STUDY OF VIOLENCE

No. 37
BEYOND THE CLASH OF CIVILIZATIONS

David A. Rothstein, M.D. *Swedish Covenant Hospital, Psychiatry, 2851 West Bryn Mawr, Chicago, IL, 60659*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1.) understand the origins of destructive behavior of nominally normal individuals and group violence, (2.) recognize the importance of psychiatry in understanding these phenomena, (3.) be aware of how the role of psychiatry applied to such phenomena differs from its role in the clinical situation, (4.) be familiar with concepts from other fields and how they can help understand the conflicts and violence which face us in the early twenty-first century, (5.) perceive how this may help us address not only our patient's needs but our civilization's needs.

SUMMARY:

Objective: To apply psychiatric concepts to understand the destructive behavior of nominally normal individuals, which, especially when functioning in groups, can undo the gains made in prevention and treatment of illness, can interfere with addressing our patients' needs, and can cause even more misery than that caused by individual psychiatric illness. Working out useful methods for the study, and hopefully the amelioration, of such behavior deserves a high priority. Method: This paper draws upon the author's experience studying violence, beginning as consultant to the Warren Commission and the Eisenhower Commission, and continuing with the study of leaders; ethnic, religious, and national violence; and assassination and terrorism, which the author has published and has presented at previous APA meetings. Concepts from other fields, such as cultural analysis, extended phenotype theory, humanities, religion and divinity studies, sociology (social identity, system justification, social dominance, and terror management theory), information theory, education, and history are used in conjunction with psychiatry to help understand the roots of group destructiveness and violence. Such concepts include: "extrapsychic levels," cultural discourse, "memes," group identity, the role of the "other," ethnicity and nationalism, "chosen traumas," psychogeographic and psychohistorical fantasies, the role of violence in identity formation, transcendence and ecstatic experience, the concept of Satan, education and indoctrination, existential and religious terror, and "costly ritual theory." Results: Individuals and groups are influenced by factors of which they are not aware, but this is not necessarily the same as the psychoanalytic idea of the unconscious. The prevalent public discourse does not help foster a solution to conflict and does not facilitate peace processes. The discourse focuses on who is right and who is wrong, on who started it, who is the aggressor and who is the victim, who is acting morally and who is acting immorally - even who is evil, who should stop fighting first, who won or lost, resulting in a circular argument getting nowhere. A psychiatric approach, informed by concepts from other fields, adds to our understanding of the conflicts and violence which face us in the early twenty-first century, such as the Arab-Israeli conflict, the war in Iraq, nuclear proliferation by Iran and North Korea, the war on terrorism, and the so-called clash of civilizations, among others. Conclusions: The study indicates that it is possible to break out of the constraints of the current discourse and provides a scaffold on which to build future research. The author develops new terminology of "extrapsychic levels" based upon information theory, analogous to the intrapsychic levels of conscious, preconscious, and unconscious.

The answers we discover apply not only to the questions of group violence, terrorism, ethnic and religious conflict and international war; they relate to fundamental human concerns which have occupied and preoccupied humanity's thoughts and feelings throughout history - concerns such as the need to accept and come to terms with the fact of our mortality.

REFERENCES:

1. Volkan, V: Killing in the Name of Identity: A Study of Bloody Conflicts. Charlottesville, VA, Pitchstone, 2006; Falk, A: Fratricide in the Holy Land: A Psychoanalytic View of the Arab-Israeli Conflict. Madison, WI, U Wisconsin Press, 2004.
2. Rothstein, DA: Ethnic Conflict in the Post-Cold-War Era. Journal for Psychoanalysis of Culture and Society, 1998; 3:131-144; Rothstein, DA: The Effects of the Nuclear Age on Society. www.psrchicago.org/Resources/PSRNEISPsychol-Nuclear081205.pdf.

No. 38
PHASES OF TRAUMA RECOVERY

Herbert L. Campbell, M.D. *U.S. Department of State, Medicine, 9300 Pretoria Place, Dulles, VA, 20189*

EDUCATIONAL OBJECTIVES:

At the end of the presentation the listener should be able to:
Define trauma
Understand the steps of trauma recovery
Differentiate victim from survivor and the impacts those terms have on recovery

SUMMARY:

Objective: To teach health care providers and the nonmedical public the phases of trauma recovery.

Method: Having treated a population of more than 300 multicultural patients post a variety of traumatic events over the past ten years, I became aware of a pattern of natural trauma recovery.

Results: Trauma recovery takes place in a natural order of phases over a set period of time. The first two phases are the most important for recovery and if the person becomes syptomatic with a posttramatic disorder it is because they did not complete one of these phases. The third phase well demarcates the terms victim and survivor and is the threshold for recovery. There are many factors that influence how the recovery proceeds. Anniversaries are at regular time intervals to test the recovery process.

Conclusions:

Trauma has become an every day word in the past ten years. The word in medical terms and especially in psychiatric terms has a more defined meaning. In this presentation after the word is clearly defined the process and stages of recovery are then described. In the past medical literature has emphasized the pathological consequences of trauma. Here the recovery process will be seen as a normal and healthy progression. The presentation is in a form so any level of health care provider can use it for their own purposes and practice. Emphasis is given to the distinction of victim and survivor. The timeline of recovery is well described including the occurrences of anniversaries of the event. Cross-cultural components are important factors of how the recovery varies with different people but overall the recovery process is the same for all people.

The best way for people to understand the trauma recovery process is be taken through each step in a short presentation. The majority of the time of this report will be spent giving this short presentation.

REFERENCES:

1. Fullerton CS, Ursano RJ: Posttraumatic StressDisorder; Acute and Long-Term Responses to Trauma and Disaster, Arlington, VA, American Psychiatric Publishing Inc, 1997.
2. Yehuda R: Treating Trauma Survivors with PTSD, Arlington, VA, American Psychiatric Publishing Inc, 2002.

No. 39
PREDICTING UNRESOLVED PTSS IN EARTHQUAKE SURVIVORS: A COMPARISON BETWEEN DECISION ANALYSIS AND LOGISTICS REGRESSION

Presenters: keng shin lin, Sr., D.M. *kai shung 2th road 180, kaohsiung, 802, Taiwan Republic of China*, Kuan-yi Tsai, M.D.

EDUCATIONAL OBJECTIVES:

m.s.

SUMMARY:

Objective: The aim of this prospective study was to compare results of logistic regression with those of decision tree analysis of an observational, psychiatric trauma data set, including quality of life (QOL) and 3-year diagnosis of posttraumatic stress symptoms (PTSS). Method: A previous study validated the Disaster-Related Psychological Screening Test (DRPST) for collecting background information on residents and determining psychological symptoms that result from disaster-related psychiatric disorders. A total of 4223 respondents were surveyed at 0.5 year after the Taiwan Chi-Chi earthquake, and 498 (11.8%) of them were PTSS-positive. 2.5 years later, 418 (83.9%) of these 498 participants were followed up. Verified values falling outside threshold limits were analyzed according to demographic data, putative risk factors, psychiatric symptoms and QOL with the aid of logistic regression. A decision tree was automatically produced from root nod to target classes (recovery from or unresolved PTSS). Results: Among 418 PTSS-positive residents at 0.5 year after the earthquake, in whom 24 variables could be assessed, outcome at 3 years was analyzed using logistic regression to determine the relative influence of participants' demographic data, putative risk factor, psychiatric symptoms and QOL. The most significant predictors of unresolved PTSS in these participants set were ''prominent financial loss'', lower score of MCS, and ''reliving the experience''.Using decision tree analysis, the authors found that ''prominent financial loss'', lower score of MCS, ''reliving the experience'', ''elder than 36 years old'' and without ''difficulty in falling or staying asleep'' are the best predictors of unresolved PTSS, with a 17% improvement in predictive accuracy (PA) over that obtained by simply predicting the largest outcomes category as the outcome for each unresolved PTSS residents at 0.5 year after the earthquake. Conclusions: Decision tree analysis confirmed some of the results of logistic regression and challenged others. This investigation shows that there is knowledge to be gained from analyzing observational data with the aid of decision tree analysis.

REFERENCES:

1. Tsai KY, Chou P, Chou FH, Su TT, Lin SC, Lu MK, Ou-Yang WC, Su CY, Chao SS, Huang MW, Wu HC, Sun WJ, Su SF, Chen MC: Three-year follow-up study of the relationship between posttraumatic stress symptoms and quality of life among earthquake survivors i.
2. Wu HC, Chou P, Chou FH, Su CY, Tsai KY, Ou-Yang WC, Su TT, Chao SS, Sun WJ, Chen MC: Survey of quality of life and related risk factors for a Taiwanese village population 3 years post-earthquake. Aust N Z J Psychiatry 2006; 40(4):355-361.

SCIENTIFIC AND CLINICAL REPORT SESSION 14—DIAGNOSTIC ISSUES

No. 40
BEYOND BIPOLAR I AND II: EVIDENCE FOR THE VALIDITY OF THE "SOFTER" BIPOLAR SPECTRUM

Presenters: Camilo J. Ruggero, Ph.D. *Brown Medical School, Department of Psychiatry and Human Behavior, 235 Plain Street, Suite 501, Bayside Medial Center, RIH, Providence, RI, 02905*, Mark Zimmerman, M.D., Iwona Chelminski, Ph.D., Diane D. Young, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe controversies surrounding the bipolar disorder spectrum and understand the extent to which empirical work supports one aspect of this controversy over another.

SUMMARY:

Objective: Over the past 30 years, a trend in psychiatric research has pushed for the broadening of the concept of bipolar disorder to include so-called ''soft'' cases of the disorder. The latter refers to cases of bipolar disorder that do not meet strict criteria for bipolar I disorder, with its pronounced episodes of mania. Bipolar II disorder is the prototype of this condition, but several researchers have argued for an even broader definition of the spectrum (e.g., hypomanic episodes lasting less than 4 days). New treatments in addition to expensive marketing campaigns by pharmaceutical companies have accelerated this trend.

Yet the extent to which these ''softer'' cases are valid manifestations of the bipolar spectrum remains in dispute. To address the issue, the current work presents data from one of the country's largest clinical epidemiology studies, the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project. People with DSM-IV- defined bipolar I and II disorder were compared to a group of people on the bipolar spectrum, so-called ''soft'' bipolar cases, and a control group. It was hypothesized that the group with the bipolar spectrum cases would more closely resemble the bipolar group than the control group in their clinical and demographic profile as well in their family rates of bipolar disorder. Method: A subset of patients (N = 500) from the MIDAS project were recruited into this study. Patients were administered the Structured Clinical Interview for DSM-IV for Axis I Disorders (SCID), the Structured Clinical Interview for Personality Disorders (SIDP), the Family History Research Diagnostic Criteria (FHRDC), as well as self-report measures including the Mood Disorders Questionnaire (MDQ). Patients were divided into three group: the first consisted of patients with SCID diagnosed bipolar I and II disorder (''bipolar group,'' n = 43). The second involved patients with ''softer'' bipolar spectrum disorders (''bipolar spectrum group,'' n = 93), defined as those who did not meet full SCID criteria for a manic or hypomanic episode, as well as those identified as bipolar by the MDQ. The third group consisted of patients who were not identified as bipolar by any instrument (''control group,'' n = 364). These three groups were compared on family history of bipolar disorder, as well as demographic and clinical characteristics, including patterns of comorbidity. Results: With respect to comorbidity, the bipolar spectrum group was significantly more similar to the bipolar group than the control group. Regarding their clinical and demographic profile, the bipolar spectrum group much more closely resembled the bipolar than the control group. Finally, family rates differed significantly among the groups. There was a trend for the family rates of bipolar disorder in the bipolar spectrum group to be more similar to the rates in the bipolar group than the control group. Conclusions: Results from the study support the notion of a broader spectrum of bipolar disorder.

Specifically, evidence from the MIDAS project suggests that "softer" cases of the disorder are more similar to the traditionally defined bipolar I and II disorder than to non-bipolar cases.

REFERENCES:

1. Akiskal, HS, Mallya, G. Criteria for the 'soft' bipolar spectrum: treatment implications. Psychopharmacology Bulletin 1987; 23: 68-73.
2. Baldessarini, R. A plea for integrity of the bipolar disorder concept. Bipolar Disorder 2000; 2: 3'7.

No. 41
A PROPOSAL FOR A NEW MULTIAXIAL MODEL OF PSYCHIATRIC DIAGNOSIS: A CONTINUUM PATIENT MODEL BASED ON EVOLUTIONARY DEVELOPMENTAL GENE-ENVIRONMENT INTERACTION

Hoyle Leigh, M.D. *University of California, 445 South Cedar Avenue, Fresno, CA, 93702*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should understand how modern developments in genetics and neuroscience necessitate a reconceptualization of psychiatric diagnosis, and understand the need for a new multiaxial patient model based on evolutionary, gene-environment interaction.

SUMMARY:

Objective: To review recent genetic and neuroscience research on psychiatric syndromes based on current diagnostic scheme, and to develop a better-fitting multiaxial patient-oriented diagnostic model. Method: DSM I, published in 1952, considered psychiatric illness as reactions or extremes of adaptations of the patient's personality to stressful environmental demands. Personality itself was determined by constitution and psychodynamic development. In 1980, this continuum model gave way to an atheoretical, categorical diagnostic scheme (DSM III) based on research diagnostic criteria for obtaining pure cultures of patients for biological research. Subsequent research using the "pure cultures" suggests that psychiatric syndromes represent a phenotypic continuum determined by genes, childhood traumas, and recent stress, mitigated by childhood nurturance, education, and current social support. Specific gene X childhood abuse X recent stress interactions have been discovered that may serve as a model of how interacting vulnerability genes may or may not result in a psychiatric syndrome, depending on the individual's developmental history and current stress. Results: A continuum model is proposed, with genes interacting with early experiences of stress or nurturance resulting in brain states that may evince minor but persistent symptoms (neurosis) or maladaptive patterns of behavior (personality disorder). The addition of recent or current stress may precipitate a major psychiatric syndrome. While severe genetic predisposition, such as a mutation, may be sufficient to cause a major syndrome, major psychiatric syndromes are best conceptualized as dysregulation of evolutionarily adaptive brain function such as anxiety and vigilance. A new multiaxial model of psychiatric diagnosis is proposed based on this model: Axis I for Phenomenological Diagnoses that include major psychiatric syndromes (e.g. Depressive Syndrome, Psychosis), Neuroses, Personality Disorders, and isolated symptoms, Axis II for Geno-Neuroscience Diagnosis, some of which may represent biological conditions associated with Axis I - genes, specific brain morphology, functional state of specific brain areas, based on labs and imaging studies, Axis III for Medical Diseases and Conditions, Axis IV for Stress - Childhood, Recent, and Current, and Axis V for Psychosocial Assets - Intelligence, Education, School/Work, Social Support, and GAF - for past 5 years / current. Conclusions: This proposed diagnostic scheme is likely to yield important new associations between Axis I (psychiatric syndromes) and Axis II (Gene/Brain morphology and function), and lead to a better understanding of the patient by formalizing the consideration of life-long stresses (Axis IV) and psychosocial strengths (Axis V).

REFERENCES:

1. Caspi A,:Influence of life stress on depression: moderation by a polymorphism in the 5-HTT gene. Science. 2003;301:386-389.
2. Munaro MR: Neuroticism Mediates the Association of the Serotonin Transporter Gene with Lifetime Major Depression.Neuropsychobiology. 2005; 24;53(1):1-8.

No. 42
IMPROVING THE UNDERSTANDING OF CAUSALITY IN PSYCHIATRIC RESEARCH

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

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to understand the major problems in etiologic research using the psychiatric diagnostic categories.

SUMMARY:

Objective: The objective of the paper is to discuss underlying problems of causality research using psychiatric diagnostic categories. Method: This is a conceptual piece drawn from the research and clinical literature including the history of psychiatry. Results:

Cooccurrence of disorders is frequent and often unmeasured, and particularly a problem in samples of convenience in small N studies. Disorders overlap; schizophrenia and bipolar; depression and anxiety. Such overlap is not in the definition of the reference group being studied. Although assumed to be homogenous, the categories can be broken into smaller units. Moreover, core symptoms of a disorder appear in other disorders. Also, specific psychiatric symptoms have built-in confounds and submerged and unmeasured elements.

Controls do not solve the problem of unmeasured selectivity as it is not possible to select for hidden elements.

Conclusions:

Although essential to understanding causality, the lack of validity of the diagnostic system is largely ignored. Psychiatric categories often contain unselected, unknown and unmeasured elements with hidden assumptions and submerged statements that lead to substantial measurement error and errors in interpretation. Unmeasured processes in the diagnostic categories can show up as causal forces. Such confounds likely render causality research using current categories as not feasible.

The first step in dealing with causality research is recognizing the magnitude of the problem of unmeasured elements in the categories. While the categories may be an issue for causality purposes, they have considerable clinical utility and will not be abandoned soon. They are central to the grand narrative of modern psychiatry and at the center of communication.

The brain appears to be endowed a limited repertoire of stereotyped mental reactions triggered by a variety of stressors. Causality is multi-layered, interconnected and multifactorial. Causal conditions only increase the probability that an effect will occur and many conditions are required for an effect to occur.

The categories appear to be too large and crude for understanding etiology. Etiologic research requires a deeper understanding of the basic units and their links.

REFERENCES:

1. Kendell, R, Jablensky A: Distinguishing between the validity and utility of psychiatric diagnoses. Am J Psychiat 2003: 160: 4-12.

2. Shadish WR, Cook T D, Campbell D T: Experimental and Quasi-experimental Designs for Generalized Causal Inference. Boston, Houghton Mifflin, 2002.

SCIENTIFIC AND CLINICAL REPORT SESSION 15—GENETICS

No. 43
CYP GENOTYPING IN PATIENTS TREATED FOR DEPRESSION

Presenters: Gualberto Ruano, M.D. *Genomas, Inc., 67 Jefferson Street, Hartford, CT, 06106,* John W. Goethe, M.D., Andreas Windemuth, Ph.D., Umme Salema Rahim, M.D.

EDUCATIONAL OBJECTIVES:

Participants will be able to (1) discuss the importance of CYP enzymes in the metabolism of psychiatric medications and (2) list polymorphisms in CYP 2D6, 2C9 and 2C19 that can affect response to and tolerance of SSRIs.

SUMMARY:

Objective: To (1) determine in a sample of depressed patients the proportion with clinically-significant CYP 2D6, 2C9, and 2C19 polymorphisms, (2) identify the types of polymorphisms and the frequency of each compared to a control group of non-psychiatrically ill medical patients. Method: The Tag-ItT Mutation Detection assays in the Luminex xMAPT system were utilized for DNA typing. Alleles were classified as deficient, functional, duplication, or null based on well-defined molecular properties of an altered gene. Null included deletions (*5), framshift (*3, *6), stop codons (8), and splicing defects (*4, *11). The psychiatric sample was 73 outpatients receiving an SSRI for depression; controls were 95 medical patients at the same facility treated for dyslipidemia. Chi-square, t-test and descriptive statistics were used for analyses. Results: Among psychiatric patients, 43 (48.9%) had polymorphisms that were potentially relevant for patients taking an SSRI in the gene that codes for the CYP2D6 enzyme. 39.7% in this group had only one functional copy of this gene, versus 24.2% among controls (p=0.02). Types of null alleles found included *4, a splicing defect (n=28) and *6, a frameshift mutation (n=4). There were two gene duplications in the psychiatric group, both of the inactive *4 allele. Overall, CYP metabolic status was categorized as "functional" in 41.1% of psychiatric patients versus 48.4% of controls (p=0.2, NS). Conclusions: Polymorphisms relevant to SSRI metabolism were common in this sample of depressed patients. The alleles identified appear to be clinically relevant and to be more prevalent in depression than in non-psychiatric patients. DNA typing may play an important role in the selection and dosing of psychiatric medications metabolized by CYP enzymes and may contribute to improved compliance with and response to psychiatric treatment.

REFERENCES:

1. Kirchheiner J, Brosen K, Dahl ML et al: CYP2D6 and CYP2C19 genotype-based dose recommendations for antidepressants: a first step towards subpopulation-specific dosages. Acta Psychiatr Scand 2002; 104:173-92.
2. Kirchheiner J, Nickchen K, Bauer M et al: Pharmacogenetics of antidepressant and the antipsychotics: the contribution of allelic variations to the phenotype of drug response. Mol Psychiatry 2004; 9:442-73.

No. 44
AN ASSOCIATION BETWEEN THE EPAC-1 GENE AND NEUROTICISM AND ANXIETY.

Presenters: Christel M. Middeldorp, M.D. *Vrije Universiteit, Biological Psychology, Van der Boechorststraat 1, Amsterdam, 1081BT, Netherlands,* Xiangning Chen, Ph.D., Jacqueline M. Vink, Ph.D., Kenneth S. Kendler, M.D., Dorret I. Boomsma, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should have learnt that Epac is a protein involved in a pathway facilitating transmitter release in the nerve terminal. Variants in the genotype for Epac-1 are possibly associated with neuroticism and anxiety. The participant should realize that these results underline the importance of psychiatric genetic research into basic cell functions instead of only focusing on neurotransmitter functions.

SUMMARY:

Objective: Epac (derived from "exchange protein directly activated by cAMP") facilitates the direct activation of Rap-1 by cyclic adenosine monophosphate (cAMP). Via this pathway, cAMP facilitates transmitter release in the nerve terminal. In depressed subjects, the cAMP signaling was found to be altered. We performed a study investigating the association between the EPAC-1 gene and neuroticism, anxiety and depression. Method: The sample consists of 845 individuals (mean age 41.1, sd 13.1) of 301 families recruited via the Netherlands Twin Register (NTR). The subjects had participated between one and five times in a survey study measuring neuroticism, anxiety and depression. Mean scores across the five occasions were analyzed. The following markers were genotyped in the Epac-2 gene: Rs757281, Rs2074533 and Rs2072155. Within family and total association were tested in qtdt while modeling a linear and a dominant effect. Results: A significant dominant effect was found for marker Rs2074533 for neuroticism and anxiety with p-values of 0.01 and 0.03 respectively. The other markers showed no significant association. Conclusions: There seems to be an association between the Epac-1 gene and neuroticism and anxiety. To our knowledge, there has not been another association study on the Epac-1 gene and anxiety related traits. Our results seem to contradict a recent study which found an increased protein level of Epac-2, but not Epac-1, in the hippocampus and prefrontal cortex of depressed suicide victims without significant changes in mRNA levels for Epac-1 or 2. However, the sample size was small and probably contained more extremely depressed subjects than our population-based sample. Considering these differences, it is encouraging that both studies suggest a role of Epac in the development of anxiety or depression and further research into this association seems warranted.

REFERENCES:

1. Dwivedi Y, Mondal AC, Rizavi HS, Faludi G, Palkovits M, Sarosi A, Conley RR, Pandey GN: Differential and brain region-specific regulation of Rap-1 and Epac in depressed suicide victims. Arch Gen Psychiatry 2006; 63:639-48.
2. Abecasis GR, Cardon LR, Cookson WO: A General test of association for quantitative traits in nuclear families. Am J Hum Genet 2000; 66:279-292.

No. 45
CIRCADIAN SYSTEM POLYMORPHISMS AND BIPOLAR DISORDER

Presenters: Daniel F. Kripke, M.D. *University of California, San Diego, Psychiatry, 8437 Sugarman Drive, La Jolla, CA, 92037-2226,* Caroline M. Nievergelt, Ph.D., John R. Kelsoe, M.D., Thomas B. Barrett, M.D., Nicholas J. Schork, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize evidence that circadian system genes may be associated with susceptibility to bipolar disorder.

SUMMARY:

Objective: The bases for suspecting circadian abnormalities in bipolar disorder include the periodicity and seasonality of symptoms, sleep and activity disturbances, the anti-depressant and pro-manic effects of bright light, and the mood affects of schedule shifts and sleep deprivation. Our group has been exploring hypotheses that polymorphisms in the circadian pacemaker genes might be associated with susceptibility to bipolar disorder. Method: Over 430 triads of bipolar probands and both parents (when available) were genotyped for 180 polymorphisms of circadian system genes. Using the transmission disequilibrium test (ETDT), unequal transmission of specific alleles from parents to bipolar offspring was examined. Results: Alleles in 16 single nucleotide polymorphisms (SNPs) were associated with bipolar disorder with a nominal $P<0.05$. The highest level of significance was found in NR1D1 (REV-ERB-alpha), for which 4 of 9 SNPs tested reached nominal significance. For SNP rs2314339, the nominal significance of the association was $P=0.00021$, which is still significant ($P<0.04$) after conservative Bonferroni correction for 180 SNPs analyzed. Because NR1D1 and THRA somewhat overlap, rs2314339 is in linkage disequilibrium with SNPs which also need exploration in THRA. Also, 7 of 14 SNPs in CLOCK reached nominal significance, with rs12504300 reaching a nominal $P<0.003$. As might be expected from the extensive linkage disequilibrium extending throughout the CLOCK gene, the significant SNPs were widely dispersed over the gene. Of note, the 3111 T/C SNP in the 3' UTR was not significantly associated. No haplotype of 2 or 3 adjacent SNPs exceeded single-SNP significance for NR1D1. In CLOCK, there were two multi-SNP haplotypes slightly more significant than rs12504300 alone. Conclusions: Currently, these data provide preliminary evidence that polymorphisms in the circadian system are involved in bipolar disorder. Additional statistical analyses, further efforts to identify the functional polymorphisms, and replication in other data sets are needed.

REFERENCES:

1. Nievergelt CM, Kripke DF, Barrett TB et al. Suggestive evidence for association of the circadian genes Period3 and Arntl with bipolar disorder. Am J Med Gen Part B (Neuropsychiatric Genetics) 2006;141B:234-41.
2. Yin L, Wang J, Klein PS, Lazar MA. Nuclear receptor Rev-erbalpha is a critical lithium-sensitive component of the circadian clock. Science 2006;311(5763):1002-5.

SCIENTIFIC AND CLINICAL REPORT SESSION 16—CROSS CULTURAL PSYCHIATRY

No. 46
SIMILAR DEPRESSIVE SYMPTOM PATTERNS IN A POPULATION BASED STUDY OF IMMIGRANTS FROM TURKEY AND MOROCCO AND DUTCH NATIVES

Presenters: Agnes Schrier *Altrecht, Tolsteegsingel 2A, Utrecht, 3582 AC, Netherlands*, Matty de Wit, Jack Dekker, Ralph Kupka, Aartjan Beekman

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to review the available epidemiological data on cultural variations in the clinical presentation of depression.

SUMMARY:

Objective: Although epidemiological research has confirmed the occurrence of affective disorders worldwide, there is an ongoing debate about the impact of cross-cultural differences in expression and reporting of symptoms. We compared depressive symptoms-patterns in Turkish and Moroccan immigrant groups and native Dutch in, both in the general population as well as in subjects with a major depressive disorder. Method: Residents (N=1736; 44.1% response) from a random community sample from the Amsterdam population register, stratified for ethnicity, participated in a general health survey. In a second wave mental health condition was assessed by bilingual interviewers using the Composite International Diagnostic Interview (CIDI 2.1), sections on anxiety and depressive disorders, and the Symptom Checklist-90-Revised (SCL-90R), subscales depression, anxiety, agoraphobia, and somatic complaints. The impact of health problems on functioning was measured by the World Health Organization Disability Assessment Schedule II (WHODAS II). Results were obtained from 812 subjects (71.0% response): N=312 Dutch, N=212 Turkish, N=191 Moroccan, N=87 Surinamese. Results: The sumscore of SCL-90R items was two- to threefold increased in Turkish and Moroccan immigrants compared to native Dutch citizens. However, patterns of SCL-90R depressive symptoms in the general population were equal in Turkish and Moroccan immigrants and native Dutch. In subjects with a major depression similar SCL-90R and CIDI symptom patters were found, also after including anxiety, phobic and somatic symptoms. A higher level of depressive, anxiety and somatic symptoms increased the level of disabilities in all ethnic groups alike. Conclusions: Depressive symptom patterns and their impact on functioning were equal in a population based study of Turkish and Moroccan immigrants and native Dutch. This underscores the similarity of depressive symptoms and major depressive disorder in different cultures when assessed with standardised instruments.

REFERENCES:

1. Kirmayer LJ: Cultural variations in the clinical presentation of depression and anxiety: implications for diagnosis and treatment. J Clin Psychiatry 2001; 62[suppl 13]:22-28.
2. Kleinman A: Culture and depression. N Eng J Med 2004; 351(10): 951-953.

No. 47
PREVALENCE AND CORRELATES OF PMDD AMONG ARAB PRIMARY CARE PATIENTS IN THE UNITED ARAB EMIRATES

Presenters: Ossama Tawakol Osman, M.D. *United Arab Emirates University, Psychiatry and Behavioral Sciences, P.O. Box 17666, Al-Ain, 000000, United Arab Emirates*, Sufyan Sabri, Ph.D., Hanan Alraeesi, Amal Shamsan, M.D., Diaa Rizk, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to:

1- Recognize the Prevalence of Premenstrual Dysphoric Disorder in a primary care community in the Gulf Country of the United Arab Emirates

2- Demonstrate understanding of the various sociodemographic correlates of the disorders among different ethnic Arabs in that community.

SUMMARY:

Objective: This epidemiologic survey studied the prevalence and impact of premenstrual dysphoric disorder (PMDD) among adult Arab women attending the primary care clinics in the city of Al-Ain in the gulf country of the United Arab Emirates. Method: A Five hundred and eight (n=508) women in their reproductive years (18-50 years old) were selected at random from 5 Primary Health Care clinics. Participation was voluntary and the subjects were explained the study in detail. After signing the consent form they were administered two diagnostic screening instruments for PMDD. The Premenstrual Symptoms Screening Tool (PSST) and the Mini International Neuropsychiatric Interview (MINI) and one instrument for assessing the degree of disability (Sheehan Diability Scale). The data were analyzed for bivariant and multivariant analysis using the Statistical Package for the Social Sciences (SPSS Inc., version II). Various sociodemographic variables were examined for their association with DSM-IV diagnosis of PMDD. Chi-square tests, single and multiple regression analysis, were used when appropriate. Results: The prevalence of severe forms of PMDD was 4.3% . Moderately severe cases were 8.1%. There was significant association between the disorder (PMDD) and several socio-demographic factors including; higher education ($p<0.002$), single marital status ($p<0.046$), personal and family history of use of sedative-hypnotics ($p<0.001$), sister with similar condition ($p<0.001$) and past personal and family psychological problems ($p<0.001$). There was no statistical difference in prevalence of the disorder between UAE national and non-nationals. No correlation was found between the presence of the disorder and age, total household income, number of children, or nationality. The degree of resulting disability was assessed using the Sheehan Disability Scale (SDS). Logistic regression analysis revealed a significant association between the presence of the disorder and four specific life stressors reported over the past 12 months. The frequency of of the top five PMDD symptoms reported were; anger/nervousness 97% (n=61), anxiety/irritability 83% (n=52), hopelessness/depression 81% (n=51), and physical symptoms 78% (n=49), tearfulness/rejection sensitivity 78% (n=49). Conclusions: The prevalence of PMDD is consistent with the reported international rates and is higher among the highly educated and single. UAE nationals report less disability in association with the disorder. There was a strong association between major past life stressors in those women with the disorder compared with those without. This points in addition to a strong association with family history may suggest a specific vulnerability that requires further study. The data also suggest co-morbidity with other psychiatric conditions which needs further study.

REFERENCES:

1. Freeman EW, Sondheimer SJ. Premenstrual dysphoric disorder: Recognition and treatment. Primary Care Companion J Clin Psychiatry 2003; 5:30-39.
2.]. Steiner M, Macdougall M, Brown E. The premenstrual symptoms screening tool (PSST) for clinicians. Arch Womens Mental Health 2003; 6:203-209.

No. 48
EFFECTIVENESS OF CULTURALLY SENSITIVE COLLABORATIVE TREATMENT FOR TREATING CHINESE AMERICANS WITH DEPRESSION IN A PRIMARY CARE SETTING : A SIX-MONTH FOLLOW-UP STUDY

Presenters: Albert Yeung, M.D. *Massachusetts General Hospital, Psychiatry, 50 Standord Street, Suite 401, Boston, MA, 02114*, Lauren Fisher, B.A., Anna M. Agoston, B.A., Wan-Chen Weng, M.A., Yantao MA, M.D., Shamsah Sonawalla, M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVES:

To learn the effectiveness of using culturally sensitive collaborative treatment for identifying, engaging, and treating depressed Chinese immigrants in primary care settings.

SUMMARY:

Objective: To examine the effectiveness of treating less acculturated depressed Chinese Americans in primary care using culturally sensitive collaborative treatment (CSCT). Method: Between March 2004 to December 2005, depressed Chinese American patients in a primary care clinic were identified through screening using the Chinese version of Patient Health Questionnaire (PHQ-9). Patients who screened positive (CB-PHQ-9≥15) were interviewed using the Engagement Interview Protocol (EIP), designed for communicating psychiatric diagnoses and for negotiating treatment options attuned to patients' cultural viewpoints. Enrolled depressed patients received medications treatment from their primary care physicians or from a liaison psychiatrist, and were randomized to receive either telephonic care management or usual care. Treatment outcomes were evaluated by blind assessors at 1.5, 3, and 6 months using the 17-item Hamilton Rating Scale for Depression (HAM-D), the Clinical Global Impression Scale (CGI), and the Social Functioning Scale (SF-12). Results: Sixty depressed Chinese Americans (72% female, mean age 50±15) were enrolled into the study; and 35 (58%) of them were randomized to receive telephonic care management. At the end of the study, 16 (27%) patients achieved remission (> 50% reduction of initial HAM-D score), 25 (42%) patients showed response to treatment (HAM-D score < 7 at last assessment), and 20 (33%) patients were lost to follow-up. Treatment outcomes were not associated with age, gender, duration in the U.S., level of education, stigma score, initial HAM-D score, or care management. Conclusions: This study demonstrated the feasibility and effectiveness of using culturally sensitive approaches and collaborative treatment to treat less acculturated, depressed Chinese American in primary care. CSCT may be a solution for reducing under-treatment of depression among ethnic minority immigrants. The lack of adherence to treatment is an important barrier in treating depressed Chinese Americans in primary care.

REFERENCES:

1. Yeung AS, Kung WW, Chung, H, Rubenstein G, Roffi P, Mischoulon D, Fava, M. Integrating psychiatry and primary care improves treatment acceptability among Asian Americans. General Hospital Psychiatry 26: 256-260, 2004.
2. Yeung AS, Yu SC, Fung F, Vorono S, Fava M Recognizing and Engaging Depressed Chinese Americans in Treatment in a Primary Care Setting. Int J Geriat Psych (in press).

SCIENTIFIC AND CLINICAL REPORT SESSION 17—TREATMENT OF PSYCHIATRIC DISORDERS IN MEDICALLY ILL PATIENTS

No. 49
PILOT TRIAL OF MODAFINIL FOR TREATMENT OF DEPRESSION SYMPTOMS AND FATIGUE IN ADULT PATIENTS WITH BRAIN TUMORS

Presenters: Thomas A. Kaleita, Ph.D. *David Geffen School of Medicine at UCLA, Psychiatry and Biobehavioral Sciences, 760 Westwood Plaza, C8-202, Los Angeles, CA, 90095-1759*, David K. Wellisch, Ph.D., Timothy F. Cloughesy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the linkage between primary malignant brain dis-

eases and subsequent depression, fatigue, as well as neurocognitive dysfunction. Results from a recently completed modafinil therapeutic trial for depression symptoms and fatigue in adult brain tumor patients will enhance the foundation of consultation liason interventions for cancer patients.

SUMMARY:

Objective: To test the efficacy and safety of modafinil for treatment of depression symptoms and fatigue in adult patients with primary malignant brain disease. Method: Patients: 30 adults, 63% male, mean age=45.3 (SD=11.7) years. Time since tumor diagnosis: mean= 2.9 years; median=1.8 years; range: 0.1-14.1 years. Pathology: Primary malignant and nonmalignant cerebral tumors: high grade, n= 18 (60%) and low grade, n=10 (33%) gliomas, CNS lymphoma, n= 1 (3%); meningioma, n=1 (3%).Tumor Locations:: frontal, n=14 (47%), temporal, n=9 (30%); parietal, n=4 (13%).Treatment: neurosurgery, n=29(97%), radiotherapy, n=24 (80%), and chemotherapy, n=21 (70%). Eleven patients received cytotoxic or cytostatic chemotherapy during study enrollment.

Outcome Measures: *Depression*: Hamilton Depression Scale-31 items (HAM-D-31); *Fatigue*: Fatigue Severity Scale (FSS), Visual Analogue Fatigue Scale (VAFS), Modified Fatigue Impact Scale (MFIS).

Design: I. 3 wk. double blind, dose-controlled randomization (200 mg/day vs. 400 mg/day in divided doses, after initial start-up, 100 mg/day x 3 days, 200 mg/day in divided doses x 4 days); II. 1 wk.washout:; III. 8 wk. open label extension (50-600 mg/day; mean daily dose: 8 wks., 225 mg; 12 wks., 258 mg).

Statistical Analysis: Percent changes: mean changes at designated time points (1, 3, 4, 6, 8, 10, 12 wks) divided by the sample means at baseline. Raw scores were used for all measures. Probability estimates: paired t-tests or Wilcoxon Signed Rank Tests. Results: Maximal outcomes at 8 and 12 weeks post modafinil initiation include:

R>Adverse Events:: events reported by ≥4 subjects include: headache, n=13 (42%); insomnia, n=8 (26%); dizziness, n=7 (23%); dry mouth, n=7 (23%); depressed consciousness, n=5 (16%); nausea, n= 4 (13%). (NCI CTC 2.0, Grade 1 or 2).

Conclusions: *Modafinil was very effective at improving depression symptoms and fatigue levels in adult patients with primary malignant brain disease.

* Highly statistically significant and clinically meaningful improvements were found on all outcome measures at 8 and 12 weeks after modafinil initiation.

*Since the substantial levels of fatigue present at baseline were so reduced, a proposed mechanism for improving depression symptoms in brain tumor patients may partially involve similar psychopharmacologic mechanisms underlying modafinil's demonstrated efficacy to alleviate fatigue in other neurologic conditions. .

* The combination of depression symptoms and fatigue in patients with cancer has not been addressed previously in clinical trials with antidepressant medications. The positive outcomes of this pilot study suggest that modafinil is an effective and safe treatment option for patients who experience depression symptoms and fatigue secondary to brain cancer.

REFERENCES:

1. Ballon JS, Feifel D: A systematic review of modafinil: Potential clinical uses and mechanisms of action. J Clin Psychiatry 2006; 67: 554-566.
2. Wellisch DK, Kaleita TA, Freeman D, Cloughesy TF, Goldman J: Predicting major depression in brain tumor patients. Psycho-Oncology 2002; 11: 230-238.

No. 50

INTRAOPERATIVE CEREBRAL OXYGEN DESATURATION: A SIGNIFICANT RISK FACTOR FOR POSTOPERATIVE DELIRIUM IN CARDIAC SURGERY PATIENTS

Presenters: Thomas S. Zaubler, M.D. *Morristown Memorial Hospital, Atlantic Health, Psychiatry, 100 Madison Avenue, Morristown, NJ, 07960*, James P. Slater, M.D., Rami T. Bustami, Ph.D., Theresa Guarino, R.N., Jessica Stack, B.A., Kateki Vinod, B.A., Kenneth Freundlich, Ph.D., Grant V.S. Parr, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to do the following:

1. Demonstrate an understanding of the signs, symptoms and risk factors for delirium in patients after coronary artery bypass grafting (CABG).
2. Recognize the significance of intraoperative cerebral oxygen desaturations as a risk factor for post-operative delirium and how intraoperative management may lower the risk of developing delirium.
3. Recognize that delirium in patients after CABG is associated with increased morbidity, increased length of hospital stay and cognitive decline.
4. Diagnose and effectively treat delirium in the cardiac and general medical setting.

SUMMARY:

Objective: Delirium after cardiac surgery is a common complication that is associated with increased morbidity and prolonged hospital stay [1,2]. Numerous articles have been published investigating the incidence and risk factors for delirium after cardiac surgery. While the etiology of delirium is often multifactorial, there is evidence that delirium or symptoms of delirium may be caused by a low cerebral oxygen supply. INVOS® Cerebral Oximeter is an FDA-approved non-invasive device that measures regional forebrain cerebral oxygen (rSO_2) desaturation. The purpose of this study is to examine whether decreased rSO_2 predicts the onset of delirium following coronary artery bypass grafting (CABG). Method: Prospectively collected data were obtained from a randomized clinical trial comparing outcomes in CABG patients who underwent blinded and unblinded intraoperative cerebral oximetry monitoring. Delirium was assessed every 2 days postoperatively in 240 patients using the Delirium Rating Scale (DRS), and was defined by a score of 10 or more. The rSO_2 desaturation risk score was calculated by multiplying rSO_2 below 30% by time in seconds. Univariate and multivariate logistic regression models were used to examine the unadjusted and adjusted effect, respectively, of decreased intraoperative rSO_2 on delirium. The multivariate model was adjusted for age, gender, race, and intraoperative neuromonitoring. Cognitive function was also assessed preoperatively and at discharge in all 240 patients with a battery of standardized neurocognitive measures. Cognitive decline was defined as a decrease of one standard deviation or more in performance on at least one neurocognitive measure. Results: Delirium was observed in 17% of patients in the study population. The univariate logistic regression analysis results showed that CABG patients with rSO_2 desaturation risk score of greater than 600 had a significantly higher risk of delirium: Odds Ratio (OR) = 5.51, 95% CI = (1.68,18.08), p=0.005. Results from the multivariate logistic regression model (adjusted analysis) also showed a significantly higher risk of delirium for patients with rSO_2 desaturation risk score of greater than 600: OR = 4.57, 95% CI = (1.17,17.82), p=0.028. Delirium was also significantly associated with older age: OR = 1.69, per 10 years increase, 95% CI = (1.13, 2.51), p=0.01, and receiving a blood transfusion: OR = 4.72, 95% CI = (1.94, 11.45), p=0.001. Additional logistic regression analyses showed that (1) increased score on the DRS was significantly associated with a higher

risk of neurocognitive decline at discharge: OR = 1.30, per 1 unit increase, 95% CI=(1.10, 1.54), p=0.002; (2) delirium was significantly associated with prolonged hospital stay (>=6 days): OR = 3.41, 95% CI = (1.55, 7.51), p=0.002. Conclusions: This study showed that commonly occurring, prolonged, intraoperative forebrain oxygen desaturation is significantly associated with an increased risk of delirium after CABG. Intraoperative management of cerebral rSO_2 may result in a lower incidence of delirium after CABG, which may lead to a decrease in length of hospital stay and in the incidence of neurocognitive decline for these patients. The elderly and patients who receive a post-surgical blood transfusion are at particularly high risk for developing delirium after CABG.

REFERENCES:

1. Roach GW, Kanchuger M, Mora Mangano C, Newman M, Nussmeier N, Wolman R, Aggarwal A, Marschall K, Graham SH, Ley C, Ozanne G, Mangano DT: Adverse cerebral outcomes after coronary bypass surgery. NEJM 1996; 335 (25):1857-1863.
2. McKhann GM, Grega MA, Borowicz LM, Bechamps M, et.al: Encephalopathy and stroke after coronary artery bypass grafting: incidence consequences and prediction. Archives of Neurology 2002; 59:1422-1428.

No. 51
MOOD AND ANXIETY DISORDERS IN PATIENTS WITH CANCER: A CASE SERIES

Presenters: Catherine L. Mancini, M.D. *McMaster University Medical Center, Psychiatry & Behavioural Neurosciences, 1200 Main Street West, Hamilton, ON, L8N 3Z5, Canada*, Andrew Cooper, B.S.C.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to:

1. Become familiar with the prevalence of common psychiatric disorders in cancer patients.
2. Examine the relationship of comorbid anxiety and mood disorders in cancer patients.
3. Become aware of the increased risk for developing depression in cancer patients with pre-existing OCD.

SUMMARY:

Objective: Studies have reported the prevalence of depression among cancer patients to be as high as 40%. Less is known about the prevalence of anxiety disorders, particularly obsessive compulsive disorder (OCD). We hypothesized that cancer patients with pre-existing obsessive compulsive disorder were at increased risk for developing major depression. Method: A retrospective chart review of 95 cancer patients referred for outpatient psychiatric consultation from a regional cancer centre was completed. Results: Sixty-five percent (62/95) of patients met DSM-IV criteria for major depression. Forty percent (38/95) of patients met criteria for OCD with another 6.3% (6/95) of patients exhibiting OCD symptoms but not meeting full criteria. In all cases the OCD preceded the onset of depressive symptoms. Fifteen percent (14/95) of patients had experienced panic attacks while 12% (11/95) met criteria for social phobia, generalized type. Conclusions: While 65% of cancer patients referred for psychiatric consultation were diagnosed with MDD, over 46% presented with concurrent OCD or OCD symptoms. Results of this preliminary retrospective study suggest that cancer patients with pre-existing OCD or OCD symptoms may have an increased risk for developing a major depressive episode. Given the higher than expected rate of OCD in these cancer patients, the association between OCD and cancer needs further exploration in prospective studies.

REFERENCES:

1. Honda K, Goodwin RD: Cancer and mental disorders in a national community sample: Fiindings from the National Comorbidity Survey. Psychother Psychosom 2004; 73:235-242.
2. Kangas M, Henry JL, Bryant RA: The course of psychological disorders in the 1st year after cancer diagnosis. J Consulting Clin Psychol 2005; 73:763-768.

SCIENTIFIC AND CLINICAL REPORT SESSION 18—EVIDENCE-BASED AND GUIDELINE APPROACHES TO PSYCHIATRIC TREATMENTS

No. 52
PREPARING FOR EVIDENCE-BASED MEDICATION-RELATED PSYCHIATRIC PRACTICE: THE OREGON EXPERIENCE

Presenters: Jennifer P. Wisdom, Ph.D. *Oregon Health Science University, Public Health and Preventive Medicine, 3181 SW Sam Jackson Park Road, CSB 669, Portland, OR, 97239*, David A. Pollack, M.D., Ann Hamer, Pharm.D., Sarann Bielavitz, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be familiar with the extent and impact of wide variations in psychiatric medication prescribing practices, the array of potential strategies that public mental health authorities may utilize in addressing this quality of care concern, and the importance and methods of assessing the readiness of providers within a system to implement such measures.

SUMMARY:

Objective: Evidence-based practices related to psychiatric medication administration, if implemented, may improve the quality and reduce the cost for psychiatric services . Implementation on a broad scale, however, has been a challenge for hospital systems and public mental health authorities. The objectives of our research are to: (a) examine statewide prescribing practices and determine areas for intervention; (b) determine the acceptability of and readiness to implement medication-oriented evidence-based practice in inpatient and outpatient psychiatric prescribers, staff, and consumers.

Method: Our mixed-method research has multiple initiatives: (1) We reviewed the literature to find strategies for increasing the use of evidence-based psychiatric medication administration. (2) We also analyzed pharmacy claims (n = 3,139 unique Medicaid patients with at least one claim for psychiatric medication) to determine current prescribing practices and how those practices may differ from evidence-based administration. (3) We conducted qualitative research at four inpatient-outpatient partnerships in four community mental health catchment areas (n = 46 interviews) to assess the facility and technological infrastructure capabilities, staff awareness of and perceptions of medication-oriented evidence-based practice, and agency readiness to change. (4) We interviewed consumers (n = 4 interviews) regarding their perceptions of and experiences with medication-oriented evidence-based practice. Results: Given the broad-reaching scope and multiple methods in our study, we present a short summary of the results here. (1) Results of the literature review indicate there are several key options for increasing the use of evidence-based psychiatric medication administration. These include: academic detailing of outlier prescribing patterns; improving data systems to provide clinicians feedback to prescribing providers on their prescribing practices; increasing use of clinical consultation; and implementing a systematic medication management initiative. (2) The pharmacy claims analysis identified several areas where consultation with prescribers may improve services. These areas

include (a) the administration of atypical antipsychotic medications at subtherapeutic dosages (e.g., quetiapine and risperidone were administered at a subtherapeutic dose in 60% and 46% of doses, respectively); (b) the concomitant polypharmacy of two or more antipsychotics (in 5% of patients) or of two or atypical antipsychotics (in 3% of patients); and (c) the use of multiple prescribers (4% of patients had three or more prescribers of psychotropic medications). (3) The qualitative research at inpatient-outpatient partnerships indicated provider awareness of and concerns about systematic medication management initiatives, low to moderate infrastructure capabilities to implement computerized symptom and outcome tracking, and high readiness to adopt evidence-based practices. (4) Consumers reported enthusiasm about attempts to increase the quality of care, and concerns regarding implementation, patient choice, and affordability regarding systematic medication management initiatives. Conclusions: This mixed-method approach will provide valuable information to guide the state in implementing medication-oriented evidence-based practice. Challenges remain in implementing practices with higher infrastructure and staff involvement, such as systematic medication management initiatives. Such implementation will require a higher level of planning and preparation. States and consumers may benefit from addressing medication-oriented evidence-based practice as a significant part of their mental health evidence-based practice. States may wish to implement advance planning and preparation to smooth the implementation of these practices.

REFERENCES:

1. Essock, SM et al.: Evidence-based practices: setting the context and responding to concerns. Psychiatric Clin N Am 2003; 26: 919-38.
2. Rush, AJ, et al.: Medication treatment for the severe and peristently mentally ill: The Texas medication algorithm project. J Clin Psychiatry 1998; 60:284-291.

No. 53
IMPROVING ADHERENCE TO TREATMENT GUIDELINES IN HOSPITALIZED PATIENTS WITH BIPOLAR DISORDER.

Presenters: Thomas E. Smith, M.D. *Columbia University, Psychiatry, Hall-Brooke Behavioral Health Services, 47 Long Lots Road, Westport, CT, 06880*, Stewart B. Levine, M.D., Judith Hampel, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be:

1. familiar with recent literature on intervention strategies for improving clinician adherence to treatment guidelines.

2. able to develop an assessment tool from existing guidelines to facilitate ratings of clinician adherence.

3. able to implement a strategy for training clinicians on guidelines that involves provider-specific ratings of adherence.

SUMMARY:

Objective: The aim of this study was to develop and test an intervention strategy for improving psychiatrists' adherence to published treatment guidelines for acutely ill bipolar patients. Treatment guidelines were introduced in the general medical literature many years ago, and in recent years many guidelines have been published for psychiatric conditions. Studies suggest that adherence to published guidelines is highly variable, with a wide range of factors proposed to contribute to clinician choice. Strategies for improving guideline adherence have been tested for general medical conditions, with generally poor results. Didactic training efforts have shown little impact on practice patterns, and experts recommend multifaceted, sustained intervention strategies. There are few published studies of efforts to improve guideline adherence in psychiatric conditions, perhaps due to the previous poor findings. We focused on acutely ill, hospitalized bipolar patients because anecdotal reports from our quality management team indicated that these patients were receiving highly variable psychopharmacologic management, often with poor outcomes. Our goal was to use a combination of didactic training and individualized feedback with data to effect change in practice patterns. Method: The study had 3 phases. First, an assessment tool was developed using the Expert Consensus Treatment Guidelines for Bipolar Disorder. The tool allows a rater to document whether a patient's psychopharmacolgic treatment followed 1st- or 2nd-line options listed in the guideline. Interrater reliability was established and clinician raters were able to judge whether the patient received medication treatment consistent with the guideline. Using this tool, closed medical records were rated for patients with bipolar disorder (depressed or manic) treated on a 16-bed acute psychiatry inpatient unit. Records were chosen based upon clinician discharge diagnosis; if the rater felt the diagnosis was inaccurate, the record was not included. In the baseline assessment, records were rated for 23 patients treated by 4 psychiatrists. In the second phase, training on the guidelines was provided to the psychiatrists. The intervention consisted of: a) 2 separate group discussions reviewing the guidelines as well as the tool used to rate records; and b) review of provider-specific data. Each clinician was shown the results from the baseline assessment, including his/her specific ratings as well as the overall group profile. To assess change in adherence, 16 records were subsequently rated for patients treated in the 6 months following the intervention. Results: Baseline ratings showed that 52% of the pateints had psychopharmacologic treatment consistent with the medication guidelines. For the subgroup of bipolar depressed patients (n= 18), the adherence rate was only 39%. At follow-up, adherence rates improved to 63% for all patients and 73% for bipolar depressed patients. Each of the psychiatrists involved showed improvements in adherence. Conclusions: These preliminary results indicate that a published treatment guideline can be used to develop an assessment tool, and that a focused intervention involving a combination of didactic training and individual provider feedback can improve guideline adherence in the treatment of acutely ill bipolar patients. This study is being expanded into a larger-scale project with more extensive data analyses.

REFERENCES:

1. Keck PE, Perlis RH, Otto MW, Carpenter D, Ross R, Docherty JP: The Expert Consensus Guideline Series: Treatment of Bipolar Disorder 2004. Postgrad Med Special Report, 2004 (December):1-120.
2. Dennehy EB, Suppes T, Rush AJ, Miller AL, et al: Does provider adherence to a treatment guideline change clinical outcomes for patients with bipolar disorder? Results from the Texas Medication Algorithm Project. Psychol Med 2005; 35(12):1695-706.

No. 54
STEPPED CARE FOR ANXIETY, DEPRESSIVE AND STRESS-RELATED DISORDERS. A RANDOMIZED CONTROLLED TRIAL IN PRIMARY CARE AND MENTAL HEALTH CARE

Presenters: Desiree Oosterbaan, Ph.D. *Adhesie, RIAGG Almelo, Hanzelaan 1, Almelo, 7607 NL, Netherlands*, Anton van Balkom, Ph.D., Marc Verbraak, Ph.D., Roelof ten Doesschate, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to identify the principles of the stepped care model and has knowledge of feasibility problems of its application in clinical care, in particular concerning the indication for selfhelp, the threshold for referral to mental health services, the role of patient preferences and the matching of specific treatments to particular patients in a cost-effective manner.

SUMMARY:

Objective: Recently, the stepped care model has received increasing attention as an opportunity to improve the quality and efficiency of mental health care. In stepped care, treatment starts with the simplest intervention that is expected to work in a particular patient. If monitoring reveals that the patient's response is insufficient, treatment is 'stepped up' according to the treatment algorithm. We developed stepped care programmes for the treatment of depressive-, anxiety-, and stress-related disorders in both primary and mental health care, and set out to investigate its feasibility and effectiveness. Method: Fourteen primary care physicians were randomized over two conditions: stepped care or usual care. A total of 158 patients with anxiety-, depressive- or stress related disorders participated. In patients with mild and moderately severe disorders guided self-help was offered in primary care. Those with moderate anxiety and depressive disorder were additionally treated with medication. Patients with severe illness were referred to the outpatient clinic. At the critical decision point at 4 months the effect of self-help was evaluated and patient with remaining complaints were referred to mental health services. Special attention was paid to improvement of communication between primary care physician and mental health services and the gearing of treatment interventions to one another. Main outcome measures were the number of responders on the Clinician Global Scale of Change at 4 and 8 months and the number of patients meeting remission criteria on the Clinician Global Scale of Severity. A set of disorder specific questionnaires is used as secondary outcome measures. Results: At 4 months significantly more patients in the stepped care condition were indicated by an independent rater as responders (75 vs. 51%, P=.002) or meeting criteria for remission (58% vs. 32%, P=.002). At 8 months, however, the patients in the care as usual condition caught up and no significant differences were found anymore (responders: 78 vs. 70%, P=.293; achieving remission: 57% vs. 53%, P=629). Results in favour of stepped care were most pronounced in the anxiety programme.

Over one-third of patients dropped out from guided self-help. Comorbidity, but not severity of complaints predict treatment success of self-help. Cost-aspects as well as suggestions for improvement of the algorithms concerning the place of self-help and referral to mental health services will be presented. Conclusions: The stepped care model yielded significant benefits for patients with anxiety-, depressive- and stress-related disorders in the short term. However, in our stepped care programmes, the indication for self-help and referral to mental health services needs to be refined.

REFERENCES:

1. Korff von M, Glasgow RE, Sharpe M: Organising care for chronic illness. BMJ 2002; 325:92-4.
2. Scogin FR, Hanson A, Welsh D: Self-administered treatment in stepped-care models of depression treatment. J Clin Psychology 2003; 59(3):341-9.

WEDNESDAY, MAY 23, 11:00 AM - 12:30 PM

SCIENTIFIC AND CLINICAL REPORT SESSION 19—PSYCHOPHARMACOLOGY AND SCHIZOPHRENIA

No. 55
NUMBER NEEDED TO TREAT AND NUMBER NEEDED TO HARM: MAKING SENSE OF CATIE

Presenters: Leslie L. Citrome, M.D. *Nathan S Kline Institute for Psychiatric Research, 140 Old Orangeburg Road, Orangeburg, NY, 10962*, T. Scott Stroup, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant will understand the Evidence-Based Medicine concepts of Number Needed to Treat (NNT) and Number Needed to Harm (NNH). Calculation of these metrics will be demonstrated. The participant will be able to apply NNT and NNH analysis to the CATIE results.

SUMMARY:

Objective: The schizophrenia medication study conducted as part of the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) will be used to demonstrate the concepts of Evidence-Based Medicine, namely Number Needed to Treat (NNT) and Number Needed to Harm (NNH). Method: NNT (NNH) can describe how many patients one needs to treat on Drug A versus Drug B to see one extra success (or adverse event). A small NNT means the relative advantage of one drug over another is big because you need to treat fewer patients to see one additional case of response or benefit than if you had been using the alternative. Effectiveness and safety outcome data was extracted from the three principal publications that documented the results of Phases 1 and 2 of the CATIE schizophrenia study. NNT and NNH were calculated from the categorical results. The formula used was NNT=1/AR, where AR is the Attributable Risk. AR is calculated by subtracting the frequency of the outcome of interest for one drug from the frequency of the outcome for the other medication being compared. Results: Olanzapine and clozapine demonstrated advantages over comparators in terms of all-cause discontinuation, largely driven by efficacy advantages. NNT for olanzapine compared to perphenazine, quetiapine, risperidone, and ziprasidone ranged from 5.5 to 10.1 in Phase 1. NNT for clozapine compared to risperidone or quetiapine was approximately 3 in Phase 2. There were marked differences in association with weight gain and metabolic effects, with olanzapine demonstrating a NNH ranging from 12.4 to 17.7 in terms of discontinuation of treatment in Phase 1 because of these effects. Results from Phase 2 reflect Phase 1 in this regard, and demonstrated an advantage for ziprasidone in terms of discontinuation because of weight gain or metabolic effects, with NNT ranging from 10.6 to 20.8. However, these notable differences in association with weight gain and metabolic effects did not seem to drive the differences in overall time to all cause discontinuation. The absolute magnitudes of the NNT that are reported here are not dissimilar to other examples in the psychiatric literature, where for example a comparison of antipsychotic versus placebo for the treatment of schizophrenia results in a range of NNT of 2 to 5 for the outcome of a 40 percent reduction in the Brief Psychiatric Rating Scale score or a rating of "much improved" on Clinical Global Impression, of family intervention versus usual care for patients with schizophrenia which nets a NNT of 7 for the outcome of relapse, antidepressant compared with placebo for the treatment of major depression which nets a NNT of 3 for the outcome of a 50% reduction in the Hamilton Rating Scale for Depression, and antidepressants compared with placebo for the treatment of bulimia nervosa which results in a NNT of 9 for remission. Conclusions: NNT and NNH can help place the wide array of CATIE results into clinical context, and permits quantification of the differences observed between the antipsychotics that were tested.

REFERENCES:

1. Citrome L, Stroup TS. Schizophrenia, clinical antipsychotic trials of intervention effectiveness (CATIE) and number needed to treat: how can CATIE inform clinicians? Int J Clin Pract 2006;60:933-940.
2. Pinson L, Gray GE. Number needed to treat: an underused measure of treatment effect. Psychiatr Serv 2003;54:145-146,154.

No. 56

SWITCHING FROM LONG-ACTING TYPICAL ANTIPSYCOTIC DRUGS TO THE SECOND GENERATION ANTIPSYCOTICS: OLANZAPINE AND RISPERIDONE IN THE TREATMENT OF PATIENTS WITH CHRONIC SCHIZOPHRENIA

Presenters: Marnina Swartz-Vanetik, M.D. *Abarbanel Mental Health Center, Open ward-5-b, 15 KKL ST. Bat-Yam, Israel, 14 Openheimer St., Tel-Aviv, 69203, Israel*, Ella Lavun, M.D., Yehuda Baruch, M.D., Yoram Barak, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to re-evaluate the need for switching schizophrenia patients from typical long-acting treatment to second-generation antipsychotics.

SUMMARY:

Objective: The introduction of long term neuroleptics improved adherence. Lata have several advantages, yet being typical antipsychotics are charchterized by adverse events which in turn may reduce compliance.

Studies examining the efficacy of typical versus sga reported benefits due to switching to sga in the treatment of chronic schizophrenia patients: lower rate of side effects and improved adherence leading to better quality of life.

Only a few published studies examined switching from lata to orally administered sga.

We aimed to examine outcome of switching from lata to oral sga in chronic schizophrenia patients followed-up for18 months. Variables tested were: compliance, change in side effects profile, duration of hospitalization and whether following switching an additional antipsychotic was needed. Method: Retrospective chart review of all patients admitted to the abarbanel mental health center in the years 1999-2004. all had been diagnosed according to icd-10 as suffering from schizophrenia in the 5 years prior to the study. Results: the sample included 88 patients, mean age 39.7 years, 33 women and 55 men. Mean disease duration was 12.8 years. Included were patients treated by lata for at least 6 months prior to the switch to sga. The group was subdivided to those who switched to olanzapine (n=19) or risperidone (n=50). Controls were patients whose treatment remained unchanged with lata (n=19).

Primary outcome was the cgi. secondary outcome measures included side effects and use of anti-cholinergics, benzodiazepines and other psychotropics.

CGI after 18 months of follow-up had decreased significantly for all 3 subgroups. Between group analysis demonstrated that olanzapine treated patients had the best outcome (p=0.004). Rates of side-effects were similar between groups, in the range of 30%-35%. Adherence was positively associated with sga treatment. Conclusions: Switching schizophrenia patients from lata to oral sga treatment contributed to improved clinical outcome coupled with better adherence.

REFERENCES:

1. Barak Y, Shamir E, Mirecki I,Weizman R, Aizenberg D. Switching elderly chronic psychotic patients to olanzapine. Int J Neuropsychopharmacol. 2004;7(2):165-169.
2. Godleski LS, Goldsmith LJ, Vieweg WV, Zettwoch N, Stikovac D, Lewis S. Switching depot antipsychotic drug responders to oral olanzapine. Prog europsychopharmacol Biol Psychiatry. 2005;29(1):141-144.

No. 57

ZOLPIDEM IN TREATMENT RESISTANT CATATONIA: TWO CASE REPORTS AND LITERATURE REVIEW

Cristinel M. Coconcea, M.D. *University Hospitals of Cleveland/Case School of Medicine, Psychiatry, 11100 Euclid Avenue, Cleveland, OH, 44106*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to:

1. Recognize catatonic states and special needs of patients experiencing catatonia
2. Understand current physiopathological concepts of catatonia and suggested sites of activity for therapeutic agents
3. Consider treatment options available including suggestions for the management of treatment resistance

SUMMARY:

Objective: Recent developments in the understanding of catatonia are raising the GABAa vs GABAb hypothesis in the pathophysiology of this condition. Method: This paper describes 2 cases of benzodiazepine-resistant catatonia responding to treatment with zolpidem and critically reviews the current literature on the treatment of catatonia. Results: The first case discussed was of a 65 y/o man with a history of schizoaffective disorder and severe catatonic episodes resistant to benzodiazepines and ECT who showed dramatic response after the initiation of treatment with zolpidem (with an effective dose determind to be in the range of 10 mg PO TID).

The second case presented was of a 23 y/o woman with a history of chronic paranoid schizophrenia and partial response to benzodiazepines, showing a marked improvement after initiation of zolpidem (effective dose in the range of 10 mg BID), and relapse into catatonia upon self-discontinuation of zolpidem. From the review of the literature on catatonia, there is growing evidence suggesting the role of GABAa agonists in the treatment of catatonia, as well as for the possible pro-catatonic effect of the GABAb agonists. This could explain the effectiveness of zolpidem (GABAa agonist) even in benzodiazepine non-responders, and could have clinical implications in the treatment of a severe condition. Conclusions: Zolpidem, a GABAa specific agonist appears to be a new and safe therapeutic approach for catatonia, potentially useful in benzodiazepine-resistant patients. More research is needed in order to replicate these clinical findings and further refine the understanding of its mechanism and sites of activity.

REFERENCES:

1. Mastain B, Rascle C, Thomas P, Goudmand M: Zolpidem in Catatonic Syndrome: from a Pharmacological Test to a Pathophysiological Hypothesis. Movement Disorders 1998;13: supp 2; 46.
2. Northoff G. What catatonia can tell us about ƒtop-down modulation§: A neuropsychiatric hypothesis. Behavioral and Brain Sciences 25: 555-604, 2002.

SCIENTIFIC AND CLINICAL REPORT SESSION 20—MANAGING VIOLENCE

No. 58

"VARIABLES AFFECTING VIOLENCE THAT REQUIRED PHYSICAL RESTRAINT AMONG PSYCHIATRIC INPATIENTS DURING THE FIRST WEEK OF HOSPITALIZATION."

Presenters: Pinkhas Sirota, M.D. *Abarbanel Mental Health Center and Sackler Faculty of Medicine,Tel Aviv University, 6a, 15 Keren*

Kayemet Street, Bat-Yam, 59100, Israel, Yuri Markman, Nuc.E., Rachel Rushanski Rosenberg, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize, that based on the results of this study, two categories of variables that affect patients' violent behavior that was treated with physical restraint were found. The first category relates to variables that depend on the patient, such as, age of patient, marital status, the legal status of hospitalization, drug use, and verbal violence.The second category relates to variables that are not dependent on the patient such as overcrowding of the ward, number of staff members, and days of the week.

SUMMARY:

Objective: To examine the characteristics of restraint in a group of psychiatric inpatients who exhibited violent behavior during the first week of their hospitalization to an adult acute psychiatric ward. Method: A retrospective chart review of 100 male psychotic inpatients, who were admitted to an adult acute ward, over a 60 month period between the years 2000-2005 and exhibited violent behavior within the first week of their hospitalization and had to be restrained as a result. Results: The majority (83%) of physical restraints, following violent behavior, occurred in patients who were admitted involuntarily. A significant statistical difference has been found between compulsory admissions versus free will admissions. Thirty three percent of restraints were observed among patients aged 26-35 years. A significant statistical difference has been found between patients who lived alone without partners in comparison with married patients .Patients living alone were restrained more often than married patients. Regarding the involuntary admissions,a significant statistical difference has been found between native Israeli patients in comparison with new immigrants. Forty six percent of restraints took place during the evening shift, when staff/patient ratios were lower. Thirty five percent of the restraints were during the weekends when staff/patient ratios were lower. Fifty one percent of the restrains occurred when the number of patients on the ward exceeded 30 patients. A positive correlation has been found between the number of patients on the ward and restraining events. Sixty eight percent of the patients used various psychoactive substances prior to their hospitalization. Seventy two percent of physical violent behaviour was preceeded by non-physical violence.A significant ststistical difference was found between violent behaviour that was preceeded by non-physical violence as compared to violent behaviour that was not preceeded by non-physical violence. Thirty three percent of restrained patients suffered from hallucinations. No correlation was found between restraint and perception disturbances. A significant statistically difference was found between single patients who suffered from perception disturbances as compared to married patients who suffered from perception disturbances . No correlation was found between patients' violent behaviour that were treated with steady antipsychotic medications, sporadic antipsychotics, hypnotics or no treatment.

Conclusions: Based on the results of this study, two categories of variables that affect patients' violent behavior that was treated with physical restraint were found. The first category relates to variables that depend on the patient, such as, age of patient, marital status, the legal status of hospitalization, drug use, and verbal violence.The second category relates to variables that are not dependent on the patient such as overcrowding of the ward, number of staff members, and days of the week. Larger prospective studies are needed to help in identifying these correlates and their effects on the pattern of restrain.

REFERENCES:

1. Tunde-Ayimonde, M. Little, J., 2004. Use of seclusion in psychiatric acute inpatient unit Australian Psychiatry 12,347-351.
2. Dolan, M., Doyle, M., 2000. Violence risk prediction:Clinical and actuarial measures and the role of the Psychopathy Checklist. British Journal of Psychiatry 177,303-311.

No. 59
DECREASING THE USE OF RESTRAINT AND SECLUSION AMONG PSYCHIATRIC INPATIENTS

Presenters: David J. Hellerstein, M.D. *New York State Psychiatric Institute, Administration, Columbia U. Department of Psychiatry, 180 Ft. Washington Ave., #HP256, New York, NY, 10032*, Amy Bennett Staub, M.B.A., Elizabeth LeQuesne, M.D.

EDUCATIONAL OBJECTIVES:

describe how an urban psychiatric hospital decreased restraint and seclusion with no increase in adverse outcomes

SUMMARY:

Objective: Restraint and seclusion (R/S) of psychiatric patients are "last resort" measures used when a patient presents an imminent risk to self or others. R/S episodes may cause emotional trauma, even physical harm or death. Clinical and ethical considerations and external regulations stipulate that R/S should be used as seldom as possible. We describe a hospital-wide effort to decrease R/S, with the hypotheses that interventions could: 1) reduce the number of patients in R/S, 2) reduce patient hours in R/S, 3) without an increase in adverse outcomes (fights/assaults, staff injuries). Method: Study was performed at an urban academic psychiatric hospital (NY State Psychiatric Institute) with 3 inpatient units totaling 57 beds. Interventions included 1) decreased initial time in R/S from 4 to 2 hours before new order was required; 2) staff education to identify patients at risk of R/S and provide early interventions to avoid crises; 3) a coping questionnaire to assess patient preferences for dealing with agitation. Data was assessed 18 months before and 66 months following these interventions. Results: Mean number of patients restrained went from 0.35 to 0.32 patients/month, and hours of restraint decreased from 0.05 to 0.03 hours per 1000 patient hours. Mean number of patients secluded decreased from 3.18 to 1.13 patients/month. Mean hours of seclusion decreased markedly, from 1.28 to 0.09 hours per 1000 patient hours. There was no increase in patient-related staff injuries or in fights/assaults. Conclusions: Interventions were successful in decreasing R/S usage over five year follow-up. Such interventions may be adapted to other settings.

REFERENCES:

1. 1) Schreiner GM, Crafton CG, Sevin JA: Decreasing the use of mechanical restraints and locked seclusion. Adm Policy Ment Health 31:449-63, 2004.
2. 2) Fisher WA: Elements of successful restraint and seclusion reduction programs and their application in a large, urban, state psychiatric hospital. J Psychiatr Pract 9:7-15, 2003.

No. 60
CES REDUCES AGGRESSION IN VIOLENT NEUROPSYCHIATRIC PATIENTS

allen childs, M.D. *Southwestern Medical School, 4111 Honeycomb Rock Circle, Austin, TX, 78731*

EDUCATIONAL OBJECTIVES:

At the end of the presentation, the participant should be able to describe the anti-aggressive effects of CES.

The participant should be familiar with the technique for treatnig aggressive patients.

The participant will be familiar with the neurochemical and electrophysiologic changes during CES

SUMMARY:

Objective:

Cranial Electrotherapy Stimulation (CES) was used to treat 48 chronically aggressive neuropsychiatric patients in a maximum security psychiatric hospital. This treatment involves the transcranial application of extremely low dose electrical current to the brain (600 microamperes or less), from a wallet sized device through moistened electrodes attached to the ears. Retrospective chart review of three months prior to treatment and 3 months of active therapy tallied the numbers of significant aggressive episodes, seclusions, restraints and as needed emergency medications (PRN's). Psychotic diagnoses were made in 45 cases, mental retardation was present in 31 individuals, and co-morbid personality disorders were noted in almost all subjects. In aggregate, 40 of the 48 cases responded positively to CES with a 41% reduction in episodes of violence (p.001), were secluded 40% less often (p), required 40% fewer restraints (p<.001), and PRN's decreased 42% (p<.01). A sub-group of 10 psychotic patients, 8 of whom who had been hospitalized from 10 to 25 years, was designated as having the "Sudden Assault Syndrome" (SAS), characterized by repeated attacks without warning or apparent motivation, and unresponsiveness to multiple medications and all other interventions. In this sub-group, there was a 48% reduction in aggressive episodes (p<.01), requiring 44% fewer seclusions (p), 54% less frequent restraints (p< .05), and PRN's were needed 80% less often (p<.05). There were no significant side effects requiring discontinuation of treatment. These data confirm an earlier report of the anti-aggressive effects of CES in a violent, treatment resistant, neuropsychiatric population. CES is safe, cost effective and should be considered for wider use in seriously ill patients. Method: .. Results: .. Conclusions: .

REFERENCES:

1. Klimke, A & Klieser, E. Effectiveness of neuroelectric therapy in drug resistant endogenous psychoses. Forsch Neurol Psychiatry. 59: 53-9, 1991.
2. Childs, A. Cranial Electrotherapy Stimulation Reduces Aggression in a Violent Retarded Population: A Priliminary Report. J Neuropsychiatry Clin Neuroscience 17:4, 548-51, Fall 2005.

SCIENTIFIC AND CLINICAL REPORT SESSION 21—CONTINUATION AND DISCONTINUATION OF SSRIS

No. 61
COMPARISON OF THE PROPHYLACTIC EFFICACY OF ANTIDEPRESSANTS-FACTORS ASSOCIATED WITH BETTER OUTCOME

Presenters: Sabrina J. Khan, M.D. *NYU, Department of Psychiatry, 344 Third Ave, apt 17F, New York NY, NY, 10010*, Eric D. Peselow, M.D., Barbara Orlowski, Ph.D.

EDUCATIONAL OBJECTIVES:

To compare efficacy of various antidepressants in maintenance therapy and to assess what factors lead to better long-term prophylaxis

SUMMARY:

Objective: Naturalistic studies regarding the efficacy antidepressants have been pretty scarce. Long-term efficacy of selective serotonin reuptake inhibitors (SSRIÃƒÂ¢Ã¢â€¢Â¬Ã¢,Â¢s), tricyclic antidepressants(TCA's) and atypical antidepressants (venlafaxine, buproprion) in preventing depressive episodes after successful treatment of the acute episode has not been shown for > 3 years in controlled trials or naturalistic studies. The purpose of this study is to evaluate the prophylactic efficacy of four SSRI-ÃƒÂ¢Ã¢â€¢Â¬Ã¢,Â¢s: (fluoxetine, citalopram, sertraline, paroxetine) 3 TCA's (imipramine, nortriptyline, desipramine), venlafaxine and buproprion in a naturalistic clinical setting to responders to these medicines during acute depression who continued on the medications for one months to ten years. Method: 488 patients who were successfully treated with various antidepressants who met DSM-IV criteria for major depression for their acute depression between Jul 1 1993 and January 1 2006 over an 8-10 week course. Patients were evaluated with the Montgomery-Asberg Depression Rating Scale (MADRS). Response was defined as at least a 50% decrease in MADRS score with a final score between 9 and 14. Patients were considered remitted if they achieved a MADRS score of 8 or less. Patients who retained this response over a subsequent month, were followed from this point (one month euthymic) until 1 of 2 outcomes:

1) termination well: The patient remained continuously well until January 1, 2006 (the end of the study evaluation) or until the patient willingly asked to discontinue medication under our supervision or the patient was terminated due to side effects or other medical problems

2) failure: The patient was rated depressed in that his MADRS increased to a score of >14 and the symptoms were of such severity as to meet DSM-IV criteria (1994) for major depression and the patient required either hospitalization or additional antidepressant treatment. The choice of medication was determined according to clinical judgement based on such factors as past history of previous response to medication and previous history of side effects. Dosages for the acute episode were determined based on clinical response and side effect tolerability. The majority of patients were kept on the dose to which they had responded for the maintenance period. Results: There was no difference between the combined SSRI group, TCA group, venlafaxine or effexor with respect to long-term efficacy. Relapse rate for the entire group of 488 patients at 1,2,3 and 4 years respetively were 83%, 72%, 60% and 51%. . Final MADRS score was highly correlated with length of time stable-the lower the MADRS score at 8-10 weeks of acute treatment the longer the time stable (r=-.18 p<.001). Remission was associated with longer time stable vs response (37.75 months vs 30.74 p<.009). Overall 236 of 488 patients were known to have had a depressive relapse (121/293 who remitted vs 115/195 who responded (p<.0001). Patients who received CBT and had no comorbid anxiety disorders had a significantly better long-term outcome Conclusions: Remitted patients do better than those who simply respond. Despite prophylactic treatment in a naturalistic setting, long-term treatment with antidepressants yielded substantial relapse.

REFERENCES:

1. Shelton CI.-Long-term management of major depressive disorder: are differences among antidepressant treatments meaningful?.
2. Peselow E.D., Dunner D.L., Fieve R.R., and DiFiglia C: The prophylactic efficacy of tricyclic antidepressants - A five year followup. Progress in Neuropsychopharmacology & Biological Psychiatry:15:71-82, 1991.

No. 62
HOW OFTEN DO SSRIS LOSE THEIR EFFECT DURING CONTINUATION TREATMENT?: EVIDENCE SUGGESTING THE RATE IS TRUE TACHYPHYLAXIS DURING CONTINUATION TREATMENT IS LOW

Mark Zimmerman, M.D. *Rhode Island Hospital, Psychiatry, 235 Plain Street, Suite 501, Providence, RI, 02905*

EDUCATIONAL OBJECTIVES:

1. Understand that some patients who respond to medication may be responding to the nonspecific effects of treatment.
2. Understand that patients who relapse in the continuation and maintenance phases of treatment may have been placebo responders rather than true drug responders.
3. Estimate the proportion of relapses that are attributable to loss of the placebo effect rather than loss of true drug effect.

SUMMARY:

Objective: A substantial number of patients who respond to SSRIs experience a relapse despite ongoing pharmacotherapy. The return of symptoms has been interpreted as a loss of the efficacy of antidepressant activity. However, patients who initially improve while taking SSRIs include an admixture of true drug responders and placebo responders. Consequently, symptom return despite ongoing treatment may not represent a loss of drug effect because the patient may not have experienced a true drug response in the first place. The goal of the present report is to estimate the proportion of relapse attributable to the loss of true drug response versus a loss of placebo response. Method: We conducted a meta-analysis of continuation studies of SSRIs that began as placebo-controlled acute phase studies. Using the formula proposed by Quitkin and colleagues, we estimated the proportion of relapse attributable to the loss of true drug response versus loss of response to the nonspecific effects of treatment. Results: During continuation treatment, the relapse rate in placebo responders was 25.0% whereas the relapse rate in SSRI responders was 8.9%. In a literature review of antidepressant efficacy trials, Walsh and colleagues estimated the placebo response rate to be 30%. Using the formula of Quitkin and colleagues we calculated that 84.3% of the SSRI relapse rate during continuation treatment could be attributed to relapse in patients who were not true drug responders Conclusions: Most of the relapse rate during SSRIs continuation treatment may be due to relapse in patients who were not true drug responders.

REFERENCES:

1. Byrne S, Rothschild A: Loss of antidepressant efficacy during maintenance therapy: Possible mechanisms and treatments. J Clin Psychiatry 1998;59:279-288.
2. Quitkin F, Stewart J, McGrath P et al: Loss of drug effects during continuation therapy. Am J Psychiatry 1993;150:562-565.

No. 63
DISCONTINUATION OF SSRI'S AFTER 5 YEARS STABILITY

Presenters: Tara M. Pundiak, M.D. *NYU, Department of Psychiatry, 20 Sherman St., Fairfield,, CT, 06824*, Eric D. Peselow, M.D., Loretta Mulcare, B.S., Brady G. Case, M.D.

EDUCATIONAL OBJECTIVES:

To evaluate whether patients who had been stable on one of three different selective serotonin reuptake inhibitors (SSRI's) for 5 years could safely come off the medication. A group of patients who had been stable on SSRI's for five years and discontinued the medications was compared to a group of patients who had been stable on SSRI's for five years who continued on medication for a subsequent three years

SUMMARY:

Objective: The Agency for Health Care Policy and Research recognizes the strong evidence that specific antidepressant medications can prevent recurrence in most patients with recurrent MDD. This is based on placebo-controlled clinical trials, which do not always translate to a naturalistic population. Additionally, in trials including SSRIâ€™s, patients are followed for brief continuation periods of usually not more than 6 months with no subsequent maintenance data extending past 2 years. As clinicians, we must ask ourselves, what happens after that? Can patients forego maintenance treatment for depression after 2 years? This study aims to address this question by following patients who had been stable for 5 years on SSRIâ€™s after which a subgroup who were discontinued were compared with a group who continued with medication past 5 years, naturalistically in a real-clinic scenario. Method: We have followed 87 patients treated for their acute depression with one of 3 antidepressantsâ€''sertraline (n=37), paroxetine (N=26) and fluoxetine (n=24). The choice of treatment was based on clinical grounds using parameters such as past history of previous response and sensitivity to side effects with the hope of achieving the best possible results for the patient. The 87 patients who recovered from the depression continued prophylaxis with SSRI monotherapy for five years with continued clinical stability.

At the end of this 5 year period, 27 patients agreed to discontinue medication and 60 wished to continue. These patients were then followed for a subsequent four year period Results: The rate of remaining well for the 27 patients discontinued from the SSRIâ€™s 46.5% at 1 year, 33.9% at 2 years, 29.3% at 3 years and 23.0% at 4 years. The rate of remaining well for the 60 patients who continued past 5 years on the SSRI was 75.9% at 1 year, 66.1% at 2 years, 55.3% at 3 years and 51.0% at 4 years. This difference was highly significant (Cox F= 2.72 p<.0003).

In the 4 year period following discontinuation of the SSRI, 21 of the 27 patients were known to have relapsed with 3 others continuously well for < 4 years and 3 others lasting 4 years off medication without relapsing. For those who continued on SSRIâ€™s past the 5 year point 28 of the 60 patients were known to have relapsed with 14 others continuously well for < 4 years and 18 others lasting 4 years past the five year point on continued medication without relapsing. The average length of time stable after the 5 year point for the discontinued group was 14.48 months SD 15.8 vs. 29.40 months SD 26.9 for the group that continued on medication. This difference was statistically significant (t=2.67 p<.009) Conclusions: Despite 5 years stability, there was a high rate of relapse in the discontinued group. This study suggests that continuing patients,with a history of good response, on SSRI prophylaxis, significantly decreases their chances at having a relapse of their depressive symptoms.

REFERENCES:

1. Peselow E.D., Dunner D.L., Fieve R.R., and DiFiglia C: The prophylactic efficacy of tricyclic antidepressants - A five year followup. Progress in Neuropsychopharmacology & Biological Psychiatry:15:71-82, 1991.
2. Keller MB Long term treatment of recurrent and chronic depression. J Clin Psychiatry 2001 (suppl 62) 24 3-5.

SCIENTIFIC AND CLINICAL REPORT SESSION 22—SEX, ATTRACTION, AND INTIMACY

No. 64
AN 8-WEEK RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED TRIAL OF PDE5I SILDENAFIL TREATMENT OF SRI-ANTIDEPRESSANT-ASSOCIATED SEXUAL DYSFUNCTION IN WOMEN WITH MAJOR DEPRESSION DISORDER IN REMISSION: IDENTIFYING A HORMONE ENDOPHENOTYPE ASSOCIATED WITH TREATMENT RESPONSE

Presenters: H. George Nurnberg *University of New Mexico, 2400 Tucker NE, MSC 095030, Albuquerque, NM, 87131*, Paula L. Hensley

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to recognize that selective phosphodiesterase type 5-inhibitor treatment with sildenafil citrate can improve female sexual dysfunction (FSD) associated with serotonin reuptake inhibitor antidepressant treatment in women with major depression disorder in remission (MDD-R) continuing antidepressant treatment. The improvements in women are similar to those observed in men with erectile dysfunction associated with SRI antidepressant treatment for depression treated with sildenafil. Furthermore, participants should understand that the potential importance of the hormonal milieu in determining the response to sildenafil in women.

SUMMARY:

Objective: To assess phosphodiesterase type 5 inhibitor (PDE5I) sildenafil treatment for serotonin reuptake inhibitor antidepressant-associated sexual dysfunction (SRI-AASD) occurring in the treatment of major depression disorder (MDD) in women and to determine pre- and postsildenafil hormone levels to ascertain if SRI-AASD treatment responder and nonresponder hormone profiles differ. Method: An 8-week double-blind, placebo-controlled (DBPC) sildenafil (flexible dose, 50 or 100mg) trial was conducted in 100 women with MDD-remission and SRI-AASD, no preexisting SD, and consistent antidepressant treatment ≥8 weeks. Positive sexual function treatment response was defined by Clinical Global Impression-Sexual Function outcome score ≤3. Other sexual function questionnaires were the University of New Mexico-Sexual Function Index (UNM-SFI), Arizona Sexual Experience Scale (ASEX), and the Sexual Function Questionnaire-Female Sexual Dysfunction (SFQ-FSD). Depression was monitored using the Hamilton Depression scale (HAM-D17). Plasma levels of free/total testosterone, prolactin, cortisol, progesterone, estradiol, FSH, LH, TSH, T_4, and sex hormone-binding globulin (SHBG) were measured at baseline and DBPC-endpoint. Results: Responders included 35/49 (71.4%) sildenafil and 17/49 (34.7%) placebo recipients (OR=2.1;95%CI,1.2-3.0;P<0.001). Sildenafil recipients had greater baseline-to-endpoint improvement in mean orgasm scores (SFQ, ASEX, and UNM-SFI; P=0.01). HAM-D scores indicated persisting depression in remission. Responders had significantly higher individual mean baseline and endpoint free testosterone and T_4 levels and lower endpoint mean estradiol levels compared with nonresponders (P<0.05). A profile of elevated free testosterone, estradiol, LH, T_4, and progesterone with lower cortisol, FSH, LH, prolactin, SHBG, and TSH distinguished responders from nonresponders. Treatment response was predicted by sildenafil (OR= 8.5;95%CI,2.7-26.3), orgasm ability (OR=3.9;95%CI,1.1-14.5), and higher progesterone (OR=3.7,95%CI,1.4-10.3) and β-estradiol (OR= 3.3; 95%CI,1.1-9.4) levels. Treatment was well tolerated; none withdrew because of adverse events. Conclusions: This DBPC sildenafil trial is the first to demonstrate clinically significant and meaningful efficacy of a PDE5I in women with SRI-AASD, suggesting benefits in allowing patients to continue effective antidepressant treatment. Furthermore, the hormonal milieu appears to be an essential factor for PDE5I treatment response in FSD.

REFERENCES:

1. Nurnberg HG, Hensley PL, Gelenberg AJ, Fava M, Lauriello J, Paine S. Treatment of antidepressant-associated sexual dysfunction with sildenafil: a randomized controlled trial. JAMA. 2003;289:56-64.
2. Nurnberg HG. Biologic basis of serotonin reuptake inhibitor antidepressant-associated female sexual dysfunction: A Novel Signaling Perspective. Current Sexual Health Reports 2005;2:85'92.

No. 65

BREAKTHROUGH INTIMACY - TREATING PERSONALITY

Yukio Ishizuka *500 Purchase Street, Rye, NY, 10580*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to:

1. Recognize personality as the cause of psychiatric distress.
2. Define, quantify, and track on 41 parameters, the patient's personality change, using 5 key Lifetrack models and Lifetrack Total Adjustment Sheet.
3. Track and interpret the patients' daily progress during therapy sessions either in person or by phone.
4. Work with the patient and his/her partner in three-way teamwork, bringing them far closer than they have ever been, according to their own daily self-rating, overcoming waves of defense (symptom spikes) until symptoms disappear by exhaustion.

SUMMARY:

Objective: To demonstrate that 'Breakthrough Intimacy' - closeness between committed couples far greater than their previous maximum experience can predictably transform couples' personalities, eliminating psychiatric symptoms such as anxiety, anger, physical-symptoms, depression, and symptoms of borderline personality disorder, without medications and often within 6 months. The results of this study supports an alternative understanding of psychiatric distress as natural and inevitable consequence of interaction between one's personality and life challenges, offering an alternative and effective treatment through personality transformation. Method: The patient and his/her partner perform daily subjective self-rating on 41 parameters to record daily changes in their psychological adjustment, according to a quantifiable model of personality and positive mental health.

The couples' daily self-rating is tracked graphically via Internet, providing accurate and comprehensive data to guide the therapist and the patients. Working in three-way teamwork, the therapist actively help the couples to achieve closeness far greater than their previous maximum experience, overcoming waves of symptoms (anxiety, anger, physical-symptoms, depression, and symptoms of borderline personality disorder) until they disappear by exhaustion, as the couple undergo personality transformation. Results: Of the 1,170 patients treated for various symptoms over the last 20 years, 48% of patients reached a level of adjustment beyond their previous maximum level, beyond symptom elimination. 31% reached a level more than twice, 24% reached more than three times, 20% reached more than four times, 16% reached more than five times, and 7.6% reached more than ten times their previous maximum level of adjustment according to their own daily subjective self-rating. Of those who failed to reach their previous maximum level at premature terminations, 75% showed significant improvement in their overall adjustment, and 77% showed significant reduction of their symptoms. However, 24% showed significant reduction of overall adjustment, and 22% showed significant aggravation of their initial symptoms at the time of their termination during the initial phase of therapy, when symptoms typically worsen. Conclusions: Psychiatric symptoms of distress can be better understood and treated as the consequence of one's personality which can be transformed through 'Breakthrough Intimacy' - closeness between committed couples far greater than their previous maximum experience. The results of this study over the last 20 years prove that traditional 'disease' concept of psychiatric distress must now be overcome to substantially improve our profession's therapeutic productivity.

REFERENCES:

1. Journal Article - Ishizuka Y: Lifetrack Therapy. Psychiatr J Univ Ottawa, Vol. 13, No 4, 1988.

2. Book - Ishizuka, Y: Breakthrough Intimacy - Sad to Happy through Closeness. Lifetrack, 2004.

No. 66
A LINK BETWEEN OXYTOCIN AND ANXIETY OF ROMANTIC ATTACHMENT

Presenters: Donatella Marazziti, M.D. *University of Pisa, Dipartiemnto di Psichiatria, Nerurobiologia, Farmacologia e Biotecnologie, Via Roma 67, Pisa, 56100, Italy*, Mario Catena, M.D., Stefano Baroni, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to be broaden their knowledge on the latest findings on the neurobiology of social attachment with a specific focus on the role of oxytocin in human relationships and love.

SUMMARY:

Objective: The formation of social bonding is fundamental for several animals, including humans, for its relevant and obvious impact upon reproduction and, thus, survival of the species. Recent data would suggest that oxytocin might be one of the mediators of this process. Given the paucity of data on the possible involvement of oxytocin in human attachment, in the present study we aimed to explore the possible relationships between the plasma levels of this neuropeptide and romantic attachment in healthy subjects. Method: Forty-five healthy subjects of both sexes who volunteered for the study, were included. The romantic attachment was assessed using the Italian version of the so-called â€œExperiences in Close Relationshipsâ€[[Unsupported ANSI Character - ]] (ECR), a self-report questionnaire for measuring this parameter in adults. Results: The results showed that attachment anxiety and oxytocin are positively linked in romantic attachment to a statistically significant degree (r=0.30, p= 0.04), that is, the higher the oxytocin levels the higher the score on the anxiety scale of the ECR. Conclusions: The authors are of the opinion that this link represents one of the biological processes resulting in those rewarding emotions related to romantic attachment.

REFERENCES:

1. Insel TR, Young LJ. The neurobiology of attachment. Nature Rev 2001; 2: 129-136.
2. Kosfeld M, Heinrichs M, Zaki PJ, Fischbacher U, Fehr E. Oxytocin increases trust in humans. Nature 2005; 2: 673-676.

SCIENTIFIC AND CLINICAL REPORT SESSION 23—PSYCHOPHARMACOLOGY AND BIPOLAR DISORDER

No. 67
EFFECT OF COMORBID ANXIETY ON ANTIDEPRESSANT USE IN A COMMUNITY SAMPLE OF BIPOLAR SUBJECTS

Presenters: Ayal Schaffer, M.D. *Sunnybrook Health Sciences Centre, Psychiatry, 2075 Bayview Avenue, Room FG29, Toronto, ON, M4N 3M5, Canada*, John Cairney, Ph.D., Scott Veldhuizen, B.A., Amy H. Cheung, M.D., Anthony J. Levitt, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss factors that influence antidepressant use among bipolar patients

At the conclusion of this presentation, the participant should be able to consider the role of community surveys in examining treatment utilization for mood disorders

SUMMARY:

Objective: There is limited understanding of factors that influence prescribing of antidepressants to patients with bipolar disorder (BD). Antidepressants are commonly used to treat anxiety symptoms, thus the presence of a comorbid anxiety disorder may be a strong driving force for antidepressant use in BD. The aim of this study was to determine whether the presence of a comorbid anxiety disorder independently increases the likelihood of antidepressant use in a community sample of individuals with BD.

Method: This study utilized data from the Canadian Community Health Survey - Mental Health and Well-Being. This nationally representative survey conducted by Statistics Canada, involved 36,984 respondents aged 15 or older. The CIDI-based interview established the diagnosis of BD (N = 789), major depressive disorder (MDD) (control group, N = 3952), and comorbid anxiety disorders (49.6% of BD subjects and 54.0% of MDD subjects). Rates of past 12-month antidepressant use were determined. Regression models including sociodemographic and clinical variables determined the independent effect of the 4 diagnostic groups (BD and MDD with and without comorbid anxiety) on past 12-month antidepressant use. Results: There was a significant difference in the likelihood of past 12-month antidepressant use across the 4 diagnostic groups ($p < 0.0001$). BD and MDD subjects with comorbid anxiety had the highest rates of past 12-month antidepressant use (38.5% and 36.4%, respectively), followed by BD and MDD subjects without comorbid anxiety (16.0% and 18.4%, respectively). Using MDD without anxiety as the reference group, the regression model identified a significantly increased likelihood of antidepressant use in the BD with anxiety group (OR = 1.83) but not in the other diagnostic groups. Conclusions: The presence of a comorbid anxiety disorder significantly increases use of antidepressants in subjects with BD. Results of this study contribute to the growing literature on treatment utilization among BD patients identified in community samples.

REFERENCES:

1. Statistics Canada. Canadian Community Health Survey, Mental Health and Well-Being 2002. Available at: http://statcan.ca/english/freepub/82-617-XIE/index.htm.
2. Simon NM, Otto MW, Wisniewski SR, et al. Anxiety Disorder Comorbidity in Bipolar Disorder Patients: Data from the First 500 Participants in STEP-BD. Am J Psychiatry 2004;161:2222-2229.

No. 68
DIFFICULT TO TREAT PATIENTS: THE ROLE OF QUETIAPINE IN THE MANAGEMENT OF ACUTE BIPOLAR DEPRESSION (WITH A FOCUS ON BIPOLAR II PATIENTS)

Michael E. Thase *University of Pittsburgh Medical Center, 3811 O'Hara Street, Pittsburgh, PA, 152132593*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that quetiapine may be a viable option in managing patients with difficult-to-treat bipolar depression, including those with bipolar II disorder.

SUMMARY:

Objective: Although current guidelines recommend either lithium or lamotrigine as first-line agents for management of acute depressive episodes associated with bipolar disorder, clinicians recognize that certain patients with depressive symptoms may respond less favorably to standard therapy. Published data on the treatment of these patients, including those with bipolar II disorder or rapid cycling

bipolar depression, are sparse. Recent well-designed studies report that olanzapine monotherapy, olanzapine- fluoxetine combination, and quetiapine monotherapy improve depressive symptoms in patients with bipolar disorder. Method: The BOLDER I and BOLDER II trials examined the efficacy and tolerability of quetiapine monotherapy at fixed doses of 300 or 600 mg/d in patients with bipolar II depression. Results: Analysis of combined data for bipolar I and II patients in the BOLDER trials (n=321, ITT population) shows that quetiapine had a significantly greater improvement in mean MADRS total scores relative to placebo at each assessment from baseline to Week 8. Changes from baseline to Week 8 for quetiapine 300 and 600 mg/d were -17.09 and -17.86, respectively, versus -13.31 for placebo (P=0.005 and P=0.001 versus placebo) . Improvements in mean HAM-D scores from baseline to Week 8 were also significantly greater with both quetiapine doses (-14.33 and -15.04) than with placebo (-11.33; P=0.001 and P<0.001, respectively). Anxiety symptoms assessed by HAM-A also showed significant improvement. Patients (bipolar I or II) with (n=82) or without (n=239) a rapid-cycling course (n=82 and 239, respectively) demonstrated significant improvements in MADRS total score. Adverse events, including dry mouth, sedation, and somnolence, were generally mild to moderate in intensity. Conclusions: In these two large controlled, randomized trials, quetiapine monotherapy demonstrated significant efficacy for the treatment of acute depressive episodes in difficult-to-treat patients with bipolar II disorder, including those with a rapid cycling disease course.

REFERENCES:

1. Calabrese JR, et al: A randomized, double-blind, placebo-controlled trial of quetiapine in the treatment of bipolar I or II depression. Am J Psychiatry 2005; 162(7):1351-60.
2. Thase M, et al: Confirmation of the efficacy of quetiapine monotherapy in bipolar depression in a second double-blind, placebo-controlled study: the BOLDER II study, presented at the XXVth Biennial CINP Congress. Chicago, Illinois, July 9-13, 2006.

No. 69
INDIRECT COMPARISON OF THE SAFETY AND TOLERABILITY OF ANTIPSYCHOTICS IN PATIENTS WITH BIPOLAR DISORDER AND SCHIZOPHRENIA

Presenters: Keming Gao, M.D. *Case Western Reserve University, Department of Psychiatry, 11400 Euclid Ave., Cleveland, OH, 44106,* Stephen J. Ganocy, Ph.D., Joseph R. Calabrese, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the differences in the safety and tolerability of antipsychotics in bipolar disorder and schizophrenia.

SUMMARY:

Objective: Most atypical antipsychotics have been approved for the acute treatment of bipolar disorder (BPD) mania. The safety and tolerability of these agents in BPD relative to schizophrenia are not clear. This study was undertaken to indirectly compare the safety and tolerability of these agents in BPD and schizophrenia. Method: English-language literature published and cited in Medline was searched with terms, *antipsychotic, typical antipsychotic, atypical antipsychotic, generic/brand name of antipsychotics, safety, tolerability, and bipolar mania or depression, BPD, or manic-depressive illness, or schizophrenia, randomized, and placebo-controlled clinical trial.* All randomized, placebo-controlled, monotherapy trials of aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, and haloperidol in acute mania or bipolar depression were prioritized. Studies in schizophrenia with comparable doses of corresponding antipsychotics as mania studies were also included. Absolute rate change and number needed to treat to harm (NNTH) of discontinuation due to adverse events (DAEs) and reported somnolence relative to placebo were used for comparison. Results: Ten trials in acute mania, 2 in acute bipolar depression, and 8 in schizophrenia were identified. In patients with schizophrenia, only ziprasidone caused more DAEs than placebo, with NNTH 14. In patients with bipolar mania, ziprasidone, aripiprazole, quetiapine, and risperidone caused more DAEs than placebo, with NNTH ranging from 32 to 222. However, in patients with bipolar depression, both quetiapine and olanzapine caused more DAEs than placebo, with NNTH ranging from 6 to 24. All antipsychotics caused higher rates of somnolence than placebo in schizophrenia, mania, and bipolar depression, but the magnitude was larger in BPD. In schizophrenia, the NNTH were > 10 except for olanzapine (NNTH=5). In mania, except for haloperidol, the NNTH were < 10 and in bipolar depression, the NNTH were 5-6. Conclusions: Patients with bipolar disorder were more sensitive to antipsychotics compared to those with schizophrenia, but patients with mania tolerated better than those with bipolar depression.

REFERENCES:

1. Ketter TA, Sachs GS, Bowden CL, Calabrese JR, Chang KD, Rasgon NL. Introduction. In Advances in Treatment of Bipolar Disorder, edited by Ketter TA, Washington DC, American Psychiatric Publishing, 2005, pp1-9.
2. Gao K, Gajwani P, Muzina D, Calabrese JR. Typical and atypical antipsychotics in bipolar depression. J Clin Psychiatry, 2005; 66:1376-1385.

SCIENTIFIC AND CLINICAL REPORT SESSION 24—TREATMENT ISSUES IN COLLEGE AND MEDICAL STUDENTS

No. 70
SUBJECTIVE SLEEP QUALITY AND SUICIDAL IDEATION AMONG COLLEGE STUDENTS

Presenters: Shamsah B. Sonawalla, M.D. *Massachusetts General Hospital, Harvard Medical School, Depression Clinical and Research Program, WAC 812, 15 Parkman Street, Boston, MA, 02114,* Amy H. Farabaugh, Ph.D., Maribeth Pender, Ph.D., Timothy J. Petersen, Ph.D., Albert Yeung, M.D., Jonathan E. Alpert, M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the importance of screening for sleep disturbance, depressive symptoms and suicidal ideation in the college population.

SUMMARY:

Objective: **To assess the relationship between subjective sleep quality and suicidal ideation among college students.** Method: **752 students from a college in the greater Boston area (mean age: 20.2 years ± 7.6 years; 59.3 % women) were screened for subjective sleep quality, depressive symptoms and suicidal ideation. After obtaining written, informed consent, the Beck Depression Inventory (BDI) and the Pittsburgh Sleep Quality Index (PSQI) were distributed to all students. Students who scored** >16 on the BDI or > 1 on BDI item #9 (suicidal ideation item), and who consented to be interviewed, were evaluated using the MDD module of the Structured Clinical Interview for DSM-IV (SCID-P). For the purpose of the analyses, significant depressive symptoms were defined as a score of > 10 on the BDI. **"Poor sleeper" was defined as a student with a PSQI global score of** > 5. Results: **19% of the students had significant depressive**

symptoms, as assessed by a score of > 10 on the BDI, and 7.3% of the students scored > 16 on the BDI. 14.4% of the students reported suicidal ideation (score of >1on BDI item #9). Age, gender and year in college did not predict suicidal ideation. Depression severity predicted suicidal ideation (P<0.0001). 48% of the students reported poor sleep quality, as assessed by a PSQI global score of > 5. Age and gender did not predict sleep quality. Year in college predicted sleep quality, with juniors reporting a worse sleep quality compared to seniors and sophomores (P<0.01). Poor sleep quality was associated with the presence of significant depressive symptoms (P<0.0001) and suicidal ideation (P<0.001). Conclusions: **A substantial percentage of students in this sample reported experiencing significant sleep disturbance, which in turn predicted suicidal ideation. This study highlights the importance of screening for sleep disturbance, depressive symptoms and suicidal ideation in the college population.**

REFERENCES:

1. Agargun MY, Kara H, Solmaz M. Subjective sleep quality and suicidality in patients with major depression. J Psychiatry Research 1997; Vol 31, No. 3, pp 377-381.
2. Sonawalla SB, Mahal Y, Masson E, Yeung A, Mischoulon D, Alpert JE, Fava M. Depressive Symptoms among college students as assessed by the Symptom Questionnaire. 156th Annual Meeting of the American Psychiatric Association, 2003.

No. 71
PREVALENCE AND ATTITUDES CONCERNING ADHD DIAGNOSIS AND USE OF STIMULANT MEDICATIONS IN MEDICAL STUDENTS

Presenters: Jeffrey Tuttle, M.D. *University of Kentucky, Department of Psychiatry, 3470 Blazer Parkway, Lexington, KY, 40509*, Neil Scheurich, M.D., John Ranseen, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant will 1) exhibit knowledge of diagnostic prevalence and use of non-prescribed medications in medical student populations; 2) be able to recognize the range of attitudes concerning ADHD diagnosis and use of stimulant medication for enhancement of cognition; 3) understand the current concerns regarding the use of stimulant medications to enhance cognition.

SUMMARY:

Objective: Several studies have explored the prevalence of ADHD diagnosis and non-prescribed stimulant use among undergraduate students. No recent studies, however, have explored these questions among professional students. Medical Students are notable for constituting a highly competitive academic environment and for their future status as ADHD diagnosticians and stimulant prescribers. The objective of this study is to determine the prevalence of ADHD diagnosis, the prevalence of non-prescribed stimulant use and attitudes toward the legitimacy of adult ADHD diagnosis and the use of stimulant medications to enhance academic performance among a sample of medical students. Method: An anonymous survey was administered to 388 medical students (84.0% return rate) across all four years of education at a large public medical college. Results: Eighteen (5.5%) medical students reported being diagnosed with ADHD (72.2% of those students were diagnosed after the age of 18. Thirty-three (10.1%) medical students reported using non-prescribed stimulant medications during their lifetime. The most commonly reported motivation for non-prescribed stimulant use was to improve academic performance. Fifteen (4.6%) medical students did not believe adult ADHD is a legitimate medical condition while 112 (34.4%) medical students believed it is over-diagnosed. One hundred and forty four (44.2%) medical students believed stimulant medications should never be used to enhance academic performance while 30 (9.2%) believed stimulant medications should be equally available to all medical students for the purpose of improving academic performance. There were no significant trends between classes. Conclusions: This population of medical students has a diagnostic prevalence only slightly higher than the population prevalence estimates for adults. Consistent with studies of college students, a sizeable number of medical students admit to past use of non-prescribed stimulants. The ambiguity of the ADHD diagnosis, particularly in adults, certainly exists among medical students and carries implications for psychiatric education and patient care.

REFERENCES:

1. Carroll BC, McLaughlin TJ, Blake DR. Patterns and knowledge of nonmedical use of stimulants among college students. Arch Pediatr Adolesc Med. May 2006;160(5):481-485.
2. Teter CJ, McCabe SE, Cranford JA, Boyd CJ, Guthrie SK. Prevalence and motives for illicit use of prescription stimulants in an undergraduate student sample. J Am Coll Health. May-Jun 2005;53(6):253-262.

No. 72
PREVALENCE AND SYMPTOM PATTERNS OF DEPRESSION AMONG COLLEGE STUDENTS: FINDINGS FROM A CROSS-CULTURAL STUDY ACROSS BOSTON AND BOMBAY

Presenters: Rajesh M. Parikh, M.D. *Jaslok Hospital and Research Center, Psychiatry, 15 Dr. G. Deshmukh Marg, Bombay, 400026, India*, Shamsah Sonawalla, M.D., Santvana Sharma, M.D., Amy H. Farabaugh, Ph.D., Albert Yeung, M.D., Steve Safren, Ph.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the cross-cultural differences and similarities in depressive symptoms among college students and understand the need to screen for depressive symptoms in this population.

SUMMARY:

Objective: Previous studies have reported significant depressive symptoms among college students (1, 2). The purpose of this study was to compare the prevalence and symptom patterns of depression among college students in Boston and Bombay. Method: We screened college students over the age of 18 years across Boston (N=701) and Bombay (N=1357) (Mean age: Boston: 21 years ± 3.0 years; Bombay: 19.3+1.5 years; t= -16.9; p<0.0001; Gender: Boston: 54.3% women, Bombay: 56% women; Chi Square= 0.3; p = 0.6, NS). After obtaining written, informed consent, the Beck Depression Inventory (BDI) and Symptom Questionnaire were distributed to all students. Chi-square tests, unpaired t-tests and logistic regression were used for data analysis. Results: The prevalence of significant depressive symptoms (total score of >16 on BDI) was 14.2 % among college students in Boston and 24% among college students in Bombay; this difference was statistically significant after adjusting for age (p<0.0001). The mean total BDI scores across the two groups of students were: Boston: 7.6 + 8.1; Bombay: 11.1 + 9.0 (P<0.0001). Among students in Bombay, 31.6% men and 18.7% women scored > 16 on the BDI (chi-square=26.1; p<0.0001). The prevalence of suicidal ideation (defined as a score of > 1 on item #9 on the BDI) was 16.4% among students in Boston and 25% among students in Bombay; this difference was also statistically significant after adjusting for age (p<0.0001). There were no significant differences across SQ sub scales of anxiety, somatic symptoms and anger-hostility across the two groups. However, students in Bombay scored significantly higher on SQ-depression subscale compared to college students in Boston. Conclusions: Significant depressive symptoms

and suicidal ideation were noted cross-culturally in this urban college population across two countries. Our study emphasizes the importance of screening for depression among college students and the need to plan effective intervention strategies in this population.

REFERENCES:

1. Sonawalla SB, Kelly K, Neault N, Farabaugh A, Almeida D, Yeung A, Mischoulon D, Pava J, Otto M, Fava M. Predictors of suicidal ideation in a college population. 154th Annual Meeting of the American Psychiatric Association, 2001.
2. Peden AR, Hall LA, Rayens MK, Beebe L. Negative thinking mediates the effect of self-esteem on depressive symptoms in college women. Nursing Research, Volume 49(4), pp 201-207, 2000.

SCIENTIFIC AND CLINICAL REPORT SESSION 25—FUNCTIONING AND DISEASE BURDENS IN MOOD DISORDERS

No. 73
DISEASE BURDEN OF BIPOLAR AND SCHIZOAFFECTIVE DISORDER IN AN AUSTRALIAN COHORT.

Presenters: Jayashri Kulkarni, M.B.B.S. *Alfred Psychiatry Research Centre, The Alfred and Monash University, Commercial Rd, Prahran, Alfred Psychiatry Res Centre, Old Baker Building, Melbourne, 3181, Australia*, Michael Berk, Paul Fitzgerald, Anthony de Castella, Seetal Dodd, Meg Smith, William Montgomery

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate an understanding of the disease burden associated with bipolar 1 or schizoaffective disorder in the Australian community setting, and be able to discuss the value of observational studies in providing 'real-life' information.

SUMMARY:

Objective: To describe the demographic, clinical, and functional status of participants with bipolar I or schizoaffective disorder (DSM-IV[1]) in an ongoing, 2-year, observational study that examines the economic, clinical, and functional outcomes associated with 'real-life' treatment. Method: This is a baseline analysis of the Bipolar Comprehensive Outcomes Study (BCOS) that describes the participants at study entry. Participants (n=240) prescribed olanzapine or conventional mood stabilizers were assessed using a range of measures, including the Young Mania Rating Scale (YMRS), 21-item Hamilton Depression Rating Scale (HAMD21), Clinical Global Impressions Scale - Bipolar Version (CGI-BP), and the EuroQol Instrument (EQ-5D). Results: On average, participants were 41.8+12.7 years of age (mean+SD), 58% (n=140) were female, and 73% (n=176) had a diagnosis of bipolar I disorder. Olanzapine was prescribed to 35% of participants, and was more commonly prescribed for schizoaffective disorder (48% vs. 31%). CGI-BP scores indicated more women were markedly ill than men (34% vs. 22%). Irrespective of gender and diagnosis, participants were, on average, hypomanic, (YMRS Total and CGI-BP Mania scores: 8.2+8.5 and 3.0 +1.6). On average, women were more depressed than men - HAMD21 Total score 14.3+8.7 vs. 12.1+8.3, p=.048, CGI-BP Depression scores 3.5+1.3 vs. 2.8+1.3, p<.001. For bipolar participants, 95% of hospitalisations for psychiatric treatment in the past 3 months were single admissions (vs. 65% for schizoaffective, p<.001). Bipolar participants rated their overall health state higher (EQ-5D scores: 68.2+18.8 vs. 61.6+22.7, p=.023). This trend was also reflected by the mean weekly wage ($500-999, 21.3% vs. 6.3%, bipolar vs. schizoaffective; Australian average ~$805[2a]), unemployment rate (22.2% vs. 48.4%; Australia-wide 5.1%[2b]), and relationship status (current romantic relationship, 47.1% vs. 26.6%, p=.005). Conclusions: Participants were characterised by social and occupational dysfunction at entry, but those with schizoaffective disorder appeared to be more severely affected. Effective treatment is required to address both clinical and functional impairment.

REFERENCES:

1. First MB, Frances A, Pincus HA: Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. Washington, DC, American Psychiatric Press, 2000.
2. Australian Bureau of Statistics. 2005a. 6302.0 - Average Weekly Earnings, Aug 2005 and 2005b. 6202.0 - Labour Force, Australia, Dec 2005. http://www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/7AFBCF0AA65EB2DACA25711D000DF2-B2?opendocument.

No. 74
DAYS MISSED FROM WORK IN PATIENTS WITH MAJOR DEPRESSIVE DISORDER WITH OR WITHOUT A PERSONALITY DISORDER.

Presenters: Daniela A. Boerescu, M.D. *Rhode Island Hospital, Psychiatry, 49 Progress Street, Pawtucket, RI, 02860*, Mark Zimmerman, M.D., Iwona Chelminski, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to appreciate how the presence of a personality disorder influences the amount of time missed from work by depressed patients.

SUMMARY:

Objective: Major Depressive Disorder (MDD) is a common and debilitating condition. Part of the disease burden is measured by the time missed from work. Personality disorders are frequently associated with MDD, and are themselves associated with occupational impairment. The objective of the current report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project is to investigate the impact of a personality disorder on time missed from work by patients with non-bipolar, non-psychotic major depression. Method: 679 patients from the Rhode Island Hospital outpatient practice with non-bipolar, non-psychotic MDD as principal diagnosis based on Structured Clinical Interview for DSM-IV were also administered the Structured Interview for DSM-IV Personality. Patients were asked about days missed from work due to psychiatric reasons in the past 5 years. Results: 312 (45.9%) patients received a diagnosis of a personality disorder. The presence of any personality disorder was significantly associated with a higher percent of days missed from work. Almost one quarter (23.7%) of the depressed patients with a personality disorder missed at least one year of work, compared to 13.0% of the depressed patients without a personality disorder (p<0.01). Patients with a cluster A, B or C personality disorder were 2.5, 2.4 and 2.2 respectively more likely to miss one year or more from work in the last 5 years prior to the evaluation. Conclusions: The presence of a personality disorder in depressed patients is associated with significantly increased time missed from work.

REFERENCES:

1. Skodol AE, Gunderson JG, McGlashan TH, et al: Functional impairment in patients with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorder. Am J Psychiatry 2002;159:276-283.
2. McDermot W, Mattia Jill, Zimmerman M: Comorbidity burden and its impact on psychosocial morbidity in depressed outpatients; J Affective Disorders 2001;65:289-295.

No. 75

THE RELATIONSHIP BETWEEN GLOBAL FUNCTIONING, DEPRESSION AND PAINFUL SOMATIC SYMPTOMS IN PATIENTS WITH MAJOR DEPRESSIVE DISORDER

Presenters: Thomas N. Wise *Inova Fairfax Hospital, 3300 Gallows Road, Falls Church, VA, 22046*, Adam L. Meyers, Durisala Desaiah, Craig H. Mallinckrodt, Michael J. Robinson, Daniel Kajdasz

EDUCATIONAL OBJECTIVES:

Educational Objectives: At the conclusion of this presentation, the participant should be able to understand the relationship between the functional improvement, depression, and painful somatic symptoms in patients with major depressive disorder.

SUMMARY:

Objective:

Functional impairment is associated with major depressive disorder (MDD) episodes[1]. Many patients with MDD present with painful somatic symptoms (PSS) including joint pain and back pain[2]. This presentation examines the relationships between improved global functioning and both core depressive symptomology and PSS in patients with MDD. Method: These post-hoc analyses are based on pooled data from two identical 8-week double-blind clinical trials designed to assess the efficacy of duloxetine in the treatment of MDD. A total of 759 patients were randomized to duloxetine, paroxetine, or placebo. The Sheehan Disability Scale, $HAMD_{17}$ Maier subscale score, and Visual Analog Scale for Overall Pain were used to measure global functional impairment, core symptoms of depression, and PSS respectively. Patients were not excluded from entry based on any criteria associated with pain or PSS. Pearson partial correlations were used to assess the magnitude and significance of the associations between global functional impairment, depression, and PSS. Path analysis was used to assess the relative contributions of improvement in depression and PSS on improved functioning associated with active treatments. Results: At baseline and at endpoint, the associations between global functional impairment and depression controlling for PSS were .15 and .45, respectively. At baseline and at endpoint, the associations between global functional impairment and PSS controlling for depression were .34 and .45, respectively (all $P<.05$). Path analysis demonstrated that 43.2% and 19.1% of improvement in global functional impairment was attributed to the treatment effect of core symptoms of depression and PSS, respectively. Conclusions: In patients with MDD, the greater proportion of functional improvement was mediated through improvement in depression, however; the contribution associated with improvements in PSS was clinically significant. To maximize global functional improvement in patients with MDD, it may be important to treat both the painful somatic and core symptoms of depression.

REFERENCES:

1. Mintz J, Mintz LI, Arruda MJ, Hwang SS. Treatments of depression and the functional.
2. Tylee A, Gandhi P. The importance of somatic symptoms in depression in primary care. Primary Care Companion, J Clin Psych 2005, 7: 167-176.

SCIENTIFIC AND CLINICAL REPORT SESSION 26—STIGMA AND DISCRIMINATION

No. 76

HOW DANGEROUS IS STIGMA? PERCEIVED STIGMA AND HIV RISK AMONG WOMEN WITH SEVERE MENTAL ILLNESS

Presenters: Pamela Y. Collins *Columbia University, 722 West 168th Street, Room 1713, New York, NY, 10032*, Patricia Zybert, Ph.D., Annika Sweetland, M.S.W.

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant should be able to recognize the relationships between selected HIV risk factors and perceived stigma for women with severe mental illness.

SUMMARY:

Objective: As a group, women with severe mental illness (SMI) in urban centers have higher HIV prevalence than the general population. Poverty, gender inequality, and other contextual factors likely elevate their risk. The stigma of mental illness may be one contextual factor that also increases vulnerability. We examined the relationship between perceived mental illness stigma and sexual partner type, intoxication during sex, and unprotected sex. Method: We interviewed 92 women age 18 and older in urban community mental health programs using the Stigma of Psychiatric Illness and Sexuality among Women Questionnaire (SPISEW). The SPISEW examines six domains, including mental illness stigma (alpha = .86); relationship stigma (alpha=.79); and perceived attractiveness (alpha =.61). Results: We employed a one-way between-groups analysis of variance to explore the relationship between sexual partner type, intoxication during sex, and unprotected sex and perceived stigma. We grouped participants according to partner type: no sexual partner, steady partner, or other (casual partners and partners with whom women exchanged sex for money or drugs).There was a significant linear relationship between partner type and mental illness stigma scores ($F=6.32$, $p=.014$), relationship stigma scores ($F=5.49$, $p=.021$), and perceived attractiveness scores ($F=4.46$, $p=.037$). Women with no partner reported the least amount of perceived mental illness stigma [Mean=1.36 (SD=1.74)]; those with a steady partner, an intermediate amount [Mean=2.54 (SD=2.30)]; and those with a casual or exchange partner, the greatest amount [Mean=3.29 (SD=2.18)]. Greater perceived mental illness stigma was significantly associated with having sex while intoxicated (Mean 4.1 vs. 2.4, $p=.009$), but not with use of condoms during sexual intercourse. Conclusions: Women who report higher perceived stigma due to mental illness also report behaviors that increase risk for HIV infection. Experience of stigma due to mental illness may play an important role in women's HIV risk.

REFERENCES:

1. Link BG, Phelan JC. Conceptualizing stigma. Annual Review of Sociology Vol 27 2001, 363-385.
2. Meade CS, Sikkema KJ. HIV risk behavior among adults with severe mental illness: A systematic review. Clinical Psychology Review 2005,25:433-457.

No. 77

COMPARISON OF PUBLIC'S STIGMA ATTITUDE BETWEEN MENTAL ILLNESS AND PHYSICAL HANDICAP

Presenters: Chih-Wei Yang, M.D. *E-DA Hospital, Department of Psychiatry, No 1, Yi-Da Road, Jiau-Shu Tsuen,, Yan-Chau Shiang, Kaohsiung county, 824, Taiwan Republic of China*, Chih-Yu Yang, Ph.D., Pi-Fem Hsu, Ph.D., Li-Min Su, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize and compare the severity and influencing factors of public's stigma attitude toward schizophrenia, depression, and physical handicap.

SUMMARY:

Objective: Public's stigma attitude toward mental illness is harmful to public health and human right as well as other diseases. Several studies had been conducted to evaluate the public's attitude toward mental illness and how to improve it. However, in these studies, no appropriate disease population has been used and compared as control

group. The objective of this study was to compare the public's stigma attitude toward schizophrenia, depression, and physical handicap. Method: A total of 507 university students completed three questionnaires about the stigma attitude toward schizophrenia, depression, and physical handicap. Each stigma questionnaire consisted of four subscales measuring familiarity, stereotype, dangerousness, and social distance. The subjects' basic data, religious belief, and mental health education experience were also collected. Results: The mean age of the subjects was 19.7 years, and 58% were male. The scores of stigma attitude toward schizophrenia were highest among these three scales: stereotype, dangerousness, and social distance. The scores of stigma attitude toward depression were higher than physical handicap only in the stereotype subscale. Female subjects had higher scores in dangerousness and social distance subscales with the schizophrenia questionnaire. Subjects with mental health education experience had lower scores in all subscales of schizophrenia and depression questionnaires. Conclusions: The results of this study showed that the public's stigma attitude toward schizophrenia is more severe than depression and physical handicap. Mental health education in university campus is a practical way to reduce the stigma attitude toward mental illness.

REFERENCES:

1. Angermeyer MC, Matschinger H, Corrigan PW: Familiarity with mental illness and social distance from people with schizophrenia and major depression: testing a model using data from a representative population survey. Schizophr Res 2004; 69: 175-182.
2. Mann CE, Himelein MJ: Factors associated with stigmatization of persons with mental illness. Psychiatr Serv 2004; 55: 185-187.

No. 78
OBSESSIONS ABOUT HOMOSEXUALITY AND THE Y-BOCS - LESSONS FROM A ANTI-DISCRIMINATION CASE IN SWEDEN

Christian Rück, M.D. *Karolinska Institutet, Clinical Neurosciences, Sect Psychiatry, Psychiatry, Karolinska Hospital, Stockholm, 17176, Sweden*

EDUCATIONAL OBJECTIVES:

This presentation will give the participant insights in obsessions concerning sexual orientation. Ways of approaching this topic with the patient will be discussed. Discriminations issues will be discussed.

SUMMARY:

Objective: Determining if the use of the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) checklist is discriminatory against gays and lesbians. Method: Literature review and review of a anti-discrimination case involving sexual obsessions. Results: The Y-BOCS consists of a symptom checklist and a severity rating scale. One of the items on the symptom checklist concerning sexual obsession is "content [that] involves homosexuality." In response to this item, a Swedish patient filed a complaint to The Ombudsman against Discrimination on grounds of Sexual Orientation, which is a Swedish public agency that was created to address homophobia and discrimination based upon sexual orientation. After investigation, the agency concluded that use of the Y-BOCS should be discontinued because the scale is heteronormative and discriminatory, since sexual obsessions involving heterosexuality per se is not covered in the checklist, and, according to the Ombudsman, the item concerning homosexual obsessions is placed within a context of criminal and aberrant sexual behavior that is associated with scientific arguments that are unfounded and considered outdated. According to Swedish antidiscrimination laws, use of the Y-BOCS could, therefore, be grounds for legal prosecution. Inour opinion, the Ombudsman does not distinguish between the sexual orientation homosexuality and obsessions about homosexuality as a part of a psychiatric disorder. That is to say, homosexual obsessions on the Y-BOCS are placed in the context of other sexual obsessions because the thought of being gay or lesbian by some patients with obsessive-compulsive disorder is repulsive and undesirable to them, in the same manner that the thought of being a pedophile might become an obsession to other patients.

We argue that the Y-BOCS does not contain data that are biased regarding sexual orientation. Concerning the Ombudsman's assertion of the Y-BOCS as a heteronormative assessment, our understanding and clinical experience is that gay and lesbian patients with obsessive compulsive disorder never or rarely experience obsessions about heterosexuality, whereas the inverse is fairly common, explaining why obsessions about heterosexuality are not listed.

A clinical situation with an improper use of the Y-BOCS (not stressing that it assesses obsessions, not sexual orientation) might rightly be considered offensive and discriminatory to some patients. Conclusions: The Y-BOCS in itself is not discriminatory.

REFERENCES:

1. Goodman WK, Price LH, Rasmussen SA, Mazure C, Fleischmann RL, Hill CL, Heninger GR, Charney DS: The Yale-Brown Obsessive Compulsive Scale, I: development, use, and reliability. Arch Gen Psychiatry 1989; 46:1006'1111.
2. Rück C, Bergström J. Is the Y-BOCS Discriminatory Against Gays and Lesbians? Am J Psychiatry 2006;163(8):1449.

SCIENTIFIC AND CLINICAL REPORT SESSION 27—SUICIDE AND SELF DESTRUCTION

No. 79
THE 10-YEAR COURSE OF PHYSICALLY SELF-DESTRUCTIVE ACTS OF PATIENTS WITH BORDERLINE PERSONALITY DISORDER

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that the long-term course of physically self-destructive acts engaged in by borderline patients is more benign than previously thought.

SUMMARY:

Objective: The purpose of this study was to assess the prevalence and time-to-remission of self-mutilation and suicide attempts among patients with borderline personality disorder (BPD) followed prospectively for 10 years. Method: Both self-mutilation and suicide attempts were assessed using a semi-structured interview of proven reliability: the Lifetime Self-destructiveness Scale (LSDS). This interview was administered at baseline to 290 patients meeting DIB-R and DSM-III-R criteria for BPD. The LSDS was also administered at five contiguous two-year follow-up periods. All told, 92% of surviving borderline patients participated in all six assessments. Results: At baseline, 90.3% of borderline patients had a history of self-mutilation, 79.3% had a history of attempting suicide, and 73.5% had a history of both. By the time of their 10-year follow-up, 17.7% of borderline patients reported mutilating themselves, 12.9% reported making a suicide attempt, and 6.8% reported engaging in both forms of physically self-destructive behavior. Using survival analyses, 93.3% of borderline patients experienced a remission of their self-mutilation over the ten years of follow-up and 97.9% experienced a remission of their suicide efforts. Of those whose self-mutilation

remitted, 22.4% experienced a recurrence. Of those whose efforts to commit suicide remitted, 31% experienced a recurrence. In addition, only 4.1% of borderline patients actually committed suicide. Conclusions: The course of both self-mutilation and suicide attempts among borderline patients seems more benign than previously recognized, with remissions being very common and recurrences being relatively rare.

REFERENCES:

1. Mehlum L, Friis S, Vaglum P, Karterud S: The longitudinal pattern of suicidal behavior in borderline personality disorder: A prospective follow-up study. Acta Psychiatr Scand 1994; 90:124-130.
2. Sabo AN, Gunderson JG, Najavitz LM, Chauncey D, Kisiel C: Changes in self-destructiveness of borderline patients in psychotherapy: A prospective follow-up. J Nerv Ment Dis 1995; 183:370-376.

No. 80
INDICATORS OF TREATMENT REFRACTORY ILLNESS AND RISK OF SUICIDE

Presenters: Bonnie S. Szarek, R.N. *Institute of Living, Burlingame Center for Psychaitric Research & Education, 400 Washington Street, Hartford, CT, 06106-3309*, John W. Goethe, M.D., Stephen B. Woolley, D.Sc

EDUCATIONAL OBJECTIVES:

Attendees will be able to list at least three indicators associated with post-discharge self-rated suicidality.

SUMMARY:

Objective: To examine the associations between indicators of "treatment refractory" illness and suicidality. Method: Clinical data from 277 consenting adult in-patients ages 18-67 (mean 41.7) years were recorded during index hospitalization, including eleven clinical features suggestive of chronicity or treatment refractory illness (e.g., borderline personality disorder (BPD), polypharmacy). These variables were tested for association with post-discharge suicidality, which was assessed by telephone interview using the Beck Hopelessness Scale (BHS) three months after discharge. Bivariate and multivariate regression analyses produced odds ratios (ORs) and their 95% confidence intervals (95% CIs) for associations between suicidality (BHS ≥9) and each of 11 clinical features and with a single potential summary indicator (defining treatment refractory as the presence of >3 of the 11 individual indicators). Results: Among diagnostic variables tested, having >2 diagnoses (OR=2.04; 95% CI= 1.20-3.45) and BPD (4.58; 2.32-9.06) were associated with BHS scores ≥9. Four treatment variables were also associated with suicidality: antipsychotic (1.62; 0.96-2.73), typical antipsychotic (1.97; 0.92-4.24), >1 antidepressant (2.21; 1.10-4.46), or >3 psychotropics (2.67; 1.50-4.75). Clozapine treatment, taking >1 antipsychotic, readmission, and a >10 day LOS were not individually associated. Having >3 of these 11 clinical features was significantly associated with suicidality (3.61; 2.02-6.48). Stepwise logistic regression to assess the association between suicidality and having >3 of the treatment refractory indicators while controlling confounding resulted in a stronger association for this variable (4.04; 2.18-4.49) and retained age and major depression (but not schizophrenia, schizoaffective disorder, or bipolar disorder) in the model. Conclusions: Self-reported suicidality three months after hospital discharge was predicted by several clinical features that may be indicators of a persisting or treatment refractory condition. Early identification of patients at increased risk of suicide is an important issue for acute treatment and post-discharge planning.

REFERENCES:

1. Oquendo MA, Currier D, Mann JJ: Prospective studies of suicidal behavior in major depressive and bipolar disorders: what is the evidence for predictive risk factors? Acta Psychiatr Scand 2006; 114:151-158.
2. Beck AT, Weissman A, Lester D, Trexler L: The measurement of pessimism: the Hopelessness Scale. J Consul Clin Psychol 1974; 42:861-865.

No. 81
PERSONALITY TRAITS AS PROSPECTIVE PREDICTORS OF SUICIDE ATTEMPTS: NEGATIVE AFFECTIVITY/TEMPERAMENT AND DISINHIBITION IN A PERSONALITY DISORDER SAMPLE

Presenters: M. Tracie Shea, Ph.D. *Providence, Providence, RI, 22222*, Shirley Yen, Ph.D., Charles A. Sanislow, Ph.D., Andrew E. Skodol II, M.D., Carlos M. Grilo, Ph.D., Robert L. Stout, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be knowledgeable regarding the comparative risk of various personality traits as risk factors for suicidal behavior in a personality disordered sample.

SUMMARY:

Objective: Borderline personality disorder (BPD) is associated with an increased risk of suicidal behaviors. To the best of our knowledge, no study has *prospectively* examined two dimensions hypothesized to underlie BPD, negative affectivity/temperament and disinhibition, as predictors of suicidal behavior. Our objective is to examine negative affectivity/temperament and disinhibition, as prospective predictors of suicide attempts over 5 years of follow-up in a personality disorder (PD) sample. Method: Data from the Collaborative Longitudinal Personality Disorders Study (CLPS), an ongoing naturalistic, longitudinal investigation with annual follow-up assessments was analyzed. Six hundred sixty-three participants completed at least two years of follow-up; 99 reported a suicidal attempt during the five years of follow-up. Negative affectivity/ temperament and disinhibition were assessed using the NEO Personality Inventory and the Schedule for Nonadaptive and Adaptive Personality (SNAP). Per Trull's (2001) model, Negative Affectivity using the NEO was operationalized as the combination of depression, anxiety, and angry hostility facet scores; Disinhibiton was operationalized by impulsivity, deliberation, and self-discipline facets. In the SNAP, Negative Temperament and Disinhibition are each higher order factors. Results: Negative affectivity/temperament was significant in predicting suicide attempts; disinhibition and the interaction of these variables were not significant in multivariate analysis. Results were consistent for both the NEO and SNAP models, and remained significant even after covarying for well-established risk factors of suicidal behavior such as sex, history of childhood sexual abuse, and history of a substance use disorder. Trait negative affectivity/temperament at baseline was a significant prospective predictor of suicide attempts over five years of follow-up whereas major depressive disorder diagnosis at baseline was not. Contrary to hypothesis, disinhibition was only significant in univariate analysis; once negative affectivity/temperament was entered into the model, it was no longer significant. Conclusions: Negative affectivity/temperament emerged as a stronger and more robust predictor of suicide attempts in a predominantly PD sample than disinhibition, and warrants greater attention in suicide risk assessment. Given the extensive empirical literature which suggests impulsivity as a risk factor for suicidal behavior, it is surprising that disinhibition was not significant. It is possible that another component of impulsivity, other than trait disinhibition, accounts for this relationship. Our data suggests that any association between disinhibition and suicide attempts is better

accounted for by negative affectivity/temperament in a personality disorder sample.

REFERENCES:

1. Brodsky BS, Malone KM, Ellis EP, et al.: Characteristics of borderline personality disorder associated with suicidal behavior. Am J Psychiatry 1997; 154:1715-1719.
2. Yen S, Shea MT, Sanislow CA et al.: Borderline personality disorder criteria associated with prospectively observed suicidal behavior. Am J Psychiatry 2004; 161:1296-1298.

THURSDAY, MAY 24, 11:00 AM - 12:30 PM

SCIENTIFIC AND CLINICAL REPORT SESSION 28—PHARMACOTHERAPY AND PERSONALITY DISORDERS

No. 82
PERSONALITY TRAITS AND PROPHYLACTIC TREATMENT WITH SELECTIVE SEROTONIN REUPTAKE INHIBITORS

Presenters: Sabrina J. Khan, M.D. *NYU, Department of Psychiatry, 344 Third Ave,, apt 17F, Brooklyn, NY, 10010*, Eric D. Peselow, M.D., Barbara Orlowski, Ph.D.

EDUCATIONAL OBJECTIVES:

To examine whether the presence or absence of personality traits/ disorders affects the long-term course of depressed patients who have recovered from their depression

SUMMARY:

Objective: It is the purpose of this paper to examine whether the presence or absence of personality traits/disorders affects the long-term course of patients who continue treatment on an antidepressant after complete recovery from a depressive episode. Method: Over an 11 year period we measured personality traits and diagnosed personality disorders (PD) following clinical response to antidepressant treatment. Overall 168 patients treated at an urban community mental health clinic with a DSM-IV diagnosis of a major depressive episode as determined by a psychiatrist were included. Over the 11 year period depressed patients were treated with either paroxetine (n=67) or sertraline (N=101). 90 recovered with total remission of symptoms defined as a Montgomery-Asberg depression score (MADRS) of 8 or less. Another 78 patients responded to treatment with a 50% decrease in MADRS score and a final MADRS of between 9 and 14 . All patients who had responded or remitted from their depression were continued on the medication to which they responded either paroxetine or sertraline until one of 2 outcomes--termination well meaning the patient remained continously well for the length of time they were on prophylactic antidepressant or until Jan 1 2005 the endpoint of our analysis or failure which meant the patient relapsed with a major depressive episode

The Structured Interview for DSM-IV Personality Disorder (SIDP) was given to these patients to measure maladaptive personality traits. The SIDP measures ratable traits of the 10 DSM-IV personality disorders. All items are rated on a 0-3 point scale. For the present study, we examined both trait dimensions of personality and the categorical diagnoses for PD's in these recovered depressed patients. We simply assigned a point score (0-3 points) for each trait within the personality disorder, and a total personality trait score for each PD. A score of 2 or 3 meant the trait was definitely present and this counted toward the categorical diagnosis. The SIDP was obtained 1-2 weeks after the patient showed response or complete remission from the depression. Results: Correlations between dimensional personality traits vs. months stable for Cluster A, B and C traits were as follows: Cluster A r=-.29, Cluster B r=-.42 and Cluster C= -.41. For all clusters, this was highly significant (p<.001). Thus the greater the deviant cluster A, B and C traits, the shorter time to relapse with another depressive episode. Overall 95 patients did not have one of the 10 DSM IV PD's and 73 had one or more PD's. Length of time stable for the 95 patients with no PD was 46.38 SD 23.3 months vs 23.30 SD 27.8 months for those who had one or more PD's. (p<.0001). Overall, only 21 of 95 patients with no PD relapsed with a depressive episode vs 43 of 73 with one or more PD's. (p<.0001) Conclusions: This study confirms the view that comorbid personality pathology in depressed patients affects long-term outcome; the greater the personality pathology, the shorter the time to relapse, even with continued antidepressant treatment

REFERENCES:

1. Peselow E.D., Fieve R.R., and DiFiglia C: Personality traits and response to desipramine. Journal of Affective Disorders:24:209-216, 1992.
2. Burch D Prophylactic antidepressants. Lancet. 2001 Apr 7;357(9262):1140.

No. 83
OLANZAPINE FOR THE TREATMENT OF BORDERLINE PERSONALITY DISORDER: A FLEXIBLE-DOSE 12-WEEK RANDOMIZED DOUBLE-BLIND PLACEBO-CONTROLLED STUDY

Presenters: S. Charles Schulz, M.D. *University of Minnesota Medical School, Dept. of Psychiatry, 2450 Riverside Avenue, Minneapolis, MN, 55454*, Mary C. Zanarini, Ed.D., Holland C. Detke, Ph.D., Quynh Trzaskoma, M.S., Daniel Lin, Ph.D., Walter Deberdt, M.D., Sara Corya, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the effects of treatment with flexibly dosed olanzapine relative to placebo in patients with borderline personality disorder.

SUMMARY:

Objective: We examined the efficacy and safety of flexibly-dosed olanzapine for the treatment of borderline personality disorder (BPD) in one of the largest scale clinical trials conducted to date in this population. Method: In this 12-week double-blind trial, patients 18-65 years of age with a diagnosis of DSM-IV BPD were randomized to receive olanzapine (2.5-20 mg/day; N=155) or placebo (N=159). Patients were seen every two weeks, with a telephone visit in between. The primary efficacy measure was the change from baseline to last-observation carried forward endpoint (LOCF) on the Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD) total score. Rate of response (defined as ≥50% reduction in ZAN-BPD total from baseline to anytime postbaseline) and time to the first occurrence of response were assessed. Results: Mean baseline ZAN-BPD total scores were indicative of moderate symptom severity (17.01 in olanzapine vs. 17.70 in placebo, p=0.156). Both the olanzapine- and placebo-treated patients showed significant improvements in overall symptom severity, based on mean changes from baseline to LOCF endpoint in ZAN-BPD total score, but did not differ in the magnitude of improvement at endpoint (-6.56 olanzapine vs. -6.25 placebo, p=.661). Response rates were 64.7% for olanzapine-, and 53.5% for placebo-treated patients (p=.062). However, time to response was significantly shorter for the olanzapine treatment group (p=.022). Treatment-emergent adverse events reported significantly more frequently among olanzapine-treated patients included somnolence, sedation, increased appetite and weight increase. Mean weight

change from baseline to endpoint was significantly different for olanzapine- relative to placebo-treated patients (2.86 vs. -0.35kg, p<.001). Conclusions: Both the olanzapine- and placebo-treated patients showed significant but not statistically different improvement on overall symptoms of borderline personality disorder. The types of adverse events observed in the olanzapine treatment group appeared similar to those observed previously in adult populations.

REFERENCES:

1. Bogenschutz MP, George Nurnburg H: Olanzapine versus placebo in the treatment of borderline personality disorder. J Clin Psychiatry 2004; 65(1):104-109.
2. Zanarini MC, Frankenburg FR: Olanzapine treatment of female borderline personality disorder patients: a double-blind, placebo-controlled pilot study. J Clin Psychiatry 2001; 62(11):849-854.

No. 84
A DOSE COMPARISON OF OLANZAPINE FOR THE TREATMENT OF BORDERLINE PERSONALITY DISORDER: A 12-WEEK RANDOMIZED DOUBLE-BLIND PLACEBO-CONTROLLED STUDY

Presenters: Mary C. Zanarini, Ed.D. *McLean Hospital, Department of Psychiatry, 115 Mill Street, Belmont, MA, 02478*, S. Charles Schulz, M.D., Holland C. Detke, Ph.D., Yoko Tanaka, Ph.D., Fangyi Zhao, Ph.D., Walter Deberdt, M.D., Sara Corya, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the effects of treatment with olanzapine at low and moderate doses relative to placebo in patients with borderline personality disorder.

SUMMARY:

Objective: We examined the efficacy and safety of low vs. moderate olanzapine doses for the treatment of borderline personality disorder (BPD) in the largest controlled clinical trial ever conducted in this population. Method: This 12-week, double-blind trial involved patients 18-65 years of age with a diagnosis of DSM-IV BPD randomized to receive 2.5 mg/day olanzapine (N=150), 5-10 mg/day olanzapine (N=148), or placebo (N=153). Patients were seen every two weeks, with a telephone visit in between. The primary efficacy measure was the change from baseline to last-observation-carried-forward endpoint (LOCF) on the Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD) total score. Rate of response and time to response were also examined, with response defined as a ≥50% reduction in ZAN-BPD total score. Secondary measures included the SCL-90-R, the Modified Overt Aggression Scale, and Sheehan Disability Scale. Results: Mean baseline ZAN-BPD total scores ranged from 17.01 to 17.42, indicating moderate symptom severity. Treatment with OLZ5-10 was associated with significantly greater mean change from baseline to LOCF endpoint in ZAN-BPD total score than placebo (-8.50 vs. -6.79, p=.010). Response rates were significantly higher for OLZ5-10 (73.6%) than for OLZ2.5 (60.1%, p=.018) and placebo (57.8%, p=.006). Time to response was significantly shorter for OLZ5-10 than placebo (p=.028). Both olanzapine dose groups showed significantly greater improvement on irritability, suicidality, and family life functioning relative to placebo. Treatment-emergent adverse events seen more frequently in the olanzapine groups included somnolence, increased appetite, and weight gain. Mean weight change from baseline to endpoint was 2.09kg for OLZ 2.5, 3.17kg for OLZ5-10, and 0.02kg for placebo. Conclusions: The results of this study suggest that moderate doses of olanzapine (5-10 mg/day) are effective in the treatment of overall borderline psychopathology. Also, the types of adverse events observed with olanzapine treatment were similar to those seen previously in adult populations.

REFERENCES:

1. Bogenschutz MP, George Nurnburg H: Olanzapine versus placebo in the treatment of borderline personality disorder. J Clin Psychiatry 2004; 65(1):104-109.
2. Zanarini MC, Frankenburg FR: Olanzapine treatment of female borderline personality disorder patients: a double-blind, placebo-controlled pilot study. J Clin Psychiatry 2001; 62(11):849-854.

SCIENTIFIC AND CLINICAL REPORT SESSION 29—LONG-TERM OUTCOMES OF SCHIZOPHRENIA

No. 85
RELATIONSHIP BETWEEN NEUROCOGNITIVE PERFORMANCE AND INSTRUMENTAL WORK FUNCTIONING IN SCHIZOPHRENIA AND OTHER DISORDERS: A 20-YEAR PROSPECTIVE LONGITUDINAL STUDY

Presenters: Linda S. Grossman, Ph.D. *University of Illinois at Chicago, Psychiatry, 912 S. Wood Street (M/C 913), Chicago, IL, 60612*, Martin Harrow, Cherise Rosen, Ph.D., Henry W. Dove, M.D., Robert Faull, B.S.

EDUCATIONAL OBJECTIVES:

Educational Objective: At the conclusion of this presentation, psychiatrists will have a greater understanding of the relationship between neurocognitive performance and instrumental work functioning for patients with schizophrenia and other disorders, based on multiple prospective assessments over a period of 20 years.

SUMMARY:

Objective: Previous research has debated the question of whether schizophrenia patients undergo progressive deterioration of neurocognitive functioning as they grow older, and whether neurocognitive impairment is a major factor involved in patients' poorer work functioning and poorer global outcome. The current study was designed to explore whether neurocognitive abilities decline with age in schizophrenia, other psychotic disorders, and nonpsychotic disorders. We also explore the relationship between neurocognitive impairment and global functioning, ability to work, and other psychiatric symptoms. Method: To provide longitudinal data about potential neurocognitive deterioration in schizophrenia compared to control samples of other psychotic disorders and nonpsychotic depression, we prospectively followed-up and tested a large sample of patients from the Chicago Follow-up Study. Patients were assessed 6 times over a 20-year period, using standardized research instruments evaluating neurocognitive impairment, symptoms, psychosocial functioning, and treatment. Results: 1) Based on 3 neurocognitive measures (indices of processing speed, long-term memory, and social comprehension), there was no evidence of neurocognitive decline over time for schizophrenia patients. Surprisingly, their processing speed improved over time. 2) Schizophrenia patients had significantly more impairment in neurocognitive impairment than the other diagnostic groups. 3) Schizophrenia patients with poorer neurocognitive performance had significantly poorer work functioning and poorer global outcome. 4) Work performance was associated both with neurocognitive impairment and also with several types of symptoms including psychotic and affective symptoms. Conclusions: Prospective longitudinal multi-followup data as seen in the current study have not previously been available to the field. Our data indicated that neurocognitive performance does not decline as schizophrenia patients begin to grow older. Our findings support other schizophrenia studies showing that global outcome and work functioning are associated with impaired neurocognitive performance. Contrary to some theo-

ries, current data also suggest that outcome in schizophrenia is also associated with major symptom constellations, including positive symptoms.

REFERENCES:

1. Green MF: What are the functional consequences of neurocognitive deficits in schizophrenia? Am J Psychiatry 1996;153:321-330.
2. Reed RA, Harrow M, Herbener ES, Martin EM: Executive function in schizophrenia: Is it linked to psychosis and poor life functioning? J Nerv Ment Dis 2002; 190:725-732.

No. 86
A 20-YEAR MULTI-FOLLOWUP STUDY OF PERSECUTORY DELUSIONS IN SCHIZOPHRENIA

Presenters: Martin Harrow, Ph.D. *University of Illinois College of Medicine, Psychiatry, 1601 West Taylor Street, M/C 912, Chicago, IL, 60612*, Thomas H. Jobe, M.D., Linda S. Grossman, Ph.D., Dennis D. Beedle, M.D., Joseph F. Goldberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation participants will have a better understanding of the prominence and importance of persecutory delusions in schizophrenia as well as a better understanding of its longitudinal course and of the impact of persecutory delusions on work dysfunction. They will also have increased knowledge about the potential recurrence of persecutory delusions and will learn about protective factors which reduce their recurrence in schizophrenia.

SUMMARY:

Objective: The present 20-year longitudinal, multi-followup, study was designed to determine the potential prominence and importance of persecutory delusions in schizophrenia, their relation to other types of psychotic and nonpsychotic symptoms, and their relationship to work dysfunction. We also studied factors that protect against the recurrence of persecutory delusions. Method: 56 patients with schizophrenia and 141 other psychotic and nonpsychotic control patients from the Chicago Followup Study were evaluated prospectively at index hospitalization and then followed up 6 times over the next 20 years. Using standardized research instruments, patients were assessed at each followup for persecutory and non-persecutory delusions and at each followup for psychosocial functioning, rehospitalization, global outcome, and medication treatment. Results: 1. Schizophrenia patients with persecutory delusions did not have better global outcomes than schizophrenia patients with other types of delusions. Both delusional groups had poorer global outcomes and more work disability than nondelusional schizophrenia patients ($p<.05$).

2. Schizophrenia patients with good premorbid developmental achievements were less likely to experience persecutory delusions over their later longitudinal course ($p<.05$).

3. Fitting with a stress-diathesis model, among schizophrenia patients the risk for persecutory delusions is increased by vulnerability to anxiety, poor prognostic factors, neurocognitive impairment, poor social comprehension, and disorders in selective attention ($p<.05$). Conclusions: 1. Contrary to some theories, schizophrenia patients with persecutory delusions do not have better subsequent long-term outcomes than schizophrenia patients who have other types of delusions.

2. With modern-day treatment, less than 10% of the schizophrenia patients showed continuous (throughout the 20 years) persecutory delusions, and a small subgroup (about 20%) did not re-experience any persecutory or non-persecutory delusions over the 20 year period.

3. Protective factors exist which reduce vulnerability to persecutory delusions. Many of these involve internal characteristics of patients (including better premorbid developmental achievements) as well as attitudinal and personality variables.

REFERENCES:

1. Kapur S: Psychosis as a state of aberrant salience: A framework linking biology, phenomenology, and pharmacology in schizophrenia. Am J Psychiatry 2003; 160: 13-23.
2. Harrow M, Herbener E, Shanklin, A, Jobe J, Rattenbury F, Kaplan, K: Followup of psychotic outpatients: dimensions of delusions and work functioning in schizophrenia. Schizophr Bull 2004; 30(1): 147-161.

No. 87
NEUROCOGNITION, COMPLEX SOCIAL COGNITION, AND FUNCTIONAL OUTCOME IN SCHIZOPHRENIA

Presenters: Joseph Ventura, Ph.D. *UCLA, Psychiatry, 300 Medical Plaza, Room 2243, Los Angeles, CA, 90095-6968*, Michael F. Green, Ph.D., Mark J. Sergi, Ph.D., Kimmy S. Kee, Ph.D., Sarah A. Wilson, M.A., Keith H. Nuechterlein, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to:

1. Understand that there are various domains of neurocogntive functioning and appreciate the relationship between neurocognition and social cognition in chronic schizophrenia.

2. Identify key predictors of complex social cognition in schizophrenia patients and discriminate these factors from relatively more simple aspects of social cognition.

3. Understand the clinical importance of relationship between social cognition and social functioning and work functioning in schizophrenia patients

SUMMARY:

Objective: Deficits in social cognition, such as difficulty in perception of emotions and social cue recognition, have been linking to poor functional outcome in schizophrenia, including poor work outcome (Kee at el., 2003; Brekke et al., 2005). Basic neurocognitive deficits have also been associated with social cognitive deficits (Sergi & Green, 2002). Neurocognitive deficits are a defining feature of schizophrenia and are closely related to community outcomes (Green et al., 2004; Green and Nuechterlein, 1999). Knowing more about how neurocognition, social cognition, functional outcome are interrelated could improve the understanding and prediction of outcomes in schizophrenia patients. Method: Participants were 68 UCLA or VA outpatients with chronic schizophrenia or schizoaffective disorder who were mostly male (64%) and mostly single (92%). The patients had a mean age of 34.4 years and a mean educational level of 13.9 years. Patients were assessed with symptom rating scales (e.g., BPRS, SANS), several neurocogntive measures (e.g., working memory, verbal learning, problem-solving), tests of relatively simple and complex aspects of social cognition, and measures of social and work functioning. Results: Higher-level neurocognitive abilities (e.g., memory, problem-solving) were more robustly correlated with complex social cognition (e.g., processing of social cues, relationship perception) (r's range .31 to .79) than with perception of emotion (r's range from .25 to .44). Complex social cognition, but not perception of emotion, was also correlated with functional outcome, including social functioning ($r = .26$, $p < .05$) and work functioning ($r = .40$, $p < .05$). Conclusions: Schizophrenia patients with relatively preserved higher-level neurocognitive abilities also show relatively intact complex social cognition. Complex social cognition, but not perception of emotion, was related to social functioning and particularly to work functioning. These results suggest that more complex social cognitive processes are particularly relevant to functional out-

come in schizophrenia and deserve more emphasis in clinical practice.

REFERENCES:

1. Green, M., & Nuechterlein, K. (1999). Should schizophrenia be treated as a neurocognitive disorder? Schizophrenia Bulletin, 25, 309-318.
2. Brekke, J., Kay, D.D., Lee, K.S., Green, M.F (2005) Biosocial pathways to functional outcome in schizophrenia. Schizophrenia Research, 80, 213-225.

SCIENTIFIC AND CLINICAL REPORT SESSION 30—NOVEL APPROACHES TO WELLNESS

No. 88
A NEW KIND OF PSYCHIATRY: INFORMATION THEORY IN THE 21ST CENTURY

David A. Rothstein, M.D. *Swedish Covenant Hospital, Psychiatry, 2851 West Bryn Mawr, Chicago, IL, 60659*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1.) understand basic concepts of information theory including how information is measured; (2.) understand how the physical concept of entropy relates to the concept of information; (3.) recognize the parallels between current information technology and neuroscience; (4.) appreciate how this interdisciplinary approach can be applied in psychiatric practice.

SUMMARY:

Objective: To apply concepts of information science to healing in order to better address patient needs. Method: Forty one years ago, the author explained how the mathematical theory of information can provide a useful model for conceptualizing and understanding central nervous activity. He proposed that "higher biological and psychological functioning, and ultimately consciousness, can be related to the increasing abstraction of biologically relevant information into patterns with optimal levels of redundancy and internal constraints, accompanied by the elimination of irrelevant information." This paper reviews current techniques in computer, information, and media technology to examine how they add to this conceptualization. Results: Recent advances in computer, information, and media technology for the efficient recording, transmission, processing, and storage of information promise to fulfill the author's earlier expectation. Wolfram proposes computational algorithms as the key to "a new kind of science." In the search for efficient information compression, technology is moving in the direction already utilized by biological systems. Olshausen commented: "The human brain may hold the secrets to the best image-compression algorithms." Conversely, the algorithms devised for transmission of information over the airwaves and Internet provide insights into the relationship between brain and mind. Conclusions: This model provides the intellectual and esthetic satisfaction implicit in an approach toward comprehending both the living and non-living, conscious and nonconscious, universe, physical brain and psychological mind, in a single conceptual framework, and provides insights helpful in clinical psychiatry.

REFERENCES:

1. Rothstein, DA: Psychiatric Implications of Information Theory. Arch Gen Psychiat 1965; 13:87-94; Applications of Information Theory to Psychogeriatrics. International Psychogeriatric Association Congress, Chicago, IL, Aug, 2003.
2. Olshausen, BA: Vision and the Coding of Natural Images. Amer Scientist 2000; 88:238-245; MacKay, DJC: Information Theory, Inference, and Learning Algorithms. Cambridge, UK, Cambridge Univ Press, 2003.

No. 89
SPIRITUALITY AND RECOVERY FROM PANIC ATTACKS

Presenters: Caroline B. Williams, M.D. *NYU School of Medicine, Department of Psychiatry, 126 East 36 th Street, Apt #5, New York NY, NY, 10016*, Eric D. Peselow, M.D., Barbara Orlowski, Ph.D.

EDUCATIONAL OBJECTIVES:

The educational is to assess spirituality, by virtue of a structured scale, in patients with active panic attacks treated in an outpatient anxiety-depression clinic with SSRIâ€™s (escitalopram, sertraline paroxetine) and evaluate whether response to pharmacotherapy treatment has a correlation with degree of spirituality and belief in God.

SUMMARY:

Objective: It is the purpose of this paper to assess spirituality, by virtue of a structured scale, in patients with panic attacks treated in an outpatient anxiety depression clinic with SSRIâ€™s (escitalopram, sertraline or paroxetine) and evaluate whether spirituality, and belief in God correlate with changes in the frequency of panic attacks, anxiety symptoms, depressive symptoms and functional status following pharmacotherapy treatment. Also, we hope to better understand the factors involved in the relationship between panic attacks and spirituality by assessing hopelessness and dysfunctional attitudes. Method: The study involves the evaluation of 49 patients who were having acute panic attacks who were clinically treated for their panic attacks with one of three antidepressants, escitalopram (N= 17), sertraline (N=19) or paroxetine (N=13). The choice of treatment was based on clinical grounds incorporating factors such as history of previous response and sensitivity to side effects, with the hope of achieving the best possible results for the patient.

All patients met DSM-IV TR criteria for panic disorder which, in the opinion of the psychiatrist treating them, required SSRI medication. Prior to treatment, patients were initially evaluated with a modified SCID to confirm the diagnosis of panic disorder. In addition, the patients were evaluated with the panic inventory which measures the frequency of panic attacks as well as the frequency and severity of anticipatory anxiety and agoraphobic fears. In addition the Montgomery-Asberg Scale (MADRS), the Hamilton Anxiety Scale the Beck Hopelessness Scale and the Dysfunctional Attitude Scale (DAS) of Beck which measures cognitive distortions were also used in this evaluation Results: Overall there were strong statistical differences between the patients who believed in God (N=38) and those who did not (N=11). Those who believed in God had greater improvement with respect to improvement in the frequency of panic attacks ($p<.05$), psychic ($p<.002$) and somatic ($p<.007$) anxiety, severity of anticipatory anxiety ($p<.006$), degree of depression as measured by the MADRS ($p<.03$), DAS change ($p<.02$), and Beck Hopelessness Scale ($p<.007$) People who believed in God had less generalized anxiety comorbidity (18/38) than those who did not (9/11- $p<.05$).

Spirituality score as measured by the Goldfarb et al 1996 scale statistically correlated with improvement in the frequency of panic attacks (p04), improvement in psychic ($p<.005$) and somatic anxiety ($p<.02$) improvement in severity of anticipatory anxiety ($p<.02$) improvement in DAS ($p<.02$), and Beck Hopelessness Scale ($p<.02$) Conclusions: Spirituality can constitute a system of meaning which emphasizes hope, adaptation, insight, greater self esteem and the belief that circumstances are not senseless or meaningless. We will discuss the fact that we may need to help our patients consider their own spiritual beliefs, and this may be important in helping them obtain the maximum benefits from the treatments that we offer. This study seemed to suggest that belief in God and a greater belief in

spirituality gave a greater response to pharmacotherapy for panic disordered patients.

REFERENCES:

1. Goldfarb, L.M., Galanter, M., McDowell, D., Lifshutz, H., Dermatis, H. Medical Student and Patient Attitudes Toward Religion and Spirituality in the Recovery Process. Am J Drug Alcohol Abuse 1996; 22(4): 549-561.
2. . Larson, D., Patterson, E., Blazer, D., Monran, A., Kaplan, B. 1986. Systematic analysis of research on religious variables in four major psychiatric journals, 1978-1982. Am. J. Psychiatry 143, 329-334.

No. 90
FOSTERING SPIRITUAL VALUES AND WELL-BEING : THE NEED IN PSYCHIATRY

Presenters: Russell F. D'Souza *Northern area Mental Health, Melbourne, Australia, Northern Hospital, 185 Coopers Street, Epping, Melbourne, 3073, Australia*, Pedro Ruiz, M.D., Jack S. McIntyre

EDUCATIONAL OBJECTIVES:

1. Learn the need for Psychiatrits and mental health professonals to consider the need for happiness and positive emotions besides the need to reduce disesae and distress in their patients.
2. The place of Positve emotions in achieving welll-being
3. Understanding the Science of well-being
4. Aware of the neurobiology of well-being
5. Well-being therapies- evidence available

SUMMARY:

Objective: The increasing awareness of the basic need of all human beings for a source of meaning that is greater than one's self. This growth in this awareness is driven by our practical goal of reducing disability and improved function from mental disorders and by the heart felt wishes of the suffering patients, for their therapists to recognize the need for self transcendence.

Study the need to achieve well being for patients and the community.

Consider the evidence of spiritual values for patients in supporting them find meaning beyond the illnees and set backs one has to cope withj Method: Review the science of well-being and the under pinnings of the neurobiology of well being.

fostering and exercising the branches of mental self governance measured as character traits in the Temperament and Character Inventory that are associated with well-being. The particular exercising of the self transcendental character trait by adding the important dimension of existential, spiritual resources and positive emotions brings significant positive outcomes to demoralization enhancing well being and function. Results: The evidence currently suggest there has been no improvement whatsoever in the average levels of life satisfaction in the general population as a result of the introduction of psychotropic drugs or manulaised forms of psychotherapy to the present time.

Recent work on well being has shown that it is possible to improve well being and reducing disability in general population as well as in most if not all mental disorders. The particular exercising of the self transcendental character trait by adding the important dimension of existential, spiritual resources and positive emotions brings significant positive outcomes to demoralization enhancing well being and function Conclusions: Fostering of spirituality and well-being is crucial for psychiatry to achieve its meaning and purpose.

In doing so Psychiatry has the oppertunity to recognise a broader understanding of what it is to be a human being

Fostering Spiritual values and well-being incorporates the longitudinal blend of physics and philosophy, the practical and the spiritual, venerable Eastern Wisdom and the cutting edge western science with the evidence of dynamic results.

REFERENCES:

1. D'Souza RF, Rodrigo A, Spiritually Augmented cognitive behavioral therapy. Australasian Psychiatry 2004; 12(2):148-152.
2. Cloninger CR Feeling Good: The Science of well-being, New York, NY: Oxford University Press; 2004.

SCIENTIFIC AND CLINICAL REPORT SESSION 31—METHOLOGICAL ISSUES IN PSYCHIATRIC DISORDERS

No. 91
JOINT CRISIS PLANS FOR PEOPLE WITH PSYCHOSIS: ECONOMIC EVALUATION OF AN RCT

Presenters: Claire Henderson, M.D. *James J Peters VA Medical Center, Mental Illness Research Education and Clinical Center, 130 W Kingsbridge Road, Bronx, NY, 10468*, Sarah Byford, Ph.D., Chris Flood, M.S.C., Morven Leese, Ph.D., Graham Thornicroft, M.B.B.S., George Szmukler, M.B.B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the Joint Crisis Plan intervention and understand the evidence for its cost-effectiveness compared to usual care.

SUMMARY:

Objective: To investigate cost-effectiveness of joint crisis plans (JCP), a form of advance agreement for people with severe mental illness. Method: **Design** Single blind randomised controlled trial, with randomisation of individuals to JCP or a standardised service information (SSI) control.

Setting Eight community mental health teams in southern England.

Participants 160 people with a diagnosis of psychotic illness or non-psychotic bipolar disorder, with a hospital admission within the previous two years.

Intervention The JCP was formulated by the patient, care coordinator, psychiatrist, and project worker, containing contact information, details of illnesses, treatments, relapse indicators, and advance statements of preferences for care for future relapses.

Main outcome measures Admission to hospital, and service use over 15 months. Results: JCP use was associated with relatively lower service use and costs on average than the SSI group, but differences were not statistically significant. Total costs during follow-up were £7264 for each JCP participant and £8359 for the SSI group (mean difference £1095; 95% confidence interval -£2814 to £5004). Cost-effectiveness acceptability curves, used to explore uncertainty in estimates of costs and effects, suggest there is a greater than 78% probability that JCPs are more cost-effective than SSI in reducing the proportion of patients admitted to hospital. Conclusions: JCPs produced a non-significant decrease in admissions and total costs. Whilst acknowledging the wide confidence intervals for the cost estimates, exploration of the associated uncertainty suggests there is a relatively high probability of JCPs being more cost-effective than SSI for people with psychotic disorders.

REFERENCES:

1. Henderson C, Flood C, Leese M, Thornicroft G, Sutherby K, Szmukler G: Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial. BMJ 2004; 329(7458):136-138.

2. Sutherby K, Szmukler GI, Halpern A, Alexander M, Thornicroft G, Johnson C et al: A study of 'crisis cards' in a community psychiatric service. Acta Psychiatr Scand 1999; 100:56-61.

No. 92
LOCF (LAST OBSERVATION CARRIED FORWARD) AND DISTORTION OF FINDINGS IN A PSYCHOTOPIC DRUG CLINICAL STUDY

Presenters: Alex A. Cardoni, M.S. *Institute of Living, Burlingame Center for Psychiatric Research and Education, 200 Retreat Avenue, Hartford, CT, 06106*, Stephen B. Woolley, D.Sc, John W. Goethe, M.D.

EDUCATIONAL OBJECTIVES:

After attending this session, the learner will be able to (1) evaluate the impact of LOCF data analysis on clinical study outcomes and (2) identify suitable alternative methods of data imputation.

SUMMARY:

Objective: To demonstrate how use of LOCF (last observation carried forward) data analysis can alter study results and conclusions in a clinical study. Method: Missing data from a comparative clinical study of bupropion augmentation (bupropion + SRI) versus usual care (index SRI) were imputed by inserting the last rating scale score obtained for each subject (last observation) into the vacant cells for each subsequent assessment time. Statistical analyses were run for each outcome rating tool (24-item Hamilton Depression Rating Scale [HAM-D], Beck Depression Inventory [BDI-II], Clinical Global Impression Scale [CGI], and Heinrich's Quality of Life Scale [QOL]) and trend analyses were plotted. Results for LOCF-imputed data were compared with those from non-LOCF Intent-to-Treat (ITT) and Per Protocol (PP) data from the same study. Results: Use of LOCF produced substantially decreased effects for the HAM-D, Beck-II, CGI, and QOL in comparison to ITT and PP data for both bupropion (B) and usual care (U) groups. The magnitude of the difference was greatest for the BDI-II (-90 % in B,-73% in U), followed by the CGI (-58% in B, -8.3% in U), HAM-D (-50% in B, -16% in U), and QOL (-7.7% in B, -2.4% in U). Use of LOCF greatly underestimated the effects of both interventions and, if used, would seriously distort findings. Conclusions: Use of LOCF introduces bias that may invalidate study results. It deceptively increases the statistical power of a clinical trial by inflating the number of value points and may falsely widen the difference between two treatments, leading to erroneous conclusions. Use of LOCF to impute missing data in clinical studies should be replaced by more valid statistical imputation techniques.

REFERENCES:

1. Siddiqui O, Ali MW: A comparison of the random effects pattern mixture model with last-observation-carried-forward (LOCF) analysis in longitudinal clinical trials with dropouts. J Biopharm Stat 1998; 8:545-563.
2. Juni P, Altman DG, Egger M: Assessing the quality of controlled clinical trials. Br Med J 2001; 323:42-46.

No. 93
COMPARISON OF DEPRESSION AND PERSONALITY RATINGS BY A PATIENT AND INFORMANT REGARDING THE PATIENT'S PSYCHOPATHOLOGY

Presenters: Gavi Hollander, D.O. *NYU School of Medicine, Department of Psychiatry, 216 East 29th Street, New York, NY, 10016*, Eric D. Peselow, Barbara Orlowski, Ph.D.

EDUCATIONAL OBJECTIVES:

To evaluate the accuracy of dpression and personality traits during depression and following clinical recovery by having both a patient and informant report on the patient's psychopathology

SUMMARY:

Objective: Rating scales in psychiatry such as the Montgomery Asberg Depression Scale (MADRS) and personality scales such as the Scale for DSM-IV Personality Disorders (SIDP) have evolved to ensure comprehensive assessment of current and past psychopathology. In the absence of laboratory or x-ray validators of pathology in psychiatry, we must rely on clinical signs and symptoms for which we use the above rating scales. Patients treated in outpatient settings are often seen for 15-45 minutes q1-4 weeks, and thus we can not be sure if their observed behavior during this brief time period represents the way they are during the rest of the week-month . In addition, their pathology might obscure accurate reporting of their behavior. Thus, the purpose of this presentation is to assess and compare observations made by an informant and the patient of the patients' â'¬â,¢s depressive symptoms before and after treatment. Method: To date, we have evaluated 89 depressed outpatients by evaluating data obtained from the patient and comparing it with observations of his/her spouse/live-in companion or other family member to identify if the 2 assessors agree. Patients in this study from the clinicianÃ¢â'¬â,¢s point of view met DSM-IV criteria for major depression & had a minimum score of 18 on the MADRS as based on the clinicianÃ¢â'¬â,¢s rating of the patient. The clinician rated the patient with the SIDP and met with an informant to assess the informantâ€™s impression of the patientâ€™s personality pathology. These scales were given to the patient and informant at baseline and after 8-10 weeks of antidepressant treatment. After 8 weeks the above scales were repeated with the patient and informant evaluating change in the patientÃ¢â'¬â,¢s depressive pathology and personality traits Results: Of the 89 patients, 31 were rated from the patient's perspective to have remitted from their depression (MADRS 8 or less), 28 were rated to have shown a 50% or greater decrease from baseline (MADRS score 9-14) and 30 showed no change from baseline (MADRS > 15) based on the patient's report, The patient's average MADRS score was significantly higher at baseline based on the patient's vs informant's report (26.6 vs 23.5 p<.01). 65 of the 89 informants did not think the patient met DSM IV criteria for depression. The patients tended to have less dimensional personality traits for Cluster B and C as compared with the informant's impression (Cluster B-patient 6.2, informant 8.9 p<.009, Cluster C-patient 4.7 vs 9.9 p<.0003). At both baseline and following treatment the informant felt the patient had more categorical personality diagnoses (N=56 at baseline) than the patient felt he did (N=36 at baseline) Conclusions: The study shows significant differences in how patients and informants view patientsâ€™ pathology. The patient on the depressive rating scale MADRS reported more pathology than the informant; however, based on the personality scale (SIDP) the informant reported more personality pathology than the patient. For both the patient and informant, improvement from depression led to a lower reporting of maladaptive personality traits

REFERENCES:

1. Rush AJ, Carmody TJ, Ibrahim HM, Trivedi MH, Biggs MM, Shores-Wilson K, Crismon ML, Toprac MG, Kashner TM.- Comparison of self-report and clinician ratings on two inventories of depressive symptomatology.
2. Peselow E.D., Sanfilipo M.P., and Fieve R.R: Assessment of personality traits/disorders based on patients and informants reports. Journal of Abnormal Psychology:103:819-824, 1994.

SCIENTIFIC AND CLINICAL REPORT SESSION 32—TRAUMA, AGGRESSION, AND PSYCHOPATHOLOGY

No. 94
CLINICAL DIFFERENCES BETWEEN PATIENTS WITH POST TRAUMATIC STRESS DISORDER WITH AND WITHOUT PSYCHOTIC SYMPTOMS

Presenters: Brian P. Mika, M.D. *Brown Medical School, Department of Psychiatry and Human Behavior, 30 Freeman Street, Warwick, RI, 02886,* Anu Asnaani, Iwona Chelminski, Ph.D., Diane Young, Ph.D., Mark Zimmerman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the clinical differences between patients with post traumatic stress disorder who do and do not have psychotic symptoms.

SUMMARY:

Objective: The presence and prevalence of psychotic symptoms in patients diagnosed with Post Traumatic Stress Disorder have been established in several studies with rates up to 40%. However, there is a dearth of literature comparing patients with PTSD who have psychotic symptoms (PTSD-P) to those without psychotic symptoms (PTSD-NP). Biological, genetic, symptom severity and demographic differences have been suggested in small studies consisting of homogenous veteran populations. In the present report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project, we compared the demographic and clinical characteristics between PTSD-P and PTSD-NP in a large sample of patients seeking treatment in a community based outpatient practice. Method: Psychiatric outpatients with PTSD-P (12.7% of all PTSD patients, N=55) and PTSD-NP (N=377) were evaluated with structured clinical interviews to assess DSM-IV Axis I and II disorders, psychosocial functioning and symptom severity. Results: Black patients were more likely than non-black patients to have PTSD-P (27.3% vs 12.0%, p= 0.036). PTSD-P patients were less likely to have achieved educational levels beyond high school or GED (45.5% vs 61.0%, p=0.028). Patients with PTSD-P were more likely to have attempted suicide (60.0% vs 36.5%, p=0.001) and to have required inpatient hospitalization (58.2% vs 34.2%, p=0.001) than PTSD-NP patients. PTSD-P patients were more likely to have fair or poor current (62.3% vs 47.3%, p=0.03) and past (62.1% vs 43.6%p=0.009) social functioning. Patients with PTSD-P had higher rates of OCD (23.6% vs 12.5%, p=0.03), Cluster A personality disorders (28% vs 7%, p<0.001) and OCPD (20% vs 6.3%, p=0.01) than PTSD-NP patients. Mean GAF scores were lower in PTSD-P patients (39.5+11.8 vs 49.2+8.6, p<0.001). Conclusions: The results of this study suggest that the presence of psychotic symptoms in the context of PTSD is associated with a more severe and disabling course of illness.

REFERENCES:

1. Hamner MB, Frueh BC, Ulmer HG, Arana GW: Psychotic features and illness severity in combat veterans with chronic post traumatic stress disorder. Biol Psychiatry 1999; 45:846-852.
2. Sautter FJ, Cornwell J, Johnson JJ, Wiley J, Faraone SV: Family history study of post traumatic stress disorder with secondary psychotic symptoms. Am J Psychiatry 2002; 159:1775-1777.

No. 95
A CONTROLLED COMPARISON STUDY OF A YOGA BREATH-BASED PROGRAM AND A CLIENT-CENTERED EXPOSURE THERAPY FOR POST TRAUMATIC STRESS DISORDER AND DEPRESSION IN SURVIVORS OF TSUNAMI DISASTER

Presenters: Patricia L. Gerbarg, M.D. *New York Medical College, Psychiatry, 86 Sherry Lane, Kingston, NY, 12401-4724,* Richard P. Brown, M.D., Teresa Descilo, M.S.W., A. Vedamurthachar, Ph.D., R. Damodoran, Ph.D., B.N. Gangadhar, M.D.

EDUCATIONAL OBJECTIVES:

I. At the conclusion of this presentation, the participant should be able to:

A) Understand the benefits of a Yoga Breath-Based Program for relief of symptoms of PTSD and/or depression in survivors of mass disasters.

B) Understand the effects of a Yoga Breath-Based Program in combination with a Client-Centered Exposure Therapy for PTSD and/or depression in survivors of mass disasters.

C) Recognize and know how to obtain effective alternative treatment programs for survivors of mass disasters.

SUMMARY:

Objective: The purpose of this study was to evaluate the yoga-based Breath Water Sound (BWS) Course enhanced with 10-minute Sudarshan Kriya (SK) and Traumatic Incident Reduction (TIR) for relief of post-traumatic stress disorder (PTSD) and depression in survivors of the December 2004 tsunami. Method: Eight months after the 2004 tsunami, survivors in refugee camps in Nagapattanam, India were screened using the PCL-C-17, a PTSD self-assessment scale. Those who scored > 50 met criteria for PTSD and were assigned to 3 groups of 80 each and given additional baseline measures: Beck Depression Inventory (BDI-21) and General Health Questionnaire (GHQ-12). The first group, received an 8-hour BWS Course plus 10 minute SK (cyclical breathing). The second group was given the same intervention followed by (TIR), a one-on-one client-centered exposure-based treatment of 4 to 6 sessions. The third group served as a 5-week wait-list control. Subjects were re-tested after the interventions, at 6 weeks, 3 months, and 6 months. Results: BWS plus SK significantly reduced scores for PTSD and depression while increasing scores for general health at course completion and one-month follow-up in comparison to the control group. BWS plus SK followed by TIR significantly reduced scores for PTSD and depression while increasing scores for general health at course completion and one-month follow-up in comparison to the control group. Improvements on all test measures were sustained at 3-month and 6-month follow-ups. Conclusions: This study suggests that the Breath Water Sound course with 10-minute Sudarshan Kriya is a viable intervention for rapid relief from PTSD and depresion and for improving general health indicators in victims of mass disasters. The addition of TIR following BWS and Sudarshan Kriya training may further benefit survivors.

REFERENCES:

1. Brown RP and Gerbarg PL. Sudarshan Kriya Yoga breathing in the treatment of stress, anxiety, and depression: Part I - Neurophysiological model. J Altern Complement Med. 2005 ; 11:189-201.
2. Brown RP, Gerbarg PL: Sudarshan Kriya Yoga breathing in the treatment of stress, anxiety, and depression: Part II: Clinical Applications and Guidelines. J Altern Complement Med. 2005; 11:711-717.

No. 96
EXPLORATORY FACTOR ANALYSIS OF BORDERLINE PERSONALITY DISORDER CRITERIA IN HISPANIC MEN AND WOMEN WITH SUBSTANCE USE DISORDERS

Presenters: Daniel F. Becker, M.D. *Mills-Peninsula Medical Center, 1783 El Camino Real, Burlingame, CA, 94010*, Luiz Miguel Anez, Psy.D., Manuel Paris, Psy.D., Carlos M. Grilo, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the factor structure of the *DSM-IV* criteria for borderline personality disorder in Hispanic patients, and the extent to which this structure may differ according to gender.

SUMMARY:

Objective: This study examined the factor structure of the *DSM-IV* criteria for borderline personality disorder (BPD), and the extent to which this structure may be affected by gender. Method: Subjects were 130 monolingual Hispanic adults (90 males, 40 females), who had been admitted to an outpatient psychiatric clinic specializing in the aftercare treatment of substance abuse. All were reliably assessed with the Spanish-Language Version of the Diagnostic Interview for *DSM-IV* Personality Disorders. Correlational analyses examined the associations among the BPD criteria, then an exploratory factor analysis was performed using principal components with varimax rotation. Subsequent analyses examined males and females separately. Results: For the males, a unidimensional solution accounted for 55% of the variance (eigenvalue = 4.93). For the females, a two-factor solution accounted for 64% of the variance. After rotation, "abandonment fears," "identity disturbance," "affective instability," "feelings of emptiness," and "paranoia or dissociation" loaded most heavily on the first factor (eigenvalue = 4.28). A second factor (eigenvalue = 1.49) consisted of "unstable relationships," "self-destructive impulsivity," "suicidality or self-injury," and "inappropriate anger." Conclusions: Factor analysis of the BPD criteria in Hispanic outpatients produced results that differ somewhat from similar studies in non-Hispanic samples. Separate analyses by gender revealed factor structures that were distinct. While the male subgroup demonstrated a unidimensional structure, we found two factors for the female subgroup. The first of these factors reflects uncertainties and anxieties that the borderline patient may have about self or others, and includes affective instability. The second factor reflects poorly modulated aggressive impulses directed at self or others, and encompasses unstable interpersonal relationships. Our results suggest that, among Hispanic patients, there may be gender differences in the underlying structure of BPD. These findings have implications for understanding borderline psychopathology in this population, and may also have implications for treatment.

REFERENCES:

1. Fossati A, Maffei C, Bognato M, Donati D, Namia C, Novella L: Latent structure analysis of DSM-IV borderline personality disorder criteria. Compr Psychiatry 1999; 40:72-79.
2. Grilo CM, Becker DF, Anez LM, McGlashan TH: Diagnostic efficiency of DSM-IV criteria for borderline personality disorder: an evaluation in Hispanic men and women with substance use disorders. J Consult Clin Psychol 2004; 72:126-131.

SCIENTIFIC AND CLINICAL REPORT SESSION 33—GENDER ISSUES IN PSYCHIATRIC DISORDERS

No. 97
SUICIDE AMONG FEMALE VETERANS IN THE GENERAL U.S. POPULATION

Presenters: Bentson Mc Farland, M.D. *Oregon Health & Science University, Psychiatry, 3142 SW Altadena Terrace, Portland, OR, 97239-1339*, Mark Kaplan, D.P.H., Nathalie Huguet, Ph.D., Jason Newsom, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize risk factors for suicide among women in the general population and to discuss risk of suicide among female veterans.

SUMMARY:

Objective: Little is known about suicide among women veterans in the general United States population. This topic is important because the participation of women in military service has increased substantially in recent decades. Data from the United States Census showed that there were about one million female veterans in 1980 and in 1990. By the 2000 Census, the numbers of women veterans in the United States had increased to over one and a half million. As it happens, most, if not all, previous studies on veteran suicide focused on Department of Veterans Affairs (VA) patients and-or on those who served during the Vietnam War era. However, in a given year, most veterans have little or no contact with the VA system. Moreover, the vast majority of female veterans served after the Vietnam War era. Other studies have examined suicidal ideation or suicide attempts, rather than suicide mortality. In addition, nearly all studies pertaining to suicide among veterans focused chiefly on men. Therefore, this project examined risk of suicide fatality among women veterans.

Method: Participants in the study were adult women who had been interviewed as part of the general population National Health Interview Survey during the years 1986 through 1994. The National Health Interview Survey data were linked with the 1986 through 2000 National Death Index to identify individuals who had committed suicide. Cox proportional hazards models were used to estimate relative risks of suicide among 287,913 female respondents while adjusting for potential confounders.

Results: There were 138 suicide fatalities among these women with eight female veteran suicide deaths. Cox proportional hazards analysis showed that female veterans had markedly elevated risk of death by suicide with hazard ratio adjusted for confounders of 4.24 (p less than 0.0001). Proportional hazards analysis also showed that suicide risk was elevated for women who lived alone (p less than 0.003), were not in the work force (p less than 0.01), lived in the West (p less than .05), had mental disorder (p equals 0.001), or were in fair (p equals 0.02) or poor (p equals 0.002) self-rated health. Overweight (p equals 0.01) or obese (p equals 0.004) women had reduced suicide risk.

Conclusions: Although the numbers of fatalities were small, these data suggest that female veterans in the general U.S. population are at elevated risk of death by suicide. Clinical and community interventions that are directed toward female veterans in both VA and non-VA health care facilities may well be needed.

REFERENCES:

1. Goldsmith SK, Pellmar TC, Kleinman AM, Bunney WE: Reducing suicide: A national imperative. Washington, DC: National Academies Press; 2002.
2. Pollock DA, Rhodes P, Boyle CA, Decoufle P, McGee DL: Estimating the number of suicides among Vietnam veterans. Am J Psychiatry 1990; 147:772-77.

No. 98
DIAGNOSTIC AND GENDER DIFFERENCES IN SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS IN FIRST EPISODE PSYCHOSIS

Presenters: Robert W. Marvin, M.D. *912 S Wood, Chicago, IL, 60612*, Cherise Rosen, Ph.D., James L. Reilly, Ph.D., Hugo A. Solari, M.D., John A. Sweeney, Ph.D.

EDUCATIONAL OBJECTIVES:

Educational Objective: At the conclusion of this presentation, psychiatrists will have greater knowledge of diagnostic and gender differences in patients with schizophrenia and other psychotic disorders (sociodemographic variables, age of onset, family history, symptom presentation, and global functioning).

SUMMARY:

Objective: Previous research has found that women present with later age of onset of first psychotic symptoms and milder symptom severity. It is necessary to replicate these differences in new cohorts of first episode psychosis patients. We report here early results of demographic variables and treatment response in first episode psychosis in both schizophrenia and other psychotic disorders.

Method: Patients were recruited from the University of Illinois Medical Center. First episode psychosis patients were evaluated free of pharmacological treatment. Lifetime exposure to psychotropics was less than 16 weeks. Diagnosis was determined using the DSM-IVtr and consensus with clinical team. All patients were assessed on standardized research instruments evaluating symptoms and global functioning at baseline and 4 weeks after treatment with atypicals. Results: In this ongoing study women with schizophrenia presented for psychiatric treatment an average of 2 years earlier than men. Overall, women with psychotic symptoms presented with greater impairment in global functioning and more severe level of depression. Men with other psychotic disorders presented for treatment an average of 3 years earlier than women. Overall, males with psychosis presented with more severe psychotic symptoms. There was a trend in reduction of PANSS negative subscale after 4 weeks of treatment with atypicals in patients with schizophrenia. Interestingly, the degree of improvement was not significantly different between schizophrenia and other psychotic disorders as measured by the PANSS positive and total scores. Conclusions: Early data emerging from this study suggests that women with schizophrenia present for initial psychiatric treatment at an earlier age than men. However, the converse is true of men with other psychotic disorders in that they presented for initial psychiatric treatment at an earlier age. These finding suggest a demographic effect and treatment response that may depend on a given cohort as well as the context of clinical evaluation.

REFERENCES:

1. Gelber EI, Kohler CG, Bilker WB, Gur RC, Brensinger C, Siegel SJ, Gur RE: Symptom and demographic profile in first-episode schizophrenia.
2. Bromet EJ, Schwartz JE, Fennig S, Geller L, Jandorf L, Kovasznay B, Lavelle J, Miller A, Pato C, Ram R, Rich C: The epidemiology of psychosis: the Suffolk County Mental Health Project.

No. 99
COMPARISON OF LONGITUDINAL COURSE OF ILLNESS BETWEEN WOMEN AND MEN: A 25-YEAR MULTI-FOLLOWUP STUDY OF SCHIZOPHRENIA, OTHER PSYCHOTIC DISORDERS, AND NONPSYCHOTIC DEPRESSION

Presenters: Cherise Rosen, Ph.D. *University of Illinois at Chicago, Psychiatry, 1601 West Taylor Street, Suite 489, Chicago, IL, 60612*, Linda S. Grossman, Ph.D., Martin Harrow, Ph.D., Robert Faull, B.S.

EDUCATIONAL OBJECTIVES:

Educational Objective: At the conclusion of this presentation, psychiatrists will have become acquainted with sex differences in outcome (recovery, persistence of symptoms, and global functioning) for patient with psychotic and nonpsychotic disorders based on multiple assessments during a 25-year period.

SUMMARY:

Objective:

Previous research has suggested that women with schizophrenia have a better clinical courses than men. However few have studied sex differences using multiple data points over the course of several decades. This study is unique in that it affords comparison of sex differences in psychotic and nonpsychotic disorders, which may enhance scientific understanding of the potential protective properties of estrogen over time. Method: As part of The Chicago Follow-up Study, we prospectively assessed patients at index hospitalization and then again 7 times over 25 years (n=127), to provide longitudinal data about sex differences in global functioning and outcome. Patients were assessed on standardized research instruments evaluating symptoms, psychosocial functioning, treatment, and global outcome. Results: 1) Regarding patients with psychotic disorders, women showed consistently better functioning over time, showing significantly better overall outcomes, and more periods of recovery than men. 2) These sex differences were not as strong or consistent for patients with other psychotic disorders. 3) There were no significant sex differences for patients with nonpsychotic disorders. 4) Female schizophrenia patients had significantly more psychosis-free interims over the 25-year period. However, contrary to the hypothesized protective properties of estrogen, psychosis diminished as women grew older and approached menopause. Conclusions: Current data support the patterns of sex differences found in other studies. Women with schizophrenia and other psychotic disorders showed a better course of illness and fewer psychotic symptoms than their male counterparts. Contrary to theory, at the 20- and 25-year followup, women's psychosis improved, despite potential decreases in estrogen over time. These sex differences did not occur for patients with nonpsychotic depression.

REFERENCES:

1. McGlashan TH, Bardenstein KK: Gender differences in affective, schizoaffective, and schizophrenic disorders. Schizophrenia Bulletin 16:319-329, 1990.
2. Grossman, L.S., Harrow, M., Rosen, C., Faull, R: Sex Differences in Outcome and Recovery for Schizophrenia and Other Psychotic and Nonpsychotic Disorders. Psychiatric Services, 57(6), 844-850, 2006.

SCIENTIFIC AND CLINICAL REPORT SESSION 34—NEUROSCIENCE AND NEUROPSYCHIATRY IN MOOD DISORDERS

No. 100
BRAIN-DERIVED NEUROTROPHIC FACTOR (BDNF) LEVELS IN DEPRESSED PATIENTS DURING ANTIDEPRESSANT TREATMENTS

Presenters: Armando Piccinni, M.D. , *Pisa*, Mario Catena, M.D., Donatella Marazziti

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to get up-dated information on the role of neurothrophic factors in the neurobiology of depression and on the possible use of them as predictors of response to antidepressants

SUMMARY:

Objective: Latest hypotheses on the neurobiology of depression suggest a major role for the brain-derived neurotrophic factor (BDNF). Plasma and serum BDNF levels have been reported to be decreased in drug-free depressed patients. In this study, we aimed

to assess the changes in serum and plasma BDNF levels during a one-year antidepressant treatment. Method: Plasma and serum BDNF levels were assayed using the ELISA method, in 15 drug-free patients suffering from major depression and in 15 healthy control subjects, at the baseline and at the 2nd week, 1st, 3rd, 6th and 12th month of antidepressant treatment. The diagnoses were assessed by the Mini International Neuropsychiatric Interview. The severity of depression was evaluated at each time point using the Hamilton Depression Rating Scale (HDRS) and the Montgomery-Asberg Depression Rating Scale (MADRS). Results: Baseline serum and plasma BDNF levels (meanÂ±SD=19300Â±8800 pg/ml and 2900Â±1900 pg/ml) of patients were significantly lower than those found in the control subjects (33600Â±8600 pg/ml and 5400Â±2300 pg/ml). Patientâ€™s plasma BDNF levels did not differ significantly from the values reported in healthy control subjects starting from the 1st month of treatment (p=.079). On the contrary, in all evaluations, serum BDNF levels in patients were significantly lower than the values detected in controls. On the other hand, a significant clinical improvement of depressive symptoms was detected at the 1st month evaluation (HAM-D baseline=22.8Â±5.3, HAM-D 1st month= 12.2Â±5.7, p=.002; MADRS baseline=29.6Â±5.6, HAM-D 1st month=16.8Â±6.8, p=.002) and at the following time points. Conclusions: A chronological relationship between the achievement of a significant clinical improvement and the normalization of plasma BDNF up to the values found in control subjects was found. At every time assessment, patientâ€™s serum BDNF levels were lower than those of control subjects suggesting that serum BDNF might represent a non-specific trait marker of depression.

REFERENCES:

1. Gervasoni N, Aubry J-M, Bondolfi G, Osiek C, Schwald M, Bertschy G et al. Partial normalization of serum brain-derived neurotrophic factor in remitted patients after a major depressive episode. Neuropsychobiol 2005; 51:234-238.
2. Aydemir O, Deveci A, Taneli F. The effect of chronic antidepressant treatment on serum brain-derived neurotrophic factor levels in depressed patients: a preliminary study. Prog Neuropsychopharmacol Biol Psychiatry 2005; 29:261-265.

No. 101
INFORMATION PROCESSING IN BIPOLAR DISORDER DURING REMISSION

Presenters: Camilo J. Ruggero, Ph.D. *Brown Medical School, Department of Psychiatry and Human Behavior, 235 Plain Street, Suite 501, Bayside Medial Center, RIH, Providence, RI, 02905*, Sheri L. Johnson, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe how information-processing models relate to bipolar disorder, understand evidence to support processing biases in bipolar disorder and discuss what implications these biases have for the treatment of bipolar disorder.

SUMMARY:

Objective: Few laboratory studies have been carried out to determine if people with bipolar disorder in remission process emotional stimuli differently than people without the disorder. While significant work suggests that mood episodes, especially episodes of depression, influence the way people process emotional stimuli, very little is known about whether these biased forms of processing exist independent of episodes in bipolar disorder. If they do, they might represent part of the diathesis for future episodes of depression or mania. Method: Two groups of individuals were recruited. One group had a diagnosis of bipolar I disorder in remission (n = 25), confirmed by standard semi-structured interviews (SCID). The other group acted as a control and consisted of individuals with no history of a mood disorder (n = 24). A battery of tasks was administered to both groups to assess their attention and different types of memory. Attention was assessed using a standard dot probe task modified to present faces with differnt emotional expressions as the stimuli. Two types of memory were assessed, including implicit and explicit memory. Stimuli included presentation of word sets that had different emotional valences. Outcomes were the tendency to attend to positive or negative emotion faces, as well a preference for recalling stimuli with either positive or negative valence. Results: Few group differences emerged on cognitive variables. However, there was a pattern for people with bipolar disorder to demonstrate more of an effect from mood state on their explicit memory of emotional stimuli than was seen among healthy controls. Specifically, positive mood states led to greater recall of positively valenced stimuli in the bipolar group compared to the control group. Moreover, results found that even minor symptoms of depression affected memory, though this was not unique to the bipolar group. Conclusions: Findings from this study underscore that even during periods of remission, mood state exerts a significant influence on how individuals process emotional stimuli. Although preliminary, results suggest a memory bias for positive information in the bipolar group. Findings also show that even minor depressive symptoms influence what kind of information is recalled. Given that people with bipolar disorder often have some symptoms of the disorder, even during periods of remission, results suggest possible mechanisms that place people at risk for episode recurrence.

REFERENCES:

1. Eich E, Macaulay D, Lam, RW: Mania, depression, and mood dependent memory. Cog and Em 1997; 11: 607-618.
2. Ingram, RE, Miranda, P, Segal, ZV: Cognitive Vulnerability to Depression. New York, Guilford Press, 1998.

No. 102
MITOCHONDRIAL FUNCTION IN THE ANTERIOR CINGULATE AND TREATMENT RESPONSE IN MDD

Presenters: Dan V. Iosifescu, M.D. *Massachusetts General Hospital, 50 Staniford Street, Suite #401, Boston, MA, 02114*, J. Eric Jensen, Ph.D., Andrew A. Nierenberg, M.D., Nicolas R. Bolo, Ph.D., Dana Charles, B.A., Maurizio Fava, M.D., Perry F. Renshaw, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand 1) the role of mitochondrial dysfunction in several brain areas in subjects with major depressive disorder (MDD) and 2) the association between re-normalization of mitochondrial function (measured as bioenergetic metabolism) in the anterior cingulate gyrus and response to SSRI treatment in MDD.

SUMMARY:

Objective: Metabolic abnormalities in the anterior cingulate cortex (ACC) have been associated with treatment response in major depressive disorder (MDD) (Mayberg et al, 2002). Decreased brain bioenergetic metabolism (suggestive of mitochondrial dysfunction) has also been reported in MDD subjects (Renshaw et al, 2001). In the current study we investigate changes in bioenergetics in the ACC during treatment with escitalopram in MDD. Method: We report the data from the first 22 subjects meeting DSM-IV criteria for MDD, mean age = 48.0 + 10.6 years, (9 females, 41%) who completed a 12-week treatment with escitalopram 10-20 mg/day. Depression severity was measured with the 17-item Hamilton Rating Scale for Depression (Ham-D-17) at every visit. Phosphorus magnetic resonance spectroscopy (31P MRS) spectra at 4 T were obtained at baseline, week 2 and week 12 from a 25-cm^3 effective voxel centered

on the ACC. We also collected baseline 31P MRS data from 10 healthy volunteers. Results: 16 MDD subjects (72%) were treatment responders (Ham-D-17 reduction > 50%) after 12 weeks. At baseline MDD treatment responders had higher intracellular Mg++ concentration (lower pMg, $p<0.05$) and a trend ($p<0.1$) for lower beta NTP (nucleoside triphosphate) compared with MDD non-responders and with healthy volunteers. No significant changes of 31P MRS metabolites occurred in the first two weeks of antidepressant treatment. At week 12 MDD treatment responders had significant increases in the bioenergetic metabolism in the ACC compared to treatment non-responders. Responders showed increases in beta NTP, total NTP, and ADP levels in the ACC compared to non-responders ($p<0.05$). There was also a trend towards increases in intracellular pH ($p=0.087$) and pMg ($p=0.056$) in treatment responders but not in non-responders. Conclusions: The antidepressant effect of the SSRI escitalopram is associated with a selective re-normalization of bioenergetic metabolism in the ACC of treatment responders, but not in non-responders. This is consistent with a re-normalization of impaired mitochondrial function in brain areas involved in mood regulation. These findings are also consistent with the previously reported changes in glucose metabolism in the ACC of MDD treatment responders.

REFERENCES:

1. Mayberg HS, Silva JA, Brannan SK, Tekell JL, Mahurin RK, McGinnis S, Jerabek PA. The functional neuroanatomy of the placebo effect. Am J Psychiatry. 2002;159(5):728-37.
2. Renshaw PF, Parow AM, Hirashima F, Ke Y, Moore CM, Frederick Bde B, Fava M, Hennen J, Cohen BM. Multinuclear magnetic resonance spectroscopy studies of brain purines in major depression. Am J Psychiatry. 2001; 158(12): 2048-55.

SCIENTIFIC AND CLINICAL REPORT SESSION 35—ANTIDEPRESSANTS AND MOOD DISORDERS: OUTCOME STUDIES

No. 103
IMPACT OF STUDY DESIGN ON THE RESULTS OF CONTINUATION STUDIES OF ANTIDEPRESSANTS

Presenters: Mark Zimmerman, M.D. *Rhode Island Hospital, Psychiatry, 235 Plain Street, Suite 501, Providence, RI, 02905*, Michael A. Posternak, M.D., Camilo J. Ruggero, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be aware of the two different designs used in continuation studies of antidepressant medications, and the impact of study design on the results of continuation studies.

SUMMARY:

Objective: Antidepressant continuation studies have used two different designs. In the *Placebo Substitution* design all patients are initially treated with active medication in an open-label fashion, and then treatment responders are randomized to continue with the active medication or switch to placebo in a double-blind manner. In the *Extension* design patients are randomized to a double-blind placebo-controlled acute study at the outset, and responders to active treatment and placebo are continued on the treatment to which they initially responded. We hypothesized that the design of antidepressant continuation studies would impact on the likelihood of relapse. In the Extension design there is no change in the treatment prescribed. Whether patients responded to placebo or active medication, the treatment that produced the response is continued. In contrast, in the Placebo Substitution design there is an obvious change in treatment protocol upon initiation of the continuation phase. Patients are aware that they initially received active medication and that there is now a chance that they will be switched to placebo. We speculate that the expectation of a continued positive response is lower in patients treated using the Placebo Substitution design than the Extension design, and therefore predicted that relapse rates would be higher. Method: We conducted a meta-analysis of antidepressant continuation studies and compared the relapse rates in continuation studies using these two different designs. Results: As predicted, for both the active medication and placebo groups the frequency of relapse was lower in studies using an Extension design. We also found that the difference in relapse risk between antidepressants and placebo was greater with the Extension design. Conclusions: The design of continuation studies of antidepressants was associated with the absolute percentage of patients who relapse on both active medication and placebo, as well as estimates of differential relapse risk between antidepressants and placebo.

REFERENCES:

1. Geddes J, Carney S, Davies C, et al.: Relapse prevention with antidepressant drug treatment in depressive disorders: A systematic review. The Lancet 2003;361:653-651.
2. Byrne S, Rothschild A.: Loss of antidepressant efficacy during maintenance therapy: possible mechanisms and treatments. J Clin Psychiatry 1998;59:279-288.

No. 104
THE EFFECTIVENESS OF VENLAFAXINE AND ITS METABOLITE IN REFRACTORY DEPRESSED PATIENTS

Presenters: Patrick Samuel MBAYA *Psychiatry, University Hospital of South Manchester, Southmoor Road, Manchester, M23 9LT, United Kingdom*, Faouzi Alam, M.D., Aung Tint, M.D., Edgar Specer, Ph.D.

EDUCATIONAL OBJECTIVES:

At the end presentation the participant should be aware that high dose venlafaxine is an effective and safe strategy in refractory depressed patients and this is due to both venlafaxine and its active metabolite ODV.

SUMMARY:

Objective: To assess efficacy and safety of venlafaxine and ODV in refractory depressed patients treated with high dose venlafaxine XL. Method:

This was a cross sectional study in which 50 patients with treatment refractory depression who had been on high dose venlafaxine XL (225mg-525mg) for a minimum of 12 months were assessed. All study patients had been on at least one antidepressant and 50% had been on more than two antidepressants prior to starting venlafaxine.

One assessment of each of the measures was done. Global assessment of functioning (GAS) and self rating rating scale of mood and general functioning were efficacy measures. Safety measures included reported side effects, ECG and blood pressure measurements. Venlafaxine and O-desmethylvenlafaxine (ODV) levels were measured 8-10 hours post dose.Non-parametric colleration tests were used to determine colleration between variables. Results: There was a colleration between both venlafaxine ($P<0:01$) and ODV ($P<0.03$) levels. 82% of patients had a level of functioning between 70% to 100% on GAS (mild impairment to full functioning). 84% and 78% of patients rated themselves as much better in mood and general feelings respectively, while being on venlafaxine compaired with their previous treatment. ODV was collerated with mood ($P<0.04$) and general feeling ($P<0.02$) but not Venlafaxine levels ($P<0.76$ and $P<0.42$) although this was collerated with patient functioning ($P<0.03$). There was no colleration between high dose Venlafaxine

and the number of side effects and ECG parameters, although ODV was associated with less adverse effects. Conclusions: Chronic use of high dose venlafaxine XL is safe and effective in treatment of refractory depressed patients and this is due to both velafaxine and ODV. Serum ODV levels was associated with a good efficacy and safety profile.

REFERENCES:

1. Veefkind AH, Haffmans PM, Hoencamp E: Venlafaxine serum levels and CYP2D6 genotype. The Drug Monitor 2000 Apr;22(2):202-8.
2. Gex-Fabry M et al: Time course of clinical response to venlafaxine: relevance of plama level and chirality. Eur J Clin Pharmacol. 2004 Feb;59(12):883-91.

No. 105
DISCONTINUATION OF ANTIDEPRESSANT PROPHYLAXIS--ARE THERE PREDICTORS

Presenters: Tara M. Pundiak, M.D. *20 Sherman St., Fairfield, CT, CT, 06824*, Eric D. Peselow, M.D., Loretta Mulcare, B.S., Brady G. Case, M.D.

EDUCATIONAL OBJECTIVES:

The purpose of this presentation is to determine for patients stable on antidepressant prophylaxis for 1-10 years if there are any predictors that would lead to successful discontinuation of medication

SUMMARY:

Objective: To evaluate the rate of stability after discontinuing one of three selective serotonin reuptake inhibitors (SSRIâ€™s): fluoxetine, sertraline and paroxetine in a naturalistic clinical setting. These patients had responded to one of the above medications during acute depression and were continued on these

medications for 1-10 years with continued stability of response and were then discontinued from the above SSRI's. Method: Over an 13 year period, 121 patients who were treated for depression with one of the three SSRIâ€™s (Fluoxetine N=27, Paroxetine N=41 and Sertraline N=63) after a period of clinical stability chose (with the concurrence of the treating MD) to be tapered and discontinued from their SSRIâ€™s over a 2-5 month period. On the day of discontinuation the degree of depression as measured by the Montgomery-Asberg Depression Scale (MADRS) was noted and the Structured Interview for DSM IV Personality Disorders (SIDP) was carried out during the period of taper whereby there were no depressive symptoms Results: Overall 88 of the 121 patients were noted to have had a depressive relapse in the 4 year period post discontinuation (73%). The probability of remaining free of a depressive episode following discontinuation was 56.6% at one year, 37.2% at two years, 30.9% at 3 years and 25.0% at four years. Months stable post discontinuation significantly correlated with MADRS score on the day of discontinuation ($p<.0001$)-lower MADRS score on day of discontinuation was correlated with greater length of stability off medication. In addition, the presence of cluster B dimensional traits ($p<.007$) and categorical diagnosis ($p<.025$) and cluster C dimensional traits ($p<.0001$) and categorical ($p<.015$) were highly significant; that is the greater the number of cluster B & C dimensional traits and categorical diagnosis the shorter length of stability off medication. In addition length of time stable on medication highly correlated with length of time stable off medication. The longer one remained stable on medication the longer he remained stable off medication ($p<.0007$) Conclusions: It appeared that the degree of depression, frequency of cluster B and C personality dimensional traits/categorical diagnoses and length of time stable on medication were important factors in determining the feasibility of discontinuing SSRI treatment

REFERENCES:

1. Hirschfeld RM, Schatzberg AF. Long-term management of depression. Am J Med. 1994 Dec 19;97(6A):33S-38S.
2. Greden JF' Antidepressant maintenance medications: when to discontinue and how to stop. J Clin Psychiatry. 1993 Aug;54 Suppl:39-45.

SYMPOSIUM 1—SCHIZOPHRENIA WITH COMORBID CONDITIONS: CLINICAL ISSUES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the current state of knowledge in assessment and treatment of common and challenging comorbid clinical conditions in patients with schizophrenia.

No. 1A
DIAGNOSTIC ISSUES AND TREATMENT STRATEGY IN SCHIZOPHRENIA WITH DEPRESSION

Siegfried Kasper *Medical University Vienna, MUV, General Psychiatry, AKH, Wahringer Gurtel 18-20, Wien, A1090, Austria*, Dietmar Winkler, M.D.

SUMMARY:

Depression is an integral part of schizophrenia and longitudinal studies revealed that up to 60% of our schizophrenic patients exhibit depressive symptoms of substantial severity during the course of their illness. Moreover, 15% of schizophrenic patients commit suicide during their illness. When the depressive symptom is not considered at the beginning of the illness, the long-term outcome, specifically with regard to compliance as well as quality of life, is significantly impaired in those patients. Whereas treatment with the older antipsychotic medication, the so called typical neuroleptics, commonly caused medication induced depression, it appears to be a much less problem with the newer so called atypical antipsychotics in patients with schizophrenia. Specifically, long-term studies comparing older with newer medications indicated that atypical antipsychotics demonstrated a significantly better outcome with regard to the depressive symptomatology. The antidepressant pharmacodynamic properties of these newer antipsychotics, specifically the 5-HT2 blockade and the dopamine auto-receptor agonistic properties, as well as, norepinephrine and serotonin reuptake inhibiting properties are discussed to be responsible for the antidepressant effects. A specific emphasis therefore should be given to patients with a depressive symptomatology in the course of the schizophrenic illness in order to maximise their treatment outcome.

No. 1B
SCHIZOPHRENIA WITH OBSESSIVE-COMPULSIVE AND PANIC SYMPTOMS: TREATMENT ISSUES

Michael Y. Hwang, M.D. *East Orange VA Medical Center, Department of Psychiatry, 385 Tremont Ave # 116A, East Orange, NJ, 07018-1023*

SUMMARY:

Obsessive-compulsive (OC) and panic symptoms in schizophrenia have been recognized and debated over the years. However, its biological and clinical implications schizophrenic spectrum disorder remains poorly understood and continue to challenge practicing clinicians. Earlier DSM diagnostic criteria precluded simultaneously diagnosing schizophrenia and anxiety disorders, partly due to the traditional belief that obsessive-compulsive and panic symptoms constitutes a neurotic reaction to the psychotic phenomena. Furthermore, these anxiety symptoms were believed to occur rarely and carry no meaningful significance in clinical course and outcome in schizophrenic illness. However, recent epidemiological, neuropsychological, and treatment studies found much greater prevalence rate, worse clinical course and treatment response with poor long-term outcome among schizophrenia with comorbid anxiety disorders. In addition, recent treatment studies with a specific anti-anxiety treatment intervention in schizophrenic patients with comorbid OCD and panic symptoms have shown symptom reduction and functional improvements. Unfortunately, in clinical practice schizophrenic patients with comorbid anxiety disorders continues to challenge practicing clinicians. Current research evidence suggests that this subgroup of schizophrenic patients require in-depth clinical assessment and individualized therapeutic intervention for optimal outcome.

In this symposium presentation we will examine the current clinical, pharmacological, and neuropsychological evidence in schizophrenia with comorbid anxiety disorders and suggest their optimal management.

No. 1C
EATING DISORDER COMORBIDITY IN SCHIZOPHRENIA: CLINICAL IMPLICATIONS FOR MANAGING OBESITY AND METABOLIC DISORDERS

Sun Young Yum, M.D. *NJVAHCS / UMDNJ NJMS, Psychiatry, 183 S. Orange Ave, E-1428, Newark, NJ, 07101*, Michael Y. Hwang, M.D.

SUMMARY:

Eating disorders and schizophrenia are widely believed to be mutually exclusive. With increasing morbidity and mortality associated with obesity and metabolic illnesses in patients with schizophrenia, the impact of eating behavior warrants further systematic exploration. Recent molecular examinations have assumed biological differences in hunger, satiation, and satiety mechanisms in schizophrenia and have focused on metabolic signals to find managment strategies. The underlying assumption is often that the homeostatic signals are offset by schizophrenia or psychotropic medications. But this assumption is challenged by the heterogeneous patterns of weight and changes in appetitive behaviors consumption in clinical patients with schizophrenia under identical diagnosis and medication. Hypothalamic sum of physiological feeding signals can be easily overridden by emotions, and thoughts. The salience of the motivation to eat, whether this actually results in enough drive to lead to eat, factors involved in eating termination, hedonic responses and how that changes future expectations of food reward are all big chunks of the missing picture. Such cognitive processes may account in part for the individual variability in changes of food intake and body weight associated with the illness and its medications. Cognitive and emotional processing theories of eating disorders and schizophrenia, as well as etiological hypotheses based on neurobiological explorations of the two illness categories have overlapping areas. The presentation will discuss systematic observations of overlapping clinical phenomena, ensuing diagnostic issues, therapeutic implications, including cognitive therapies.

No. 1D
RECENT INCREMENTS IN KNOWLEDGE ABOUT SUICIDALITY IN SCHIZOPHRENIA

Alec Roy, M.D. *UMDNJ, Psychiatry, 140 Dwight Pl, Englewood, NJ, 07631-3607*, Marco Sarchiapone, M.D., Vladimir Carli, M.D., Michael Hwang, M.D.

SUMMARY:

Recent studies about the incidence of suicide in schizophrenia will be reviewed.Information will also be presented about risk factors

for suicidal behavior in schizophrenia .A possible conceptual model will be discussed which will incorporate new information about possible developmental and genetic risk factors as well as the risk conferred by comorbid substance abuse,comorbid depression,and noncompliance with neuroleptic medication.Lastly recent intervention studies aimed at preventing suicidal behavior in schizophrenia will be discussed

REFERENCES:

1. Yum SY, Hwang MY, Halmi KA. Eating disorders in schizophrenia. Psychiatric Times. Vol XXIII, No 7. June, 2006.
2. Hawton K, Van Heeringen C. (2000) The International Handbook of Suicide and Attempted Suicide. Chichester: John Wiley & Sons.
3. Kim SW, Kim SJ, Yoon BH, Kim JM, Shin IS, Hwang MY, Yoon JS. Diagnostic validity of assessment scales for depression in patients with schizophrenia. Psychiatry Research 2006 Sep 30;144(1):57-63.
4. Poyurovsky M, Koran LM. Obsessive-compulsive disorder (OCD) with schizotypy vs. schizophrenia with OCD: diagnostic dilemmas and therapeutic implications. J Psychiatr Res. 2005 Jul;39(4):399-408. Epub 2004 Nov 13.

SYMPOSIUM 2—BIOLOGICAL FOUNDATIONS OF BIPOLAR DISORDER: NEW INSIGHTS AND PROSPECTS FOR TREATMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to gain insight on the most recent biological foundations of bipolar disorder from the cognitive, molecular, pathophysiological, and genetic perspectives by reflections on the future treatment strategies.

No. 2A
COGNITION, NEUROPLASTICITY, AND TREATMENT OF BIPOLAR DISORDER

Eduard Vieta, M.D. *University of Barcelona Hospital Clinic, Institute of Neuroscience, Rossello 140, Barcelona, 08036, Spain*

SUMMARY:

Cognitive dysfunctions and their neurochemical correlates play a central role in the pathophysiology of bipolar disorder, but this fact has been neglected for many years as manic-depressive illness was supposed to be a "good-prognosis" condition, as compared to schizophrenia. Recent studies suggest that bipolar patients show subtle but clinically relevant neuropsychological disturbances, which go beyond acute episodes (1). Neuroimaging techniques, both structural and functional, have been used to address changes in the brain across different mood states, and also to understand the mechanism of action of classic and novel mood-stabilizers. This presentation will address critical issues related to the neurobiology of bipolar disorder that may have clinically meaningful implications for patients'care. The last decade has been full of exciting findings on the neurobiology of bipolar disorder. We are indeed beginning to understand the neuropsychological, neuroanatomical, and neurofunctional changes in the brain that may underlie this condition, and there is a huge number of studies on genetics providing further data on the heritability of the disorder. Moreover, we start to understand how lithium works at the intracellular level, and the molecular mediators of the regulation of synaptic function and plasticity (2). All these findings are unequivocally important, and real steps towards a better understanding of the nature of the disease. However, from the clinician's standpoint, it is difficult to even mention one single change in the way we treat our patients or their outcome, that comes as a result of this further knowledge on neurobiology, neuroplasticity and neurogenesis. This presentation will try to fill as much as possible the gap between basic research and clinical practice as far as neurocognition and treatment outcome are concerned.

No. 2B
IS THE PROTEIN KINASE C INHIBITION A KEYSTONE IN TREATMENT OF BIPOLAR DISORDER?

Aysegul Yildiz-Yesiloglu, M.D. *Dokuz Eylul University, Psychiatry, Huzur Mah. Saffet Baba Sok., 27/12, Narlidere, Izmir, 35320, Turkey*

SUMMARY:

Several steps in second messenger pathways, such as increased calcium release, over activation of the inositol pathway and of protein kinases, have been implied not only in cellular hypermetabolism, but also in mania as a behavioural correlate. In most cases, the pathway was indicated by clinical discovery of an effective agent which consequently initiated research in its potential mechanisms of action. More recently, however, this relation became bidirectional. For example, calcium antagonists, such as nimodipine, and protein kinase C (PK-C) inhibitors, such as tamoxifen, are recently being tested in acute mania studies. In a double blind placebo controlled trial of tamoxifen, among the 67 manic patients randomized, 50 (74.6%) completed the three weeks of the trial and adhered to protocol. In the tamoxifen group 14 out of 29 (48%) patients achieved a positive response, defined as ≥ %50 improvement in the Young Mania Rating Scale-YMRS, compared to only 1 out of 21 (%5) patients in the placebo group (χ^2= 11.267, p= 0.001). The tamoxifen group had a mean 18.07 (standard deviation, SD=11.21) decrease (t=8.681, df= 28, p< 0.001), whereas the placebo group had a mean 5.19 (SD=9.38) increase (t= -2.535, df= 20, p= 0.02) in the YMRS at three weeks compared to baseline. ANOVA repeated measures indicated significance for change in the YMRS and Clinical Global Impressions-CGI mania with respect to time between tamoxifen and placebo groups (F=13.584, p= 0.001; F=6.427, p= 0.015, respectively). These findings indicate that tamoxifen has strong anti-manic properties. If this finding is replicated one of the direct targets of lithium and valproate will be identified and PKC inhibition will be considered as keystone in treatment of bipolar disorder. Eventually, targeted treatment strategies for patients with bipolar disorder will be possible.

No. 2C
GLIAL CELL DYSFUNCTION IN THE PATHOPHYSIOLOGY OF BIPOLAR DISORDER.

Dost Ongur, M.D., Ph.D. *11 Arthur Ter, Watertown, MA, 02472-4101*

SUMMARY:

"I will review postmortem studies showing a reduction in glial cell number and density in the prefrontal cortex (PFC) in subjects with mood disorders. This reduction is found in the medial, orbital and dorsolateral PFC as well as the amygdala, but not in somatosensory cortex. It is also accompanied by less impressive changes in neuronal cell size, density and number. The PFC is involved in the setting of mood, and abnormalities in this region are found in depression and mania.

Consistent with the postmortem literature, several genetic studies point to polymorphisms in glia-related genes as being associated with bipolar disorder. Finally, magnetic resonance spectroscopy studies have identified changes in neurochemical levels consistent with a reduction in glial cell function in the brain in bipolar disorder *in*

vivo. These findings highlight a possible role for impairments in glial cell function in the PFC in the pathogenesis of mood disorders.

I will then describe recent findings of glial changes following electroconvulsive seizures (ECS), an animal model for electroconvulsive therapy (ECT), which is an effective treatment for both depression and mania. Emerging work indicates that in addition to its well-established effects on neurogenesis in the hippocampus, ECS enhances glial proliferation in the medial PFC and amygdala. There is some additional evidence that other effective treatments for bipolar disorder also have an impact on glial cell regeneration and survival.

Taken together, these findings indicate that glial cell dysfunction, especially in the PFC, may play a role in mood disorders, and that ECT may exert its salutary effects by enhancing glial cell proliferation. I will finish with some thoughts on the biological implications of glial cell dysfunction for mood disorders (synaptic regulation, neuronal metabolism) and the importance of different glial subtypes."

No. 2D
GENETICS OF BIPOLAR DISORDER: RECENT ADVANCES AND COMING ATTRACTIONS

Jordan W. Smoller, M.D. *Massachusetts General Hospital, Center for Human Genetic Research, 185 Cambridge St. Rm 6240, Boston, MA, 02114-3117*

SUMMARY:

Family and twin studies have established that bipolar disorder (BPD) is a familial and highly heritable phenotype. Over the past two decades, a great deal of effort has been devoted to identifying specific susceptibility genes for BPD. While no specific genes have been conclusively implicated, accumulating evidence from linkage and association studies and advances in genomic research methods have fueled renewed optimism about the prospects for gene identification. This presentation will address advances in the genetics of BPD and highlight emerging methods and themes in this area of research. Recently, a large meta-analysis of BPD linkage studies identified genome-wide significant linkage on chromosomes 6q (for bipolar I disorder) and 8q (for bipolar I + bipolar II disorder)(1), suggesting that these genomic regions harbor BPD susceptibility genes. Several specific genes have been associated with BPD in independent samples or meta-analyses including DAOA, DISC1, SLC6A3, SLC6A4, and BDNF. Evidence is mounting that genes influencing BPD overlap with those influencing other disorders including schizophrenia and major depression (2). The cataloguing of human genetic variation through the International HapMap project and the integration of genomics with gene expression, neuroimaging and methods of gene characterization offer unprecedented tools for the identification of susceptibility genes. The next wave of genetic research will include whole genome association studies capable of surveying the entire genome for genetic variants that contribute to the disorder. If these studies are successful, they may reveal novel pathways for drug development and, perhaps, opportunities for risk prediction. This presentation will conclude with a discussion of the potential clinical impact of genetic research in BPD.

REFERENCES:

1. Corbella B, Vieta E. Molecular targets of lithium action. Acta Neuropsychiatrica 2003; 15:1-25.
2. Bebchuk JM, Arfken CL, Dolan-Manji S, Murphy J, Hasanat K, Manji HK: A preliminary investigation of a protein kinase C inhibitor in the treatment of acute mania. Arch Gen Psychiatry 2000; 57:95-97.
3. Öngür D, Drevets WC, Price JL (1998): Glial reduction in the subgenual prefrontal cortex in mood disorders. Proc Natl Acad Sci U S A 95:13290-5.
4. Craddock N, O'Donovan MC, Owen MJ: Genes for schizophrenia and bipolar disorder? Implications for psychiatric nosology. Schizophr Bull 2006; 32(1):9-16.

SYMPOSIUM 3—PHYSICAL ILLNESS IN PEOPLE WITH SEVERE MENTAL DISORDERS

EDUCATIONAL OBJECTIVES:

1. After the presentation the participants should become better aware of the frequency and nature of physical illness occurring in people who have a mental disorder
2. Participants should be able to improve their planning for comprehensive care for people with mental disorders

No. 3A
PHYSICAL ILLNESS AND MENTAL DISORDER: NEGLECTED FACTS

Norman H. Sartorius, M.D. *Chemin Colladon 14, Geneva, CH 1209, Switzerland*

SUMMARY:

In the early part of the twentieth century public health authorities, clinicians and researchers paid considerable attention to the co-occurrence of mental and physical diseases. More recently the interest and engagement to clarify the nature, causes and consequences of this phenomenon has lessened although, according to reports from many countries physical illnesses still often precede mental disorders, occur simultaneously with them and follow them. Research into the nature of this relationship is likely to contribute to the understanding of the etiology and pathogenesis of both physical and mental illness. More importantly, valid information about the frequency of the co-occurrence of disorders could orient public health action and improve the care that people with mental and physical illnesses receive.

The paper will present illustrative data on the mortality of people with schizophrenia and mood disorders and make suggestions about the desirable directions of future public health action, research and training for care.

No. 3B
PHYSICAL ILLNESS AND SCHIZOPHRENIA - EXTENSIVE REVIEW OF THE LITERATURE

Stefan Leucht, M.D. *Technical University of Munich, Psychiatry and Psychotherapy, Ismaningerstr. 22, Munich, 81675, Germany*

SUMMARY:

People with schizophrenia on average die 10 years younger than the general population. Suicide and accidents account for only 40% of this excess mortality, the rest is due to physical diseases. We, therefore, reviewed the literature on the association between schizophrenia and physical illnesses to provide a basis for strategies to fight this inacceptable situation. We searched MEDLINE (1966-2006) combining the MeSH term of schizophrenia with MeSH terms of general physical disease categories to relevant epidemiological studies. 44202 abstracts were screened. The quality and the amount of the studies identified in the different areas varied substantially. Increased rates of HIV and hepatitis infections, osteoporosis, altered pain sensitivity, sexual dysfunction, obstetric complications, cardiovascular diseases, overweight, diabetes, dental problems and polydipsia have been consistently found. On the other hand there are also a number of medical peculiarities, especially decreased rates of rheumatoid arthritis and of cancer. Schizophrenia is associated with unacceptably high rates of physical diseases. Reasons may partly be

inherent to the disorder and the consequence of antipsychotic drug treatment, but are also related to our health systems, training of psychiatrists and awareness of general practitioners, and last not least stigma towards mental disorders. Concrete steps to fight this unsatisfactory situation are needed.

No. 3C
DIABETES AND MENTAL DISORDERS: WHAT DO WE KNOW ABOUT RISKS AND LINKAGES?

Michelle B. Riba, M.D. *University of Michigan, Department of Psychiatry, 1500 E Medical Center Dr, Rm F6236 MCHC/Box 0295, Ann Arbor, MI, 48109-0999*

SUMMARY:

Type 2 diabetes mellitus is a serious, prevalent and chronic problem in approximately 8 percent of adults in the United States (Harris 1998) and is increasing globally (Wild 2004). There is mounting evidence that patients with major mental disorders may have even higher prevalence rates (Dixon et al 2000). There have been many explanations offered for the higher risk of type 2 diabetes in patients with schizophrenia, for example, a biological link (Ryan et al 2003); unhealthy lifestyles, such as smoking, lack of exercise, and a high-fat diet (McCreadie et al 2003). Recent issues relate to metabolic consequences of using second-generation antipsychotics (Citrome et al 2004) as well whether antidepressants raise diabetes risk (Levin 2006). Citrome and colleagues (2006) determined there was a doubling of the treated incidence rate and the rise in prevalence of identified cases of diabetes among psychiatric inpatients from 1997 to 2004. This underscores major public health problems especially for vulnerable psychiatric patients. In addition, we are finding that for children and young adolescents with Type 1 diabetes, mental health care, including psychological interventions such as cognitive behavioral, family systems and psychodynamic therapy, are particularly useful in improving hemoglobin A1c levels (British Medical Journal 2006) . This presentation will review the literature on the issues of comorbidity, linkages and risks between diabetes and mental disorders and provide suggestions for future directions in research and clinical care.

No. 3D
PHYSICAL ILLNESS IN PATIENTS WITH MENTAL DISORDERS SEEN IN ANAMBRA, NIGERIA

Richard Uwakwe, M.B.B.S. *Namdi Azikiwe University, Mental Health, 68 Onitsha Road, Nnwi North, Nnewi, 042, Nigeria*

SUMMARY:

Summary: Studies have consistently shown over the years that there is a high physical morbidity and mortality rate among patients with schizophrenia and bipolar disorders. Most of these studies have been based on clinical records, which are often either incomplete or totally absent espacially in developing countries. The present study, desgned to estimate the frequency of, and risk factors for, physical illness in patients with mental disorders invovled all 413 first ever referrals to the psychaitric clinic of Nnamdi Azikiwe University Teachung Hospital (Nigeria) during a twelve month period. At intake, comprehensive physical and neurological assessment, electrocardiogram, and laboratory tests were done for each patient and repeated at discharge or 3 months later. Nearly 36% of the patients were found to have physical diseases compared to 15% whose physical illnesses were known before evaluation. The individual disease rates include diabetes melllitus 5.3%, cadiovascular diseases 15%, gastrointestinal 1.5%, respiratory 0.5%. Obesity sharply increased from zero to 13% after discharge. Among patients with schizophrenia-spectrum disorders, the prevalence of physical illness was 55.2%, while it was 27.4% among those with mood disorders, and 11.8% among those with neurotic disorders. Patients with dementia (n=17) were at higher risk of having cardiovascular diseases compared to patients with other mental disorders (OR=3-11).

REFERENCES:

1. Hopper K, Harrison G, Janca A, Sartorius N (Eds): Recovery from Schizophrenia: an international perspective, In press.
2. Brown S, Inskip H, Barraclough B: Causes of the excess mortality of schizophrenia. Br J Psychiatry 2000; 177:212-217.
3. Levin A: Depression and Diabetes: Is it the drug or Disease? Psychiatric News 41:15;21, 2006.
4. Kilbourne A. Medical diseaeses in patienys with bipolar disorders. Bipolar Disorders 2004., 12: 25-30.

SYMPOSIUM 4—SUICIDE ACROSS THE LIFE CYCLE: A SPANISH LANGUAGE UPDATE (MANEJO Y TRATAMIENTO DEL PACIENTE SUICIDA EN LAS DISTINTAS ETAPAS DE LA VIDA)

EDUCATIONAL OBJECTIVES:

The objectives of this presentation are to:

1. Understand the range of factors that can contribute to suicide
2. Learn the neurochemical changes that have been associated with suicide
3. Learn the genetic factors that have been postulated to play a role in suicide

No. 4A
NEUROBIOLOGICAL CORRELATES OF SUICIDE

Pedro L. Delgado, M.D. *University of Texas Health Science Cente, Dept of Psychiatry (7792), 7703 Floyd Curl Drive, San Antonio, TX, 78229-3900*

SUMMARY:

Suicide is a complex, multifaceted act unlikely to be simply explained by the identification of any neurobiological correlate. It is clear from epidemiological data that rates of suicide vary widely from region to region within the United States and across the world. This pattern is unlikely to be driven by genetic or neurobiological factors alone and probably represents the influence of various environmental and cultural factors. However, as our understanding of the neurochemical regulation of behavior evolves, it may be possible to understand how changes in mental function can contribute to a greater likelihood that a person will initiate suicidal acts.

This presentation will review research findings on the neurobiology of suicide. This will include data relevant to monoamine systems, genetics, and the neurobiological effects of environmental stress and/or pharmacological agents that could alter brain function so as to increase the likelihood of suicide.

No. 4B
YOUTH SUICIDE (SUICIDIO INFANTOJUVENIL)

Gabriel Kaplan, M.D. *St. Mary Hospital Hoboken, 535 Morris Ave, Springfield, NJ, 07081-1038*

SUMMARY:

Suicide is the third leading cause of youth death in the United States. Children and adolescents typically do not perceive suicide in the same way as adults. Thus, assessment of suicide risk in this population must take into account specific developmental circum-

stances. This presentation will focus on the epidemiology, assessment and management of suicidal youth. Recent issues in the field of psychopharmacology and suicide risk will also be addressed.

El suicidio es la tercera causa de mortalidad en jovenes en los Estados Unidos. Infantes y adolescents no entienden el suicidio en la misma forma que los adultos. Por lo tanto, la evaluacion de riesgo de suicido en esta poblacion debe tener en cuenta estadios del desarrollo especificos. Esta presentacion se ocupa de la epidemiologia, evaluacion, y manejo del joven suicida. Tambien tratara la interaccion entre psicofarmacologia y riesgo de suicidio.

No. 4C
SUICIDAL BEHAVIOR IN ADULTS

Maria A. Oquendo, M.D., *New York State Psychiatric Institute, Department of Neuroscience, 1051 Riverside Drive, Box 42, New York, NY, 10032*

SUMMARY:

Prospective studies over the past 30 years have identified several predictive indicators for suicidal acts. However, prediction of suicidal behavior remains an elusive goal. The most robust predictors for future suicidal behavior are a past history of suicidal behavior and the presence of refractory or recurrent depressions. Protective factors include religious affiliation and increased reasons for living. In this lecture, an update of what is currently known in terms of risk and protection regarding suicidal behavior will be summarized.

No. 4D
SUICIDAL BEHAVIOR IN LATE LIFE

Jacobo E. Mintzer, M.D. *MUSC, ARCP, 5900 Core Ave Ste 203, N Charleston, SC, 29406-6076*

SUMMARY:

Elderly patients suffer from numerous physical and emotional losses. They also have to cope with often times weakening support network. It is therefore not surprising that the suicide rate especially among Caucasian elderly men is one of the highest rates found in adults.

During the presentation the risk factors associated with suicide in the elderly will be reviewed. The early signs of suicidal behavior in the elderly will be reviewed. Ethnic differences will be discussed in the context of the culture, the patient emerges from. The early diagnosis of suicidal behavioral will be reviewed. Finally, interventions to prevent suicidal behavioral as well as management of the patient after suicide attempts will be carefully reviewed.

Finally, two cases will be presented to provide a clinical example of early signs diagnosis and interventions.

No. 4E
SUICIDE IN THE MEDICALLY ILL

Humberto Marin, M.D. *UMDNJ/Robert Wood Johnson Medical School, Psychiatry, 671 Hoes Ln, Room D-321, Piscataway, NJ, 08855-1392*

SUMMARY:

Medical illness is a risk factor for suicide. The importance of this factor is growing as the average patient gets older and suffers from more medical disorders. Compounding this situation is the increasing likelihood of treatments for medical disorders affecting psychic dimensions, such as mood and impulse control, that also influence suicidal ideation/behaviours. Following is a description of suicidality associated with the most common medical disorders and their treatment, especially in old age, as well as considerations on some medical disorders which show a high association with suicidal behaviors. Then, a review is made about management of acute and chronic suicidality in the medically ill, including physical and psychosocial interventions.

REFERENCES:

1. Sublette, ME; Hibbeln, JR; Galfalvy, H; Oquendo, MA; Mann, JJ. Omega-3 Polyunsaturated Essential Fatty Acid Status as a Predictor of Future Suicide Risk. Am J Psychiatry. Vol 163(6) Jun 2006, 1100-1102.
2. Alan L. Berman, PhD; David A Jobes, PhD; and Morton M. Silverman, MD: Adolescent Suicide: Assessment and Intervention, Washington DC, American Psychiatric Press, 2005.
3. Cohen D, Llorente M, Eisdorfer C: Homicide-suicide in older persons. Am J Psychiatry 1998; Mar;155(3):390-6.
4. Starks H, Pearlman RA, Hsu C, et al. Why now? Timing and circumstances of hastened deaths. J Pain Symptom Manage 2005;30(3):215-226.

SYMPOSIUM 5—INSIGHTS ON OBESITY AND DRUG ADDICTION FROM BRAIN IMAGING
National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize that the function of the orbitofrontal cortex has been implicated in the reward salience of food as well as in reward of drugs of abuse.

At the conclusion of this presentation, the participant should understand that orbitofrontal brain activation during exposure to food stimuli might be altered by mood state, body mass, and brain maturation.

No. 5A
MODULATORS OF ORBITOFRONTAL ACTIVATION IN RESPONSE TO FOOD STIMULI

Deborah Yurgelun-Todd, Ph.D. *McLean Hospital/Harvard Medical School, Department of Psychiatry, 115 Mill Street, Belmont, MA, 02478*

SUMMARY:

It has been hypothesized that addictive drugs activate the same brain reward mechanisms involved in the control of normal appetitive behavior. The orbitofrontal cortex consistently emerges as a critical convergence zone for the stream of afferent sensory information related to rewarding stimuli, particularly for primary reinforcers such as food. Functional magnetic resonance imaging (fMRI) techniques provide a method for characterizing orbitofrontal response. To clarify the neurobiological mechanisms by which body weight, mood and age may influence appetitive response, we presented healthy, normal-weight adolescent and adult females with color photographs of foods differing in fat-content/calorie-density (i.e., high-reward or low-reward) while they underwent blood oxygen level dependent (BOLD) functional magnetic resonance imaging (fMRI).

Body mass was observed to be negatively correlated with activity of the orbitofrontal cortex when adult females viewed images of highly rewarding food, suggesting a relationship between weight status and rewarding effects of the food images. In addition, activation of the orbitofrontal cortex was shown to be significantly related to mood ratings. Positive affect was associated with decreased medial orbitofrontal activity during the viewing of high fat food, whereas negative affect was associated with increased activation of this region during the viewing of high-reward high calorie food. These associations suggest that mood may play an important role in moderating

the approach to foods that differ in reward salience. In a complementary study, a significant positive correlation was observed between age and activation of the orbitofrontal cortex in adolescent females viewing high calorie images. Taken together these results indicate that mood state, body mass and development of the brain circuitry may moderate the reinforcing capacity of rewarding stimuli. These findings have important implications for clarifying models underlying reward response and for the development of more effective therapies of eating disorders and drug addiction.

No. 5B
HUNGER AS AN ADDICTION

Alain Dagher, M.D. *McGill University, Montreal Neurological Institute, 3801 University Street, Montreal QC, PQ, H3A 2B4, Canada*

SUMMARY:

Drug addiction is an interesting model to try to understand cognitive control. The addict attempting to abstain from drugs is under the influence of two contradictory phenomena: a compulsion to use the drug, and a desire to quit. These two thought processes are likely mediated by different, but interacting, brain regions, all of which are innervated by dopamine. It is also instructive to view obesity from the standpoint of addiction neuroscience. There are obvious parallels between attempting to lose weight and abstaining from a drug.

Drugs of abuse are thought to target the same neural systems as natural rewards. The most likely candidate brain region is the mesolimbic and mesostriatal dopamine system. In animals, dopamine is released in the striatum in response to food, sexual mates, and to almost all drugs of abuse. Different theories propose that dopamine acts by mediating the hedonic impact of a reinforcing stimulus, by promoting associative learning about the stimulus, or by serving as an incentive to the consumption of the stimulus. Moreover, it has been suggested that the magnitude of the dopamine response to drugs and stressors may be a marker of vulnerability to addiction.

The research described here uses two techniques: functional MRI to measure neural activity during craving induced by drug or food cues, and positron emission tomography to measure dopamine release in human volunteers using [11C]raclopride, a D2 receptor ligand. We have used these techniques to study the brain response to abused drugs (alcohol, amphetamine, nicotine) and natural rewards such as food and money.

We will review some of the factors that favor the expression of abstinence or relapse in addicts, and the similarities and differences between drugs of abuse and natural rewards such as food.

No. 5C
APPLICATION OF INCENTIVE-SENSITIZATION THEORY OF DRUG ADDICTION TO OVEREATING

Dana M. Small, Ph.D. *John B. Pierce Laboratory/Yale University School of Medicine, Psychiatry, 290 Congress Avenue, New Haven, CT, 06519*

SUMMARY:

Food reward is multifaceted. The motivation to eat and the perceived pleasure associated with eating are represented by distinct neural circuits in humans and nonhuman animals. In this lecture I will examine the predictive utility of Robinson and Berridge's incentive-sensitization theory of addiction in understanding overeating. Incentive sensitization attribution is the process in which, by virtue of their association with a drug, sensory features of ordinary stimuli transform so that they become especially salient and are able to elicit approach behaviors. The theory posits that it is this aspect of reward that leads to compulsive drug taking, not the liking or hedonic pleasure associated with the drug. Applying this to feeding we predict that overeating results from a heightened responsiveness to sensory cues that predict food reward not from increased pleasure derived during the experience of eating. Behavioral and neuroimaging data will be presented to support this hypothesis.

No. 5D
NEUROIMAGING STUDIES OF OBESITY AND DRUG ADDICTION

Gene-Jack Wang, M.D. *Brookhaven National Laboratory, Medical Department, Building 490, Upton, NY, 11973-5000*, Nora D. Volkow, Joanna S. Fowler, Ph.D.

SUMMARY:

The cerebral mechanisms underlying the behaviors that result in pathological overeating and obesity are poorly understood. The regulation of food intake is a complex balance between excitatory and inhibitory processes. The excitatory processes arise from the bodys needs for nutrients and calories. Studies using Positron Emission Tomography (PET) implicate the involvement of brain dopamine (DA) in non-hedonic motivational properties of food intake in humans. We also found reductions of striatal DA D2 receptors in pathologically obese subjects, which were similar to those in drug-addicted subjects. We postulated that decreased levels of DA receptors predisposed subjects to search for reinforcers; in the case of drug-addicted subjects for the drug and in the case of the obese subjects for food as a means to temporarily compensate for a decreased sensitivity of DA regulated reward circuit. The inhibitory processes arise from satiety signals (i.e. electrical and chemical) after food consumption. We used PET to measure the brain metabolic responses in obese subjects who had an implantable gastric stimulator, which induces stomach expansion via electrical stimulation of the vagus nerve in order to identify the brain circuits responsible for its effects in decreasing food intake. These findings corroborated the role of the vagus nerve in regulating hippocampal activity as well as the importance of the hippocampus in modulating eating behaviors linked to emotional eating and lack of control. The brain regions (orbitofrontal cortex, hippocampus, cerebellum and striatum) activated by gastric stimulation overlap with those reported during craving responses in addicted subjects supporting the commonalities in the neurocircuitry that underlie compulsive food intake and compulsive drug intake.

REFERENCES:

1. Kringelbach ML, Rolls ET: The functional neuroanatomy of the human orbitofrontal cortex: evidence from neuroimaging and neuropsychology. Progress in Neurobiology 72 (2004) 341a-372.
2. Small DM, Jones-Gotman M, Dagher A. Feeding-induced dopamine release in dorsal striatum correlates with meal pleasantness ratings in healthy human volunteers. Neuroimage 2003, 19(4):1709-1715.
3. Small DM, Gerber JC, Mak YE, Hummel T: Differential neural responses evoked by orthonasal versus retronasal odorant perception in humans. Neuron 2005; 47: 593-605.
4. Wang G-J et al. Similarity between obesity and drug addiction: Neurofunctional imaging. Journal of Addictive Disease 2004; 23(3): 39-53.

SYMPOSIUM 6—TREATMENTS FOR MALADAPTIVE PERSONALITY TRAITS WITH SOME EMPIRICAL SUPPORT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize several different treatment approaches to maladaptive personality traits and to recognize when each might be useful.

No. 6A
THE EFFECT OF AXIS II ON OUTCOME OF AXIS I DISORDERS

James H. Reich, M.D. *Stanford, UCSF, Psychiatry, 2255 N Point St, Suite 102, San Francisco, CA, 94123-1438*, Simone Kool, M.D.

SUMMARY:

Clinicians have long felt that the presence of personality pathology might affect the treatment outcome of Axis I disorders. This seemed to make theoretical sense from a number of perspectives. Initial literature reviews of empirical data on the subject going back to the early 1990's seemed to support this notion. However, as time went on the results of these reviews began to produce contradictory findings. Some finding Axis II caused no effect on Axis I outcome while others found the reverse. The authors of the conflicting reviews all claimed methodological superiority. This presentation will examine two such recent high quality reviews with conflicting outcomes to try to determine the sources of the differences and get a sense of where this area has been and needs to go in the future. Guidelines will be presented for clinicians in their decision whether to treat either Axis I or Axis II disorder or both at the same time in case of comorbidity.

No. 6B
INITIAL FINDINGS FROM THE CANADIAN RCT OF DIALECTICAL BEHAVIOR THERAPY FOR BPD

Paul Links, M.D. *University of Toronto, Psychiatry, 30 Bond Street 2010 D, Shuter Wing, Toronto, ON, M5B 1W8, Canada*, Shelley McMain, Ph.D., Robert Cardish, M.D., William Gnam, M.D., Lorne Korman, Ph.D., Adam Quastel, M.D., Ian Dawe, M.D., David Streiner, Ph.D.

SUMMARY:

This paper describes the initial findings of an ongoing clinical trial that integrates efficacy and effectiveness elements in studying psychotherapy interventions. The study is a two-armed randomized controlled trial that compares Dialectical Behavior Therapy (DBT) with the General Psychiatric Management (GPM) intervention. GPM is derived from the care promoted in the American Psychiatric Association's Practice Guidelines for the treatment of BPD. A total of 180 chronically suicidal BPD patients have been enrolled. Participants are randomly assigned to either DBT or GPM treatment, and primary and secondary clinical outcomes are assessed by changes in: (1) parasuicidal behaviour, (2) treatment retention, (3) psychiatric symptomatology, (4) BPD Axis II criteria, (5) anger expression, and (6) social and global functioning. Clinical evaluations are carried out at pre-treatment, every four months over the course of the one-year treatment, and every six months during a two-year follow-up period. Analyses will be conducted on an intention-to-treat-basis. In addition to evaluating clinical effectiveness, the cost-effectiveness of DBT will be studied. Baseline data indicated no significant differences between the two treatment arms; although there were more males in the GPM versus DBT arm, the difference was not significant (17.8% versus 10%; p=0.20). The 4 and 8 month outcomes will be available for analyses and presentation by May 2007. We anticipate that our results could significantly influence clinical practice in Canada and elsewhere as well as policy and planning for the treatment of BPD patients.

No. 6C
THE STEPPS MODEL: A COGNITIVE GROUP TREATMENT FOR BPD

Donald W. Black, M.D. *Univ of Iowa Carver College of Medicine, Department of Psychiatry, Psychiatry Research, 2-126bMEB, Iowa City, IA, 52242*

SUMMARY:

Systems Training for Emotional Predictability and Problem Solving (STEPPS) is a 20 week (two hours/week) outpatient cognitive-behavioral, skills training treatment program for borderline personality disorder (BPD). The program is fully manualized with detailed lesson plans. With STEPPS, patients learn to manage their disorder with specific emotion and behavior management skills. Key professionals, friends, family members, and significant others who are referred to as the patients' "reinforcement team" also learn to reinforce and support these skills. STEPPS can be implemented by facilitators from diverse training backgrounds and used in a variety of settings. STEPPS is supported by preliminary studies in the US and The Netherlands, and results from a recently completed RCT involving over 170 patients will be presented. STEPPS achieves high levels of acceptance from patients and therapists. Compared with treatment as usual, patients enrolled in STEPPS show improvement in multiple domains, including mood, symptoms relevant to BPD, and health care utilization.

No. 6D
SCHEMA FOCUSED THERAPY: AN EVIDENCE-BASED TREATMENT FOR BPD

David P. Bernstein, Ph.D. *Maastricht University, Medical, Clinical, and Experimental Psychology, 6200 MD Maastricht, Box 616, Maastricht, 6200, Netherlands*, Arnoud Arntz, M.D.

SUMMARY:

Several promising treatments for Borderline Personality Disorder (BPD) have recently been developed, including Dialetical Behavior Therapy (DBT), Transference Focused Psychotherapy (TFP), and Schema Focused Therapy (SFT). Recent evidence suggests that Schema Focused Therapy (SFT) is effective in treating BPD, but may produce more far-reaching effects than either DBT or TFP. SFT is an integrative form of psychotherapy for personality disorders that combines cognitive, behavioral, psychodynamic object relations, and existential/humanistic approaches. In a recent 3-year randomized clinical trial of BPD in the Netherlands, patients given SFT showed impressive gains in nearly all areas, including self-harm, other core BPD symptoms (e.g., identity disturbance, interpersonal problems), general psychopathology, and quality of life. Fifty percent of SFT patients were considered recovered from BPD after 3-years. Gains were maintained or improved on at follow-up. SFT outperformed a comparison treatment, Transference Focused Psychotherapy (TFP), on nearly all measures. In this presentation, we will review these findings, and compare SFT with DBT and TFP. While no direct comparisons of SFT and DBT have yet been conducted, these findings suggest that DBT may be most useful as a front line treatment for BPD patients with dangerous self-harm behaviors, while SFT may go further in alleviating patients' suffering and improving their quality of life.

No. 6E
PHARMACOLOGIC TREATMENT OF PERSONALITY DISORDER TRAITS

Erika Saunders, M.D. , *Ann Arbor, MI*, Kenneth R. Silk

SUMMARY:

The psychopharmacology of personality disorders remains an area where specific and consistent data is lacking. Currently there is no agent that carries an indication for the treatment of any personality disorder, and the number of randomized control trials is small. Data are limited to borderline, schizotypal, antisocial, and avoidant personality disorders. Many studies of the psychopharmacologic treatment of personality disorders show improvement in global psychopathol-

ogy ratings, but those studies do not provide details as to what specific subgroupings of psychopathology respond to specific medications. The treating psychiatrist must make appropriate pharmacologic decisions while avoiding polypharmacy that can lead to drug-drug interactions and weight gain. A reasonable approach to this dilemma is to consider trait response in the psychopharmacology of personality disorder. In this approach, clinical presentation of trait disturbances such as anxiety, impulsivity, aggression, mood lability or dysregulation are considered when examining axis II psychopharmacology studies (as well as axis I studies) to determine which agents have been shown to be effective in treating that trait.. This presentation reexamines the psychopharmacology of axis II studies to appreciate better the details of the specific trait areas embedded in the global ratings of psychopathology that improve when patients with personality disorders are treated pharmacologically. The psychopharmacology of personality disorders literature over the last 10 years is reexamined to extract more specific detail as to which traits found in patients with personality disorders can be expected to be impacted by which specific classes of psychopharmacologic agents. Such specificity in understanding the costs and benefits of a given treatment are needed if we are to use judiciously the current pharmacologic agents available to us.

REFERENCES:

1. Reich J:The effect of Axis II disorders on the Outcome of Treatment of Anxiety and Unipolar Depressive Disorders. J Pers Disorders 2003;17: 387-405.
2. American Psychiatric Association. Practice guideline for the treatment of patients with borderline personality disorder. Am J Psychiatry 2001;158:1-52.
3. Black DW, Blum N, Pfohl B, St John D: The STEPPS treatment program for outpatients with borderline personality disorder. J Contemp Psychother 2004; 34: 193-210.
4. Giesen-Bloo, J., van Dyck, R., Spinhoven, P., van Tilburg, W., Dirksen, C., van Asselt,.
5. Soloff PH: Psychopharmacology of borderline personality disorder. Psychiatric Clin No Am 2000; 23(1):169-92.

SYMPOSIUM 7—NEUROSCIENCE AND PHENOMENOLOGY OF SCHIZOPHRENIA

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize that psychiatrists can reason back and forth between the clinical phenomenology of schizophrenia and neurobiology conceivably associated with the disorder; demonstrate the relevance of phenomenological approaches to schizophrenia to present-day neurobiological investigations; and diagnose early signs of schizophrenia as reflective of associated neurobiological conditions.

No. 7A
INTEGRATING THE NEUROSCIENCE AND PHENOMENOLOGY OF SCHIZOPHRENIA; A CHALLENGE FOR THE 21 CENTURY PSYCHIATRY

Michael A. Schwartz, M.D. *University of Hawai'i, Psychiatry, 1106 Blackacre Trl, Austin, TX, 78746-4307*

SUMMARY:

During recent decades, we have witnessed an explosive growth in basic and clinical neuroscience. At the same time, the phenomenological methods introduced into clinical psychiatry at the beginning of the 20th century have been supplemented by multidisciplinary approaches to neural systems, leading to a profound transformation in the present manner in which we conceptualize mental disorders. We believe that it is time to integrate the main findings of basic and clinical fields aimed at potential causes and treatments of disorders such as schizophrenia. In particular, we want to focus on the phenomenology and pathophysiology of the early stages of schizophrenia. To this end, we have gathered young investigators from basic and clinical neuroscience together with well-established investigators in the field of clinical phenomenology. We anticipate that a dialogue between basic and clinical neuroscientists and clinical phenomenologists can provide new insights leading to new lines of investigation in schizophrenia. Two presenters will discuss clinical phenomenology and two others clinical neuroscience. The phenomenological presentations will summarize the history of the application of the phenomenological method to clinical psychiatry; and then characterize the phenomenology of early stages of schizophrenia, particularly the prodromal ones. This first neurobiological presentation will focus upon the maturation of prefrontal cortex dopamine-glutamatergic interactions in rodents and the potential relevance of these findings towards understanding the pathophysiology and phenomenology of early schizophrenia. The second neurobiological presentation will review findings suggestion that glutamatergic hyperactivity may underlie the pathophysiology and phenomenology of schizophrenia. Bridges between these two approaches, phenomenology and neuroscience, will then be discussed.

No. 7B
THE HISTORY OF THE PHENOMENOLOGICAL METHOD IN CLINICAL PSYCHIATRY

Otto F. Doerr Zegers, M.D. *Universidad de Chile, Psiquiatría, Av Luis Thayer Ojeda #0115, 502, Santiago, 7510004, Chile*

SUMMARY:

Almost a century has passed since Edmund Husserl founded the phenomenological method and Karl Jaspers first applied this method to psychiatry. Husserl's goal was to provide an approach to objects that might get "to the things themselves," apart from all presuppositions, and prejudices. For Jaspers, this led to a 'descriptive' approach to mental life and the promise of an unbiased characterization of patient's experiences in illness; and afterwards, to present-day catalogues of mental disorders such as ICD and DSM. More modern iterations of these manuals have moved away from the fine-grained phenomenology of Jaspers by emphasizing operationalizing of terminology, positivistic data collection, and reliability over validity. The psychopathological and diagnostic constructs that emerge seem transitional, provisional, and increasingly disconnected from emerging findings in contemporary neuroscience. This presentation will describe post-Jaspersian efforts in phenomenological psychiatry in relation to contemporary efforts to link neurobiology to patient's experiences of illness and to treatment. Contributions from phenomenology include investigations of human temporality, spatiality, the embodied person, intersubjectivity, world-relatedness, world-openness, delusions, hallucinations, depression and mania. In the present era, phenomenology and neuroscience are related in a reciprocal and complimentary manner: Phenomenological approaches to health and illness can clarify and advance reasoning about the brain; and, investigations in neuroscience can facilitate understanding of mental life in health and illness.

No. 7C
NEURODEVELOPMENTAL DISRUPTION OF HIPPOCAMPAL-PREFRONTAL CORTICAL SYNAPTIC CONNECTIVITY: IMPLICATIONS FOR SCHIZOPHRENIA PATHOPHYSIOLOGY

Kuei-Yuan Tseng, Ph.D. *Rosalind Franklin University of Medicine and Science, The Chicago Medical School, Cellular and Molecular*

Pharmacology, 3333 Green Bay Road, room 2.172, North Chicago, IL, 60064

SUMMARY:

Schizophrenia has been recognized as a neurodevelopmental disorder caused by interactions between genetic and environmental factors. These may lead to abnormal synaptic connectivity observed in several brain regions in schizophrenia, including the hippocampal formation and the prefrontal cortex (PFC). First, I will introduce the complexity of dopamine modulation in the PFC during critical periods of postnatal cortical development and its relationship for developing mature PFC-related cognitive abilities through the adulthood. Secondly, I will summarize recent evidences showing how a bilateral neonatal disruption of the ventral hippocampus could lead to a simultaneous hyper-excitable and hypo-functional PFC state. Plausible mechanisms will be discussed in light of recent evidences showing how dopamine-glutamate interactions regulate PFC neuronal activity and how these systems interact with the local GABAergic interneurons from the early postnatal period through adulthood. Finally, I will highlight how disruption of dopamine-glutamate-GABA interactions in the PFC could contribute to abnormal coordination of local neuronal firing resulting in the cognitive deficits observed in schizophrenia, a disorder characterized by hypofrontality.

No. 7D
FROM THE NEUROBIOLOGY OF ADOLESCENCE TO THE NEUROBIOLOGY OF EARLY SCHIZOPHRENIA

Rodrigo D. Paz, M.D. *Instituto Psiquiatrico Dr. Jose Horwitz Barak, Neurociencias Clinicas, Avenida La Paz 841, Santiago, 5620000069, Chile*

SUMMARY:

The refinement of molecular genetic, electrophysiological and neuroimaging techniques has allowed uncovering some of the cellular, molecular and circuiting events underlying the changes that occur within the adolescent brain. In this presentation I will try to integrate this data with growing evidence suggesting that hyperactive glutamatergic neurons within the prefrontal cortex and probably other brain areas such as the cerebellum may underlie some of the critical phenomena in the pathophysiology of schizophrenia. Based upon this model the possibility of using glutamate modulating drugs during prodromal stages of schizophrenia will be discussed.

REFERENCES:

1. Doerr-Zegers O: Existential and phenomenological approach to psychiatry. In New Oxford Textbook of Psychiatry, Edited by Gelder MG, López Ibor Jr. JJ, Andreasen NC, Oxford, Oxford University Press, 2000, pp 357-362.
2. Tseng et al., 2006 Biological Psychiatry; Tseng & O'Donnell, Cerebral Cortex 2005, 2006.
3. Paz RD., Andreasen NC., Daoud S., Bustillo J., Roberts R., Perrone-Bizzozero N: Increased expression of activity dependent genes in cerebellar glutamatergic neurons of patients with schizophrenia. Am J Psychiatry., In Press.
4. Schwartz MA, Wiggins OP: Schizophrenia: Diagnostic and Anthropological Perspectives. In M Chung (Ed), The Philosophical Understanding of Schizophrenia, Oxford University Press, in press.

SYMPOSIUM 8—HOW TO PRACTICE SPORT PSYCHIATRY: A DEMONSTRATION

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the need for psychiatric intervention in the athletic arena; diagnose ADHD, substance use, mood disorder and suicidal ideation and behavior in the athlete; and understand how involvement in sports impacts these diagnoses and their treament. This goal will be achieved through didactics and in vivo patient interviews.

No. 8A
THE OVERVIEW OF THE FIELD OF SPORT PSYCHIATRY

Ira D. Glick, M.D. *Stanford Univ, Psychiatry, 401 Quarry Rd,, Suite #2122, Stanford, CA, 94305*

SUMMARY:

This paper will focus on a definition and boundaries of the field of sports psychiatry.

Psychiatric professionals diagnose and treat problems, symptoms and disorders associated with a particular athlete, their family/significant others, their team or their sport. We also work on performance enhancement.

We will review in detail 1) the origins and aims of adult and child/adolescent sport psychiatry, 2) diagnosis and psychopathology of athletes and their families, 3) treatment focused not only on the athlete, but also their supporting significant others, as well as their agents, 4) specific sports, e.g. basketball, soccer, etc., and 5) working with teams.

No. 8B
THE ADHD AFFECTED ATHLETE AND ROLE OF THE PSYCHIATRIST

David O. Conant-Norville, M.D. *Oregon Health and Sciences University, Psychiatry, 15050 SW Koll Parkway, Suite 2A, Beaverton, OR, 97006*

SUMMARY:

ADHD is the most common psychiatric disorder presenting to child and adolescent psychiatrists and one of the most prevalent psychiatric disorders among athletes of any age. Hence, the sport psychiatrist must have a solid understanding of ADHD symptoms and treatments as well as knowledge of the unique challenges and competition rules faced by the athlete. ADHD may affect sport performance in many ways, both positively and negatively. Treatments for ADHD may enhance performance by bring the athlete to psychiatric health or may lead to a decline in performance. Since psychostimulants, the first line pharmacological treatment for ADHD, have been labeled as potentially dangerous performance enhancing drugs, the sport psychiatrist must have a clear and accurate understanding of when and how these drugs may be used in a particular sport or league.

David Conant-Norville MD, child and adolescent psychiatrist and psychiatric consultant on ADHD for the U.S. Anti-Doping Agency, will present a brief summary of ADHD diagnostic criteria and the process of making a diagnosis of ADHD in an athlete.. Basic treatment strategies for the ADHD affected athlete, both pharmocological and psychological will be briefly discussed.

To illustrate the story of the ADHD affected athlete through the life cycle, Dr Conant-Norville will interview Michael Stabeno about the effect that ADHD has had on his life. Mr Stabeno is a former collegiate football and wrestling athlete and high school wrestling coach who has lived with ADHD. He has two sons affected by ADHD, one of whom is an elite collegiate soccer player. Mr. Stabeno is author of **The ADHD Affected Athlete**, a book for athletes, their families and coaches. He has been quoted in national magazines about the affect of ADHD on athletes and is a coaching consultant for an NFL team.

No. 8C
INTERVIEWING THE ATHLETE WITH A SUBSTANCE ABUSE PROBLEM

Ronald L. Kamm, M.D. *Director, Sport Psychiatry Associates, 257 Monmouth Rd., A-5, Oakhurst, NJ, 07755*

SUMMARY:

Elite athletes at the high school through professional level use and abuse substances at a higher rate than the general population, and in higher quantities (54% of college athletes participated in high-quantity alcohol consumption versus 36% of non-athletes in one study).

Athletes begin using substances (alcohol, marijuana, etc.) for the same reasons that those in the general population do (to fit in, escape problems, have fun).

As the athlete continues his or her usage, however, the reasons may change (stress, relief, reduction of negative emotions, psychological and/or physiological dependence).

Continued use also frequently exacerbates underlying Axis I disorders, and behavior begins to change. Concerned others often note that the athlete is failing to fulfill major team and personal obligations, is using in hazardous situations, and is changing inter-personally.

In this part of the symposium, a retired professional boxer will be interviewed by a sport psychiatrist in order to demonstrate both Sport Psychiatry interviewing techniques, and how the athlete's substance abuse problem evolved.

The interview will demonstrate, among other things, how to elicit a history of how the abuse began, the effect on performance, the impact on personal life, the athlete's treatment history, and current status.

With so many of our adolescents involved in organized youth sports (30 million children 5-17 overall) and with high-performance teens being more vulnerable to substance abuse than their non-athletic peers, it is important that psychiatrists, sports medicine physicians, pediatricians and orthopedists know the best ways to ask about substance abuse during the initial consultation, and that physicians understand the evolution of the disease in the specific case of the athlete and his or her unique world.

No. 8D
THE ATHLETE WITH DEPRESSION—UNDERSTANDING ETIOLOGY AND TREATMENT THROUGH THE INTERVIEW

Antonia L. Baum, M.D. *George Washington University, Psychiatry, 5522 Warwick Place, Chevy Chase, MD, 20815*

SUMMARY:

Mood disorders are prevalent in the general population, and in spite of the appearance of invincibility, athletes are not immune to being afflicted by them. Athletes are also vulnerable to suicidal ideation and behavior (1). Though involvement in sport can sometimes be therapeutic for one suffering from depression or bipolar illness, it is also true that some of the unique stressors in the athletic arena, particularly in the world of elite or professional athletes may exacerabate, or even precipitate an episode of illness. An additonal stressor may be that sports is an area where mental toughness is revered, and the stigma associated with psychiatric illness remains strong.

Through education, athletes, coaches and trainers can be helpful in recognizing those in need of treatment, and can become important in implementing treatment. A consultation-liaison approach is key to gaining the confidence of those in the world of sports (2). With athletes, there are unique considerations in the psychopharmacologic treatment of mood disorder, as certain side effects may interfere with athletic performance, and some governing bodies in sport prohibit the use of psychotropic medications. (3). Greg Louganis, an Olympic champion diver who dominated his sport for many years, but suffered from depression—and even attempted suicide—will be interviewed to illustrate the intersection between his illness and his sport.

REFERENCES:

1. Glick ID, Horsfall JL: Psychiatric conditions in sports: diagnosis, treatment, and quality of life. The Physician and Sportsmedicine, 29: 45-55, 2001.
2. Conant-Norville D. and Tofler I: Attention Deficit/Hyperactivity Disorder and Pharmacologic Treatments in the Athlete. Clinics in Sports Medicine 2005; 24:829-843.
3. Kamm,RL:Interviewing Principals for the Psychiatrically Aware Sports Medicine Physician.In Clinics in Sports Medicine:The Interface Between Sport Psychiatry and Sports Medicine,Tofler, IR,Morse,ED,Philadelphia,Saunders Press,2005:24,4: pp745-69.
4. Baum AL: Suicide in Athletes: A Review and Commentary. In Clinics in Sports Medicine, edited by Tofler IR, Morse ED, Philadelphia, W.B. Saunders Company, 2006, pp 853-869.

SYMPOSIUM 9—CRF-ANTAGONISM FOR TREATMENT OF ALCOHOLISM AND AFFECTIVE DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be familiar with: long-term neuroadaptations that occur following a history of alcohol dependence, changes in voluntary alcohol intake and sensitivity to stress and negative emotional states induced by the neuroadaptations, the role of the Corticotropin-Releasing Hormone system in mediating these effects, and the prospect for CRH antagonists as novel treatments for alcohol dependence and other stress related disorders such as depression and anxiety.

No. 9A
NEGATIVE AFFECT AND EXCESSIVE ALCOHOL DRINKING DRIVEN BY CENTRAL CRF SYSTEMS: REVERSAL BY THE NVEL CRF1 ANTAGONIST MTIP

Markus Heilig, M.D. *NIAAA, 10 Center Drive, 10/1-5334, Bethesda, MD, 20892-1108*

SUMMARY:

Prolonged exposure to repeated cycles of alcohol intoxication and withdrawal triggers long-term neuroadaptations resulting in excessive voluntary alcohol consumption. Along with the elevation of alcohol intake, post-dependent animals have a long lasting up-regulation of behavioral stress responses, increased sensitivity to stress-induced alcohol consumption, and suppressed rates of new neuron formation. All the behavioral pathology of post-dependent subjects is normalized by the orally available, brain penetrant CRF1-antagonist antalarmin, currently developed for use in addictive and affective disorders by a consortium of NIH institutes. Based on the pharmacological findings, we predicted that up-regulated expression of CRF1 receptors in brain areas controlling emotionality is central to the neuroadaptive process resulting in the post dependent state, and underlies its behavioral phenotype. This prediction was recently confirmed using *in situ* hybridization analysis.

Although a history of dependence and the resulting neuroadaptations emerge as a key process in alcoholism, a more than 50% heritability of human alcohol dependence additionally indicates important genetic susceptibility factors. These can be modeled in laboratory animals using genetic selection for high alcohol preference. We have analyzed one of the preferring lines resulting from genetic

selection, the Marchegian-Sardinian Preferring (msP) line. In these animals, high levels of stress sensitivity and anxiety accompany high voluntary alcohol intake. Using analysis of differential gene expression, we found that expression of CRF1 receptor transcript is elevated in these subjects even prior to a history of dependence, and that, similar to post-dependent animals, the behavioral pathology is reduced or eliminated using antalarmin. Sequence analysis has revealed that msP rats carry a unique variant allele of the CRF1 gene, and two distinct single nucleotide polymorphisms (SNPs) may underlie the elevated receptor expression.

These data illustrate that a phenotypically identical state can be arrived at either by a prolonged history of dependence, or due to genetic makeup.

No. 9B
THE DARK SIDE OF ALCOHOLISM: NEUROADAPTATIONAL MECHANISMS WITH THE CRF SYSTEM CRITICAL FOR EXCESSIVE DRINKING

George F. Koob, Ph.D. *The Scripps Research Institute, 10550 North Torrey Pines Road, La Jolla, CA, 92037*

SUMMARY:

The conceptualization of drug addiction as a disorder that moves from an impulse control disorder to a compulsive disorder to produce excessive drug intake provides a heuristic framework with which to identify the neurobiological and neuroadaptive mechanisms involved in addiction. Key neurochemical elements involved in reward and stress within a basal forebrain macrostructure termed the extended amygdala are hypothesized to be dysregulated in addiction to convey the vulnerability for compulsive drug. Specific elements in the extended amygdala include not only decreases in reward neurotransmission such as dopamine and opioid peptides, but also dysregulation of the brain stress systems such as corticotropin-releasing factor (CRF), norepinephrine, and neuropeptide Y. A CRF receptor antagonist injected into the central nucleus of the amygdala blocks the excessive drinking associated with alcohol dependence (but not non dependent drinking). Small molecule CRF antagonists have similar effects, selectively blocking dependent, but not non-dependent, drinking. A stress response system is hypothesized that begins with acute excessive drug intake and an activation of the hypothalamic-pituitary-adrenal axis response to stressors, followed by activation of the extrahypothalamic CRF system having a critical role in the compulsivity associated with the loss of control over drug-seeking behavior. The combination of loss of reward function and recruitment of anti-reward systems provides a powerful motivation for the compulsive alcohol-seeking behavior associated with addiction.

No. 9C
AMYGDALA PROTEIN KINASE C EPSILON REGULATES CORTICOTROPIN RELEASING FACTOR, ANXIETY, AND ALCOHOL SELF-ADMINISTRATION

Robert O. Messing, M.D. *Ernest Gallo Clinic and Research Center, UCSF, 5858 Horton Street, Suite 200, Emeryville, CA, 94608*

SUMMARY:

Alcoholism and anxiety disorders often occur together, suggesting that they are controlled by common molecular mechanisms. Corticotropin releasing factor (CRF) is induced in the amygdala by chronic ethanol exposure, promotes anxiety, and increases alcohol consumption. The signaling pathways linking ethanol to amygdala CRF and CRF to anxiety and alcohol consumption are not known. Previously we found that mice deficient in the epsilon isozymes of protein kinase C (PKC) show reduced anxiety-like behavior and ethanol self-administration suggesting that PKC epsilon might regulate these behaviors through CRF. To examine this question, we examined CRF levels in mice that lack PKC epsilon through gene targeting and developed lentivirus to reduce PKC epsilon locally in the amygdala of wild type mice by RNA interference (RNAi). We also cultured amygdala neurons to examine regulation of CRF expression by PKC epsilon. Mice lacking PKC epsilon showed a 50% reduction in amygdala CRF without a change in amygdala CRF1 receptor binding. Reducing PKC epsilon locally in the amygdala using RNAi decreased anxiety-like behavior in wild type mice. Conversely, injection of 100 ng CRF into the amygdala of PKC epsilon null mice increased their anxiety-like behavior. Treating wild type mice with RNAi in the amygdala also reduced alcohol drinking. Finally, activation of PKC epsilon in cultures of amygdala neurons increased CRF levels, and RNAi against PKC epsilon blocked this response. These results show that amygdala PKC epsilon regulates the local expression of CRF and modulates both anxiety and alcohol self-administration in mice. This work provides evidence for an amygdala PKC epsilon and CRF signaling pathway that regulates anxiety and alcohol consumption, and likely contributes to the co-morbidity of these disorders. Most importantly, these results provide a strong rationale for development of PKC epsilon inhibitors as treatments for anxiety and alcohol use disorders.

No. 9D
TARGETING THE CORTICOTROPHIN RELEASING FACTOR (CRF) SYSTEM FOR THE TREATMENT OF ALCOHOL DEPENDENCE

Selena Bartlett, Ph.D. *University of California, Ernest Gallo Clinic and Research Center, Director of Medications Development Group, 5858 Horton St, Emeryville, CA, 94608*, Antonello Bonci, M.D.

SUMMARY:

Stress and exposure to situations previously associated with alcohol drinking (referred to as "cues") are found to contribute to relapse drinking. Corticotrophin releasing factor (CRF) is a 41-aa peptide that has been shown to induce various behavioral changes related to adaptation to stress. The multiple actions of CRF are mediated by two classes of specific CRF receptors, CRF-R1 and CRF-R2 and CRF-BP. CRF interaction with CRF-BP positively modulates CRF-R2 function and this has been shown to potentiate NMDA receptor currents in the ventral tegmental area (VTA) (Ungless et al., 2003). Intra-VTA CRF has been shown to modulate dopamine function in the nucleus accumbens (Kalivas et al., 1987) and reinstate cocaine seeking (Wang et al., 2005). We tested the hypothesis that intra-VTA CRF via activation of CRF-R2 and/or CRF-BP modulates ethanol consumption and/or reinstatement. Rats were trained to self-administer 10% ethanol using an operant chamber. CRF or CRF (6-33) or vehicle was microinjected into the VTA prior to the self administration session. We show that CRF modulates ethanol consumption in rats either self-administering 10% ethanol or drinking 10% ethanol in a 2 bottle choice preference paradigm. This suggests in animals drinking moderate amounts of ethanol that are not "stressed" or dependent upon ethanol that the VTA is a target site for CRF modulation of ethanol consumption. Our data suggest that CRF in the VTA of drinking animals may play a role in titrating the amount of ethanol consumed. Together with results presented by the previous speakers it suggests the CRF system is an important target for the treatment of alcohol dependence.

No. 9E
GENETIC ASSOCIATION OF THE HUMAN CORTICOTROPIN RELEASING HORMONE RECEPTOR 1 (CRHR1) WITH BINGE DRINKING AND ALCOHOL INTAKE PATTERNS IN TWO INDEPENDENT SAMPLES.

Gunter Schumann, M.D. *King's College, Addiction Biology, Div. of Psychological Medicine, POB 080, London, SE5 8AF, United Kingdom*

SUMMARY:

To investigate the role of the corticotropin-releasing-hormone - receptor 1 (*CRHR1*) in patterns of human alcohol drinking and its potential contribution to alcohol dependence, we analysed two independent samples: a sample of adolescents, which consisted of individuals from the "Mannheim Study of Risk Children" (MARC), who had little previous exposure to alcohol, and a sample of alcohol-dependent adults, who met DSM-IV criteria of alcohol dependence. Following determination of allelic frequencies of 14 polymorphisms of the *CRHR1* gene, two haplotype tagging (ht)SNPs discriminating between haplotypes with a frequency of >=0.7% were identified. Both samples were genotyped and systematically examined for association with the htSNPs of *CRHR1*. In the adolescent sample, significant group differences between genotypes were observed in binge drinking, lifetime prevalence of alcohol intake and lifetime prevalence of drunkenness. The sample of adult alcohol-dependent patients showed association of *CRHR1* with high amount of drinking. This is the first time that an association of *CRHR1* with specific patterns of alcohol consumption has been reported. These findings support results from animal models, suggesting an importance of *CRHR1* in integrating gene-environment effects in this disease.

No. 9F
GENETIC VARIATION AT THE CRH LOCUS AND IT'S ASSOCIATION WITH ANXIETY AND ALCOHOL CONSUMPTION- LESSONS FROM THE MACAQUE

Christina S. Barr, Ph.D. *NIAAA-NIH, P.O. Box 529, Poolesville, MD, 20837*

SUMMARY:

Individuals who routinely consume alcohol for its anxiolytic effects are at increased risk for developing alcohol dependence. Corticotropin Releasing Hormone (CRH) is a neuropeptide critically involved in stress responding, and there is evidence that CRH system perturbation accompanies transition from alcohol abuse to addiction. We have identified a polymorphism within the 5'flanking region of the rhesus *CRH* gene (rh*CRH*-2232C>G) which disrupts a glucocorticoid response element half-site and would be expected to result in attenuation of the tonic negative feedback regulation of *CRH* expression by corticosteroids. We wanted to determine whether this variant was associated with individual differences in behavior, alcohol response, and consumption in rhesus macaques. We observed mother-infant interactions for the first 24 weeks of life. When animals reached adulthood, we administered 2 binge doses of alcohol and, 2 weeks later, offered simultaneous access to aspartame-sweetened ethanol solution and vehicle. Blood was collected for assessment of HPA axis activity under baseline conditions (infancy and adulthood) and in response to alcohol challenge. Factor analysis was conducted using behavioral measures collected during infancy, and ANOVA performed to assess relationships between the rh*CRH*-2232G allele and rotated behavior factor scores, ACTH/cortisol levels, and alcohol consumption. There was an association of the rh*CRH*-2232G allele with higher ACTH levels in the absence of stress. Infants carrying the G allele were less independent and exhibited an anxious-depressed phenotype. There was also an interaction with alcohol exposure; G allele carriers demonstrated higher HPA responses to alcohol challenge and were more likely to consume alcohol. These data demonstrate that *CRH* variation in rhesus macaques is associated with increased anxiety and HPA axis activity in the alcohol-naUïve, non-stressed state and, further, influences alcohol-induced stress axis activity and voluntary alcohol consumption. Such findings may suggest a role for human *CRH* gene variation in susceptibility to alcohol use disorders.

REFERENCES:

1. Hansson AC. Cippitelli A. Sommer WH. Fedeli A. Bjork K. Soverchia L. Terasmaa A. Massi M. Heilig M. Ciccocioppo R. Variation at the rat Crhr1 locus and sensitivity to relapse into alcohol seeking induced by environmental stress. Proceedings of the National Academy of Sciences of the United States of America. 103(41):15236-41, 2006 Oct 10.
2. Wang et al., J. Neuroscience. 2005 Jun1;25(22):5389-96.
3. Ayala AR, et al. Behavioral, adrenal, and sympathetic responses to long-term administration of an oral corticotropin-releasing hormone receptor antagonist in a primate stress paradigm. J Clin Endocrinol Metab 2004; 89:5729-5737.
4. Koob GF. The neurobiology of addiction: a neuroadaptational view relevant for diagnosis. Addiction. 2006 Sep;101 Suppl 1:23-30.

SYMPOSIUM 10—THE CALIFORNIA MENTAL HEALTH SYSTEMS ACT: TRANSFORMING SYSTEMS OF CARE TO REDUCE MENTAL HEALTH DISPARITIES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the California Mental Health Systems Act (MHSA) and its focus on reducing mental health disparities; and understand innovative MHSA approaches in community support services, workforce training, and prevention/early intervention toward reducing mental health disparities.

No. 10A
OVERVIEW OF CALIFORNIA MENTAL HEALTH SERVICE ACT

Rachel Garcia Guerrero, M.S.W. *CA State Department of Mental Health, State Office of Multicultural Services, 1600 9th Street, Room 350, Sacrametno, CA, 95814*

SUMMARY:

The California Menal Health Services Act (MHSA) was passed by CA. voters in 2004. This voter supported initiative created a new major financial investment in Ca. Mental Health System. This new proposition 63 required all CA tax payers with a personal income tax in the excess of $1 million would pay 1% increase in taxes. This presentation will present a history and current update of the MHSA. The MHSA targets six major focus areas for funding for a major potenical redesign and possible transformation of mental health services. The six target areas of the MHSA to be discussed in this symposium will include the state and local roll out of 1) Community Program Planning, 2)Community Services and Supports, 3) Capital Facilities and Technological Needs, 4) Education and Training Programs, 5) Prevention and Early Intervention and 6) Innovation . The act targets a focus on unserved and underserved populations. Information on how the MHSA provides an expanded opportunity for community mental health to develeop and design new and innovative programs to reduce and eliminate mental health dispariites for CA under and unserved racial and ethnic populations. This new funding

allows local mental health programs to design programs and services that are more flexable, creative and responsive to community needs. It requires programs to include strategies to address disparities that are identifed by local community based programs. It requires demonstrated involvment of mental health consumers and family members. The opportunities and challenges are many, will local programs be able to design their programs to effectively address Ca disparities in mental health care for underserved and unserved populations. The expectation of MHSA is transformation. The question is, will this transforamtion include evidence of significant reduction in mental health disparities? These opportunities and challenges will be included in this MHSA overview presentation.

No. 10B
THE COMMUNITY SERVICES AND SUPPORTS COMPONENT OF THE MHSA: EVALUATING EFFORTS TO ADDRESS DISPARITIES IN MENTAL HEALTH

Katherine Elliott, Ph.D. *UC Davis Medical Center, Internal Medicine, 3300 Stockton Blvd, Sacramento, CA, 95820*

SUMMARY:

Proposition 63, the Mental Health Services Act (MHSA) passed in 2004 in the state of California, offers a singular opportunity to reduce racial and ethnic disparities in mental health through major changes in the state's approach to mental health service delivery. The current study is an initial effort to evaluate the extent to which programs and plans developed in response to the Mental Health Services Act address disparities in mental health for Latino children and youth.

California counties were required to submit three-year program and expenditure plans to obtain MHSA funding. From those counties that had submitted proposals at the time of this study, ten were selected for review. A literature review and key informant interviews were conducted to develop a tool with which to evaluate county proposals for funding. The results of this process yielded criteria that fell into four categories: assessment, access, quality, and evaluation. Each county proposal was then evaluated using the review tool.

Overall, counties provided an adequate assessment of their population, proposed strategies to improve workforce diversity and language access, and identified several general approaches for improving physical access to care for Latino children and youth. However, there was a lack of specificity in the plans.

It is recommended that counties partner with the state Department of Mental Health and academic institutions. This collaboration will facilitate the development, identification, and dissemination of evidence- and community- based strategies to improve access and quality of care to Latino children and youth. Continuous monitoring and evaluation of the effectiveness of strategies employed in reducing disparities will be an essential component of this process. Finally, continued support and leadership from the state level supporting the efforts to reduce disparities are critical in ensuring the success of MHSA programs in fulfilling the original intent of the act.

No. 10C
MHSA WORKFORCE AND TRAINING: CULTURAL COMPETENCE AND DISPARITIES REDUCTION

Sergio Aguilar-Gaxiola, MD, PhD, M.D. *Center for Reducing Health Disparities, UC Davis, Internal Medicine, 2921 Stockton Blvd., Suite 1400, Sacramento, CA, 95817*

SUMMARY:

The Mental Health Services Act (MHSA) charged the State Department of Mental Health (DMH) to collect county data, complete a statewide occupational needs assessment, and develop a five-year plan addressing a statewide mental health education and training program. In meeting this legal obligation, DMH is committed to increasing the quantity and quality of trained persons available for employment in the mental health system while increasing family and consumer involvement in service delivery and encouraging development of a diverse workforce. A state-wide Education and Training Committee has embarked with workgroups in the following areas: 1) Training and technical assistance; 2) Consumers & family member employment in mental health; 3) Regional partnerships; 4) Stipends/Loan Forgiveness/Scholarship programs; 5) Distance learning; 6) Mental health career pathway programs; 7) Post-secondary education/training programs; 8) Licensing and certification. The presentation will highlight innovative programs focused on cultural competence and disparities reduction in these areas such as the following: Cultural competence training for existing staff and trainees; recruitment plans to attract diverse staff, trainees, and consumer/families as employees; regional partnerships to share training resources.

No. 10D
PREVENTION AND EARLY INTERVENTION IN UNDERSERVED POPULATIONS: OPPORTUNITIES FOR CHANGE

Katherine G. Ruiz-Mellott, M.D. *Cambridge Health Alliance, Harvard Medical School, Psychiatry, 170 Brookline, 611, Boston, CA, 02215*

SUMMARY:

Background: Disparities in mental health care contribute to a disproportionate number of minorities with behavioral health issues coming in contact with the juvenile justice system, incarceration, educational problems, and limitation on activity and potential. Early intervention and prevention programs offer a window of opportunity for clinicians and policy makers alike. Routine mental health screening among at risk populations could significantly improve access to mental health care among minorities.

Methods: Focused interview with innovative program developers, individual providers and health care policy faculty were performed. Systematic literature review of pub med, best practices, expert consensus, foundation reports, professional organization position papers, advocacy group reports and Health and Human Services commission reports was performed. Data was utilized from the 2005 Los Angeles County Department of Public Health Survey and CDC vital statistics databases. These sources provided a foundation on which to develop a program framework.

Findings and Recommendations: Numerous sources including national recommendations, programmatic data, and consensus among policy makers and clinicians alike indicate that access to mental health services could be improved through programs which offer screening, integrative services and early intervention. Integrated programs in partnership with primary care are likely to reduce disparities in mental health for minority populations. A collaborative care model emphasizing screening and early intervention is proposed based on successes in early childhood programs. The model focuses on at risk populations treated at community health centers, and emphasizes a life course. Systematic changes needed for the success of this program and funding strategies through the Mental Health Services Act are discussed and will be presented to DMH.

REFERENCES:

1. Report, The President's New Freedom Commission on Mental Health, Achievining the Promise: Transforming Menal Health Care in America, U.S. DHHS.

2. Department of Health and Human Services (2001). Mental Health: Culture, Race, Ethnicity. Supplement to Mental Health: Report of the Surgeon General.
3. Institute of Medicine: Increasing workforce capacity for quality improvement. In Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series, Washington, the National Academy of Sciences, 2006, pp. 264-299.
4. McCormick M, Brooks-Gun J, Buka S, Goldman J, et al. "Early Intervention in Low Birth Weight Premature Infants." Pediatrics 2006; 117(3): 771-780.

SYMPOSIUM 11—ETHICS, HUMAN RIGHTS AND DYNAMIC PSYCHIATRY

EDUCATIONAL OBJECTIVES:

1. Understand the foundation of medical ethics which prohibit physicians from participating in torture as well as their appropriate role in the treatment of detainees

2. Understand some of the unique aspects of the current "War on Terror" and why the APA and AMA have established positions that bar physicians from participating in interrogations

3. Provide an ethical guideline for physicians in the military and in civilian law enforcement as they discharge their duties and responsibilities

No. 11A
CHALLENGE TO MEDICAL ETHICS: PSYCHIATRISTS PARTICIPATING IN THE INTERROGATION OF DETAINEES

Steven S. Sharfstein, M.D. *Sheppard Pratt Health System, 6501 N Charles St, Towson, MD, 21204-6819*

SUMMARY:

In May 2006, the American Psychiatric Association passed a position statement that stated, "No psychiatrist should participate directly in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities whether in the United States or elsewhere. Direct participation includes being present in the interrogation room, asking or suggesting questions or advising authorities on the use of specific techniques of interrogation with particular detainees." This position statement was prompted by ethical concerns about detainees being held in Guantanamo Bay, Cuba, and the role of physicians on Behavioral Science Consultation Teams (so called "Biscuit" teams) in consulting with authorities on proper interrogation techniques. The position statement elaborated on a long-standing APA ethical position against torture. This paper will elaborate on a physician psychiatrist's duties to "do no harm" and "to alleviate suffering." It will also expand the concept to include the type of interrogations that have occurred in Guantanamo, Cuba, and elsewhere as contrary to our ethical core. We must respect human rights and dignity in this unprecedented era of the "War on Terror."

No. 11B
ETHICAL IMPLICATIONS OF BIG PHARMA

Stephen A. Green, M.D. *Georgetown Universiy Schol of Medicine, Psychiatry, 5410 Connecticut Ave NW, Ste 109, Washington, DC, 20015-2859*

SUMMARY:

The presenter will discuss the pharmaceutical industry's influence on psychiatric training and practice, and its ethical implicaions for the profession.

No. 11C
A REORIENTATION TOWARDS PROFESSIONALISM IN MEDICINE: OUR ETHICS, OUR FUTURE.

Joseph P. Merlino, M.D. *Queens Hospital Center - Mt. Sinai School of Medicine, Psychiatry, 205 E 78th St, Apt 17J, New York, NY, 10021-1242*

SUMMARY:

The Code of Ethics adopted by the American Medical Association and the American Psychiatric Association together with the sweeping changes in medical education following the Flexner Report resulted in a professionalism that guided the practice of medicine until the past few decades.

Multiple forces over the past quarter century have radically transformed the practice and profession of medicine. Among these: the doctor-patient relationship, economic competition, managed care and other 3rd party payers, and the encroachment in clinical decision making.

This paper argues that the above forces together with the resultant changes impact medicine in a way that threatens its very professionalism. The role of ethics in medical education and medical practice is presented as a compass to lead practitioners back to the values that have historically guided them and the profession. Such a focus will center on both the patient-doctor relationship as primary with a simultaneous community-organizational-political orientation to impact policy on the local and national level.

No. 11D
ETHICAL ISSUES IN SEXUAL CONVERSION ("REPARATIVE"™) THERAPIES

Jack Drescher, M.D. *William Alanson White Institute, 420 W 23rd St, Apt 7D, New York, NY, 10011-2174*

SUMMARY:

Since the American Psychiatric Association's 1973 decision to remove homosexuality per se from the list of mental disorders, mainstream mental health practitioners have shifted their clinical focus from "the cure" of homosexuality to treating the many other mental health concerns of gay and lesbian patients. However, there are those who reject the mainstream's view, continue to regard homosexuality as a mental disorder and further claim they can change an individual's sexual orientation.

This presentation reviews the modern history of theories of homosexuality, up to the removal of "homosexuality" from the second edition of the Diagnostic and Statistical Manual. Clinical debates about "reparative therapies" are then placed in the context of contemporary "culture wars." The presentation goes on to discuss clinical issues surrounding sexual conversion therapies, including inflated claims of "cures" and some of the reported harmful side effects.

The presentation concludes with discussions of the many ethical concerns raised by clinical efforts to convert an individual's sexual orientation. In addition to inadequate selection criteria, routine ethical violations by conversion therapists include inadequate informed consent, breaches of confidentiality, improper pressure placed on patients, and the relinquishment of fiduciary responsibility to patients who eventually come out as gay.

No. 11E
ETHICS IN RESIDENCY

Lea E. de Francisci Lis, M.D. *New York University, Child Psychiatry, 30 E 21st St, Apt 6B, New York, NY, 10010-7222*

SUMMARY:

This interactive presentation will describe some of the typical ethical issues that are common to residents. Residents are the least experienced but often handle the toughest patients. While much of the responsibility for the resolution of ethical dilemmas officially lies with the attendings and the hospital administration, the residents are frequently the individuals asked to make spur of the moment decisions. It is exactly this grey area that complicates the residents' abilities to function ethically and in the best interest of the patient. Furthermore the ethics curriculum in many training programs is deficient in teaching residents what they need to know to practice in a responsible manner.

Examples described include the cases of emergency room ethical breeches that may arise when residents deny access to psychiatric beds from certain hospitals or with certain diagnosis (such as substance abuse).

The presentation will conclude with a discussion of the curriculum of training programs in New York and elsewhere as well as recommendations for a model curriculum and ethics guidelines for residents.

REFERENCES:

1. Miles S: Oath Betrayed: Torture, Medical Complicity, and the War on Terror. New York, Random House, 2006.
2. Angell, M.: The Truth About Drug Companies. New York, Random House, 2004.
3. Swick HM, Bryan CS, Longo LD: Beyond the physician charter: reflections on medical professionalism. Perspect Biol Med 2006; Spring; 49(2):263-75.
4. Drescher, J & Zucker, K.J., eds. (2006), Ex-Gay Research: Analyzing the Spitzer Study and Its Relation to Science, Religion, Politics, and Culture. New York: Harrington Park Press.
5. Opinions of the Ethics Committee on The Principles of Medical Ethics, with annotations especially applicable to psychiatry. 2001 Edition, published by the American Psychiatric association, Washington D.C.

SYMPOSIUM 12—EATING DISORDERS 2007: EXPANDING BIOLOGICAL AND CLINICAL PERSPECTIVES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe and discuss altered reward and taste stimuli processing in anorexia nervosa, the stability of eating disorder diagnoses over time, impulse control disorders in eating disorder women, body image concerns and the desire for plastic surgery after bariatricsurgery, and emerging pictures of eating disorders in older patients.

No. 12A
ANOREXIA NERVOSA AND OBSESSIVE COMPULSIVE DISORDER

Walter H. Kaye, M.D. *University of Pittsburgh & Univeristy of California San Diego, Department of Psychiatry, 3811 O'Hara Street, 600 Iroquois Building, Pittsburgh, PA, 15213*

SUMMARY:

Anorexia nervosa (AN) has been described as a form of obsessive-compulsive disorder (OCD) for more than 70 years. Comorbidity between OCD and AN, as well as bulimia nervosa (BN) is high, with reported rates ranging from 10% to 70%. Moreover, obsessive, anxious, and perfectionistic traits tend to occur in childhood before the onset of AN and BN, and persist after remission of eating and body image symptoms. In addition, there is a higher rate of lifetime eating disorder diagnosis in OCD patients compared to the general population. Rates of OCD are also elevated in first-degree family members of individuals with eating disorder. However, several studies did not find an increased rate of ED in families of probands with OCD. AN in particular is also associated with high rates of obsessive compulsive personality disorders (6 to 60%). In addition, both AN and BN have a number of symptoms that have the qualities of obsessions or compulsions, including ritualized feeding, odd food choices, obsessive interest in diet recipes, window shopping in supermarkets, preoccupation with body image distortions "compulsive" exercise and fidgeting.

Recent studies have begun to address whether these disorders are related. For example, these disorders may have similar neurocognitive features. Neuroimaging data suggest some shared brain circuitry between AN/BN and OCD but state and methodological differences confound comparisons. Genetic studies have begun to question whether ED and OCD involve similar genes. Controlled trials show BN, and perhaps AN, respond to "antidepressant medications" but little is known about whether there is preferential response to serotonin-specific drugs. One working hypothesis is that ED and OCD involve similar brain pathways, although the loci of the disturbances are specific to each disorder.

No. 12B
HOW STABLE ARE EATING DISORDER DIAGNOSES?

David B. Herzog *55 Colbert Rd E, West Newton, MA, 02465-2906,* Kamryn T. Eddy, Ph.D., Debra L. Franko, Ph.D., David J. Dorer, Ph.D., Kavita Tahilani, B.S.

SUMMARY:

In preparation for the DSM-V, the current diagnostic classification system is being re-examined to determine the merits of the existing categories. High rates of diagnostic crossover among individuals with eating disorders may limit the utility of the current system. We examined 218 female participants in the Longitudinal Study of Anorexia and Bulimia Nervosa who were followed for 7 consecutive years. During this period, only a small minority of women consistently retained their intake diagnosis, while the majority experienced diagnostic crossover and/or recovery. Notably, women with AN were most likely to crossover between subtypes (AN-restricting and AN-binge/purge), while women with BN were most likely to crossover to Eating Disorder Not Otherwise Specified (EDNOS) and to recover from their eating disorder. These findings support the distinctiveness of AN and BN, but do not support the AN subtyping schema. Furthermore, these data suggest that for women with a lifetime history of AN or BN, EDNOS may represent a phase in the illness on the way to full recovery.

No. 12C
IMPULSE CONTROL DISORDERS IN EATING DISORDER WOMEN

Katherine A. Halmi *New York Hospital, Cornell Medical Center, 21 Bloomingdale Rd, White Plains, NY, 10605-1504*

SUMMARY:

Lifetime impulse control disorders (ICD) were assessed in 658 women with a history of eating disorders and who were participating in a genetic study. Lifetime prevalence of all ICDs was 15.8% and of the latter 76% were compulsive buying disorder and 31% were kleptomania. ICDs were present most frequently in women with purging bulimia nervosa (BN-P) and those with a history of both BN and anorexia nervosa (BN/AN). Those with a diagnosis of compulsive buying disorder had greater laxative, diuretics and appetite

suppressant use and greater neuroticism, PTSD, anxiety disorders, OCD, depression, Cluster B personality disorders and psychoactive substance abuse compared to individuals without compulsive buying disorder.

Conclusion - Presence of compulsive buying disorder in ED women is associated with worse eating related psychopathology, more severe pathological personality traits and a higher frequency of comorbid Axis I and II conditions.

No. 12D
BODY IMAGE CONCERNS AND THE DESIRE FOR PLASTIC SURGERY AFTER BARIATRIC SURGERY

James E. Mitchell, M.D. *Neuropsychiatric Research Institute, 700 1st Ave S, Fargo, ND, 58103-1802*

SUMMARY:

As the prevalence of overweight and obesity continue to increase in the United States, the number of patients who are viable candidates for bariatric surgical procedures continues to increase as well and the number of such surgeries performed has increased approximately tenfold over the last ten years. Procedures performed most commonly in the United States, Roux-n-Y gastric bypass results in substantial weight loss and generally a partial weight gain but an eventual stable weight well below baseline weight. However, many patients who undergo bariatric procedures having problems with hanging redundant skin which represents both a cosmetic problems and in many cases a health issue as well in that skin breakdown and infections are common. Data will be presented from a follow-up study of 137 patients who underwent bariatric surgery two years prior to assessment and from a cohort of bariatric surgery patients 8-10 years post surgery, now being collected. In the two year sample, 15 patients reported having undergone plastic surgery after bariatric surgery and four of these patients have undergone multiple procedures. When asked if they were considering plastic surgery for various body areas the following responded affirmatively: face (18%), upper arms (59%), chin/neck (31%), chest/breast (60%), waist/abdomen (87%), rear/buttock (46%), and thighs (61%). These results show that the majority of patients having undergone bariatric surgery are considering plastic surgery procedures as a way of removing excess redundant skin. This phenomenon has been little studied and must be considered in the cost/benefit analysis of the use of bariatric surgery in the treatment of obesity. The longer term follow-up data will focus on utilization of plastic surgery procedures and reimbursement for these procedures

No. 12E
EATING DISORDERS IN LATE LIFE

William J. Apfeldorf, M.D. *University of New Mexico Health Science Center, Department of Psychiatry, 1 Univ of New Mexico Place NE, MSC09 5030, Albuquerque, NM, 87131-0001*, Joel Yager, M.D., C. Nathaniel Roybal

SUMMARY:

The existing databases on anorexia tardive and other late-life eating disorders are sparse. Individual case reports and case series suggest many commonalities with mixed-age eating disorder patients but also areas of uniqueness. Sixteen patients with eating disorders received assessments and treatment through the Geriatric Psychiatry Services at the University of New Mexico in the past 4 years. All were referred by clinicians. Fifteen of the sixteen were asssessed to meet criteria for inpatient treatment of the eating disorder and hospitalized on the geriatric psychiatry inpatient service. Fiftysix percent (9/16) were between ages 18 and 39, 25% (4/16) were between 40-54 inclusive, and 19% (3/16) were age 55 or greater. The information gathered by assessments and questionnaires of those in the oldest group will be compared with the information available from the younger eating disorder patients and with the information available from the literatiure. Although the small size of our case series does not provide sufficient power for statistical tests of significance, it does allow the initial exploration of how eating disorders are impacted the the biological, psychological, and interpersonal processes of aging. This promotes hypothesis generation for future prospective testing.

REFERENCES:

1. Kaye WH, Bulik CM, Thornton L, Barbarich N, Masters K, Fichter MM, et al. Comorbidity of anxiety disorders with anorexia and bulimia nervosa. Am J Psychiatry. 2004; 161:2215-2221.
2. Eddy KT, Keel PK, Dorer DJ, Delinsky SS, Franko DL, Herzog DB: Longitudinal comparison of anorexia nervosa subtypes. Int J Eat Disord 2002; 31:191-201.
3. Keel PK, Fichter M, Quadflieg N, et al: Application of a latent class analysis to empirically define eating disorder phenotypes. Archives of General Psychiatry 2004; 61: 192-200.
4. Scuderi N, Alfano C, Mezzana P:Obesity and plastic surgery. Ann Ital Chir 2005; 76:455-460.
5. Lee S: The clinical validity of tardive anorexia nervosa. Aust N Z J Psychiatry 1992; 26:686-688.

SYMPOSIUM 13—DECONSTRUCTING PSYCHOSIS: RESEARCH PLANNING FOR DSM-V

EDUCATIONAL OBJECTIVES:

The participants will learn the proposed endophenotypes in psychoses and their potential value to clarify the classification of psychotic disorders

No. 13A
PARSING ENDOPHENOTYPES ACROSS PSYCHOTIC DISORDERS: TOWARD A REFINED NOSOLOGY OF PSYCHOSES

Matcheri Keshavan *Wayne State University, School of Medicine Psychiatry and Behavioral Neuroscience, Associate Department Chair, Professor, 9B-26 540 E. Canfield, Detroit, MI, 48201*

SUMMARY:

Nosology of psychotic disorders remains a major challenge, being still based on arbitrary phenomenological distinctions. The blurring of nosological boundaries across psychotic disorders results from the overlaps in etiology, pathophysiology and treatment response seen across psychotic disorders. Identifying disease-related endophenotypes that may cut across diverse psychotic disorders is critical for revising diagnostic schemes based on pathophysiology as well as eventually guiding treatment development. Endophenotypes are stable traits, with known biological substrates, are heritable, and are associated with disease liability. Proposed endophenotypes for psychoses include neurophysiological deficits (e.g., eye tracking, P50, PPI, and P300 event related potentials), neurocognitive impairments (e.g., processing speed, vigilance, episodic memory, and working memory), and abnormalities in brain structure (e.g., volumes of gray and white matter in specified brain regions. Few studies have comprehensively studied such endophenotypes, within the same study, across psychotic disorders such as schizophrenia, bipolar disorder and major depression. Characterizing similarities and differences in the endophenotypic signatures across major psychotic disorders will guide future genetic studies, will illuminate common and unique aspects of pathophysiology, and clarify phenotypic bound-

aries between disorders. These efforts will go a long way toward refining our classificatory system for psychotic disorders.

No. 13B
DELUSIONS IN UNIPOLAR AND BIPOLAR MAJOR DEPRESSION: RECOMMENDATIONS FOR THE REVISION OF THE *DSM-IV*

Mario Maj, M.D. *University of Naples SUN, Department of Psychiatry, Largo Madonna delle Grazie, Naples, 80138, Italy*

SUMMARY:

Currently available empirical evidence supports the usefulness of the DSM-IV specifier "severe with psychotic features" in the diagnosis of a major depressive episode, since the presence of delusions in depressed patients has been found to have significant therapeutic and short-term prognostic implications. However, research evidence indicates that the boundary between delusions and non-delusional sustained preoccupations in major depression is somewhat fuzzy; that delusions may also occur in subjects whose major depressive episode is either mild or moderate; and that mood-congruent and mood-incongruent delusions may coexist in several depressed patients. Moreover, the association mentioned in the DSM-IV between the occurrence of psychotic symptoms and suicide risk is controversial, and one group reported that the risk for suicide was significantly increased in patients with "mood-congruent depressive preoccupations or delusions", but not in those with psychotic features as defined by the DSM-IV. Finally, the prognostic significance of the mood-incongruent nature of the delusions has not been consistently confirmed. These findings suggest that the new edition of the DSM should be more explicit in clarifying what a delusion and a non-delusional sustained preoccupation are in a major depressive episode, with several clinical examples which can guide the clinician and the researcher. It will be advisable to provide more detailed criteria for the evaluation of the mood congruence of delusions, and to allow recording mood-congruent and mood-incongruent psychotic features at the same time in an individual patient. It will be useful to provide distinct specifiers for "severity" and "psychosis". A clearer and more detailed phenomenological characterization of delusions in major depression is likely to increase their utility in predicting outcome and treatment response.

No. 13C
DECONSTRUCTING PSYCHOSIS: A BRAIN IMAGING PERSPECTIVE

Raquel E. Gur, M.D. *Univeristy of Pennsylvania, Psychiatry, 3400 Spruce, Philadelphia, PA, 19104*

SUMMARY:

Advances in Neuroimaging technologies have created both opportunities and challenges for psychiatry. We are at the threshold of a new era of psychiatric research that can capitalize of progress in diverse method to study brain structure and function.

Most studies have examined one population, schizophrenia or bipolar disorder. However, there is a growing structural MRI literature comparing diagnostic groups. The study of First-Episode Psychosis and longitudinal follow-up enables to examine common and specific differences between the groups. The functional imaging literature is more limited in direct comparisons. Neuroimaging can play an important role in research elucidating brain circuitry across these disorders, address issues of specificity, provide a developmental perspective, examine endophenotypic measures in genetic paradigms, provide a bridge to basic neuroscience and examine treatment effects.

No. 13D
EPIDEMIOLOGICAL AND PSYCHOPATHOLOGICAL APPROACHES TOWARDS PSYCHOTIC DIAGNOSES IN *DSM-V*

Jim Van Os *Maastricht University, Netherlands and Institute of Psychiatry, London, UK, PO BOX 616, Maastricht, 6221BV, Belgium*

SUMMARY:

The diagnostic constructs that go under the name of schizophrenia and bipolar disorder have clinical utility and reasonable reliability but remain of uncertain validity. Basic epidemiological and psychopathological approaches towards enhancing the validity of these diagnoses have been:

i) Showing mean differences between i) controls and diagnostic groups and ii) different diagnostic groups in course, outcome, treatment and cognitive, developmental and biological correlates;

ii) Subtyping within diagnostic groups (isolating individuals with extreme features within a diagnostic group and showing mean differences, for example deficit syndrome);

iii) Single-symptom research (analyzing cognitive and biological correlates of, for example, hallucinations or hypomanic mood);

iv) Identifying dimensions of related symptoms within specific diagnostic categories or (better) within broadly defined groups with any psychotic disorder;

v) Direct comparisons between different diagnostic representations of psychotic disorders, eg direct comparisons between dimensional and categorical representations.

vi) Identifying population distributions of subthreshold expressions of psychosis and their correlates in the general population, and linking these to clinical phenotypes.

The above approaches have shown that

i) Diagnostic categories and their subtypes, however defined, show mean differences on some variables and similarities on other. However, diagnostic likelihood ratios approaching clinical utility have not consistently been established for any cognitive, psychopathological or biological variable.

ii) There is no evidence that alternative categorical classifications of psychosis or its subtypes add substantially to the diagnostic function.

iii) The combined diagnostic use of dimensional and categorical representations of psychosis does appear to add to the diagnostic function.

iv) Single symptom approaches including cognition as a separate symptom domain may improve the diagnostic function.

v) In terms of the validity question: what *is* schizophrenia and what *is* bipolar disorder, the likely answer may be that broadly distributed population phenotypes exist, only part of which is associated with need for mental health care.

No. 13E
PHARMACOLOGY OF PSYCHOSIS: CONTRASTING SCHIZOPHRENIA WITH BIPOLAR 1 DISORDER

Carol A. Tamminga, M.D. *UT Southwestern Medical School, Department of Psychiatry, 5323 Harry Hines Blvd, Dallas, TX, 75390*

SUMMARY:

The treatment of schizophrenic psychosis has been antipsychotic drugs, first and second generation. Increasingly, other drug classes are also used in the treatment of schizophrenia, including antidepressants, mood stabilizers and antianxiety agents. In contrast, for the treatment of bipolar 1 disorder, whereas lithium and depakote used to be used exclusively, second generation antipsychotic drugs are often used, either in combination or alone. With the conceptualization of dimensions of illness, the idea that psychosis would be treated with APDs independent of diagnosis, has been increasingly exam-

ined. This paper will look at the treatments for psychosis in schizophrenia, BD, and other psychosis and find the similarities and differences.

REFERENCES:

1. Keshavan MS, Diwadkar V, Rosenberg DR. Developmental Biomarkers in schizophrenia and other psychiatric disorders. Epidemiologia e Psichiatria Sociale. 2005 Oct-Dec;14(4):188-93.
2. Maj M, Pirozzi R, Magliano L, Fiorillo A, Bartoli L: Phenomenology and prognostic significance of delusions in major depressive disorder: a 10-year prospective follow-up study. Submitted for publication.
3. Gur RE, Gur RC. Neuroimaging in Schizophrenia: Linking Neuropsychiatric Manifestations to Neurobiology. In H.I. Kaplan, B.J. Sadock (eds.), Comprehensive Textbook of Psychiatry/VIII, Philadelphia: Lippincott Williams & Wilkins, 2005.
4. Van Os J, Verdoux H: Diagnosis and classification of schizophrenia: Categories versus dimensions, distributions versus disease, in The Epidemiology of Schizophrenia. Cambridge, Cambridge University Press, 2003, pp 364-411.
5. Tamminga C.A. Principles of the Pharmacotherapy of Schizophrenia. In Neurobiology of Mental Illness, edited by Charney D.S. and Nestler, E.J. Oxford University Press, 2004, pp 339-355.

SYMPOSIUM 14—BRIEF THERAPIES: AN UPDATE FOR CLINICIANS

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation. the participant should be able to demonstrate an understanding of essential ingredients in successful psychotherapy and enhance the treatments they provide by employing suggested tips drawn from research evidence.

No. 14A
USEFUL TIPS FOR PSYCHOTHERAPISTS FROM RESEARCH

Roger P. Greenberg, Ph.D. *SUNY Upstate Medical University, Psychiatry, 750 E. Adams St, Syracuse, NY, 13210*

SUMMARY:

Research has consistently shown that psychotherapy is beneficial to patients. For example, a classic meta-analysis of 375 studies found that 75% of patients receiving psychotherapy treatments did better than those who did not. However, head-to-head studies comparing different models of psychotherapy have typically demonstrated equivalent outcomes among different brands of psychotherapy. This has led to the speculation that psychotherapy benefits are more a product of factors common to different approaches than to ingredients unique to any single psychotherapy model. Objectives for this presentation are to review the case for the common factors explanation of psychotherapy benefits and to highlight he importance of variables like patient expectations and pre-therapy patient characteristics in determining how successful psychotherapy will turn out to be. The presentation will also look at the placebo effect and suggest it is a potent (and not inert) factor in generating therapeutic results for psychotherapy, as well as medication treatments. Tips for practice will also be addressed in terms of therapist behaviors that have proven to be either helpful or harmful.

Target audience: psychiatrists, psychologists and all professionals involved in providing treatment services for emotional problems.

No. 14B
FORMULATION AND INTERVENTION IN TIME-LIMITED DYNAMIC PSYCHOTHERAPY

Hanna Levenson, Ph.D. *Wright Institute, Berkeley, CA, 2728 Durant Avenue, Berkeley, CA, 94704*

SUMMARY:

Time-limited dynamic psychotherapy (TLDP) is an interpersonal, time-sensitive approach for patients with chronic, pervasive, dysfunctional ways of relating to others. TLDP makes use of the relationship that develops between therapist and patient to kindle fundamental changes in the way a person interacts with others and self. The theory, procedures for formulating and deriving goals, and therapeutic strategies will be presented and illustrated with a clinical case. Training and empirical support for this model will also be addressed.

No. 14C
COGNITIVE THERAPY

Judith Beck, Ph.D. *Beck Inst for Cognitive Therapy; Univ of Pennsylvania, Psychiatry, One Belmont Avenue, Bala Cynwyd, PA, 19004-1610*

SUMMARY:

Cognitive therapy has demonstrated clinical efficacy for a variety of presenting concerns, including depression, anxiety, and personality disorders. This presentation uses case examples to present the practice basics of cognitive including: using a cognitive formulation of the case according to the patient's diagnosis; conceptualizing individual patients according to the cognitive model; using case formulation to plan treatment within and across sessions; establishing and maintaining a strong therapeutic alliance; structuring therapy sessions effectively; implementing cognitive and behavioral techniques; and assessing the efficacy of treatment.

REFERENCES:

1. Greenberg RP: Essential ingredients for successful psychotherapy: Effect of common factors:In The Art and Science of Brief Psychotherapies, edited by Dewan M, Steenbarger B, Greenberg R, Washington DC, American Psychiatric Publishing, 2004, pp398-407.
2. Levenson, H: Time-limited dynamic psychotherapy: Formulation and intervention. In The Art and Science of Brief Psychotherapies, edited by Dewan MJ, Steenbarger BN, Greenberg RP, Washington, DC, American Psychiatric Publishing, Inc., 2004, pp 157-187.
3. Beck JS: Cognitive therapy: basics and beyond. New York: Guilford Publications, 1995.
4. Manring J, Beitman BD, Dewan MJ. Evaluating competence in psychotherapy. Acad Psychiatry. 2003 Fall;27(3):136-44.

SYMPOSIUM 15—WHAT IS THE DIRECTIONALITY OF THE ONSET OF COMORBID SUBSTANCE USE AND OTHER PSYCHIATRIC DISORDERS?
National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to better understand the forces that influence prescribing practices and antidepressants, and be better able to evaluate the influence of these forces on their own prescribing practice.

No. 15A
METHODOLOGICAL ISSUES IN ASSESSING THE DIRECTIONALITY OF THE ONSET OF SUBSTANCE USE AND OTHER COMORBID PSYCHIATRIC DISORDERS

Helena C. Kraemer, Ph.D. *Stanford University, Stanford University, Palo Alto, CA, 94301*

SUMMARY:

Traditionally, risk research has focused on correlational models in which the time order of the potential risk factors was not specified (Kraemer et al., 1997), and even more narrowly on linear models in which it is assumed that the multiple potential risk factors did not "work together" other than additively (Kraemer, Stice, Kazdin, & Kupfer, 2001). In addition, comorbidity has often been assessed under circumstances where even random association between morbidities would statistically appear to be associated (Kraemer, Wilson, & Hayward, 2006). These and other such common methodological problems will be discussed and better tactics for future research indicated.

No. 15B
EVIDENCE OF DIRECTIONALITY IN EPIDEMIOLOGICAL STUDIES OF ADULTS

Ronald Kessler, Ph.D. *Harvard Medical School, Deepartment of Health Care Policy, Harvard Medical School, Deepartment of Health Care Policy, Boston, MA, 02115*

SUMMARY:

Substantial comorbidity has been documented between substance disorders and mental disorders. Most previous research on the temporal priority in this comorbidity in studies of adults has been based on analysis of retrospective age of onset reports in cross-sectional surveys. The latter generally suggests that associations are reciprocal — that temporallty primary mental disorders predict the subsequent first onset of substance disorders and that temporally primary substance disorders predict the the subsequent firsrt onset of mental disorders. Some evidence has also been presented in these studies that comorbid substance disorders and mental disorders predict persistence of each other. A small number of longitudinal studies have generally found results consistent with these retrospective results, but the evidence base is thin. The current report presents data from the National Comorbidity Survey Follow-up (NCS-2), a ten-year panel survey of a nationally representative sample of people who were in the age range 15-54 at baseline and who were followed a decade later in an effort to determine the extent to which baseline mental disorders predict subsequent transitions involving substance disorders and baseline substance disorders predict subsequent transitions involvingt mental disorders. As the age of onset distributions of substance and mental disorders differ, it is also important to examine these patterns separately within cohorts and to focus on parts of the life course in which transitions are likely to occur. The current report presents a broad overview of NCS-2 results regarding basic patterns in inter-temporal associations involving onset, progression, and recovery from substance use and substance disorders in relation to mental disorders.

No. 15C
GENETIC FACTORS AND THE DIRECTIONALITY OF COMORBID DISORDERS

Michael Vanyukov, Ph.D. *Center for Education and Drug Abuse Research, Department of Pharmaceutical Sciences, Center for Education and Drug Abuse Research, Department of Pharmaceutical Sciences, Pittsburg, PA, 15261*

SUMMARY:

Despite the diversity of addictive substances, genetic variance in the risks for disorders related to them is largely nonspecific. This suggests that mechanisms other than those involved in pharmacologic action may play a significant role. Attention is drawn to the traits developmentally predating drug abuse, particularly psychological characteristics, including liabilities to childhood behavioral disorders. Genetic overlap between some of these indicators of psychological regulation and liability to substance use disorders (SUD) points to common factors that are likely involved in neurotransmission, neuromaturation and physiological maturation. Studies longitudinally tracking genetic relationships of behavioral development and providing information on their mediators at biochemical and physiological levels (including neuroimaging), combined with structured environmental data, may be able to disambiguate comorbidities and elucidate the individual trajectory to SUD.

No. 15D
DEVELOPMENTAL MODELS TO EXPLAIN THE ONSET AND DIRECTIONALITY OF COMORBID DISORDERS

Monique Ernst, M.D. *Mood and Anxiety Disorders Program, Mood and Anxiety Disorders Program, Bethesda, MD, 20892-2670*

SUMMARY:

Directionality of onsets of psychiatric disorders raises much interest because it can inform causality, and thus mechanisms underlying pathology. Here, a neurodevelopmental model of vulnerability to psychiatric disorders that are characterized by core deficits in reward systems will be presented. Findings from neuroimaging studies addressing structural and functional patterns of neural circuitry engaged in reward-related processes, across both development and psychopathology, will be reviewed. These findings concur to suggest that vulnerability to substance use and other psychiatric disorders could be conferred by the different timelines in maturation of neural circuits controlling behavior. Schematically, these circuits comprise the amygdala that promotes avoidance behavior, the ventral striatum that promotes approach behavior, and the medial prefrontal cortex that supervises these subcortical systems (see Ernst et al., 2006). Different maturational trajectories are proposed to result in states of imbalance relative to the normative adult coordination of motivated behavior. For example, risk taking behaviors peak in adolescence, and account for the sharp and paradoxical raise in morbidity and mortality during this period of life. The proposed model assumes a relative delay in maturation of the supervisory structures, in a context of prominence of engagement of approach-related neural system relative to the system underlying avoidance behavior. Although reductionistic, this model has the merit be testable and to provide directions for the study of directionality of comorbid disorders.

No. 15E
TREATMENT IMPLICATIONS OF DETERMINING THE DIRECTIONALITY OF COMORBID DISORDERS

Edward V. Nunes, M.D. *NYSPI, NYSPI, New York, NY, 10032-1007*

SUMMARY:

Co-occurring psychiatric disorders are associated with poor treatment outcome in substance dependent patients, suggesting the hypothesis that specific treatment of co-occurring disorders should improve substance use outcome. However, accurate diagnosis of co-occurring disorders such as depression has been a challenge, since substance abuse may induce psychiatric symptoms. Naturalistic stud-

ies on the impact of comorbidity on treatment outcome of substance use disorders, and placebo-controlled trials of antidepressant medications in depressed, substance dependent patients, will be reviewed. The findings suggest that a careful diagnosis that takes account of the order of onset and offset of depression in relation to substance use is important in identifying depressive syndromes that affect prognosis and respond to treatment. This supports the DSM-IV definition of independent, as opposed to substance-induced depression, although more research is needed to directly test the treatment implications of these diagnostic categories.

REFERENCES:

1. Kraemer, H. C., Kazdin, A. E., Offord, D. R., Kessler, R. C., Jensen, P. S., & Kupfer, D. J. (1997). Coming to Terms with the Terms of Risk. Archives of General Psychiatry, 54, 337-343.
2. Conway, K.P., Compton, W., Stinson, F.S., Grant, B.F. (2006). Lifetime comorbidity of DSM-IV mood and anxiety disorders and specific drug use disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. J Clin Psychiat.
3. Tarter, R, Vanyukov M, Giancola, P, Dawes, M, Blackson, T, Mezzich, A, and Clark, DB. (1999) Etiology of early age onset substance use disorder: a maturational perspective. Dev. Psychopathol, 11: 657-683.
4. Ernst M, Pine DS, Hardin M. Triadic model of the neurobiology of motivated behavior in adolescence. Psychol Med. 2006 Mar;36(3):299-312.
5. Nunes EV, and Levin FR. Treatment of depression in patients with alcohol or other drug dependence: a meta-analysis. JAMA. 2004 Apr 21;291(15):1887-96.

SYMPOSIUM 16—CATEGORIES AND DIMENSIONS IN CLINICAL AND RESEARCH CONTEXTS OF DIAGNOSTIC CLASSIFICATION FOR DSM-V
National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the research and clinical challenges that need to be explored to make incorporation of a dimensional aspect feasible in the current categorical classification system.

No. 16A
SEVERITY IS THE MOST IMPORTANT DIMENSION OF DEPRESSION

Michael E. Thase, M.D. *University of Pittsburgh Medical Center, 3811 O'Hara Street, Pittsburgh, PA, 15213-2593*

SUMMARY:

Although major depressive disorder is a categorical diagnosis, useful information about depressive states is conveyed by several relevant dimensions. The most important dimension is syndrome severity, as typically expressed in terms of the number and intensity of depressive symptoms. In DSM-IV, severity is rated along a four point ordinal continuum, ranging from mild to severe with psychotic features. In preparation of DSM-V, it is timely to evaluate the utility of this dimension. Syndrome severity also can be expressed as a score on a well-validated rating scale. Although the venerable HAM-D and BDI scales have been studied the most, both measures are flawed (i.e., neither assess all 8 of the DSM-IV criteria for MDD without modification). Among the numerous alternatives, the Inventory of Depressive Symptoms (IDS) is a particularly strong and is available in both clinician-rated and self-report forms, as well as a shorter or "quick" (QIDS) version. Severity ratings are typically normally distributed, with higher scores associated with more comorbidity, poorer response to placebo, greater amounts of state-dependent neurobiologic disturbances (i.e., elevated cortisol levels or alterations in cerebral glucose metabolism), greater functional impairment, and higher risk of relapse. Although patients with higher severity ratings are less likely to remit spontaneously, they obtain relatively greater benefit from specific therapies, including the combination of psychotherapy and antidepressant medication. It will be recommended that depressive severity continue to be included in the DSM-V, with consideration of supplementing clinical global impressions with a standardized, user-friendly rating scale such as the QIDS.

No. 16B
ANXIETY DISORDERS

Katherine Shear, M.D. *Columbia University, 1255 Amsterdam Ave, NY, NY, 10027*

SUMMARY:

Anxiety disorders share a number of features, including panic, anticipatory anxiety, avoidance behavior and dysphoric affects.. These can be, and often are, rated dimensionally by researchers. Though it is not feasible nor useful at this time to attempt to reconfigure anxiety disorders based on dimensional ratings of core symptoms, systematic use of dimensions by researchers interested in nosology could be very useful. Some symptoms do lend themselves to dimensional ratings. In DSM IV both panic attacks and agoraphobic symptoms are assessed across disorders. Assessment of panic across disorders led to the important observation that panic is a core symptom, highly predictive of the occurrence of severe psychopathology, across disorders (Goodwin et al 2004) . Panic spectrum assessment, a dimensional measure of panic-related symptoms, has been shown by researchers to be an important predictor of illness severity and treatment outcomes (Frank et al 2002). Dimensional measures can also be used to enhance. Simple measures are now available for this purpose. For example, the Panic Disorder Severity Scale (PDSS Shear et al 2001) is a 7-item scale that is a simple way of operationalizing severity, has a 1-month time frame, includes defined anchor points (0-4) and has been found to be sensitive to change in treatment studies. Dimensional assessment could be used to support a staging approach to illness. Using panic disorder as an example, using dimensional assessment of panic, anxiety, phobia and other psychopathology, the evolution of the disorder could be staged, with stage 1 being isolated panic attacks, stage 2 panic disorder, uncomplicated, and stage 3 panic disorder complicated by other problems such as agoraphobia, other anxiety disorders (GAD, phobias, PTSD, OCD), depressive disorders, and substance use disorders. Staging is an approach that has been used in other areas of medicine to inform treatment decisions and predict course.

No. 16C
DIMENSIONAL APPROACHES TO DIAGNOSING ADDICTIVE DISORDERS

Wilson M. Compton, M.D. *National Institute on Drug Abuse, Div'n of Epidemiology Services and Prevention Research, 6001 Executive Boulevard, MSC 9589, Bethesda, MD, 20892-9589*

SUMMARY:

Inherent in the current DSM approach to diagnosis of substance use disorders is a decision about whether or not a disorder is present. Such a categorical approach is necessary for clinical decision-making. However, continuous measures are of potential utility as well. For example, the severity of a condition may play an important role

in determining treatment and outcomes. The question remains about how a dimensional approach to diagnosis fits with the current DSM-IV approach and whether dimensional approaches can inform the development of the new DSM-V system. Specifically, how do dimensional approaches to the diagnosis of alcohol, marijuana, nicotine and other drug disorders compare to categorical approaches?

Methods: Using data from the National Epidemiologic Survey on Alcohol and Related Conditions, a large nationally representative sample of the US population ages 18 and older (N = 43.093), two-parameter logistic item response theory (IRT) models were constructed to estimate the severity and discrimination of each DSM-IV criterion. In addition to the diagnostic items, information about regular consumption was also included.

Results: DSM-IV criteria combined with consumption variables form a continuum of substance use disorder severity. Abuse and dependence criteria do not apply consistently to the mild or severe end of the spectrum and some criteria provide redundant information regarding underlying disorder severity.

Conclusions: IRT models may provide a robust way to eliminate redundant diagnostic items and to efficiently categorize individuals along the continuum of addiction severity.

No. 16D
A DIMENSIONAL PROTOTYPE FOR BORDERLINE PERSONALITY DISORDER

Andrew E. Skodol, M.D. *New York State Psychiatric Institute, Personality Studies, 1051 Riverside Drive, Box 129, New York, NY, 10032*, Robert F. Krueger, Ph.D., W. John Livesley, M.D., Patrick Shrout, Ph.D., Yueqin Huang, M.D.

SUMMARY:

Research supports a hierarchical dimensional structure for personality psychopathology. At the top level are broad domains of internalizing and externalizing traits and behaviors: under internalizing are two intermediate level dimensions of emotional dysregulation vs. stability and introversion vs. extraversion; under externalizing are dimensions of impulsivity vs. constraint and antagonism vs. compliance. Beneath these lie the individual lower order primary traits that make up the descriptive manifestations of personality disorders.

To augment DSM personality disorder classification and diagnosis with a dimensional approach, criteria are necessary for determining if a personality disorder is present and for representing individual differences in PDs, i.e., different forms of the disorder. The variability among PDs can be captured by roughly 25-30 descriptive elements. A dimensional representation of borderline PD based on the empirically-derived Dimensional Assessment of Personality Pathology (DAPP) model is presented.

The general criteria for a personality disorder would require 1) a disturbance of self and interpersonal relations, 2) distress and/or impairment in social and occupational functioning, 3) a minimum duration, and 4) a disturbance not due to another cause. These features can be rated on dimensional scales, with cut-points for clinical significance determined by empirical research on relevant external validators. The BPD prototype would show elevations on 6 core DAPP traits: affective liability, anxiousness, pessimistic anhedonia, insecure attachment, cognitive dysregulation, and self-harm. These traits could be rated on simple 3-point descriptive scales: lacking the trait, average levels, or high on the trait. A dimensional measure of BPD personality prototype resemblance would simply be a count of the number of elevations on these core traits.

Dimensional representations of personality psychopathology may prove more clinically useful than categories in that they could provide better coverage, allow flexibility in level of assessment (i.e., very broad vs. very specific), and focus treatment interventions on specific traits and behaviors.

No. 16E
DIMENSIONAL APPROACH TO MAJOR PSYCHOSES

Patricia Suppes, M.D. *UT Southwestern Medical Center, Psychiatry, 5323 Harry Hines Blvd, Dallas, TX, 75390-9121*

SUMMARY:

Objectives: To provide physicians with an understanding of the relationship and interaction between dimensional and categorical approaches, and how the dimensional approach impacts the diagnosis and treatment of psychotic disorders.

Methods: The relationship between dimensional and categorical approaches to major psychosis is explored. Implications of using a dimensional approach in diagnosing and treating psychotic disorders are discussed.

Results: A dimensional approach to diagnosis and treatment of psychotic disorders may be a valuable complement to the current categorical approach of the DSM-IV. The categorical approach is essentially binary, with limited room for identification of subsyndromal or prodromal symptoms. This approach is contrary to clinical experience, where psychotic symptoms often present on a continuum. The recommendation is to assess for impairment using available scales and/or a simple graduated scale such as 0=absent to 4=severe to assist in decision-making. Diagnostic domains to consider include deficiency in reality testing, disorganization of thought, cognitive dysfunction, negative symptoms, and social impairment. Additional domains to consider include affective disturbances, activities in daily life, social support networks/assets, participation in productive activities, and substance use. All of these domains are relevant to care, and some are critical for treatment decision-making. Analysis of existing data and new research will be useful in defining optimal cutpoints and developing guidelines merging categorical and dimensional assessment approaches.

Conclusions: It is important to consider the relationship between dimensions and categories of psychotic symptoms, which in turn may impact treatment. A combined dimensional and categorical approach to psychosis will encourage and support better recognition of prodromal and subsyndromal psychotic symptoms, which may lead to earlier therapeutic intervention for disorders such as schizophrenia and bipolar I disorder.

REFERENCES:

1. Thase ME: Treatment of severe depression. J Clin Psychiatry 2000; 61(Suppl 1):17-25.
2. Frank E, et al. Clinical significance of lifetime panic spectrum symptoms in the treatment of patients with bipolar I disorder. Arch Gen Psychiatr 59: 905-11 2002.
3. Saha TD, Chou SP, Grant BF. Toward an alcohol use disorder continuum using item response theory: results from the National Epidemiologic Survey on Alcohol and Related Conditions. Psychological Medicine 2006;36(7):931-941.
4. Krueger RF: Continuity of axes I and II: toward a unified model of personality, personality disorders, and clinical disorders. J Personal Disord 2005; 19:233-261.
5. Kupfer DJ. Dimensional models for research and diagnosis: A current dilemma. Journal of Abnormal Psychology 2005; 114(4):557-559.

SYMPOSIUM 17—THE DISRUPTIVE PHYSICIAN: REHABILITATE OR RETALIATE?

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participants will:

- become familiar with the profile of doctors referred to the PHP due to disruptive behaviour,

- understand the staged approach to management advised by the PHP and
- recognize some important challenges to managing cases of disruptive behaviour in physicians.

No. 17A
MANAGING DISRUPTIVE BEHAVIOUR IN PHYSICIANS: THE EXPERIENCE OF ONTARIO'S PHYSICIAN HEALTH PROGRAM

Michael Kaufmann, M.D. *Ontario Medical Association, Physician Health Program, 525 University Avenue, Suite 300, Toronto, ON, M5G 2K7, Canada*

SUMMARY:

This presentation reviews the experience of the Physician Health Program (PHP) of the Ontario Medical Association managing cases of physicians referred because of their disruptive behaviour in the workplace.

This presentation begins by describing the profile of these doctors and then moves to focus on a phased, rational, non-punitive approach to rehabilitation which is matched to the nature, frequency, and intensity of the presenting behavioural problems. In particular, this presentation details the following phased approaches: Level I_prompt recognition and informal response aimed at initial, relatively minor incident(s); Level II_intervention involving a comprehensive assessment and management plan focused on a continuing pattern of disruptive behaviour; and Level III_intervention as an urgent response to either (i) egregiously disruptive behaviour or (ii) a persistent pattern of disruptive behaviour despite prior rehabilitative efforts. Level III interventions may involve suspension or revocation of privileges and reporting to regulatory authorities.

This presentation portion of the symposium underlines how infrequently physicians with disruptive behaviour are well managed, offers possible reasons for this worrisome situation, and provides suggestions on how physicians with disruptive behaviour may be identified earlier and approached more effectively.

No. 17B
PHYSICIAN DISRUPTIVE BEHAVIOR PATTERNS: ASSESSMENT, INTERVENTION AND MONITORING

Larry J. Harmon, Ph.D., *Physicians Development Program, 2000 S. Dixie Highway, Suite 103, Miami, FL 33133-2441*

SUMMARY:

Audience will learn about the Pulse Survey to assess physician disruptive vs. teamwork behavior patterns. Methods will be discussed to design an educational intervention to reduce disruptive conduct and to remediate teamwork and leadership skill deficits. Monitoring progress will also be addressed.

No. 17C
THE FORENSIC PSYCHIATRIC CONTRIBUTION TO ASSESSING AND UNDERSTANDING DISRUPTIVE PHYSICIAN BEHAVIOUR

Hy Bloom, M.D. *University of Toronto & McMaster University, Psychiatry, 1200 Bay Street, 1202, Toronto, ON, M5R 2A5, Canada*

SUMMARY:

Workplaces are increasingly relying on mental health consultants to help them assess and manage inappropriate workplace behaviours ranging from disruptive behaviour to frank violence. Healthcare settings are no exception to this trend. Experts have responded to increasing demands for consultations regarding a range of inappropriate and disruptive physician behaviours (DPB). The increase in referrals reflects heightened awareness of the problem (with concomitant diminution in tolerance for such behaviour), and new workplace codes of conduct that provide clearer definitions of actionable behaviours. The primary mandate for experts is almost always to assess the physician, explain the behaviour, estimate risk for recurrence, make meaningful recommendations concerning remediation of psychopathology, and where requested, address any systemic contribution.

Forensic psychiatrists are well-positioned to assist healthcare settings with problems of this kind. The "forensic model" of assessing anomalous, problematic, and aggressive behaviour relies on conducting a thorough multidisciplinary assessment of the DPB and the environment in which the behaviour was enacted. Forensic evaluators do not establish therapeutic relationships with evaluees, nor do they accept information at face value. All information is critically appraised against the substantial fund of collateral data.

Evaluations of disruptive physicians may take place in the context of litigation. Forensic clinicians are comfortable with the likelihood that an assessment of DPB will result in needing to testify in a number of potential settings, including the hospital's medical advisory committee, at a discipline or capacity hearing held by the clinician's professional regulatory body, in a criminal proceeding, or in a civil trial.

Finally, forensic clinicians often have unique training and experience in both assessing and treating Axis I and Axis II disorders associated with inappropriate or aggressive behaviour. Forensic expertise may help in making the most meaningful recommendations concerning both the psychological and psychopharmacological management of disruptive and aggressive physician behaviour.

No. 17D
DISRUPTIVE DOCS: HOW ARE THEY?

Eva C. Ritvo, M.D. *University of Miami, Department of Psychiatry, 4300 Alton Road, MRI building second floor, Miami Beach, FL, 33140*

SUMMARY:

This presentation will describe the demographic characteristics of approximately 70 physicians referred for disruptive behavior. DSM-IV diagnoses will be presented. Personality traits and disorders will be discussed.

REFERENCES:

1. Kaufmann M: Management of Disruptive Behaviour in Physicians: a staged rehabilitative approach. Ontario Medical Review Oct. 2005; 59-64.
2. Keogh T, Martin W: Dealing with Disruptive Behavior: Managing unmanageable physicians: leadership, stewardship and disruptive behaviour. The Physician Executive 2004; Sept-Oct: 18-22.
3. Journal Article- Harmon LJ, Pomm R: Disruptive Physicians: Evaluation, Education and Monitoring. Psychiatric Annals, 2004; 14(10):770-774.
4. Harmon, L & Pomm, R: Disruptive Physicians: Evaluation, Education and Monitoring. Psychiatric Annals, 2004, 14(10): 770-774.

SYMPOSIUM 18—IMPULSIVITY: FROM NEUROPHENOMENOLOGY TO TREATMENT OPTIONS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to diagnose and recognize the impulsivity among psychiatric

disorders, to discriminate between normal and pathologic impulsivity, and understand the pathophysiological pathways of impulsivity and have the instruments to choose appropriate treatments.

No. 18A
TREATMENT OF IMPULSIVITY AND COMPULSIVITY

Eric Hollander, M.D. *Mount Sinai School of Medicine, Department of Psychiatry, 380 Orienta Ave, Mamaroneck, NY, 10543-3936*, Daphne Simeon, Andrea Allen, Ph.D., Thomas Mick, M.D., Heather Berlin, Ph.D., Jennifer Bartz, Ph.D.

SUMMARY:

Treatments for impulsivity are influenced by the varying developmental trajectories to impulsivity, along with impact of comorbidity and associated symptom domains. For example, if compulsivity and anxiety play a role in the development of impulsivity, then SSRI's may be the initial treatment of choice. If affective instability plays a role in the development of impulsivity, then the initial treatment of choice involves mood stabilizers, such as lithium, valproate or topiramate. If craving and addiction are associated with the development of impulsivity, opiate antagonists such as naltrexone or nalmefene may be the initial treatment selection. Finally, if inattention and motor hyperactivity drive the development of impulsivity, then stimulants or dopamine reuptake inhibitors may be the initial treatment of choice.

With greater heterogeneity and increasing associated symptom domains, a rational hierarchy for the treatment of impulsivity can be developed.

No. 18B
PHARMACOLOGICAL CHALLENGE IN PATHOLOGICAL GAMBLING

Stefano Pallanti *University of Florence, Psychiatric and Neurologic Sciences, V.le U. Bassi 1, Florence, 50137, Italy*, Silvia Bernardi, M.D., Ilenia Pampaloni, Eric Hollander

SUMMARY:

Pathological gambling (PG) is classified in DSM-IV TR as an Impulse Control Disorder Not Elsewhere Specified (ICDNOS), but may also serve as a more homogenous model of behavioral addiction. Emerging data demonstrate that PG may be responsive to various psychopharmacological agents with different actions, involving serotonergic, dopaminergic, and opiate activity (1-4).

This is the first study exploring the specific role of the NE system in gambling impulse control. With this aim and in order to clarify altered NE and serotonin (5-HT) metabolism in PG, we assessed behavioral and neuroendocrine (prolactin, cortisol and GH) responses to NE and 5-HT pharmacological stimuli. The α2-adrenergic receptor agonist clonidine, and the partial serotonin agonist meta-chlorophenylpiperazine (m-CPP) compared to placebo in PG and matched controls as been used in two different samples. Moreover, the neuroendocrine response relationship to clinical PG severity has been assessed.

Regarding serotonergic stimulus, pathological gamblers had significantly increased prolactin response compared to controls. Greater PG severity correlated with increased neuroendocrine responsiveness to m-CCP, suggesting greater 5-HT dysregulation. PG patients showed also a significantly increased "high" sensation after m-CPP administration compared with control. These results provide additional evidence for 5-HT disturbance in PG and they support the hypotheses that the role of the 5HT dysfunction related to the experience of "high" might represent the pathway that leads to dyscontrolled behavior in PG. Moreover, the "high" feeling induced by m-CPP in pathological subjects, may represent a marker of vulnerability to both behavioral and substance addictions.

Pathological gamblers showed also significantly blunted GH response compared to controls post clonidine. These results provide evidence for NE disturbance in PG, and are consistent with deficits in alert biasing signals. From this view, NE dysfunction may indicate a deficient alert signal in impulsive behavior.

No. 18C
SEARCHING FOR ENDOPHENOTYPES IN OCD FAMILIES: RESULTS FROM NEUROPSYCHOLOGY AND BRAIN IMAGING STUDIES

Naomi A. Fineberg *Queen Elizabeth II Hospital, Department of Psychiatry, AL7 4HQ, Welwyn Garden City, AL7 4HQ, United Kingdom*, Lara Menzies, Ed Bullmore

SUMMARY:

Obsessive compulsive disorder (OCD) is a highly heritable neuropsychiatric illness, yet attempts to elucidate contributing genes have met with limited success. Neurocognitive or radiological endophenotypes, representing intermediate markers of brain dysfunction, may help focus the search for genetic contributions. Such markers should be present in people at risk of developing OCD, even in the absence of clinical symptoms.

OCD is linked to cognitive deficits that can be measured using objective laboratory-based tests. Compared to healthy controls, OCD patients showed impairment on tasks measuring response inhibition and cognitive flexibility (Chamberlain et al., 2005, 2006a). Neuropsychological and neuroimaging parameters may constitute a meaningful link between genotype and phenotype in OCD and related disorders. Examination of these functions in unaffected first-degree relatives is a vital first step in the search for endophenotypes.

Recent work has combined genetic measures, cognitive assessment, and structural neuroimaging in order to investigate brain function in unaffected first-degree relatives of OCD patients. Compared to matched controls without a family history of OCD, unaffected first-degree relatives of OCD patients showed impaired response inhibition ($p<0.01$) and cognitive inflexibility ($p<0.01$) that were comparable in magnitude to cognitive deficits in patients (Chamberlain et al., 2006b). OC personality disorder traits were highest in patients, intermediate in relatives, and lowest in controls. The same individuals were also subjected to structural brain imaging using MRI and diffusion tensor imaging. Preliminary analysis suggested volumetric abnormalities in unaffected relatives.

These data support the utility of brain-based measures in the search for OCD endophenotypes that can exist in 'at risk' individuals in the absence of clinically significant symptoms or medication confounds. Examination of relationships between these abnormalities, genetics, and structural/functional brain changes, will help to elucidate etiological contributions to OCD and related spectrum disorders.

No. 18D
EXPLORING IMPULSIVITY AND COMPULSIVITY USING NEUROCOGNITIVE PROBES: TRANSLATIONAL APPROACHES

Samuel Chamberlain, Ph.D. *University of Cambridge, Department of Psychiatry, Hills Road Addenbrooke's Hospital, Box 189, Level E4, Cambridge, CB2 2QQ, United Kingdom*, Trevor Robbins, Ph.D., Barbara Sahakian, Ph.D.

SUMMARY:

The terms impulsivity and compulsivity have proved fruitful in describing psychiatric symptoms. Impulsivity refers to a tendency towards rapid unplanned actions without due regard for negative

consequences (Moeller et al., 2001). Compulsivity involves repetitive inappropriate driven behaviours performed according to rigid rules or in response to obsessions (DSM-IV). Impulsivity and compulsivity may be construed as occupying extreme poles of a dimension associated with 'risk-seeking' and 'risk-aversiveness' respectively. Alternatively, they may be rather closely linked, since both appear to involve problems with inhibitory control (Stein and Hollander, 1995; Chamberlain et al., 2005). Animal models have been used to explore this relationship; for example disruption of the Hoxb8 gene leads to aberrant grooming and hair-pulling in mice, while repeated administration of the dopamine agonist quinpirole in rats induces compulsive checking behaviour (Eilam and Szechtman, 2005).

Trichotillomania and OCD are obsessive-compulsive spectrum disorders characterised by difficulties suppressing behaviour. OCD is an archetypal disorder of compulsivity, whereas trichotillomania is currently classified as an impulse control disorder (DSM-IV). We compared these two disorders using objective tests of behavioural inhibition (cognitive inhibition and motor inhibition). Both patient groups showed impaired motor impulse control as indexed by the stop-signal task ($p<0.05$). Only OCD patients showed additional impairment on tests of cognitive flexibility, such as set-shifting (CANTAB set-shift task) ($p<0.05$) (Chamberlain et al., 2006).

Our findings support the hypothesis that different impairments in behavioural inhibition underpin the manifestation of impulsive and compulsive features of these disorders. Evidence from studies in volunteers suggests that motor impulse control (stop-signal test) depends upon the right inferior frontal gyrus, and is modulated by neurotransmitters other than serotonin (such as noradrenaline). Comparing inhibitory function between spectrum disorders may allow us to refine neurobiological models and signal novel treatment directions for these prevalent debilitating disorders.

REFERENCES:

1. Hollander E et al. Does sustained release lithium reduce impulsive gambling and affective instability versus placebo in pathological gamblers with bipolar spectrum disorders? Am J Psychiatry 2005, 162:137-145.
2. Hollander E, DeCaria CM, Mari E, Wong CM, Mosovich S, Grossman R, Begaz T (1998): Short-term single-blind fluvoxamine treatment of pathological gambling. Am J Psychiatry155:1784-1786.
3. Chamberlain SR, Fineberg NA, et al. Impaired cognitive flexibility and motor inhibition in unaffected first-degree relatives of OCD patients: on the trail of endophenotypes. Am J Psychiatry. 2006b (in press).
4. Chamberlain SR, Fineberg NA, Blackwell AD, Robbins TW, Sahakian BJ. Motor inhibition and cognitive flexibility in obsessive-compulsive disorder and trichotillomania. Am J Psychiatry. 2006 Jul;163(7):1282-4.

SYMPOSIUM 19—THE "HIDDEN" DIAGNOSES IN PSYCHIATRY: IMPLICATIONS FOR TRAINING, CLINICAL CARE, AND OUTCOMES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize that there are common, co-occurring diagnoses, often missed, that have important clinical relevance, affect outcomes, and are important to consider in how residents are trained.

No. 19A
THE IMPORTANCE OF EARLY-ONSET PSYCHIATRIC DISORDERS AND DEVELOPMENTAL PSYCHOPATHOLOGY FOR THE PSYCHIATRIST

Daniel F. Connor, M.D. *University of Connecticut Medical School, Psychiatry/MC1410, 263 Farmington Avenue, Farmington, CT, 06030-1410*

SUMMARY:

Recent epidemiological evidence from the National Comorbidity Study suggests that many psychiatric disorders have their onset in the developing years. This appears most true for impulse-control disorders such as attention deficit hyperactivity disorder (ADHD), and anxiety disorders. Longitudinal research finds that ADHD and early-onset depression have marked continuity into adolescence and adulthood. Thus, the clinical psychiatrist will assess and treat adult patients who have developmental histories characterized by early-onset psychopathology. This presentation will review the prevalence, characteristics, comorbities, and longitudinal course of early-onset psychiatric disorders including ADHD, depression, bipolar disorder, and the anxiety disorders for the practicing adult psychiatrist. How a developmental history of early-onset disorder influences later treatment decision making will be reviewed. Implications for adult psychiatry training and clinical care will be discussed.

No. 19B
DYSMORPHOLOGY, MENTAL ILLNESS, AND LEARNING DISABILITIES: GENETIC SYNDROMES WITH BEHAVIORAL PHENOTYPES

Carolyn M. Drazinic, M.D. *University of Connecticut Health Center, Department of Psychiatry, 263 Farmington Avenue, MC 2103, Farmington, CT, 06030-2103*

SUMMARY:

Several genetic disorders have behavioral phenotypes that are being increasingly recognized as a common feature of these disorders. Examples of genetics disorders with behavioral phenotypes include VeloCardioFacial Syndrome (VCFS), Williams Syndrome (WS), Klinefelter Syndrome (KS), Prader-Willi Syndrome (PWS), and Angelman Syndrome (AS). This presentation will provide an overview of the major clinical and behavioral features of these syndromes, as well as current knowledge about specific molecular genetic abnormalities contributing to these features. Two syndromes, VCFS and WS, and their behavioral phenotypes of schizophrenia and anxiety respectively, will be discussed in greater detail. Possible candidate genes for schizophrenia are actively being pursued in VCFS microdeletion region, and the latest research advances in the literature will be presented. Genetic microdeletion syndromes provide molecular biologists an exciting opportunity to discover genes that contribute to mental illness in these populations, and these same genes may also be relevant to the development of mental illness in the general population. From a clinical perspective, genetic syndromes may be missed in indigent patients and in patients who present predominantly with mental illness, even though they may have coexisting dysmorphic features and learning disabilities. Based on family, twin, and association studies, genetics clearly serves as the driving force behind mental illnesses, so it is essential that modern psychiatrists become trained to recognize dysmorphic features and other hidden clues to genetic syndromes in their mentally ill patients. By integrating genetic syndromes into the differential for mental illness, psychiatrists can engage genetic consultants, provide the best individualized care for their patients, and lead the way in discovering genes that cause mental illness.

No. 19C
COMMON DIAGNOSTIC CONFUSIONS, ADDICTIONS, DEPRESSION AND ASPD - WHICH IS WHICH?

Victor Hesselbrock, Ph.D. *University of Connecticut School of Medicine, Psychiatry, 263 Farmington Avenue, MC 2103, Farmington, CT, 06030-2103*

SUMMARY:

From both epidemiological data and clinical studies, persons with addictive disorders often have other co-morbid conditions. Similarly, patients presenting with either an affective disturbance or a behavioral disorder often have an underlying substance use disorder. The two most common conditions co-occurring with substance dependence (including alcohol dependence) are major depressive disorder with estimates ranging as high as 80% and antisocial personality disorder (ASPD) with estimates as high as 25%. It is well known that the pharmacological actions of a variety of substances, including alcohol, can produce symptoms of depression, particularly during the withdrawal state. Further, heavy use of alcohol and other substances can lead to behaviors that resemble conduct problems. This complex presentation of symptoms can lead to confusion on the part of the clinician, and successful unraveling of this difficult clinical picture is important for the development of an appropriate treatment plan. Unfortunately patients with a primary complaint of an affective disturbance are not always evaluated for substance use problems, while affective problems in patients with substance use problems persons are often viewed as unimportant. This presentation will provide an overview of several key research findings regarding the diagnostic issues surrounding the co-occurrence of depression, ASPD and substance use disorders. Further, the presentation will offer strategies on how these findings can be used inform clinical practice and enhance psychiatric training.

No. 19D
RECOVERING THE DIAGNOSIS OF POST-TRAUMATIC STRESS DISORDER IN PSYCHIATRIC TRAINING

Julian D. Ford, Ph.D. *UCHC, Psychiatry, 263 Farmington Avenue, Farmington, CT, 06030-1410*

SUMMARY:

More than half of all Americans experience a traumatic stressor in their lives, and as many as one in ten women and one in twenty men develop post-traumatic stress disorder (PTSD). Traumatic stressors place children and adults at risk not only for PTSD but also for a range of Axis I and II psychiatric disorders that often co-occur with and are exacerbated by PTSD (e.g., mood, anxiety, substance use, dissociative, eating, and Clusters B and C personality disorders). Children with serious emotional disturbance and adults with severe mental illness also are at risk for past and current experiences of traumatic stress and for complex debilitating forms of PTSD. Despite these compelling findings from epidemiological and clinical studies, many clinicians are skeptical about the importance of psychological trauma and PTSD in psychiatric nosology and treatment. Most psychiatry training programs relegate trauma and PTSD to minor roles in the curriculum and in practica and residency experiences, giving far greater emphasis to putatively more biologically-based syndromes such as the psychotic, affective, and mood disorders. However, a strong scientific evidence base demonstrates that trauma and PTSD involve significant neurobiological alterations, and powerful preclinical and clinical models are rapidly evolving to explain the biology of PTSD. This presentation will provide an overview of how key psychobiological findings and models of trauma and PTSD can can inform clinical practice, and how these scientific and clinical advances can enrich psychiatric education and training.

No. 19E
PAY ATTENTION ... THE IMPACT OF ADHD IN ADULTHOOD

Leighton Y. Huey, M.D. *University of Connecticut Health Center, Department of Psychiatry, 263 Farmington Ave, Farmington, CT, 06030-0001*

SUMMARY:

The field is many years past the point when it was originally thought that all ADHD in childhood ended in adolescence, that individuals simply "outgrew" ADHD. While devising operational criteria for the diagnosis of ADHD in adulthood has been problematic, perhaps as few as 10% and as many as 50-60% of children diagnosed with ADHD in childhood will continue to have some or all of the same symptoms as adults. The presence of Adult ADHD with other diagnoses has implications for treatment and outcomes and this becomes an issue in residency training. This paper will discuss the presentation of ADHD in Adulthood and ways to improve efforts to include this disorder as part of a comprehensive diagnostic assessment

REFERENCES:

1. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE: Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication. Arch Gen Psychiatry 2005; 62:593-602.
2. Meyer-Lindenberg A, Mervis CB, Faith Berman K: Neural mechanisms in Williams syndrome: a unique window to genetic influences on cognition and behaviour. Nature Reviews Neuroscience 2006; 7(5):380-93.
3. Schuckit MA Comorbidity between substance use disorders and psychiatric conditions. Addiction 2006; 101 Suppl 1:76-88.
4. Ford J: Treatment implications of altered affect regulation and information processing following child maltreatment. Psychiatric Annals 35:410-419; 2005.
5. biederman J: Attention deficit hyperactivity disorder: A lifespan perspective. Journal of Clinical Psychiatry, 1998; 59(7):4-49.

SYMPOSIUM 20—PSYCHIATRIC PRACTICE IN THE NURSING HOME

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants will be able to describe a behavioral management program in the nursing home, discuss clinical aspects of behavioral management in the nursing home, describe the administrative aspects of behavior managements, and identify challenges and rewards of conducting research in nursing home settings.

No. 20A
NURSING HOME CONSULTATION

Olivera J. Bogunovic, M.D. *VAWNY Hospital, psychiatry, 3495 Bailey ave, Buffalo, NY, 14215*

SUMMARY:

Five percent of population over age 65 currently live in skilled nursing home facilities. The prevalenc3 of psychiatric disorders in skilled nursing home facilities may go as high as 91-94%.

In the past nursing home residents were often sent to an outpatient clinic. Now many psychiatrists use the psychiatrist consultation liaison model to provide psychiatric care for the residents.

The geriatric psychiatrist in the nursing home focuses on clinical care (doing psychiatric assessment and treatment, observing OBRA standards, resolving conflicts between patient and staff, helping caregivers cope with dementia care, crisis management, team meetings, end of life care); administrative issues (psychiatrist is at times a liaison with medicine, nursing and social work, ethics committee, medical committee);education of staff; research and provides expert testimonies. Two models for nursing home reimbursement are available. In the first model the consultant and the nursing home agree to an hourly rate for psychiatric services and the nursing home bills the patient or third party. The other model is fee for services. The requirement for requesting a consultation in the nursing home and the documentation for completing a consultation will be reviewed.

No. 20B
RESEARCH IN THE SKILLED NURSING FACILITY: IT IS DIFFERENT?

Sanjay Gupta, M.D. *Olean General Hospital, Department of Psychiatry, 515 Main St, Olean, NY, 14760-1513*

SUMMARY:

There has been recent interest in conducting trials in elderly patients in skilled nursing facilities (SNFs), as little was known about the use of psychotropic medications in the elderly especially the group over the age of 85. However, doing clinical trials in the SNFs still presents many challenges. Setting up and staffing a trial center, present many obstacles, especially if the center is going to be involved in nursing home trials. There are several other important issues such as gathering accurate data, protocol compliance and reporting of serious adverse events in a timely fashion to the research team. There are key personnel in the SNF who could make or break a study. Trying to get protocols approved by Institutional Review Boards who often have mixed feelings about the inclusion of the elderly in research often requires a very persistent approach. Recruitment strategies are a vital part of running a successful trial, and there are also many concerns about obtaining informed consent, especially in cognitively impaired or severely depressed or psychotic patients. All this occurs in the context of ever shrinking budgets and more and more competition from other clinical trials in the SNFs is very rewarding. Whilst there are many ethical concerns about including this potentially vulnerable population in research, for many patients it provides improved medical care, and provides the scientific basis for evidence based medicine that is all the rage now. Conducting a trial also brings education to the SNF staff. This talk will focus on the various nuances of conducting clinical trials in the SNFs, including dealing with key personnel, open communication, and building lasting relationships.

No. 20C
BEHAVIOR MANAGEMENT PROGRAM

Subramoniam Madhusoodanan, M.D. *St. John's Episcopal Hospital, Psychiatry, Beach 19th St, 327, Far Rockaway, NY, 11691*

SUMMARY:

The increasing number of psychiatric patients in the nursing homes, regulatory requirements like the OBRA 87 and new FDA warning regarding antipsychotic medications warrant the need for establishing behavior management programs. The goals are to minimize abusive behaviors, protect residents and staff, promote diversional care and activites, prevent resident to resident/staff altercations and improve quality of life. An overview of the process for behavior management is identification of problematic behaviors, assessments from various disciplines, comprehesive documentation of the behaviors, development of an individualized plan of care, and evaluations of the effectiveness of the plan's intervention. Multidisciplinary treatement is the cornerstone approach of the program. The team identifies the poblem behavior, appropriate treatment plan is formulated and put into effect and caregivers are inserviced with respect to the psychiatric, psychological and behavior manifestations of the mental disorder, including the triggers and links to prior roles.

Identification of barriers to the use of the program will be reviewed and solutions will be discussed. The expected outcome is resolution or reduction of frequency of problem behaviors, resulting in improved quality of care and quality of life to all nursing home residents.

REFERENCES:

1. Gupta S,Goldstein M.Psychiaric Consultation to Nursing Home.Psych Services 1999;50(12):1547-1550.
2. Jones JK: Continuing to Conduct Research in Nursing Homes Despite Controversial Findings: Reflections by a Research Scientist .Qualitative Health Research, Vol. 13, No. 1, 114-128 (2003).
3. Symposium presented 2006 AAGP Puerto Rico, USA.
4. Madhusoodanan S, Bogunovic O. The switching of risperidone to olanzapine in elderly nursing-home patients with dementia: a retrospective study. CNS Spectr. 2007 Jan;12(1):46-50.

SYMPOSIUM 21—CHILDREN OF IMMIGRANTS IN THE CHANGING MOSAIC OF THE U.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will understand the acculturation processes of immigrants and the children of immigrants, and apply this knowledge in practice to improve cultural competence.

No. 21A
A PERSONAL INTRODUCTION

Consuelo C. Cagande, M.D. *RWJMS - Cooper University Hospital, Psychiatry, 401 Haddon Ave, Rm 352, Camden, NJ, 08103*

SUMMARY:

Filipinos are products of "multicultural people" (i.e. Chinese, Spanish, Indonesian, American, Muslim). My blood is a mixture of Chinese, Japanese, and Spanish. Immigrating to the United States with my family when I was 5 years old allowed us to lay down new roots to the changing mosaic of this country. There will be presenters who will provide more detailed personal experiences and insight into being a child of immigrants and an immigrant parent. Each presentation will provide a unique educational experience and enhance the audience's cultural competence.

No. 21B
CHILDREN OF IMMIGRANTS: AN OVERVIEW

R. Rao Gogineni, M.D. *Robertwood Johnson Medical School, Psychiatry, 1 Bala Ave Ste 118, 118 one Bala ave, Bala Cynwyd, PA, 19004-3207*

SUMMARY:

About 20% of U.S. children are immigrants or children of immigrants,up from 13% in 1990.Great majority of New Immigrants are from Latin America or Asia.Socioeconomic demographics,country of origin,ehnicity,language conflicts,gender,refugee/visa status,religion,compatability,age of entry into U.S.,Family seperations,Family

level of acculturation,intergenerational conflicts,levels of education,peer relationships,acceptance by neighborhood/larger culture,-preparedness of schools,parentaral involvement in education,exposure to trauma etc. contribute to outcome of these youth.Protective/ rescilient factors of Family cohesion/resources,neighborhood cohesion,self esteem,social skills,innate intelligence,social agencies help these youth to overcome barriers.

'The results can be variable.Problem bevaviors of conduct disordered bevaviors,violene,running away,gang involvement,school failure,depression,suicide can be higher.Or children of immigrants can become much succesful,creative than others as it has been since formation of U.S.A.

Proper adaptation,establishment of bicultural identity are 2 helpful tools in overcoming some of the obstacles.But larger issue remains with the larger community in providing array of multicultural interventions

No. 21C
BALANCING ACT BETWEEN TWO CULTURAL IDENTITIES

Alyssa S. Kwon, M.D. *UMDNJ-RWJMS Cooper University Hospital, Dept of Psychiatry, 401 Haddon Ave, Camden, NJ, 08103*

SUMMARY:

To better grasp the struggles which immigrant children experience in the United States, I will discuss various socio-cultural aspects of immigrant life and their contributions on the formation of self-identity. The discussion will include an autobiographical examination of the acculturation process during childhood, adolescence, and young adulthood, family dynamics (particularly role reversal, resilience, attachment etc.), and concerns faced while contending with society at large. The presentation will discuss how these elements contribute to the formation of a bicultural identity and prevention of pathological forms of identity. Examples gained from personal experiences as a child of Korean immigrants in the United States will be used to illustrate the main points.

No. 21D
AN IMMIGRANT PARENTAL JOURNEY - TRIALS, TRIBULATIONS AND TRIUMPHS

Dilip Ramchandani, M.D. *Drexel University College of Medicine, Psychiatry, 241 Merion Rd, Merion Sta, PA, 19066-1718*

SUMMARY:

The presenter, an immigrant psychiatrist from India, will utilize brief personal vignettes to illustrate themes of affirmation, assimilation, education, ethnicity, identity, language, racial differences and religion that emerged in his experience as a father.

No. 21E
THE SECOND GENERATION: RISKS AND OPPORTUNITIES

Andres J. Pumariega *The Reading Hospital and Medical Center, Psychiatric Department, 6th Ave and Spruce St, Reading, PA, 19611*

SUMMARY:

The second generation of immigrants to the United States often present our brightest and most valuable resource. Amongst second generation immigrants are numerous achievers who have shaped the landscape of this nation.The second generation also presents our best linkages to the cultures of origin from which they came from, serving to bridge cultural practices and influencing American culture through their modification and integration of their traditional values and beliefs into the mainstream culture. At the same time, the second generation is often conflicted between the more traditional values and beliefs of their parents and the mainstream culture, particularly peer culture. As a result, the risk of problems such as margination, over-acculturation, and overall alienation are high in the second generation of immigrants. Thes risks contribute to increased vulnerability for mental health morbidities in second generation immigrant youth, including suicidality, substance abuse, conduct disturbances, and eating disorders. This presentation will sum up the previous ones on the upbringing of immigrant youth and place them in the context of the literature that points to these opportunities and risks. It wil also discuss how mental health services can be more sensitive to the needs of 1st/ 2nd generation immiigrant families in order to address these critical challenges.

REFERENCES:

1. McGoldrick M, et al: Filipino Families. In Ethnicity & Family Therapy, edited by McGoldrick M, Giordano J, Garcia-Preto N, New York, The Guilford Press,, pp 319–331.
2. Carola Suarez-Orozco,Marcelo M Suaraz-Orozco —Children of Immigration by Harvard University Press.,2001.
3. Akhtar S: Immigration and Identity. Northvale, Jason Aronson Inc, 1999.
4. Gupta k: Intergenerational cultural differences: learning from the experiences of immigrant families from India. Dissertation Abstracts International 2005; 66(4B):2307.
5. Pumariega AJ, Rothe E, & Pumariega JB. Mental Health of Immigrants and Refugees. Comm Mental Health J 2005 41: 581–59.

SYMPOSIUM 22—UPDATE ON SUPPORTIVE PSYCHOTHERAPY

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation the participant should be able to understand and integrate the different theories underlying supportive psychotherapy.

At the conclusion of the presentation the participant should be able to understand and integrate useful techniques based on the theories underlying supportive psychotherapy.

No. 22A
THEORY OF SUPPORTIVE PSYCHOTHERAPY

Arnold Winston, M.D. *Beth Israel Medical Center, Department of Psychiatry, 1st Avenue And 16th St, New York, NY, 10003*, Michael Goldstein, M.D.

SUMMARY:

Supportive psychotherapy is based on a number of theoretical approaches, which must be integrated by the therapist in the treatment of individual patients. Psychoanalytic theory is generally viewed as the basis for supportive psychotherapy, with an emphasis on ego psychology and development, object relations theory, self psychology issues, and interpersonal and relational approaches. The emphasis is on relational/interpersonal issues and the self within the reality of the present every day world, as opposed to working on conflict, instinctual issues and focusing on the past. The therapist serves as an attachment figure providing a secure base for the patient. A major outgrowth of the psychoanalytic/dynamic approach is the conceptualization of the psychopathology/ psychotherapy continuum, which matches the patient's psychopathology to the appropriate psychotherapy within the supportive/expressive spectrum.

Supportive psychotherapy also utilizes many ideas and techniques derived from cognitive-behavioral therapy. Cognitive-behavioral techniques are an indispensable part of supportive psychotherapy and can be used for targeted problems such as panic, depression,

phobias, obsessive-compulsive symptoms and dysfunctional thinking.

Learning theory also can contribute to the techniques of supportive psychotherapy, but unfortunateley learning theory has not been incoporated into most forms of psychotherapy in a systematic fashion. A great deal of supportive psychotherapy can be conceptualized as helping patients learn about their illness and how to behave in a more adaptive manner. Some important concepts of learning theory such as critical reflection, generation, interleaving, attention, processing, interpretation and elaboration will be discussed and applied to supportive psychotherapy.

No. 22B
HISTORY OF SUPPORTIVE PSYCHOTHERAPY

Stephen J. Rojcewicz, Jr., M.D. *13808 Old Columbia Pike, Silver Spring, MD, 20904-4554*

SUMMARY:

Supportive psychotherapy has a venerable tradition through medical history and the history of ideas, and even more broadly, the history of civilization. The ancient Greeks emphasized treating the mentally ill humanely, and pioneered overall emotional support for persons in crisis.

An examination of the linguistic background for the word therapy, passages from the epics of Homer and Greek dramatists, ancient medical works, the classic writings of Shakespeare and Cervantes, and eighteenth-century psychiatrist will reveal the precursors and cultural background of supportive psychotherapy.

No. 22C
RESEARCH ON SUPPORTIVE PSYCHOTHERAPY IN THE TREATMENT OF BORDERLINE PERSONALITY DISORDER

David J. Hellerstein, M.D. *Columbia Presbyterian Medical Center, 180 Fort Washington Ave # HP256, New York, NY, 10032-3734,* Barbara H. Stanley, Kimberly Kotov, Ph.D., Ron Aviram, Ph.D.

SUMMARY:

Purpose: We have adapted Supportive Psychotherapy (SPT) for patients with borderline personality disorder (BPD) and self-injurious and suicidal behavior, for purposes of comparison to Dialectical Behavioral Therapy (DBT) in an NIMH-funded research study led by Dr. Barbara Stanley, Principal Investigator. SPT has been adapted to focus specifically on clinical issues relevant to borderline personality, and is conceptualized as an active, change-oriented treatment approach.

Methods: The study compared DBT and SPT in a cohort of patients with borderline PD, in a 4-cell randomized prospective design, including assignment to DBT vs. SPT, and fluoxetine vs. placebo treatment. SPT was provided in individual 50-minute sessions once per week for 1 year. Outcomes were determined at 6 and 12 months on measures including treatment retention, depression, suicidal behaviors, and self-injurious behavior. This analysis will present data for the SPT cell of the study.

Results: Thirty-eight subjects were assigned to SPT. 79% of SPT subjects were female, with a mean+SD age of 32.6+10 years. Race was 47% Caucasian, 32% Latino, 16% African American. 73% had single marital status. At baseline, subjects scored a mean of 11.2+5.1 on the 17-item Hamilton Depression Rating Scale. Patients had a mean of 22.8+24.4 incidents of self-injurious behavior over the prior 2 months, and a history of 2.1+1.9 lifetime suicide attempts. Results at 6 and 12 months follow-up demonstrated a high rate of retention of patients in SPT. There were significant decreases over time for SPT-treated subjects in self-rated and clinician-rated depressive symptoms, as well as in suicide attempts and in self-injurious behavior.

Conclusions: This analysis of data from a larger study suggests that supportive psychotherapy can be effectively adapted for severely impaired patients, such as those with borderline personality disorder, and that SPT treatment may be associated with a variety of positive outcomes. Further research on SPT as an active treatment approach is indicated.

No. 22D
USE OF SUPPORTIVE PSYCHOTHERAPY IN ADJUSTMENT DISORDERS.

Roger Peele, M.D. *413 King Farm Blvd Apt 401, Rockville, MD, 20850-6680,* Vicenzio h. perkins, M.D., Mozhdeh Roozegar, M.D., maryam razavi, M.D.

SUMMARY:

Supportive psychotherapy of Adjustment Disorders aims at assuring the illness is self-limited, does not become chronic, and has minimal impact on the patient's educational, occupational or social activities, through:

1. Exploring practical environmental changes that will remove or lessen the stress.
2. Helping the patient managed the signs of anxiety or depression and avoid untoward behaviors in reaction to a stress.
3. If the stress cannot be removed, then helping the patient reduce the stress through support and education.
4. Develop coping skills to address the stress.

In addition to general supportive psychotherapy, specific forms of supportive psychotherapy are used such as Sifneos's brief psychotherapy or Wise's BICEPS, three day, therapy [BICEPS = brevity, immediacy, centrality, expectance, proximity, and simplicity].

Supportive psychotherapy may not only lead to eliminating the Disorder, but has the potential to increase the patient's resilience in the fact of future stresses.

No. 22E
TEACHING SUPPORTIVE PSYCHOTHERAPY TO PSYCHIATRIC RESIDENTS

Carolyn J. Douglas, M.D. *Columbia University Medical Center, Psychiatry, 345 East 84th Street, 1, New York, NY, 10028*

SUMMARY:

Formerly regarded as the "Cinderella of psychotherapies" [Sullivan, 1971] requiring no special training or abilities beyond good common sense, interpersonal skills and a capacity for empathy, over the past several decades supportive psychotherapy has gradually assumed its rightful position of greater importance within the didactic curriculum of most residency training programs. However, there remain significant differences of opinion about how it should be taught to psychiatric residents. Some continue to teach supportive therapy as one of the psychodynamic psychotherapies, conceptually based on the psychoanalytic frame of reference [Rockland 1989], while others have argued that supportive therapy should be taught as an "atheoretical" body of techniques divorced from any one particular model of how the mind works [Pinsker, 1994]. Furthermore, among proponents of the first view, there is continuing controversy about whether it is more useful, for heuristic purposes, to teach supportive therapy as a "pure culture" form of treatment with its own special and distinct set of techniques and thereby distinguish it as much as possible from more "expressive" or "exploratory" approaches, or whether it should be taught as a dimension of psychodynamic psychotherapy, present to a greater or lesser extent depending on the particular problems and needs of the person. Dr.

Douglas will discuss these controversies and describe an approach to teaching that seeks to integrate these varying points of view.

REFERENCES:

1. Winston A, Rosenthal RN, Pinsker H: Introduction to Supportive Psychotherapy. Washington, DC, American Psychiatric Press, 2004.
2. Lain Entralgo, P: The therapy of the word in classical antiquity. New Haven: Yale University Press, 1970.
3. Aviram RB, Hellerstein DJ, Gerson J, Stanley B. Adapting supportive psychotherapy for individuals with borderline personality disorder who self-injure or attempt suicide. Journal of Psychiatric Practice 2004;10:145-155.
4. Novalis P, Rojcewicz S, Peele R: The Clinical Manual of Supportive Psychotherapy. Arlington, VA. American Psychiatric Press, 1993.
5. Winston A et al. Introduction to Supportive Psychotherapy.Washington DC, American Psychiatric Publishing, Inc., 2004.

SYMPOSIUM 23—FIRST BREAK SCHIZOPHRENIA IN FRANCOPHONE AND ANGLOPHONE COUNTRIES: TREATMENT AND NEUROIMAGING: VIVE LA DIFFERENCE

French Psychiatric Association

EDUCATIONAL OBJECTIVES:

Be more confident that early recognition of psychotic disorders and more active and sustained biopsychosocial treatment is an essential stratey in improving health outcomes for young people.

No. 23A
EARLY INTERVENTION IN PSYCHOSIS: AN EVIDENCE-BASED REFORM

Patrick D. McGorry, M.D. *ORYGEN Research Centre, University of Melbourne, Dept. of Psychiatry, 35 Poplar Road, Parkville, Victoria, 3052, Australia*

SUMMARY:

The past decade has witnessed an exponential rise in interest and research evidence relevant to early diagnosis and preventive intervention in psychotic disorders. This has raised all the usual issues pertinent to early diagnosis in medicine in that the risk benefit ratio shifts as intervention is extended to earlier phases of disorder. A key issue is that the need for care clearly precedes the capacity to assign a classic and stable syndromal diagnosis. Conversely, for most patients this is an academic issue, since delayed care even when a clearcut psychotic diagnosis is present is the rule rather than the exception. The evidence base is growing steadily and the worldwide reform in early psychosis is arguably the most evidence-based and academically-led reform process that we have so far witnessed in psychiatry. There is evidence that treatment delays, engagement, medication adherence, relapse rates, vocational recovery and suicide rates are all improved by streamed early psychosis care. An emerging problem however is narrowing the efficacy-effectiveness gap such that the work practice of clinicians and services draws on and delivers evidence-based care for patients in the critical early psychosis period.

No. 23B
CANNABIS USE AND PAST TREATMENT IN FIRST PSYCHOTIC EPISODE

Olivier J. CANCEIL, Psy.D. *Sainte Anne Hospital, INSERM U796, Paris V University, Service Hospitalo-Universitaire, 1, rue Cabanis, PARIS, F-75014, France*, Fayçal MOUAFFAK, M.D., Yannick MORVAN, Psy.D., Marie-Odile KREBS, Ph.D.

SUMMARY:

The cannabis use significantly increased from 1993 to 2003 in France: in the ESPAD Study, conducted in schools, 53% of the male subjects and 47% of the female subjects of 17 years of age used cannabis at least once in 2003, vs. 25% and 17% respectively in 1993. Cannabis use is particularly frequent in patients with psychotic disorders, mood disorders and personality disorders and worsens the course of these disorders. Lifetime prevalence of exposition, abuse or dependence on cannabis in psychiatric inpatients at first admission and comparison of the clinical features between cannabis abusing patients vs. non-exposed patients were studied in patients consecutively admitted for their first time in 11 department of psychiatry. In 132 patients included, lifetime prevalence of cannabis exposure was 67% and 36% had lifetime diagnosis of abuse or dependence on cannabis. The mean age at first exposure to cannabis was 17.3 $\pm$ 3.3 years old. Cannabis-abuse or dependence was more frequently associated with disorganization and schizotypy. The differences in the severity of psychiatric symptoms seen at admission were reversed by treatment, suggesting an acute effect of cannabis and/or a good responsiveness to antipsychotics.

Preliminary results in 105 in- and outpatients treated for a first psychotic episode, without previous structured care at inclusion, show that 30% are regular alcohol consumers, 63 % are smokers and 67% are regular cannabis consumers, with a lifetime prevalence of cannabis exposure of 75%. Only a third of them have never received a psychotropic medication and 15% take only an antidepressant treatment at their first contact in a specialized psychiatric service. The first results of this study are presented, examining particularly the role of cannabis on outcome.

No. 23C
PREVENTING SCHIZOPHRENIA: AN INTERNATIONAL INITIATIVE

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

SUMMARY:

The international field of schizophrenia research has witnessed considerable interest in the potential that early detection and intervention may hold for preventing this chronic disorder. This includes studies demonstrating that early detection is possible both after onset (i.e., during the first episode) and before onset (i.e., during the prodromal phase of illness development). Early detection in first episode schizophrenia aims to reduce the duration of untreated psychosis and to track the earlier detected patients over time compared to non-early detected patients. Such a project (from Norway and Denmark) will be presented that demonstrates how successful early detection reduces the severity of symptoms and the extent of collateral damage associated with onset of psychosis, an example of tertiary prevention. One-year follow-up data from the same project addresses the question of whether reducing the duration of untreated psychosis also reduces progression of disorder (chronicity) and confers secondary prevention in first episode schizophrenia. Identifying people prior to onset of psychosis is a second early detection and intervention strategy and targets persons in their prodromal stage of a first break of psychosis. Treatment intervention at this stage can delay or prevent the onset of illness. A double-blind, placebo-controlled randomized

trial of an atypical neuroleptic (Olanzapine) will demonstrate the benefits and risks of this approach. Concluding remarks will address the current state of prevention in schizophrenia.

No. 23D
EVALUATION OF HOSPITAL-BASED CARE FOR SCHIZOPHRENIA

Karen A. Ritchie, Ph.D. *INSERM Unit E361, Hopital La Colombiere, 39 Ave Charles Flahault, Montpellier, 34493, France*

SUMMARY:

Schizophrenia is characterized by profound disruption in cognition and emotion, affecting the most fundamental human attributes: language, thought, perception, affect and sense of self. The insidious onset of symptoms combined with the social disabilities and decision-making difficulties of patients leads to delays in treatment which are now known to be linked to poorer prognosis (Drake 2000). Evidence showing a relationship between delays in symptom stabilisation and prognosis have given rise to the hypothesis that untreated psychosis may in itself have a neurotoxic effect on the brain. Treatment delays arise due to a combination of delays in seeking treatment and difficulties in establishing the appropriate treatment in the hospital setting. In Europe and the United States there has been a general trend towards decreasing the duration of hospital care. In France on the other hand this shift has been only partially adopted so that the French system provides an excellent opportunity for the direct comparison of different approaches to care within the same catchment areas. The STEP longitudinal cohort study of first episode psychosis in the south of France examines the contribution of cognitive, social, pharmacogenetic, clinical and treatment factors to delays in seeking treatment, prolonged hospitalization and prognosis at one year. The first cross-sectional results of this study are presented, examining particularly the role of cognitive factors in determining delays to treatment and discharge.

No. 23E
TREATMENT OF FIRST EPISODE PSYCHOSIS: IMPORTANCE OF DRUG SELECTION AND EARLY INTERVENTION

Jeffrey A. Lieberman, M.D. *NYSPI - Columbia University, Psychiatry, 1051 Riverside Drive, Unit #4, New York, NY, 10032*

SUMMARY:

The first episode of psychosis is a critical opportunity for treatment of patients that could determine the long-term outcome of their illness. This presentation will review the studies of the comparative effectiveness of antipsychotics and strategies to deliver treatment earlier after the onset of symptoms. The results indicate that first episode patients respond very well to medications, require lower doses than chronic patients and are very sensitive to side effects. In addition, the shorter the symptom duration prior to treatment the better the treatment response. The results of American and European studies will be comapred and discussed.

No. 23F
NEUROIMAGING IN PATIENTS WITH FIRST PSYCHOTIC EPISODE

Olivier Maiza, M.D. *Cyceron center, Cyceron center, Caen, 14000, France*, Olivier Maiza, M.D. *CNRS, Cyceron center, Caen, 14000, France*, Olivier Maiza, M.D. *Centre Hospitalier et Universitaire, Cyceron center, Caen, 14000, France*, Annick Razafimandimby, Ph.D., Pascale Abadie, Laurent Lecardeur, Bernard mazoyer, M.D., Nathalie Tzourio-Mazoyer, M.D., Sonia Dollfus, M.D.

SUMMARY:

Over the past two decades, neuroimaging techniques have provided extensive data on structural and functional abnormalities in patients with schizophrenia. Studies in patients with first psychotic episode are of particular interest to investigate the pathophysiology of schizophrenia. They can obviate the effects of confounding factors such as medication and chronicity of illness. They can also give new insight in the temporal course of cerebral abnormalities and sort out the neurodevelopmental or neurodegenerative hypothesis. Investigating the neural network of cognitive functions, well known to be impaired in schizophrenia, is also crucial since the question of their plasticity with cognitive remediation is still open.

Several structural imaging studies have addressed these questions. They have evidenced that ventricular enlargement and temporal structures reduction are present at the very beginning of the disease and worsen over time, especially in the first years of the illness. Such results have suggested a mixed process both developmental and neurodegenerative.

So far, few functional neuroimaging studies have been published. Most of them investigated working memory and evidenced a functional deficit of dorsolateral prefrontal cortex during these tasks. In the present study, we wanted to investigate the neural networks underlying a high level cognitive function, the theory of mind (ToM), in patients with first psychotic episode. ToM is the ability to infer another's beliefs and intentions and involve a network constituted in particular of a core cerebral region, the medial superior frontal gyrus. Demonstrating a functional deficit in the ToM network in patients with first schizophrenia episode as they are implicated in ToM processing could suggest a neural basis for impaired social interaction and communication as of the beginning of illness.

REFERENCES:

1. McGorry PD: Early intervention in psychotic disorders: beyond debate to solving problems. Br J Psychiatry 2005; 48:s108-s110.
2. Krebs MO, Goldberger C, Dervaux A. Cannabis use and schizophrenia. Am J Psychiatry 2005; 162(2): 401-2.
3. McGlashan TH, et al: Randomized, double-blind trial of olanzapine versus placebo in patients prodromally symptomatic for psychosis. Am J Psychiatry 2006; 163:790-799.
4. Amminger GP. Duration of untreated psychosis and cognitive deterioration in first-episode schizophrenia Schizophrenia Research 2002; 54: 223-230.
5. Miyamoto S, Duncan GE, Marx CE, Lieberman JA: Treatments for schizophrenia: a critical review of pharmacology and mechanisms of action of antipsychotic drugs. Molecular Psychiatry 2005; 10(1):79-104.
6. Shenton ME et al.A review of MRI findings in schizophrenia. Schizophrenia Research 2001.49.1-2. 1-52.

SYMPOSIUM 24—CHALLENGES AND NEW DEVELOPMENTS IN THE PSYCHIATRIC EDUCATION OF MEDICAL STUDENTS

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to:

1. Cite concrete examples that reflect the stigmatization of psychiatric material in medical school education.
2. Discuss possible reasons for the persistance of the stigmatization of psychiatric material in medical student education.
3. Discuss new means by which this stigma can be overcome within medical school curricula and throughout medical educational opportunities.

No. 24A
PSYCHIATRIC STIGMA IN MEDICAL STUDENT EDUCATION

Steven C. Schlozman, M.D. *Massachusetts General Hospital, Department of Psychiatry, 55 Fruit Street, Yawkey Center for Outpatient Care, Suite 6900, Boston, MA, 02114*, Mary Anne Badaracco, M.D.

SUMMARY:

Stigma and bias against psychiatry as a discipline is hardly a new phenomen. In spite of the very high prevalence of psychiatric disorders, the remarkable advances in recent times in the ability to both understand and treat psychiatric illness, and the fact that most psychiatric patients present to physicians who are not psychiatrists, medical school curriculums continue to reflect a persistant bias against psychiatric material to the detriment of our future physicians and our patients. Psychiatric concepts are often given little time and attention in the medical cannon. Students routinely tell their psychiatric mentors that advisors who are not psychiatrists have counseled them against careers in psychiatry for a variety of reasons that are best described as prejudiced and biased. Add to this fact that the psychiatric clerkship at most medical schools is no more than 6 weeks and for many schools only 4 weeks. This is often far short of the time necessary for students to appreciate and understand the fundementals of psychiatry that national organizations have deemed important for physicians of the 21rst century. How does this stigma manifest throughout the traditional four years of medical education? In what ways do these biases affect the perception that our students have of psychiatric suffering and psychiatric treatment? This presentation will summarize data detailing the stigma that characterizes psychiatric education in many medical schools, will suggest means by which this stigma can be overcome, and will propose that with a new psychiatric educational activism, these biases can be diminished and their corresponding misconceptions erased.

No. 24B
THE LATENT CURRICULUM AND THE EMOTIONAL DEVELPOMENT OF MEDICAL STUDENTS

Eric R. Marcus, M.D. *Columbia University, Psychiatry, 4 E 89th St, 1D, New York, NY, 10128-0636*

SUMMARY:

The latent cirriculum in medicals education is the experiences we expose medical students to and the attitudes we convey along with our teaching and supervising. This emotional information is formative in shaping developmental capacities like empathy and caring. These emotional capacities are of great concern to psychiatric educators yet we often overlook the latent cirriculum. This paper will discuss what the latent cirriculum is, how it is conveyed and what are its effects in psychiatric education.

No. 24C
AMBULATORY EXPERIENCES IN THE PSYCHIATRY CLERKSHIP

Tamara L. Gay, M.D. *university of Michigan, Psychiatry, 2650 Alex Dr, Ann Arbor, MI, 48103-9665*

SUMMARY:

Medical Education is rapidly moving from hospital based teaching to the ambulatory setting. Third year Psychiatry core clerkships present special challenges as we attempt to shift our educational emphasis to out-patient clinics.

At the University of Michigan we began a six week ambulatory based clerkship in May 2005. Our departmental goal with respect to medical students is to ensure all graduates are able to successfully evaluate, provide initial treatment, and appropriately refer patients with common psychiatric disorders(emphasizing depression, anxiety, and substance abuse) in every medical setting as those illnesses present over the patients lifespan. Currently approximately 60% of our University based student's time is spent in out-pt. settings including child, addiction, and geriatric psychiatry. This allows students to learn and perfect the actual skills they will need in future office based clinical practice.

Sttudent evaluations of the ambulatory portions of the clerkship and shelf scores will be highlighted. Comparisons to a prior year's hospital based clerkship willl be made.

No. 24D
INTERDISCIPLINARY AND LONGITUDINAL INTEGRATION DURING CLINICAL TRAINING

Adam M. Brenner, M.D. *University of Texas Southwestern Medical School, Department of Psychiatry, 5323 Harry Hines Blvd, Dallas, TX, 75390-9070*, Derri Shtasel, M.D.

SUMMARY:

In the traditional model of the clinical curriculum in medical school, students rotate from clerkship to clerkship, and often from hospital to hospital, with little attempt to integrate and coordinate their learning across these clerkships. This absence of a coordinated curriculum can contribute todiscontinuity in the student's experience, redundancy of some areas of teaching and gaps in others, and the loss of significant learning opportunities. Some medical schools have been experimenting with new approaches to these problems, including the recent piloting of a Principal Clinical Experience (PCE) at some of Harvard Medical School's (HMS) core teaching hospitals. These PCE's, including programs at Cambridge Hospital and Brigham and Women's Hospital, involve students in a year long immersion at the hospital. They aim to provide multidisciplinary teaching, integration of basic science, clinical learning, and interpersonal skills, and longitudinal development of the students. At HMS, the Dept of Psychiatry has been centrally involved in the planning and delivery of these new curricula. The presentation will review these developments at HMS and elsewhere, and address the following: What advantages and potential disadvantages lie in integrated clinical curricula? What is the future of the traditional psychiatry clerkship in an integrated third year curriculum? What role should psychiatry faculty play in multidisciplinary teaching of clinical medicine? Should psychiatry faculty take a leading role in the development and implementation of attempts to integrate the development of interpersonal skills and professional values in the clinical years?

REFERENCES:

1. Cutler, JL: Psychiatry education for medical students. Challenges and Solutions. Acad Psychiatry 2006; 30: 95-97.
2. Marcus, ER: Medical student dreams about medical school: The unconscious developmental process of becoming a physician. Int. J. Psa. 2003; 84: 1-20.
3. Bordage G, BurackJ, IrbyD, Stritter F. Education in Ambulatory Settings: Developing Valid Measures of Educational Outcomes, and Other Research Priorities. Acad Med. 73:743-750, 1998.
4. Davies T, McGuire P: Teaching Medical Students in the New Millenium. Psychiatric Bulletin 2000; 24: 4-5.

SYMPOSIUM 25—INNOVATIVE WAYS IN PSYCHOTHERAPY SUPERVISION: THE SHORT TERM DYNAMIC THERAPY EXPERIENCE

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant will acquire knowledge about the process of learning psychotherapy using Short-

Term Dynamic Psychotherapy as an example including: (1) Use of technological means to facilitate supervision, (2) Difficulties encountered by trainees, and (3) planned systematic ways to address them in supervision.

No. 25A
INNOVATIVE WAYS INPSYCHOTHERAPY SUPERVISION: THE SHORT TERM DYNAMIC THERAPY EXPERIENCE

Amir E. Ettekal, M.D. *8730 Alden Drive #W101, Los Angeles, CA, 90036*

SUMMARY:

In today's technically advanced world supervisors and supervisees have access to numerous non-invasive tools for psychotherapy supervision. Training future psychotherapists has utilized videotaping, audio taping, and more recently one-way-mirror live supervision with text messaging, and open phone lines using small earpieces. Of the numerous psychotherapeutic modalities, Intensive Short Term Psychodynamic Therapy (ISTDP) made early use of videotaping in the teaching process. ISTDP is a time-limited psychotherapy that is gaining more attention as an effective and efficient treatment modality for a variety of psychiatric disorders. Training in this particular modality requires the trainee to have an adequate knowledge base of psychodynamic theory, and to acquire new therapeutic skills throughout the process. The highlights of these skills include assuming an active role, helping the patient to develop specific dynamic foci, challenging defensive styles, and placing the patient in direct touch with repressed impulses and feelings. For trainees, learning these new skills can be initially difficult. The trainee has to change his or her stance from the traditional active listener role to an active participant who confronts defenses, evokes and tolerates intense emotions and helps develop insights. The supervisor's role is to help the trainees develop a psychodynamic understanding of the patient's problems, to identify the patient's responses in the therapeutic interaction including verbal and non-verbal communication guiding the trainee in making the most appropriate interventions. Using ISTDP as an example, we will examine the nuances of such supervision, elucidating our experience with videotape as well as the other aforementioned technological advances. By the end of this session the participant will gain better insight into the use of supervision modalities, get a basic understanding of ISTDP, and be involved in an active discussion about the psychotherapy learning-teaching process.

REFERENCES:

1. Goldberg DA: Structuring training goals for psychodynamic psychotherapy. J Psychother Pract Res, 7:1, 10–22, 1997.
2. Gold JH. Reflections on psychodynamic psychotherapy supervision for psychiatrists in clinical practice. J Psychiatr Pract. 2004 May;10(3):162–9.
3. Abbass A. Small-group videotape training for psychotherapy skills development. Acad Psychiatry. 2004 Summer;28(2):151–5.
4. Shanfield SB, Hetherly VV, Matthews KL. Excellent supervision: the residents' perspective. J Psychother Pract Res. 2001 Winter;10(1):23–7.

SYMPOSIUM 26—ALEXITHYMIA AND EMOTIONAL DYSREGULATION: FROM THEORY TO CLINICAL PRACTICE

EDUCATIONAL OBJECTIVES:

At the end of the presentation, the participant should be able to understand the specific associations between alexithymia and depressive dimensions in eating disordered patients.

No. 26A
DEPRESSION AND ALEXITHYMIA IN EATING DISORDERS

Maurice Corcos *Institut Mutualiste Montsouris, Service de Psychiatrie, 42, boulevard Jourdan, Paris, 75014, France*, Gwenole Loas, Jean-Luc Venisse, Paul Bizouard

SUMMARY:

Objectives: This study examined alexithymia and depressive experiences in patients with DSM-IV-TR eating disorders (restricting anorexia, N = 105; purging anorexia, N = 49; bulimia nervosa, N = 98) and matched controls (N=279).

Method: Subjects were assessed with the Toronto Alexithymia Scale (TAS-20), the Beck Depression Inventory (BDI), and the Depressive Experience Questionnaire (DEQ), which defines two types of depressive personality styles (dependent and self-critical).

Results: The eating disordered patients had high levels of alexithymic features and depressive symptoms.

Comparisons of alexithymic features between patients and patients and controls, after adjustment for depression, showed a significant difference between bulimic patients and controls for the TAS Difficulty Identifying Feelings factor, and between restricting anorexic patients and controls for the TAS Difficulty Describing Feelings factor.

With regard to depressive personality styles, only scores of the self-critical dimension were significantly higher in bulimic patients than in the restricting anorexic patients and controls.

In the entire group of eating disorders, dependency was associated with the TAS Difficulty Identifying Feelings factor only in anorexic patients.

Self-criticism was associated with the TAS difficulty Identifying Feelings factor in all subtypes of eating disorders, although the relationship was significantly stronger in restricting anorexic than in bulimic patients.

Conclusions: The results of this study suggest that people with restricitng anorexia and bulimia show specific clinical profiles associating alexithymic features ans depressive dimensions.

No. 26B
RELATIONSHIPS BETWEEN ALEXITHYMIA, DEPRESSION AND DEPENDENT PERSONALITY DISORDER

Gwenole Loas *Service de Psychiatrie, Hôpital Pinel, route de Paris, Amiens, 80000, France*

SUMMARY:

Alexithymia and dependency have several common points. Firstly, they constitute vulnerability's factors to psychosomatic and psychiatric disorders. Secondly, they have common comorbidities (ie. Anxiety, eating disorders). Thirdly, their relationships with depression are close.

The aim of the study was to test the hypothesis that dependent personality disorders were more alexithymic than the subjects having other personality disorders, even when depression was controlled.

Method: 305 subjects (178 males, 127 females, mean age: 31.15 years, sd = 11.15) consulting in a department of forensic medicine after an assault and battery were recruited. They filled out three questionnaires: the SCID II personality, The Twenty-item Toronto Alexithymia Questionnaire (TAS-20) and the Beck Depression Inventory (BDI). There were 18 dependent personality disorders (DPD), 179 other personality disorders (OPD) and 108 subjects without personality disorders (NPD). The three groups were compared for the TAS-20 and BDI score using analyses of variance (ANOVA). Moreover an analysis of covariance was done using the BDI score as covariate and the TAS-20 score as dependent variable.

Results: The three groups differ significantly for the TAS and the BDI. All Post-hoc tests were significant and showed that DPD were firstly more alexithymic than OPD and NPD and secondly more depressed than OPD and NPD. Moreover, OPD were more alexithymic and depressed than NPD.

The ANCOVA was significant as well as the post-hoc tests showing firstly that DPD were more alexithymic than OPD and NPD and secondly that OPD were more alexithymic than NPD.

Conclusion: High level of alexithymia characterizes DPD comparatively to OPD and this difference is not explained by depression.

The clinical implications of these results were discussed.

No. 26C
BORDERLINE PERSONALITY DISORDER AND EMOTIONAL DYSREGULATION

Alexandra Pham-Scottez *C.M.M.E., Service du Pr Rouillon, 100, rue de la Santé, Paris, 75014, France*, Marion Robin, M.D.

SUMMARY:

Patients with borderline personality disorder experience significant problems in managing their feelings, and usually have difficulties with identifying their own (and others') emotions.

Theorical models of emotional dysregulation as a core symptom of borderline personality disorder exist and will be reviewed, but little empirical data confirm this hypothesis, and experimental procedure are not comparable, using different assessments..

Results from a french pilot study of alexithymia in borderline personality disorder and a matched control group will be presented.

A significant subgroup of borderline patients exhibits alexithymic features, and implications for the clinical management of this subgroup will be enhanced.

No. 26D
ALEXITHYMIA AND SELF-INJURIOUS BEHAVIOR : A CORE DIMENSION ? A STUDY ON 692 SUBJECTS

Ludovic GICQUEL, M.D. *Hôpital Sainte-Anne, C.M.M.E., 1, rue Cabanis, Paris, 75014, France*, Bruno FALISSARD, Ph.D., Maurice CORCOS, M.D.

SUMMARY:

Background: Self-injurious behavior (SIB) often occurs with subjects unable to express what they want or need. According to the regulation model, unmanageable emotions such as feeling of emptiness or depression turn into more manageable physical pain with SIB. Common across SIB and number of psychological disturbances such as eating disorders or substance abuse is the alexithymie dimension.

Objective: The aim of this study was to determine whether alexithymia is a transnosographic dimension associated with superficial/ moderate SIB in different clinical subgroups of subjects (eating disorders, drug dependence and alcohol dependence).

Results: Of 607 subjects, 123 (20.1 %) engaged in a SIB, and most women than men (25 % vs. 13 %). More than a quarter of women with drug dependence self-injured, such as subjects with eating disorders. On the contrary, less than 10 % of men with alcohol dependence presented a SIB. Subjects who self-injured presented a significant higher score than those who don't (57.5 vs. 54.6, p= 0.01) with TAS-20 (Toronto Alexithymia Scale). Considering TAS subscales, significant differences were noted with DIF (difficulty in identifying feelings) ($p<0.001$) and with DDF (difficulty in describing feelings) ($p=0.004$). Any significant difference was found with the third dimension, EOT (externally orientated thinking). With clinical subgroups, similar significant differences were noted with women with anorexia nervosa and men alcohol dependence as they self-injure or not. Nevertheless, only women with SIB presented also differences with DIF and DDF dimensions whereas any dimensions were different in men as they engaged in SIB or not. Finally, type of SIB (impulsive vs. compulsive) didn't differentiate subjects from alexithymia point of view.

Discussion: Alexithymia, and particularly difficulty in identifying or describing feelings, represent a core dimension with SIB. Moreover, alexithymia seems more important as subjects who self-injure are women.

No. 26E
ALEXITHYMIA IN INFERTILE WOMEN

Claire Lamas *Institut Mutualiste Montsouris, Service de Psychiatrie, 42, boulevard Jourdan, Paris, 75014, France*, Isabelle Nicolas, Maurice Corcos, René Frydman

SUMMARY:

Objective: Alexithymia was compared in women with fertility disorders and fertile women who have never been confronted with fertility problems.

Method: Self-report instruments (TAS-20 and BVAQ) were used to measure alexithymia in a group of 73 infertile women and in a comparison group of 32 fertile women. Semi-structured interviews were used to assess medical history, current and lifetime diagnosis of psychiatric disorders.

Results: Infertile women showed significantly higher rates of alexithymia than fertile women. The degree of alexithymia does not constitute a discriminating variable between unexplained infertile women and women with an organic aetiology of infertility. The prevalence of psychiatric diagnosis did not differ between the two groups of patients. Lifetime prevalence of depression, obsessive-compulsive disorders, post-traumatic stress disorder were statistically comparable.

Conclusion: This result raises the question of secondary alexithymia as a coping strategy in women with fertility troubles. Given the lack of published data on alexithymia in infertile women, there is a need to replicate our results and evaluate other aspects of affect regulation in infertile patients.

REFERENCES:

1. Speranza M, Corcos M, Loas G, Stephan P, Guilbaud O, Perez-Diaz F, Halfon O, Bizouard P, Venisse JL, Flament M, Jeammet P : Alexithymia, depressive experiences and dependency in addictive disorders. Substance Use and Misuse 2004: 39, 4: 551-579.
2. Taylor G.J, Bagby R.M, Parker J.DA :Disorders of affect regulation, alexithymia in medical and psychiatric illness, London, cambridge university press, 1997.
3. Yen S, Zlotnick C, Costello E : Affect regulation in women with borderline personality disorders traits. J Nerv Ment Dis 2002, 190: 693-696.
4. Paivio SC : Alexithymia as a mediator between childhood trauma and self-injurious behaviors. Child abuse & Neglect 2004; 28: 339-354.
5. Brody S.: Alexithymia is inversely associated with women's frequency of vaginal intercourse. Arch Sex Behav 2003; 32(1):73-77.

TUESDAY, MAY 22, 2:00 PM - 5:00 PM

SYMPOSIUM 27—BULLYING IN THE WORKPLACE: ASSOCIATED HEALTH PROBLEMS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposum, the participant should be able to:

a) understand the nature of bullying in the workplace;
b) detect its ocurrence;
c) recognize its role as a significant psychosocial stressor;
d) identify its associated morbidity:
e) advocate for the implementation of legal and policy instruments for its prevention.

No. 27A
BULLYING, BASIC ASSUMPTIONS AND SYMPTOMS OF POST-TRAUMATIC STRESS

Eva Mikkelsen, PhD, Ph.D. *CRECEA, Gotlandsvej 24, Horsens, 8700, Denmark*, Ståle Einarsen, Ph.D.

SUMMARY:

This presentation reports the results of a study which investigated possible severe health effects of exposure to bullying and emotional abuse at work. The study aimed first at assessing the prevalence and intensity of PTSD analogue symptomatology among a group of 118 victims of bullying at work. A second aim was to investigate if victims who reported being more affected by other distressing life-events than by bullying were more likely to suffer PTSD analogue symptomatology. A third aim was to investigate whether victims of bullying and non-bullied controls differed in their basic assumptions of themselves, others and the world. Based on self-report measures, 76% of the victims portrayed symptoms indicating posttraumatic stress disorder. However, while 29% were found to meet all DSM-IV-TR criteria for PTSD, another 47% only failed to fulfil the A1 criterion, i.e. they did not report serious injuries or threats to their physical integrity while being bullied. Measurements of symptom severity scores indicated that 61.7% portrayed a moderate to severe or severe level of impairment, while 73.6% displayed a moderate or severe impairment in functioning. Compared with victims who failed to meet all or several diagnostic criteria for PTSD, a significantly higher percentage of the victims meeting all criteria reported feeling more negatively affected by an event other than bullying, indicating that exposure to other traumatic life-events may increase victims' vulnerability. Finally, significant group differences on six out of eight basic assumptions were demonstrated between victims of bullying and non-bullied controls, indicating that exposure to bullying at work may result in increased negative views on self, others and the world.

No. 27B
MORBIDITY ASSOCIATED WITH WORKPLACE BULLYING AMONG HOSPITAL STAFF

Marianna Virtanen, Ph.D. *Finnish Institute of Occupational Health, Helsinki, Finland, Work and Organizations, Work and Mental Health, Topeliuksenkatu 41 a A, Helsinki, FIN-00250, Finland*, Jussi Vahtera, Ph.D., Jussi Vahtera, Ph.D., Marko Elovainio, Ph.D., Marko Elovainio, Ph.D., Mika Kivimäki, Ph.D., Mika Kivimäki, Ph.D., Mika Kivimäki, Ph.D.

SUMMARY:

This prospective study examined the association between workplace bullying and morbidity in a cohort of 5432 hospital employees. Information on workplace bullying and incident chronic diseases was collected by two surveys. Incident cases were employees reporting physician-diagnosed cardiovascular disease, depression, or fibromyalgia in 2000 but not in 1998. Data on sickness absence were derived from employers' registers. The prevalence of bullying was 5% in the first survey and 6% in the second survey. Two per cent reported bullying in both surveys, indicating prolonged bullying. Victims of bullying did not differ from the other employees in terms of sex, age, occupation, type of job contract, hours of work, income, smoking, or alcohol consumption, but they had higher body mass index and higher prevalence of chronic diseases. After adjustment for age, sex and income, the odds ratio of incident cardiovascular disease for victims of prolonged bullying was 2.3 (95% CI 1.2 to 4.6) compared to non-bullied employees. A further adjustment for overweight at baseline attenuated the odds ratio to 1.6 (0.8 to 3.5). The fully adjusted association between bullying and incident depression was 2.3 (1.5 to 3.4), and the association between bullying and incident fibromyalgia was 4.1 (2.0 to 9.6). At follow-up, victims of bullying had 1.3 (1.1 to 1.4) times higher medically certified sickness absence than non-victims. The data from hospital personnel suggest that workplace bullying is a contributing factor in the development of depression and fibromyalgia and is also associated with increased sickness absence. The victims of bullying also seem to be at a greater risk of cardiovascular disease, but this risk may partly be attributable to overweight.

No. 27C
PATTERNS OF WORKPLACE BULLYING AND PSYCHOPATHOLOGY

Jose Luis González de Rivera, MD, F.R.C.P.C. *Fundación Jiménez Diaz - Universidad Autonoma de Madrid, Department of Psychiatry, Avenida de Filipinas, 52, 8 C, Madrid, 28003, Spain*, Manuel J. Rodriguez-Abuin, Ph.D.

SUMMARY:

Objective: The purpose of this study is to describe and quantify the patterns of workplace harassment and their relationship with the psychopathological profile of people complaining of workplace harassment (WPH).

Method: We studied 141 subjects (33%males) referred by the Spanish Association Against Psychological Abuse in the Work Place. All of them completed a social evaluation of their work situation, and the reality of their complaints was assesed by the Association prior to referral. They were evaluated with the Spanish version of Derogatis' Check-List Revised (SCL 90 R) and with the LIPT-60, Spanish expanded version of Leymann Inventory of Psychological Terrorization. We applied the same instruments to a sample of 150 subjects from the general working population with similar demographic characteristics

Results: Significant higher scores of both psychopathology and harassment strategies were found in the harassed workers sample. Factor analysis of LIPT-60 responses showed six patterns of harassment, which we termed: work discredit, personal discredit, incommunication, overt intimidation, covert intimidation and blocking of advancement. There is a positive correlation between general scores of psychopathology and of work harassment (Pearson's value 0.32; $p<0.005$). Controling the influence of the SCL90R subscales, with found significant corrected correlations of Paranoidism with all harassment subscales and of Somatization with both overt and covert intimidation. Interestingly, there is a negative correlation of Interpersonal Sensitivity with all LIPT-60 subscales, but personal discredit.

Conclusions: The positive correlation between LIPT-60 scores and SCL-90R scores support the pathogenetic effect of harassment. The negative correlation of Interpersonal Sensitivity with most harassment subscales supports Gonzalez de Rivera theory of characteriological naivete as a risk factor for harassment and qualifies the high scores of paranoidism, that may be understood as a normal response to a paranogenic situation.

No. 27D
PSYCHOSOCIAL REHABILITATION OF VICTIMS OF BULLYING AND EMOTIONAL ABUSE AT WORK

Eva Mikkelsen, PhD, Ph.D. *CRECEA, Gotlandsvej 24, Horsens, 8700, Denmark*, Ståle Einarsen, Ph.D.

SUMMARY:

Research indicates that bullying at work may have serious detrimental effects on victims' health and well-being. Due to a lack of psychosocial rehabilitation programs, many victims end up unemployed or in early retirement. Thus, measures to prevent bullying at work and to rehabilitate its victims are of utmost importance. Although some programs have been described no study has yet been published testing their effects. In 2002 a two year rehabilitation project was initiated by a local branch of HK, Denmarks' largest trade union. The program included psychological counselling (individual/group), physiotherapy, medical screening and treatment as well as job counselling and "on-the-job" training. The present study examines if such a rehabilitation program has a beneficial effect on the health and well-being of victims of bullying and whether it increases the likelihood of their returning to work. Eleven victims participated in the rehabilitation program (nine women and two men). In addition we had a control group of 19 victims who did not participate in the program Measurements of mental and psychosomatic health were taken at three points in time (beginning, middle and end) of the two year rehabilitation program. Questionnaires consisted of HSCL-25 (psychosomatic symptoms, depression and anxiety) and the PTDS (symptoms of Post-Traumatic Stress). Results showed that the rehabilitation group but not the control group exhibited a significant decrease in psychological and psychosomatic symptoms as well as PTSD symptoms during the course of the program. The study thus indicates that psychosocial rehabilitation of victims of bullying at work may positively affect their health and well-being to the point that they are again able to enjoy life and return to the job market.

REFERENCES:

1. Leymann, H., & Gustafsson, A. (1996). Mobbing at work and the development of post-traumatic stress disorders. European Journal of Work and Organizational Psychology, 5, 251-275.
2. Kivimäki M, Leino-Arjas P, Virtanen M, Elovainio M, Keltikangas-Järvinen L, Puttonen S, Vartia M, Brunner E, Vahtera J. Work stress and incidence of newly diagnosed fibromyalgia. Prospective cohort study. J Psychosom Res 2004; 57:417-422.
3. Gonzalez de Rivera, JL and Rodriguez-Abuin, MJ: Cuestionario de Estrategias de Acoso Laboral. LIPT-60. Madrid, EOS, 2005.
4. Groeblinghoff, D. & Becker, M. (1996). A case study of mobbing and the clinical treatment of mobbing victims. European Journal of Work and Organizational Psychology, 5, (2), 277-294.
5. Yamada, DC: Crafting a Legislative Response to Workplace Bullying. Employee Rights and Employment Policy J 2004; 8: 475-521.

No. 27E
REGULATORY RESPONSES TO WORKPLACE BULLYING: A GLOBAL LAW AND PUBLIC POLICY PERSPECTIVE

David Yamada, J.D. *Suffolk University, School of Law, 120 Tremont Street, Suite 260-E, Boston, MA, 02108-4977*

SUMMARY:

Objective: A significant, growing body of literature is documenting that severe workplace bullying can cause or exacerbate psychiatric illness. However, in nations around the world, legal systems vary greatly in terms of providing protections to bullied employees and offering incentives for employers to act preventively and responsibly towards bullying. The purpose of this study is to discuss and analyze an emerging international body of legal and public policy responses to workplace bullying, mobbing, and harassment, with an eye towards how the law can prevent and respond to psychiatric illness prompted by abusive work environments.

Method: This study will examine legal and policy developments in the United Kingdom, the European Continent, North America, and Australia. In addition, it will consider the policy making and educative roles of transnational entities such as the International Labour Organization and the European Union.

Results: This study will demonstrate that, on a global scale, there are emerging paradigms for regulatory responses to workplace bullying. They vary greatly in terms of their effectiveness in providing protections to bullying targets who suffer from psychiatric illness caused or exacerbated by their work experiences and in offering strong incentives for employers to act preventively and responsibly towards bullying behaviors.

Conclusions: This study will conclude with recommendations for law and public policy reform with regard to workplace bullying and mental health.

SYMPOSIUM 28—NEW PERSPECTIVES IN PSYCHODYNAMIC TREATMENTS FOR BORDERLINE PERSONALITY DISORDER

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the theory, evidence, and clinical application of Transference Focused Psychotherapy(TFP) and Mentalization-Based Treatment(MBT) for the treatment of Borderline Personality Disorder.

No. 28A
MENTALIZATION: A REVIEW OF THE ORIGINS AND APPLICATIONS OF THE CONCEPT IN THE TREATMENT OF BORDERLINE PERSONALITY DISORDER

Lois W. Choi-Kain, M.D. *McLean Hospital, Psychosocial & Personality Research, 115 Mill Street, Belmont, MA, 02478*

SUMMARY:

The current concept if mentalization as applied to the treatment of Borderline Personality Disorder (BPD) has developed out of psychoanalysis, developmental psychology research, and cognitive neuroscience research. In the realm of psychoanalysis, the term mentalization has been employed to denote the symbolic transformation of bodily experiences into words or ideas (Lecours & Bouchard, 1997; Bram & Gabbard, 2001). This particular usage of the term mentalization reflects an intrapsychic aspect. In the realms of developmental psychology and cognitive neuroscience, mentalization is equated with "theory of mind." This refers to a high level automatic human function that allows us to explain and predict the action of others by understanding their mental states (Gallagher & Frith, 2003). Both aspects of mentalization, the self-reflective meaning-making as well as the social cognitive dimensions, are related to other established psychological constructs such as psychological mindedness, empathy, and mindfulness. Current usage of mentalization in the realm of treatment for BPD marries these two dimensions of mentalization, thereby underlining the interpersonal, relational context in which mentalization develops. Mentalization is impaired in the social functioning and attachment relationships of patients with BPD. Using literature review, this presentation will describe the origins of the concept of mentalization and clarify its relevance to both the etiology and treatment of BPD in Mentalization Based Treatment as well as Transference Focused Psychotherapy.

No. 28B
IS MENTALIZATION BASED THERAPY (MBT) MORE EFFECTIVE THAN STRUCTURED SUPPORTIVE PSYCHOTHERAPY FOR BORDERLINE PERSONALITY DISORDER - A RANDOMIZED CONTROLLED TRIAL

Anthony Bateman, M.D. *Royal Free and University College Medica, Halliwick Unit, St. Ann's Hospital, Halliwick Day Unit, St. Ann's Hospital., St. Ann's Road, London, N15 3TH, United Kingdom*, Peter Fonagy

SUMMARY:

Mentalization is the process by which we implicitly and explicitly interpret the actions of ourselves and others as meaningful on the basis of intentional mental states (e.g., desires, needs, feelings, beliefs, & reasons). We mentalize interactively and emotionally when with others. Each person has the other person's mind in mind (as well as their own) leading to self-awareness and other awareness. We have to be able to continue to do this in the midst of emotional states but borderline personality disorder is characterised by a loss of capacity to mentalize when emotionally charged attachment relationships are stimulated. The aim of MBT is to increase this capacity in order to ensure better regulation of affective states and to increase interpersonal and social function. Therapy has been shown to be more effective than treatment as usual in the context of a partial hospital programme both at the end of treatment and at 5-7 year follow-up. The treatment has now been manualized as an in individual plus group format for an out-patient setting. This study investigated the effectiveness of treatment in this context compared with well implemented supportive psychotherapy. Mental health nurses were trained in MBT for 3 days and offered weekly supervision. Supportive psychotherapy was implemented by trained therapists who were keen adherents of their method using primarily supportive and problem solving techniques specific to the difficulties of patients with BPD. All patients were offered weekly individual and group psychotherapy for 18 months in the respective treatment - hence both groups had equal therapy time. In addition treatments were audio recorded to assess treatment fidelity. X patients were randomised to one of the treatments after informed consent was obtained. The rationale for the trial will be presented along with demographic and other characteristics of the study population. Outcome data will be presented.

No. 28C
TRANSFERENCE FOCUSED PSYCHOTHERAPY (TFP)

Otto F. Kernberg, M.D., *Westchester Division, New York Hospital Cornell Medical Cente, 21 Bloomingdale Road, White Plains, NY 10605*

SUMMARY:

This presentation will summarize strategies, tactics, and techniques of transference focused psychotherapy (TFP). It will review the empirical research of transference focused psychotherapy (TFP), and expand on the clinical aspects of indications, prognosis, priorities of intervention, and complications. Comparison with alternative treatment methods will be explored and present controversies outlined.

No. 28D
THE ROLE OF REFLECTIVE FUNCTIONING IN AFFECT REGULATION AND PSYCHOTHERAPY

John F. Clarkin, Ph.D. *Weill Medical College of Cornell University, Psychiatry, 21 Bloomingdale Road, White Plains, NY, 10605*

SUMMARY:

The concept of mentalization as operationalized in reflective functioning (RF) has importance both for clinical intervention and to the scientific investigation of affect regulation. Psychotherapists are faced with the task of matching the focus of intervention with the psychological dysfunctions and related symptoms in their patients. The Cornell Personality Disorders Institute has utilized the concept of mentalization in the development of an object relations treatment for patients with borderline personality disorder who experience difficulties in the nuanced and integrated representations of self and others. In a randomized controlled trial, we have demonstrated that RF increases significantly in an object relations treatment, but does not change in supportive and cognitive-behavioral treatments. Initial patient RF did not predict change in psychotherapy. This data suggests that change in RF may be an important mechamism of change in therapy with these patients. In the broader context of affect regulation, our interdiscipinary group has gathered data on borderline patients with both fMRI and neurocognitive tasks. These data enable us to place the conept of mentalization into the broader context of top-down regulation of affects in patients and controls. We have found significant correlations between low RF, poor effortful control, identity diffusion, and severe symptoms. As compared to non-patient controls, borderline patients manifest impulsivity in the context of negative affect, and poor cognitive control in cortical areas. This data is useful in describing subgroups of borderline patients, and defining the mechanisms of change in psychotherapy.

No. 28E
A PSYCHOTHERAPY CASE STUDY ON ALTERNATIVE PERSPECTIVES

John G. Gunderson, M.D. *McLean Hospital, 115 Mill St, Belmont, MA, 02478-1041*

SUMMARY:

A case report of individual psychotherapy with a borderline patient will be presented with vignettes from the initial visit and subsequent sessions at 3, 11, and 48 months when the therapy ended. Comments about the therapy by Drs. Bateman (founder of Mentalization Based Treatment) and Kernberg (founder of Transference Focused Psychotherapy) will offer insights into the similarities and differences in these two empirically validated therapeutic approaches. Vignettes from follow up visits with the patient will be used to frame a discussion about the benefits and limitations of outcome from long term individual psychotherapies with borderline patients.

REFERENCES:

1. Fonagy p, Gergely G, Jurist EL, Target M: Affect Regulation, Mentalization, and the Development of the Self. New York, New York, Other Press, 2002.
2. Bateman, A. & Fonagy, P. Mentalisation based treatment of borderline personality disorder. Journal of Personality Disorder, 2004 18, 35-50.
3. Clarkin JF, Levy KN: Psychotherapy for patients with borderline personality disorder: Focusing on the mechanisms of change. Journal of Clinical Psychology 2006; 62: 405-410.
4. Gunderson JG: BPD: A Clinical Guide. American Psychiatric Press, 2001.

SYMPOSIUM 29—AGGRESSIVE BEHAVIORAL DISTURBANCES IN GEROPSYCHIATRIC PATIENTS

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize:

1. models exploring the neurobiological basis for aggressive behaviors
2. the impact of genetic and environmental factors on aggressive behaviors
3. the prevalence of aggressive behaviors in geropsychiatric patients and the clinical, financial, and ethno-cultural impact of these behaviors on the healthcare system
4. how to evaluate and manage aggressive behaviors in geropsychiatric patients.

No. 29A
NEUROBIOLOGY OF AGGRESSION

Randy J. Nelson *Ohio State University, Psychology & Neuroscience, 49 Psychology Building, 1835 Neil Avenue Mall, Columbus, OH, 43210-1222*

SUMMARY:

Aggressive behavior is not a unitary process, but is the result of complex interactions among several physiological, motivational, and behavioral systems, with contributions from the social and physical environment. Recent work using genetically-manipulated mouse models of aggression will be reviewed. The effects of nitric oxide will be emphasized to highlight the interaction of various signaling molecules with the serotonergic system. The contribution of steroid hormones and nonserotonergic neurotransmitters will also be discussed. Multiple, and often unanticipated, effects of targeted gene disruption on aggressive behavior will be reviewed. Current treatment of reactive violence displayed by geriatric clinical populations with impaired brain function decreases arousal. Decreasing reactive aggression without affecting arousal will require a multi-level approach to understanding the neurobiological, motivational, and behavioral systems involved.

No. 29B
GENE-ENVIRONMENT INTERACTIONS AND AGGRESSION

Brian C. Trainor, Ph.D. *Ohio State University, Psychology, 49 Psychology Building, 1835 Neil Avenue Mall, Columbus, OH, 43210*

SUMMARY:

Understanding the neurochemical bases of aggressive behavior has proved to be a difficult task. This is due in part to the many genetic, developmental, and environmental factors that affect aggression. Estrogens increase male aggression in many species, but decrease aggression in other species, including humans. We have examined how the environment determines the effect of estrogen on aggression in *Peromyscus* mice. Like other rodent species, males are more aggressive when housed in winter-like short day (8L:16D) photoperiods compared to males housed in summer-like long day (16L:8D) photoperiods. We have demonstrated that estrogen increases aggression when mice are housed in winter-like short days and decreases aggression when mice are housed in summer-like long days, and that activation of the estrogen receptor alpha subtype is sufficient to explain these behavioral effects. Thus, the effects of photoperiod on estrogen action must occur after binding to the receptor. A follow-up microarray experiment suggested that photoperiod may determine whether estrogen acts via genomic (driving gene expression) or non-genomic (activation of second messenger systems) pathways. In support of this hypothesis, estrogen injections increase aggression within 15 minutes in short day mice but not long day mice. This is an important result because genomic effects generally take more than one hour to occur whereas non-genomic effects can occur within seconds. These studies are important for understanding mechanisms of human aggression because they demonstrate how the environment affects the action of a hormone known to influence aggression in humans.

No. 29C
EPIDEMIOLOGY OF AGGRESSIVE BEHAVIORS IN GEROPSYCHIATRIC PATIENTS

Nhi-Ha T. Trinh, M.D. *McLean Hospital, Geriatric Psychiatry, 115 Mill Street, SB3, Belmont, MA, 02478*

SUMMARY:

Aggressive behavioral disturbances are extremely complex and can occur relative to many situations and conditions in geropsychiatric patients. For instance, aggressive behaviors in patients with Alzheimer Disease is very common, occurring in 40-90% of patients during the course of their illness. Certain risk factors, including patient demographic and ethnocultural background, psychiatric diagnoses, presence and stage of dementia, medical co-morbidity, and psychosocial factors, can contribute to observed aggressive behaviors. We will discuss the affective and behavioral manifestations associated with aggressive behaviors, and the impact of these behaviors on patient institutionalization, self-injury/harm to others, patient disability and caregiver burden, and health care costs.

No. 29D
EVALUATION AND MANAGEMENT OF AGGRESSIVE BEHAVIORS IN GEROPSYCHIATRIC PATIENTS

Helen H. Kyomen, M.D. *Harvard Medical School, McLean Division, Mass General Hospital, 115 Mill St, Belmont, MA, 02478-1041*, Theodore H. Whitfield, Sc.D

SUMMARY:

Objective: To determine (1) what primary diagnoses are most often associated with elderly patients with aggressive behaviors who are hospitalized on a geropsychiatric unit, and (2) what psychotropic medications are most often used to manage these patients, in a retrospective analysis of prospectively collected data of 240 consecutively admitted geropsychiatric patients. These findings are discussed in the context of the existing literature on longitudinal patterns of aggressive behavioral disturbances in geropsychiatric patients, the evaluation and management of aggressive behaviors in geropsychiatric patients, and caregiver support and education.

Method: Retrospective analysis of medical record data collected prospectively from 1998-2000, and literature review.

Results: A retrospective analysis of prospectively collected data of 240 consecutively admitted geropsychiatric patients revealed that 74% (n=177) had aggressive behavior, including suicidal behaviors, just prior to admission. Of these, 67% (n=119) continued to exhibit aggressive behaviors soon after admission. At the time of discharge, 16% (n=28) of the 177 still had aggressive behaviors, although they were more manageable. Primary diagnoses included: delirium (26%), psychotic disorder due to general medical condition (GMC) (24%), major depression (22%), mood disorder due to GMC (11%), and bipolar disorder (10%). Main psychotropic medication interventions that patients were taking at discharge included: antipsychotics (20%), antidepressants (12%), anticonvulsants (5%), and sedatives (3%).

Conclusions: Geriatric patients have complex medical and psychiatric disturbances that may interact and contribute to the development and expression of aggressive behavioral disturbances. These patients require comprehensive medical and psychiatric evaluation, as well as observation over time to ascertain a pattern of behavioral disturbance, so that behavioral, milieu, other psychotherapeutic and pharmacologic interventions can be effectively mobilized to intervene in these highly disruptive patterns of behavior. Also important is

considering a systemic approach, understanding the needs of informal and professional caregivers for ongoing support and training.

REFERENCES:

1. Nelson RJ: Biology of Aggression. New York, Oxford University Press, 2006.
2. Trainor BC, Kyomen HH, Marler CA. Front. Neuroendocrinol. 2006;27:170-179.
3. Chen JC, Borson S and Scanlan JM. Stage-specific Prevalence of Behavioral Symptoms in Alzheimer's Disease in a Multi-Ethnic Community Sample. Am J Geriatr Psychiatry 2000; 8(2): 123-133.
4. Kozman MN, Wattis J, Curran S: Pharmacological management of behavioural and psychological disturbance in dementia. Hum Psychopharmacol Clin Exp 2006; 21:1'12.

SYMPOSIUM 30—FORMATION OF MODERN LESBIAN AND GAY IDENTITIES: PERSONAL, HISTORICAL, AND MENTAL HEALTH PERSPECTIVES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand how lesbian and gay people integrated their identities in a time period where people did not discuss their orientation openly.

No. 30A
GERTRUDE STEIN'S MEDICAL EDUCATION, HER EVOLVING FEMINISM AND LESBIAN IDENTITY

Gene A. Nakajima, M.D. *CSP, San Francisco Comm Beh Health Services, 1700 Jackson St, San Francisco, CA, 94109*

SUMMARY:

Gertrude Stein (1874-1946) is the most famous lesbian student to have attended Johns Hopkins University School of Medicine. After medical school, she became an experimental novelist, playwright, and poet. She is well know as a mentor to authors like Hemingway and as a friend and patron of Picasso, Matisse, and other artists.

Stein was one of the few women in the Johns Hopkins Medical School class of 1901 but failed a few minor courses in her last year and never graduated. Exploring the significance of this period is important because her studies came soon before her decision to become a writer. They also coincided with a reexamination of her feminism. During her last year of medical, she had her first difficult romantic relationship with another woman, who was also involved with another Johns Hopkins classmate. This love triangle was the basis of one of her earliest unpublished lesbian novels, *QED,* and it was also used in two of her other early novels, including *The Making of Americans*, which Bryher helped financially to publish.

Stein hid the knowledge of her first relationship for about 25 years from her long time partner, Alice B. Toklas, who was outraged, not at the affair itself, but at Stein's silence about it. The revelation caused difficulties in their relationship for several years. For example, when Stein went to the US on a publicity tour for her memoir, *The Autobiography of Alice B. Toklas*, and to see the production of the opera, *Four Saints in Three Acts,* which she co-wrote with Thomson, Toklas forbid her from seeing friends who may have had knowledge of this early affair.

No. 30B
SUPERIOR GUINEA PIG: BRYHER AND PSYCHOANALYSIS

Maggie Magee, Psy.D. *Private Practice, 77-564A Counry Club DriveSuite 136, Palm Desert, CA, 92211*

SUMMARY:

Annie Winifred Ellerman, who called herself Bryher, was the daughter of the richest man in England. She was the life-long lesbian partner of imagist poet H.D. (Hilda Doolittle) as well as a devoted patron of psychoanalysis. Bryher was a novelist, film producer and journal publisher. Through the encouragment of her analyst Hanns Sachs Bryher pursued training to become a psychoanalyst. In 1933 as the Nazis rose to power in Berlin, Sachs fled to Boston, and Bryher turned from analysis to refugee work. This presentation uses Bryher's memoirs and letters to make her life and work better known to the psychoanalytic community she helped sustain in spite of its attitudes toward homosexuality.

No. 30C
"I DIDN'T WANT TO BE QUEER": VIRGIL THOMSON'S ADAPTATION TO HIS HOMOSEXUAL IDENTITY

Anthony Tommasini, D.M.A. *New York Times, Culture Department, 229 West 43rd St., New York, NY, 10036*

SUMMARY:

Virgil Thomson (1896-1989), a prominent American composer and music critic, dealt with conflicts over his homosexuality by maintaining scrupulously separate social spheres. In 1913, the year he entered his senior year of high school in Kansas City, Missouri, the local police force conducted a massive crackdown on vice, with an emphasis on prostitution and what was obliquely referred to in the press as sexual perversion. In 1920, while he was at Harvard, there was a gay witch hunt, a devastating event documented by William Wright in *Harvard's Secret Court: The Savage 1920 Purge of Campus Homosexuals* (2005). These brutal events reinforced Thomson's secret torment over his homosexual feelings during his childhood and young adulthood.

His way of coping was to maintain two circles of friends, two social spheres: one "normal," meaning mostly straight and well-behaved; the other one "queer," which was his word of choice. Within his queer circle, Thomson could be wickedly funny, catty, flirtatious and robustly sexual, but this circle was a secret world. His straight male friends and the many devoted women friends he had throughout his life knew about his homosexuality, although neither he nor they ever mentioned it. As he once said, "You didn't say everything, but you understood everything." When gay liberation arrived in the 1970s, Thomson was dubious about it. He acknowledged that ending persecution would be a good thing, but the "talking about it" was a miscalculation that would produce a backlash. His inclination not to talk about sexual matters made him an ideal fit within Gertrude Stein's circle in Paris decades earlier.

Why Thomson felt this way and why he found it inadvisable to alter his behavior when the gay closet began to open later in his life will be discussed.

No. 30D
FROM THE CLOSET TO THE TABLE: A 40 YEAR HISTORY OF GAYS AND THE APA

David R. Kessler, M.D. *3450 Sacramento St # 215, San Francisco, CA, 94118-1914*

SUMMARY:

This paper outlines the history of the slow emergence of open gay participation in the APA. It begins by describing the general cultural attitudes towards homosexuality in the US in the 1960's, the view of homosexuality as pathology, and gay psychiatrists hiding in the shadows.

It considers the events that ultimately led to psychiatry's "cure" of homosexuals in 1973, and then focuses on the development of an openly gay presence at the APA, its official recognition, and active participation in APA affairs. For example, mention will be made of the campaign against the diagnosis of Ego-Dystonic Homosexuality, and the final removal of any form of homosexuality from the diagnostic manual in 1987.

This process of establishing a group of visible gay psychiatrists offers many parallels to the establishment of a positive individual gay identity, and represents a successful response to Harvey Milk's repeated exhortation to gay people to "organize and come out!".

This history of gays and the APA exemplifies the uniquely sensitive issue of homosexuality in our society at large, the important role of "radicals" and activists, as well as of closeted gays working behind the scenes, the scientific, social, and political functions of gay visibility, and the vital role of group cohesion in effecting change and promoting a healthy gay self-concept.

REFERENCES:

1. Dydo U: How to read Gertrude Stein: The Manuscript of 'Stanzas in Meditation'. Text: Transactions of the Society for Textual Scholarship, 1981; 1: 271-303.
2. Magee, M., Miller, D. Lesbian Lives: Psychoanalytic Narratives Old and New. Hillsdale, NJ., The Analytic Press, 1997.
3. Tommasini A: Virgil Thomson: Composer on the Aisle, New York, W.W. Norton, 1997.
4. Krajeski, J: Homosexuality and the Mental Health Professio: A Contemporary History, In Textbook of Homosexuality and Mental Health, edited by Cabaj, RP and Stein, TS, Washington, DC, American Psychiatric Press, 1996.

SYMPOSIUM 31—RESEARCH UPDATE ON ADOLESCENTS WITH SCHIZOPHRENIA: IMPLICATIONS FOR PRODROMAL RESEARCH

EDUCATIONAL OBJECTIVES:

After this presentation, participants will recognize common clinical indications for ordering neuropsychological assessments for adolescents with psychosis and demonstrate knowledge of commonly used cognitive measures. Participants will understand the significance of deficits in attention, language, memory, executive and motor function in adolescents with schizophrenia for educational and treatment planning.

No. 31A
EARLY-STAGE NEUROCOGNITIVE FUNCTIONING IN ADOLESCENT PSYCHOSIS: AN EXAMINATION OF ILLNESS COURSE AND IMPLICATIONS FOR INTERVENTION

Jeffrey R. Wozniak, Ph.D. *University of Minnesota, Psychiatry, 2450 Riverside Avenue, F256/2B West, Minneapolis, MN, 55454*

SUMMARY:

Objective: This presentation will describe the results from two longitudinal studies of adolescents with schizophrenia-spectrum disorders. A substantial portion of the presentation will be devoted to a discussion of the implications of these neurocognitive findings for understanding the early course of psychotic illness during adolescence and for planning interventions including academic accommodations.

Methods: The first study examined 26 adolescents with early-onset schizophrenia and 26 matched controls at baseline and, again, at 13 months. A broad neurocognitive evaluation was completed. The second study, which is ongoing, has evaluated 37 subjects between the ages of 10 and 17. Diagnoses were made with the Kiddie SADS: Schizophrenia (n=14), Schizophreniform (n=6), Schizoaffective (n=7), and Psychosis NOS (n=10). Patients were evaluated with a neuropsychological battery emphasizing memory, attention, processing speed, and executive functioning. Clinical symptoms were rated with the PANSS. Thus far, 13 subjects have been re-tested at 12 months.

Results: Both studies demonstrated baseline neurocognitive impairments in patients relative to controls and/or normative standards. Below-average performance was seen in processing speed, working memory, verbal learning, planning, and inhibition. Longitudinal results indicated significant improvement in clinical symptoms over time, but general stability in terms of the neurocognitive deficits. Neurocognitive impairment at baseline was significantly correlated with negative symptoms at baseline and follow-up, but not necessarily correlated with positive symptoms.

Conclusion: Neurocognitive deficit is a common feature of adolescent schizophrenia-spectrum disorders. As in adults, these deficits seem to be stable, even in the face of improvement in clinical symptoms. Patients with more severe negative symptoms may have more significant cognitive impairment in both the short-term and long-term. Findings will be discussed in the context of "best practices" for evaluation of early psychosis, diagnosis, prognosis, family education, and interfacing with special educators concerning accommodations.

No. 31B
CLOZAPINE AND OLANZAPINE IN REFRACTORY EARLY-ONSET SCHIZOPHRENIA: A 12-WEEK RANDOMIZED AND DOUBLE-BLIND COMPARISON

Harvey Kranzler, M.D. *Albert Einstein College of Medicine, Bronx Children's Psychiatry Center, 1000 Water Place, Bronx, NY, 10461*

SUMMARY:

Objective: This study compared the efficacy and safety of clozapine with olanzapine in treatment-refractory adolescents with schizophrenia.

Methods: Children and adolescents, aged 10 to 18 years, who met unmodified DSM-IV criteria for schizophrenia and who failed at least two antipsychotics were randomized to receive 12 weeks of double-blind flexibly dosed treatment with clozapine (n=18) or "high-dose" olanzapine (up to 30 mg/d) (n=21). The primary efficacy measure was response (improvement), defined as a decrease of 30% or more in total Brief Psychiatric Rating Scale score from baseline and a Clinical Global Impression Scale improvement rating of '1' (very much improved) or '2' (much improved).

Results: Significantly, more clozapine-treated adolescents experienced a clinically meaningful improvement in symptoms (66%) than olanzapine-treated subjects (33%). Clozapine was superior to olanzapine in terms of reduction of negative symptoms from baseline to endpoint. Both treatments were associated with significant weight gain and metabolic abnormalities.

Conclusion: This double-blind randomized comparison of two SGAs for children and adolescents with schizophrenia supports clozapine as the agent of choice. The development of interventions to limit weight gain and metabolic side effects are needed to enhance the risk-benefit profile for both study treatments.

No. 31C
EFFICACY AND TOLERABILITY OF ATYPICAL ANTIPSYCHOTICS IN ADOLESCENTS WITH PSYCYCHOSIS

Joel Oberstar, M.D. *University of Minnesota, Psychiatry, 2450 Riverside Avenue, F256 /2B West, Minneapolis, MN, 55454*

SUMMARY:

Objective: Use of typical antipsychotics in adolescents has previously been confounded by a high rate of extrapyramidal side effects. Atypical antipsychotics represent a promising treatment alternative, but there is limited data surrounding their effectiveness and tolerability.

Method : This 12-week open-label, random assignment parallel group, study compared the effects of risperidone, olanzapine and quetiapine treatment in adolescents (12 to 18 years) with psychosis. Thirty patients meeting DSM-IV criteria for a schizophrenia-spectrum disorder (i.e., schizophrenia, schizoaffective disorder, schizophreniform or psychotic disorder not otherwise specified) using a structured interview, with a baseline CGI-S rating of >=3 were included. The primary efficacy variable was change in PANSS total score from baseline to endpoint, assessed biweekly.

Results: All treatments reduced PANSS scores from baseline (reductions of 53% for risperidone [mean daily dose=4.8 mg], 48% for olanzapine [mean daily dose=13.5mg], 20% for quetiapine [mean daily dose=675 mg]; ANOVA. n.s.). Similar improvements were observed for scales of severity of illness, depression and overall functioning. Risperidone and olanzpaine were associated with an increased frequency of adverse events compared to quetiapine (NS), particularly weight gain.

Conclusion: Risperidone and olanzapine were associated with more adverse events than quetiapine (NS). Data suggest that while all agents demonstrated symptom reduction, quetiapine may be associated with an improved tolerability profile compared to risperidone or olanzapine.

No. 31D
ANOMALIES IN WHITE MATTER MICROSTRUCTURE IN OCCIPITAL-TEMPORAL PATHWAYS IN ADOLESCENTS WITH SCHIZOPHRENIA

Sanjiv Kumra, M.D. *University of Minnesota, Psychiatry, 2450 Riverside Avenue, F256/2B West, Minneapolis, MN, 55454*

SUMMARY:

Objective: There is increasing evidence that schizophrenia is characterized by abnormalities in white matter. In this paper, the authors investigate the integrity of white matter tracts using diffusion tensor imaging in adolescents with schizophrenia.

Method: A cross-sectional case-control whole-brain voxel-based analysis using diffusion tensor magnetic resonance imaging. Forty-four individuals aged 11 to 18 years, 23 with a DSM-IV diagnosis of schizophrenia and 21 demographically-similar healthy controls. The main outcome measures were fractional anisotropy, radial diffusivity and mean diffusivity.

Results: Adolescents with schizophrenia had reduced fractional anisotropy within the left inferior temporal ($p < .001$) and occipital ($p < .001$) regions. A subsequent tractography analysis was performed using the inferior temporal cluster as a seedpoint which revealed that the two abnormal clusters were anatomically interconnected and part of the inferior longitudinal fasciculus (ILF). Patients had significantly reduced fractional anisotropy ($p < .05$) and significantly increased radial diffusivity ($p < .01$) and mean diffusivity ($p < .01$) within the ILF. Exploratory analyses revealed that patients with a history of visual hallucinations had lower fractional anisotropy in the ILF ($p < .01$) than patients without visual hallucinations.

Conclusion: Our findings, which benefited from greater imaging resolution and methodological control than previously conducted studies in adolescents with schizophrenia provide strong evidence for lower white matter integrity in occipito-temporal pathways, particularly for patients with a history of visual hallucinations. These findings may have implications for understanding the pathophysiology of deficits of social cognition and the emergence of negative symptoms in adolescents with schizophrenia.

REFERENCES:

1. Sikich L, Hamer RM, Bashford RA, Sheitman BB, Lieberman, JA: A pilot study of risperidone, olanzapine, and haloperidol in psychotic youth: a double-blind, randomized, 8-week trial. Neuropsychopharmacology. 2004 Jan;29(1):133-45
2. Kumra S, Shaw M, Merka P, Nakayama E, Augustin R: Childhood-onset schizophrenia: research update. Can J Psychiatry. 2001 Dec;46(10):923-30. Review
3. Rhinewine JP, Lencz T, Thaden EP, Cervellione KL, Burdick KE, Henderson I, Bhaskar S,.
4. Gerbino-Rosen G, Roofeh D, Tompkins DA, et.al.: Hematological adverse events in Clozapine-treated children and adolescents. J Am Acad Child Adolesc Psychiatry. 2005 Oct;44(10):1024-31.
5. Sikich L, Hamer RM, Bashford RA, Sheitman BB, Lieberman, JA: A pilot study of risperidone, olanzapine, and haloperidol in psychotic youth: a double-blind, randomized, 8-week trial. Neuropsychopharmacology. 2004 Jan;29(1):133-45.
6. Kumra S, Ashtari M, Cervellione KL, Henderosn I, Kester H, Roofeh D, Wu J,.

SYMPOSIUM 32—MIRROR NEURONS, EMPATHY, INTUITION AND INTERPRETATION: UNDERSTANDING THE MINDS OF OTHERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will:

1. demonstrate knowledge of the social brain, in general, and mirror neurons, in particular;
2. recognize how they make possible empathy and understanding the thoughts, needs and desires of others;
3. be able to use these ideas in the clinical setting in relation to transference and counter-transference.

No. 32A
LANGUAGE, SYMBOLIC REPRESENTATION AND SENSORY-MOTOR PROCESSING: IMPLICATIONS FOR INTERPERSONAL INTERACTION

Lisa Aziz-Zadeh, M.D., *Ahmanson Lovelace Brain Mapping Center, UCLA School of Medicine, 600 Charles E. Young Drive South, Los Angeles, CA 90005-7085*

SUMMARY:

What is the relationship between the motor system and language? Can you separate language as a symbolic system from language as a motor act? Here we explore this question by considering different aspects of language and how they relate to the motor system. In particular we describe brain imaging studies on how conceptual representations of actions are implemented by the motor system, the laterality of the human mirror neuron system as it relates to laterality for language, and the effects of lesions to the motor areas on a function of speech that theoretically should not require the motor system ? internal speech. Together this work helps build an under-

standing for the relationship between abstract representation and more rudimentary sensory-motor processing.

No. 32B
FROM MIRROR NEURONS TO EMPATHY

Christian Keysers, Ph.D. *University Medical Center Groningen, BCN Neuroimaging Center, Antonius Deusinglaan 2, (room 120), Groningen, 9713 AW, Netherlands*

SUMMARY:

We often effortlessly gain a feel for what goes on in the mind of other people. I will review data suggesting that this social intuition may rest upon brain mechanisms that I call shared circuits, and which translate the actions, sensations and emotions of others into our own. A circuit composed of parietal and premotor areas translate the heard or seen actions of other people into our own action programs. While the somatosensory and insular cortex translate the sensations and emotions of others into our own. I will then provide two sources of evidences for the importance of these systems for empathy. First, patient with lesions in the insula have problems both in experiencing certain emotions and in understanding the same emotions in others. Second, more empathic individuals activate their shared circuits more than less empathic individuals.

No. 32C
HOW IS THE MIRROR NEURON DISCOVERY RELEVANT TO PSYCHOANALYSIS AND PSYCHOTHERAPY?

Morris N. Eagle *Adelphi University, CA*

SUMMARY:

Mirror neurons emphasize how psychological development arises through interpersonal interaction. The mirror neuron system makes possible the ability of one individual to understand the motivations and emotions that underlie observed behavior. This is relevant to clinical work because it is the basis for the development of empathy, reflective function and theory of mind, and emphasizes the importance of non-verbal behavior in human interaction. In addition mirror neuron activity serves as a means for learning behaviors without conscious explicit instruction or recall. This is relevant clinically, because it helps explain how children unconsciously internalize the behaviors of their parents, without ever remembering having learned it. It may also serve as a way for patients to internalize the interpersonal behaviors of their therapist.

REFERENCES:

1. Keysers C, Gazzola V: Towards a unifying neural theory of social cognition. Progess in Brain Research, 156:383-406.
2. Aziz-Zadeh L, Maeda F, Zaidel E, Mazziotta J, Iacoboni M. Lateralization in motor facilitation during action observation: a TMS study. Exp Brain Res. 2002 May;144(1):127-31.
3. Wolf NS, Gales M, Shane E, Shane M. Mirror neurons, procedural learning, and the positive new experience: a developmental systems self psychology approach. J Am Acad Psychoanal. 2000 Fall;28(3):409-30.
4. Iacoboni M, Dapretto M. The mirror neuron system and the consequences of its dysfunction. Nat Rev Neurosci. 2006 Dec;7(12):942-51.

SYMPOSIUM 33—PTSD, BORDERLINE PERSONALITY DISORDER AND MOTHERHOOD: EARLY RELATIONS, RECOGNITION AND INTERVENTION

EDUCATIONAL OBJECTIVES:

The aim of this symposium is to study motherhood, mother-infant interaction, and early intervention programs in women with borderline personality disorder, and trauma, and/or PTSD. This symposium will be dedicated to the work of Dr. Marianne Butterfield. At the conclusion of this symposium participants should be able to
- give a comprehensive perspective on women with Borderline personality disorder +/- PTSD, history of abuse and their interactions with their very young children;
- screen for mother-infant situations at risk for interactive distortions during the perinatal period and preschool age;
- establish and assess specific therapeutic programs for these families.

No. 33A
PERSONAL & OTHER TERRORISM TOWARD WOMEN WORLDWIDE

Leah J. Dickstein, M.D. *3006 Dunraven Drive, Louisville, KY, 40222-6126*

SUMMARY:

Since 2004, the presenter had initiated the use of the term POT(Personal and Other Terrorism) rather than Domestic Violence as a more accurate identification of women's experiences in their personal lives, whether within their physical living space, personal relationships in and beyond this area, including at work, in the communities and everywhere they find themselves and choose to be.

This presentation will identify how worldwide, cultural, socioeconomic, educational, racial, ethnic faith-based and abuse factors can impact women's experiences of POT. Yet despite these obvious and apparently wide differences, experiences of POT are all too common, too similar, and too under-reported by women victims and others. Simultaneously, too little is done by communities, governments, the UN, families, friends and victims themselves to demand POT be stopped and interpersonal experiences for women change. The keys of repercussions, rewards and education will be discussed.

No. 33B
VIOLENCE TURNED AGAINST THE VICTIM

Nada L. Stotland, M.D. *Rush Medical College, Psychiatry, 5511 S Kenwood Ave, Chicago, IL, 60637-1713*

SUMMARY:

Women in abusive relationships may be irritable, labile, angry, mistrustful, impulsive, and hypersensitive. These feelings and behaviors are reasonable reactions to the abusive situation. They overlap, however, with signs and symptoms of borderline personality disorder, or BPD, which is a highly stigmatized diagnosis. We would encourage a woman in an abusive situation to seek mental health care, and hope that treatment would help her to recognize the damaging nature of her relationship and to take steps to free herself from it. However, for a mother, the diagnosis of BPD is a barrier to that process. Although it is the abuse that causes the symptoms and leads to the need for treatment, the perpetrator may use the diagnosis to support a bid for custody of children on the grounds that the mother is too psychologically unstable to provide adequate parenting. If this argument prevails, the children are left with an abuser as their custodial parent. Therefore clinicians must consider ongoing domestic violence as the cause of psychiatric symptoms before making a

diagnosis of BPD and carefully note their etiology in diagnostic and treatment records. Although it is desirable in general for clinicians to avoid serving in dual roles, it may be necessary to testify in court that such a patient is able to care for her children.

No. 33C
EARLY INTERACTIONS BETWEEN BORDERLINE MOTHERS AND THEIR INFANTS : WHY MORE INTERVENTION COULD MEAN LESS REPETITION TRAUMA AND DISTORTION

Gisele Apter, M.D. *Erasmus Hospital, University Paris 7, Pscyhiatry research Lab, 121 bis avenue du Général Leclerc, Bourg-La-Reine, 92340, France*

SUMMARY:

Borderline personality disorder is among the most common and most diagnosed personality disorder in psychiatric clinical practice. It is a relationship centered disorder more common in women. Borderline symptoms will be active during the fertile years.Therefore motherhood should be focused on. History of abuse and unresolved trauma are often connected to the borderline mother's confused perceptions of herself. The infants, then, find themselves at risk of enduring disturbed relationships; their mothers submitted to the very element they have major difficulty coping with, i.e. a durable and sustaining relationship. Interactions between borderline mothers and their infants have not, as yet, been abundantly studied. Our research shows how these dyads already have specific characteristics when infants are but three months of age. Maternal behaviour, in a face-to-face situation is more intrusive and repetitive in Borderline Personality disorder but with less variation and an overall smaller amount of proposed interaction than non-clinical mothers (all interactive behaviours included). Infants show more emotional dysregulation than those of control mothers, with less coping capacity after a minor stressful situation such as the Still Face. These results raise questions both regarding origin of dysregulation, and ways of managing it? Has maternal stress already had an influence in utero, and shaped neurobiological infant reaction? Is the early maternal inconsistent nurturing already responsible for hyper-reactive response? In turn, infant hyper-reactivity and regulatory difficulties would enhance distortion of interaction post-natally between mother and infant sustaining the already altered response with that specific caregiver. How much inconsistency then sets in as if directly transmitted? How different interventions in different settings in Europe (France) could help modify the interactive patterns before they are definitely set in will be discussed.

No. 33D
THE THERAPEUTIC USE OF VIDEOTAPE IN WORKING WITH PARENTS OF CHILDREN WITH PSYCHIATRIC DISORDERS

Alexandra M. Harrison, M.D. *Harvard Medical School, Psychiatry, 183 Brattle St, Cambridge, MA, 02138-3344*

SUMMARY:

The presentation focuses on two interventions for preschool children with behavioral and developmental problems. The first is an assessment method, the parent consultation model (PCM) that emphasizes the use of videotape analysis and developmental theory to provide critical information to parents as well as to the clinician. A description of the PCM will be given, as well as an expanded example of the PCM, including illustrations of how these methods can be used to organize information and engage parents in the initial evaluation and in an extended consultative relationship. The second intervention is a 10- session parent group using the analysis of home videos brought in by the parents with the goal of changing maladaptive relational patterns in the family and building more effective limit setting strategies . Another crucial aim is to counter the isolation experienced by parents of children with psychological problems through the function of the group as a support. This model of parent groups can be used for specific populations, such as parents of children with autistic spectrum disorders, or parents of bipolar children.

REFERENCES:

1. Dickstein, L.J. The Impact of Domestic Violence(Personal and Other Terrorism) Toward Women Across the Life Cycle, Directions in Psychiatry(N.Y.) In press.
2. Warshaw, C. Domestic Violence. in Psychological Aspects of Women's Health Care, ed. N Stotland, D Stewart, Washington DC, APPI, 2001.
3. Apter-Danon G, Candilis-Huisman D : A challenge for perinatal psychiatry : Therapeutic management of maternal borderline personality disorder and their very young infants. Clinical Neuropsychiatry 2005; 5:302-314.
4. Harrison AM: Herd the animals into the barn: a parent consultation model of child evaluation. The Psychoanalytic Study of the Child 2005; 60:128-157.

SYMPOSIUM 34—UNEASY PARTNERS: THE PHARMACEUTICAL INDUSTRY AND THE PSYCHIATRIC PROFESSION

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be familiar with recent analyses of academic medicine relationships, specifically psychiatry and the pharmaceutical industry; the impact of pharmaceutical industry on psychiatric research and evidence based medicine methods; potential ways to manage the psychiatric profession and the pharmaceutical industry relationship.

No. 34A
THE PHARMACEUTICAL INDUSTRY, EVIDENCE-BASED MEDICINE, AND PSYCHIATRIC PRACTICE.

Howard I. Kushner, Ph.D. *Emory University School of Public Health, Behavioral Sciences, Callaway Center S409, Atlanta, GA, 30322*

SUMMARY:

Recent revelations of distortions by the pharmaceutical industry of the evidence about the safety and efficacy of a number of aggressively marketed pharmaceuticals and devices, has led to an outpouring of warnings by academic physicians and biomedical researchers about the dangerous influence of the pharmaceutical industry on medical practice and patient health care. The fact that now-discredited research was published in mainstream professional journals has eroded confidence in the findings of clinical trials in general. Fueling this distrust is a growing fear of conflict of interest by biomedical researchers who serve as consultants for pharmaceutical industry-sponsored studies. Additionally, a number of observers have charged that direct-to-patient advertising by pharmaceutical companies has undermined the patient/practitioner relationship while exposing patients to often dangerous consequences.

At risk is the foundation of evidence-based medicine (EBM), the standard for cutting edge clinical practice. EBM is built in large part on the assumed validity and veracity of research findings published peer-reviewed medical journals. Reformers hope that, shorn of industry influence, an objective medical research will (re)emerge, ensuring not only the reliability of EBM, but also the restoration of the now fragile physician/patient collaboration. This latter result may be less

certain because EBM, even freed from industry influence, nevertheless, relies on data produced by population studies, which can serve to restrict the ability of physicians to tailor medical practice to idiosyncratic patient needs. The reasons for this, explored below, are as much historical and political they are scientific.

No. 34B
DISEASE MONGERING

David Healy, M.D. *Cardiff University, Department of Psychological Medicine, Hergest Unit Ysbyty Gwynedd, Bangor Wales, LL57 2PW, United Kingdom*

SUMMARY:

When in 1951 the FDA made ethical drugs available on prescription only and in 1962 when they steered the rapidly growing ethical pharmaceutical industry toward producing drugs for serious diseases rather than for minor ailments or for cosmetic purposes, the agency created the conditions in which selling drugs and selling diseases would go hand in hand (1). Since then psychiatry has witnessed the selling of depression, OCD, ADHD, and recently bipolar disorder (2). Disorders such as panic disorder and social phobia have come to dominate clinical discourse within a matter of a few years. This is achieved by an industrial process that ghost-writes articles, recruits academics to ornamental positions within the marketing enterprise, and plumbs medicine to find "Unmet Needs". This process affects all of medicine and not just psychiatry.

There are however specific consequences for psychiatry. In the process we have lost sight of the actual effects of the drugs, such as the tension reducing effects of the neuroleptics, or the possibility that different drugs within a class, such as norepinephrine and serotonin reuptake inhibitors might have quite different cognitive effects and clinical profiles. Thousands of treatment effect studies later, we are no nearer being able to integrate any findings into a psychopathological theory than we were in the 1950s. We think of our orientation to psychiatric diseases as Kraepelinian, when in fact academically we are as far removed from Kraepelin as it is possible to be. We think of ourselves as being evidence based when it comes to treatments, when to judge by results the only people who are evidence based in the treatment domain are the marketing departments of pharmaceutical companies.

1/ Healy D (2002). The Creation of Psychopharmacology. Harvard University Press, Cambridge Ma

2/ Healy D (2006). The Latest Mania. Selling Bipolar Disorder. PloS Medicine. http://dx.doi.org/10.1371/journal.pmed.0030185

No. 34C
CLEANING UP EVIDENCE-BASED MEDICINE

David N. Osser, M.D. *150 Winding River Rd, Needham, MA, 02492-1025*

SUMMARY:

Drug companies are shaping our decision-making, often in a direction against evidence-based medicine. They do this in a number of ways. Through their sponsorship of most of the major studies that constitute the quality evidence-base for practice, they are often able to influence the design, interpretation, and publication status of the studies. Drug company ghostwriters write many of the articles describing these studies that get published in the major journals. Another problem is that the drug companies dominate pharmacotherapy education. Tens of thousands of "detailers" use word-of-mouth means of promoting products, and most physicians say this is their preferred way of learning about drugs. Medical Education Service Suppliers are firms that set up educational programs, lectures, grand rounds, publications. They are largely marketing agents of the drug companies, advertising their services directly to them and promising that they can deliver increased use of the sponsors' products. But utilizing a variety of loopholes, they can grant CME credits and advertise themselves to physicians and hospitals as unbiased educational resources with emphasis on evidence-based practice. Finally, the practice guideline industry is dominated by the pharmaceutical firms. 87% of a group of guidelines published by professional organizations were found to have primary authors and editors that had undisclosed significant relationships with the drug companies. It is the responsibility of academic psychiatry to teach trainees and practicing physicians about the appropriate use of psychotropic drugs and proper interpretation of the evidence base. The clean-up will have to start at home.

No. 34D
DATA, DOLLARS, AND DRUGS: THE DILEMMAS OF PRACTICE AND RESEARCH

Nassir Ghaemi *The Emory Clinic Building B, 6th Flloor Suite 6100, 1365 Clifton Road, Atlanta, GA, 30322*

SUMMARY:

It is hard to ignore the fact that academic psychiatry is now in crisis. The problem is how this crisis can be solved. It is also easy enough to claim the problem is one-sided: most critics blame the pharmaceutical industry as the enemy. But over simplistic attacks may not be valid. For instance, critics feel that bipolar disorder is currently being marketed excessively, yet objective data of under diagnosis, rather than over diagnosis, exists. Clearly reforms are needed, but in lieu of reforms, what is our profession to do? From the perspective of the state of our current system today, the pharmaceutical industry is an important part of our health care system; it cannot be wished away any more than the managed care industry. The absence of sufficient federal funding for clinical research is a major part of the problem; without such funding, very limited clinical psychopharmacology research can occur. We need to identify how pharmaceutically funded clinical research can be appropriately conducted; one approach would be to limit such research to investigator initiated and controlled studies. Another issue is medical education, which again, in the absence of any other sources (such as insurance companies), is dependent on pharmaceutical funding. Psychiatrists can choose not to participate in promotional programs and continuing medical education (CME) program can become more central, with stronger oversight for objectivity. This presentation will examine practical approaches to managing and minimizing the negative aspects of the relations of our profession with the pharmaceutical industry, so as to allow a more proper role for those positive aspects which lead to truly useful medications for truly harmful diseases.

No. 34E
CONFLICT OF INTEREST IN PSYCHIATRY: HOW MUCH DISCLOSURE IS ENOUGH?

Daniel J. Carlat, M.D. *Tufts University School of Medicine, Psychiatry, 42 Pleasant Street, PO Box 626, Newburyport, MA, 01950*

SUMMARY:

Recently, several instances of lack of disclosure of commercial interests have focussed negative media attention on academic psychiatry. I will discuss two examples in detail: 1) an article published in *JAMA* on relapse to depression following discontinuation of antidepressants in pregnant women, and 2) an article published in *Neuropsychopharmacology* reviewing the use of vagus nerve stimulation in psychiatry. Each example highlights important issues and debates on the proper disclosure of conflicts of interest. Based on this discussion, I make specific recommendations regarding: 1) What types of

financial relationships should be disclosed; 2) Disclosures relating to ghost-authored articles; and 3) Disclosures of the amount of financial compensation received from industry.

REFERENCES:

1. Cohen LS, Altshuler LL, Harlow BL et al. Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. *JAMA*. 2006;295(5):499-507.
2. Nemeroff CB, Mayberg HS, Krahl SE et al. VNS therapy in treatment resistant depression: Clinical evidence and putative neurobiologic mechanisms. *Neuropsychopharmacology*. 2006; 31:1345-1355.
3. Article: Ross E.Upshur, G. Looking for Rules in a World of Exceptions: Reflections on Evidence-Based Practice,. Perspectives in Biology and Medicine, 2005, 48: 477-489.
4. Healy D: The Creation of Psychopharmacology. Harvard University Press, Cambridge Mass 2002.
5. Ban TA. Academic psychiatry and the pharmaceutical industry. Progress in Neuro-Psychopharmacology & Biological Psychiatry 2006;30:429-441.
6. Psaty BM, Rennie D. Related Articles, Links Clinical trial investigators and their prescribing patterns: another dimension to the relationship between physician investigators and the pharmaceutical industry. JAMA. 2006 Jun 21;295(23):2787-90.
7. Cohen LS, Altshuler LL, Harlow BL et al. Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. JAMA. 2006;295(5):499-507.

SYMPOSIUM 35—STALKING OFFENDERS AND VICTIMS

EDUCATIONAL OBJECTIVES:

The participant will be able to treat stalking victims and offenders by acquiring knowledge about: the causes and consequences of stalking; legal and societal responses to stalking; therapeutic and threat management techniques; and counter-transference issues.

No. 35A
STALKING: AN OVERVIEW OF THE PROBLEM

Gail E. Robinson, M.D. *University of Toronto, Psychiatry, 278 Bloor St E, #210, Toronto, ON, M4W 3M4, Canada*

SUMMARY:

Stalking or criminal harassment is defined as the willful, malicious and repeated following or harassing of another person. The behaviour includes such things as following, surveilling, making multiple phone calls, harassing the victim's employer or family, interfering with personal property or sending threatening or suggestive gifts or letters. The offender's behaviour is terrorizing, intimidating and threatening, and restricts the freedom of and controls the victim. It is estimated that 1 in 20 women will be stalked at some point in her lifetime. Most stalkers are male. In 90% of women murdered by a current or estranged intimate, the murders are preceded by some form of stalking. The majority of stalking cases are related to failed intimate relationships. Celebrities, people in positions of authority or prominence as well as health care providers are at an increased risk for attracting stalkers. Stalkers have been described as the rejected, resentful, incompetent, intimacy seekers and predators. Victims suffer from depression, anxiety, shame, embarrassment, guilt and helplessness and often fear for their lives. They often lose friendships, jobs and financial security. Victims experience added stress because of society's failure to acknowledge the seriousness of this problem.

No. 35B
STALKING VICTIMS: A COMPREHENSIVE TREATMENT APPROACH

Karen M. Abrams, M.D. *UHN - Toronto General Hospital, Dept. of Psychiatry, 200 Elizabeth Street - 8 EN, 212, Toronto, ON, M5G 2C4, Canada*

SUMMARY:

Treatment of stalking victims requires a comprehensive approach including education, supportive psychotherapy and a discussion of practical measures. Education to victims about the nature of stalking, including common emotional reactions helps to validate the patient's feelings, reduce self-doubt, and mobilize her. It is important for victims to receive the message that this is not their fault. Supportive therapy will increase the woman's self-esteem by helping her to assert herself with the stalker and, if necessary, the authorities. Therapists can empower the victim to take control through (1) documentation and collecting evidence and (2) taking safety precautions.

While treating victims, therapists must be aware of many countertransference issues that may interfere with effective therapy. Therapists may over-identify with the patient's powerlessness or hesitate to take on a case out of fear of the stalker. Female therapists may protect themselves against the realization of their own vulnerability by blaming the victim. However, a female therapist may create an empathic environment in which the patient can experience, contain and tolerate her feelings of powerlessness. Countertransference reactions in a male therapist can lead to overprotectiveness, overdefensiveness, or anger that can interfere with his ability to be helpful to the patient.

No. 35C
THE RECON TYPOLOGY OF STALKING

J. Reid Meloy, Ph.D. *University of California, San Diego, Psychiatry, PO Box 90699, San Diego, CA, 92169*

SUMMARY:

A new stalking typology, RECON, will be presented. Based upon the prior *relationship and context* in which the stalking occurred, four groups have been identified in an initial study of 1,005 stalking perpetrators: intimate, acquaintance, public figure, and private stranger. Interrater reliability (ICC = 0.95) and discriminant validity data will be briefly reviewed.

No. 35D
STALKING: THREAT MANAGEMENT BY PROFESSIONAL COOPERATION

Werner Tschan, M.D. *Zurich University, Neuensteiner Strasse 7, Basel, 4053, Switzerland*

SUMMARY:

In stalking cases there are three different avenues of approach for threat management:

- counseling and treatment of victims
- psychiatric intervention and treatment of offenders
- police intervention

The different approaches can be combined and may then have a greater impact. The presenter provides an overview on victim treatment and intervention tools in regard to threat management. Victims have to learn, that only a clear answer will help eventually stop the stalker — an unambiguous statement by the victim, that there is absolutely no interest in any further personal contact, and that he/she expects this decision to be respected. Then some aspect of the offender treatment are discussed (summary of last year presentation

on this subject at APA in Toronto). And the final approach is simply that by having a police presence may help stop the stalker.

On al levels of intervention close cooperation between the involved professional bodies is necessary. In severe cases an immediate police intervention may help save lives — a situation often seen in ex-partner stalking. Next to victims'counseling and treatment there is an ongoing need for constant monitoring of threats levels and developments — including emergency contact with law enforecment authorities. The presenter discusses his experiences in threat management, its impact on psychiatric practice, and how to incorporate this technique.

No. 35E
STALKING: THREAT ASSESSMENT AND MANAGEMENT

Jeff Dunn *Los Angeles Police Department, Threat Management Unit, 278 Bloor St. E., 210, Toronto, ON, M4W 3M4, Canada*

SUMMARY:

Becoming a victim of harassment, threats or being stalked can happen to any member of society. Often these situations begin without a specific crime being committed. If such a case is allowed to escalate, it could end in a tragedy to which law enforcement can only react after the fact. The Threat Management Unit of the Los Angeles Police Department was established to address such cases. The Unit provides risk assessment for victims of stalking and other threats and harassment. Staff also work with stalking vicitms to educate victims about the dynamics of stalking and provide common behavioural modifications that help to protect them from harm. Detective Jeff Dunn, one of the founfers of this unit, will present information on risk assessment and management.

REFERENCES:

1. Abrams KM, Robinson GE. Stalking Part I: An Overview of the Problem.
2. Abrams KM, Robinson GE. Stalking Part 2: Victims' Problems With the Legal System and Therapeutic Considerations. Can J Psychiatry 1998; 43: 477-481.
3. Mohandie K, Meloy JR, McGowan M, Williams J: The RECON typology of stalking: Reliability and validity based upon a large sample of North American stalkers. J Forensic Sciences 2006; 51:147-155.
4. Tschan W: Deliktfokussierte Behandlung von Stalkern. In: Psychologie des Stalking, edited by Hoffmann J, Voss H-GW, Verlag für Polizeiwissenschaften, Frankfurt aM, 2006.
5. James DV, Farnham FR. Stalking and serious violence . J Am Acad Psychiatry Law. 2003; 31:432-9.

SYMPOSIUM 36—HUMANE ASPECTS OF PRIVATE PRACTICE

EDUCATIONAL OBJECTIVES:

The Symposium participant will understand one resourceful and comprehensive approach to practicing psychiatry in the private sector at the present time.

No. 36A
COMPREHENSIVE PSYCHIATRY IN PRIVATE PRACTICE, 2007

Brian Crowley, M.D. *5225 Connecticut Ave NW # 215, Washington, DC, 20015-1845*

SUMMARY:

The author sees adults, and a few adolescents, in his uptown office in Washington, DC. Most are in meaningful psychotherapy, of varying intensity, with a combined dynamic/cognitive emphasis, with the author—who dislikes the modality called ''split treament'' and rarely is willing to practice it. Most appointments are for 45 minutes; a few patients are seen for shorter visits, primarily around medication and general assessment. Emergencies are easily seen at the general hospital with ER and psychiatric/substance abuse inpatient services with which the author has a 40-year ongoing relationship on the senior staff. The author is accessible to his patients by telephone and can see them promptly for extra appointments as the need arises. He currently accepts about three managed care plans, as well as fully self-paying patients. His office practice is not necessarily a model of economic efficiency. However his professional life is diversified among office practice, some hospital work, contract clinical services with the Department of Defense, private forensic practice, and teaching. The author finds the mix nicely balanced and offers the satisfaction of making a good living while making a real difference in the lives of a number of people.

No. 36B
PRIVATE PRACTICE: THE VERY MODEL OF HUMANE CARE

Ronald Abramson, M.D. *Privatre practice, 25 Main St Ste 7, Wayland, MA, 01778*

SUMMARY:

This presentation describes how the independence of outpatient private practice allows accessible humane treatment in the least restrictive setting.

Traditionally, private practice has had the reputation of being an insular restrictive model catering only to the relatively wealthy. However, a private practice relying on insurance company reimbursement can provide care to a wide variety of patients of all income levels and most diagnostic entities. Case material will be presented documenting care to a wide spectrum of patients including:

- Geriatric patients needing psychopharmacology and a therapeutic relationship
- Hispanic patients needing cross-cultural sensitivity
- Addiction patients needing psychopharmacology and group and individual psychotherapy
- Patients with Schizophrenia and Bipolar 1 Disorder needing psychopharmacology, psychotherapy, and collaboration with Department of Mental Health Treatment Teams
- Patients with chronic pain needing collaboration with chronic pain specialists
- Physically challenged patients needing easy and extensive telephone contact
- Patients with personality disorders needing long term psychotherapy
- Patients with complex behavioral problems needing collaboration with their families

This broad spectrum of services is facilitated by joining insurance company networks, including Medicare and Medicaid. Telephone access is provided through voice mail messaging and through an emergency beeper system. The psychiatrist's access to allied professionals allows for increased cultural sensitivity and provision of more family and individual services. Perhaps most importantly, patients can come and go at will, making this a very non-restrictive setting for treatment.

The independence of outpatient private practice facilitates the provision of easily accessible humane psychiatric care in the least restrictive setting for a wide variety of patients who have easy personal and telephone access to the psychiatrist.

No. 36C
COMPREHENSIVE PSYCHIATRY IN A COMMUNITY HOSPITAL AND MEDICAL CENTER PROVIDES READY ACCESS FOR LEAST RESTRICTIVE TREATMENT

John C. Urbaitis *Sinai Hospital of Baltimore, Sinai Hospital of Baltimore, Baltimore, MD, 21215-5216*

SUMMARY:

The author practices comprehensive psychiatry in an urban private-sector general hospital. Many patients also have active medical conditions and may be referred by their primary physicians associated with the hospital. His commitments are to 1) patients – he will see them in most settings, outpatient, inpatient, consultation, house calls; he will see them over the years. 2) Colleagues – he shares in patient care, teaching, and support. 3) Patient services and profession, he works through advocacy in professional and lay organizations. By maintaining a flexible schedule with times available daily for emergencies, and by working with a clinical team, the psychiatrist can better serve patients with complex conditions. These include people with recurring depressions, people with concurrent medical illnesses. By promoting teamwork within the psychiatry department and through other medical practices in the center, the psychiatrist provides accessible treatment coordinated with other services. The severely depressed patient who needs an urgent psychiatric assessment for changes in treatment can be seen promptly. This contrasts with the patient's previous experience, waiting more than 10 days for a psychiatrist appointment, getting more depressed and anxious, and requiring hospitalization. This patient may then continue in outpatient treatment or partial hospital, with flexible schedule and ready access to an urgent appointment before decompensating. Patients with concurrent medical illnesses can have coordinated care: hypertension and diabetes, for example, need not complicate the treatment of depression. Teamwork and flexible scheduling, at a medical center with full array of clinical services, can greatly improve patient care and access.

REFERENCES:

1. Gabbard GO: A Neuroscience Perspective on Transference. Psychiatric Annals April 2006; Vol 36, No. 4: 282-288.
2. 1. Langsley DG: Comparing clinic and private practice of psychiatry. Am J Psychiatry 1978; 135: 702-706.
3. Olfson M, Marcus SC, Pincus HA: Trends in office-based psychiatric practice. Am J Psychiatry 1999: 156-451-457.
4. Ruo B, Rumsfeld JS, Hlatky MA, Liu H, Browner WS, Wooley MA: Depressive symptoms and health-related quality of life. JAMA 2003; 290: 215-221.

SYMPOSIUM 37—EATING DISORDERS UPDATE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to diagnose and treat eating disorder patients according to evidence based psychiatry.

No. 37A
ALTERATIONS OF NEUROCURCUITS AND SYMPTOMS IN ANOREXIA AND BULIMIA NERVOSA

Walter H. Kaye, M.D. *University of Pittsburgh School of Medicine & University of California, San Diego, Psychiatry, 3811 O'Hara Street, 600 Iroquois Building, Pittsburgh, PA, 15213*, Ursula F. Bailer, M.D., Guido K. Frank, M.D., Angela Wagner, M.D.

SUMMARY:

Anorexia nervosa (AN) and bulimia nervosa (BN) are related disorders with relatively homogenous presentations. Many temperament and personality symptoms that occur in ill subjects present premorbidly and persist after recovery, suggesting these are traits that create a susceptibility for AN and BN. Several lines of evidence point to a dysregulation of serotonin (5-HT) and dopamine (DA) pathways in cortical, limbic, and striatal structures that may be related to altered anxiety, obsessionality, appetite, impulse dyscontrol, and body image distortions. Our group used positron emission tomography (PET) with 5-HT and DA specific radioligands to characterize 5-HT and DA pathway function in individuals recovered from AN and BN. In general, individuals after recovery have elevated 5-HT_{1A} receptor activity and reduced 5-HT_{2A} receptor activity. Restrictor AN had elevated 5-HT transporter activity whereas bulimic AN had reduced 5-HT transporter activity. And only restrictor AN had elevated DA D2 receptor activity in the antero-ventral striatum, the "reward" center.

Serotonin and DA pathways act in concert to modulate response to stimuli, particularly aspects such as behavioral inhibition or dysinhibition, goal directed behavior, error detection, or response to uncertainty. In fact, we found significant correlations between 5-HT and DA receptor activity and instruments that might reflect this encoding, such as response to positive and negative stimuli, novelty seeking, self-control, anxiety, and harm avoidance. It is likely that these findings reflect complex dysregulation of 5HT-DA pathways in AN and BN. Moreover, subtypes may have different patterns of 5HT-DA dysfunction which may shed light on understanding specific symptoms such as inflexibility and rigidity and disregard of normal rewards in AN, or unstable mood and impulse dyscontrol in BN. Finally, these findings may provide new insights into medications that might be useful in these disorders.

No. 37B
EPIDEMIOLOGY OF EATING DISORDERS

Hans W. Hoek, M.D. *Parnassia The Hague Psychiatric Institute & Columbia University New York, Epidemiology/Research, Mangostraat 15, MA15 / TV 0.35, The Hague, NL-2552 KS, Netherlands*

SUMMARY:

Objective: The purpose of this update is to evaluate recent studies on the incidence, prevalence and mortality of eating disorders.

Methods: We conducted several epidemiological studies in The Netherlands and in the Caribbean island of Curacao with a mainly black population. We also reviewed the literature on the incidence and prevalence of eating disorders. Special attention has been paid to methodological problems affecting the selection of populations under study and the identification of cases.

Results: The incidence of anorexia nervosa increased over the past century, until the 1970s, but remained stable during the 1980s and 1990s. Some evidence suggests that the occurrence of bulimia nervosa might be decreasing. The most common eating disorder both in clinical samples and in the community is Eating Disorder Not Otherwise Specified. Anorexia nervosa is a common disorder among young white females, but is extremely rare among black females.

Recent studies confirm previous findings of the high mortality rate within the anorexia nervosa population.

Discussion: Only a minority of people who meet stringent diagnostic criteria for eating disorders are seen in mental health care. Most people with eating disorders in the community do not receive treatment at all.

No. 37C
PSYCHOLOGICAL TREATMENTS OF EATING DISORDERS: STATUS QUO AND NEW DEVELOPMENTS

Ulrike Schmidt, M.D. *Institute of Psychiatry, Section of Eating Disorders, De Crespigny Park, London, SE5 8AF, United Kingdom*

SUMMARY:

Purpose: Psychotherapeutic approaches are widely seen as the central aspect of eating disorder treatment. The aim of this paper is (1) to review what we currently know about the psychological treatment of eating disorders and (2) to outline possible new directions in the psychological treatment of eating disorders.

Content: Several systematic reviews have addressed the topic of psychological treatments, (such as those published by the Cochrane library). Several countries, including the USA, UK and Australia have produced evidence-based treatment guidelines.

Findings: The evidence-base for psychological treatments of adults with bulimia is solid, and suggests that cognitive-behavioural therapy (CBT) is the treatment of choice. Self-care treatments with some guidance may be sufficient treatment for a proportion of cases. However, much less is known about useful alternatives to CBT for those who fail to respond or do not like CBT. In the treatment of adolescents with bulimia nervosa, the first randomised controlled trial (RCT) has recently been completed, suggesting that guided self-care has slight advantages over family-based treatment. The evidence base for the treatment of anorexia nervosa is much less solid. Family based- treatment is the treatment of choice for adolescents with anorexia nervosa, but there is no leading psychological treatment for adults with anorexia nervosa. Recent RCTs have somewhat questioned the utility of CBT, derived from popular models of treatment for bulimia nervosa, in the treatment of anorexia nervosa, suggesting that CBT may neither be particularly acceptable nor particularly effective in the treatment of anorexia nervosa.

Conclusions: These findings suggest that we urgently need to develop new approaches to the treatment of anorexia nervosa. Some ideas as to how to move forward will be discussed.

No. 37D
PHARMACOLOGICAL TREATMENT OF EATING DISORDERS

B. Timothy Walsh, M.D. *Columbia University/NYS Psychiatric Institute, Psychiatry, 1051 Riverside Drive, Unit 98/Room 2306, New York, NY, 10032*

SUMMARY:

The development of effective pharmacological treatments for eating disorders remains an area of active research interest, characterized by both significant progress and persistent challenges.

Pharmacological treatment of Bulimia Nervosa is now a well-established, 'mature' intervention. Numerous placebo-controlled trials have documented that antidepressant medication is useful, either used alone or combined with psychotherapy. Recent investigations have attempted to identify predictors of treatment response, in hopes of limiting the duration of interventions which will ultimately prove to be ineffective. Evidence is accumulating that the first few weeks of treatment response may be a useful indicator of eventual response. Recent studies suggest that the anti-obesity agent, sibutramine, and the anti-convulsant, topiramate, are also useful in the treatment of Bulimia Nervosa.

Progress in the pharmacological treatment of Anorexia Nervosa has proved much more difficult. A small number of placebo-controlled trials of a variety of agents, most completed before 2000, indicated that antidepressants, lithium, typical antipsychotics, and cyproheptadine (a serotonin antagonist) were largely ineffective in underweight patients. Preliminary data suggested that antidepressant medication might prolong time to relapse among patients who had regained to normal weight, but a recently published placebo-controlled trial indicates that fluoxetine does not provide substantial benefit. Placebo-controlled trials of other agents, including atypical antipsychotics, are currently underway.

This presentation will provide an overview of the evidence base regarding pharmacological treatment of eating disorders, and treatment guidelines for practitioners involved in the care of patients with Anorexia Nervosa and Bulimia Nervosa.

No. 37E
CHILDREN AND ADOLESCENTS WITH EATING DISORDERS

Annemarie A. van Elburg, M.D. *Altrecht Mental Health Institute, Rintveld, Centre for Eating Disorders, Oude Arnhemseweg 260, Zeist, 3705BK, Netherlands*

SUMMARY:

The percentage of patients in treatment who are under 16 years of age increases and the age of onset of eating disorders seems to drop. Diagnostic procedures, treatment goals and setting need to be adjusted for this particular age group. Family based treatment is the treatment of choice in young patients with anorexia nervosa and sofar it is the only evidence based treatment available.

Research interest in this particular age group has been limited by the problems that arise as a result of minority. The pathogenesis of eating disorders remains unclear despite the advances made in understanding the neuroendocrinological mechanisms that regulate appetite and food intake in animal models. Adolescents are the age group with the highest anorexia nervosa incidence rates and it is likely that anorexia nervosa and the onset of puberty are related. Therefore this age group presents a window of opportunity regarding the study of early (neuro-) biological changes.

This presentation will provide an overview of the specific features involved for practitioners working with very young patients and illuminates some of the points of interest for research into the early (neuro-) biological changes.

REFERENCES:

1. Kaye WH, Wagner A, Frank GK, Bailer UF: Review of Brain Imaging in anorexia and bulimia nervosa. In the AED Annual Review of Eating Disorders, Part 2, edited by Mitchell J, Wonderlich S, Steiger H, de Zwaan M (eds). 2006, pp 113-130.
2. Hoek HW: Incidence, prevalence and mortality of anorexia nervosa and other eating disorders. Current Opinion in Psychiatry 2006; 19:389-394.
3. Schmidt U et al. (2006). A Randomized Controlled Trial of Family Therapy and Cognitive-Behavioral Guided Self-Care for Adolescents with Bulimia Nervosa or Related Disorders. Am J Psychiatry. In press.
4. Walsh BT, Kaplan AS, Attia E, Olmsted M, Parides M, Carter JC, Pike KM, Devlin MJ, Woodside B, Roberto CA, Rockert W: Fluoxetine after weight restoration in anorexia nervosa: a randomized controlled trial. JAMA. 295:2605-12, 2006.
5. Hillebrand JJ, van Elburg AA, Kas MJ, van Engeland H, Adan RA. Olanzapine reduces physical activity in rats exposed to activity-based anorexia: possible implications for treatment of anorexia nervosa? Biol Psychiatry 2005 Oct 15;58(8):651-7.

SYMPOSIUM 38—LUMPING VERSUS SPLITTING IN PSYCHIATRIC NOSOLOGY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to follow the current controversy about either removing or

adding diagnoses in DSM V, so as to enhance access and quality of care.

No. 38A
THE CONTROVERSY OVER LUMPING VS. SPLITTING IN PSYCHIATRIC NOSOLOGY

Ahmed Okasha, M.D. *Institute of Psychiatry - Faculty of Medicine, Ain Shams University - Cairo, 3 Shawarby St.- Kasr El Nil, 402, Cairo, 1111, Egypt*

SUMMARY:

Psychiatric classification should be directed toward the patient's care. Lumping or splitting psychiatric disorders did not help in the management or outcome or quality of life of our patients. Psychiatric disorders have mushroomed in the last twenty years with variable validity, reliability and utility for the patient. The inflation of nosological entities did not offer any objective advancement in the management of the psychiatric patient. For example an antipsychotic treat all psychotic disorders regardless of the entity and antidepressants are misnomers as they treat apart from depression GAP, OCD, ICD, Panic.. etc. Nosologists are swinging their attitude toward splitting or lumping in all medical disorders. We do not have any valid or reliable studies to show which is better for the patients. The presentation will discuss the real problem we are currently facing in Medicine and Psychiatry, and what should we do with evidence based studies.

No. 38B
LUMPING VS. SPLITTING: PSYCHOPATHOLOGY AND THE REST OF MEDICINE

G. Scott Waterman, M.D. *University of Vermont College of Medicine, Department of Psychiatry, 89 Beaumont Avenue, Given E215, Burlington, VT, 05405*

SUMMARY:

Contemporary taxonomies of disease, specifically the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD), "split" off psychopathology from other forms of illness. The DSM divides "mental disorders" from "general medical conditions," while the ICD slices the universe of disease more finely, with psychiatric disorders occupying one of its chapters. Both nosological systems are predicated on the assumption that mental disorders form a natural - or, at least, useful - category. This presentation will examine that assumption and its consequences.

Parameters along which diseases are typically classified are etiopathogenesis (e.g., infectious diseases, neoplastic diseases) **or** location/manifestations (e.g., pulmonary diseases, gastrointestinal diseases). It may be argued that events in the social environment are uniquely salient to the etiopathogenesis of psychopathology, **or** that the manifestations of psychiatric illness are distinguished from those of other types of disease in consisting of abnormal subjective experiences as opposed to abnormal objective findings. Both of those arguments, however, fail. Moreover, the consequences of the "split" between mental and other illnesses are numerous and largely adverse. These conclusions will be discussed in the context of recommendations that recognize the legitimacy of psychiatry as a specialty, though not of mental disorder as a category.

No. 38C
SPLITTING IN ORDER TO BETTER LUMP

Hagop Akiskal, M.D. *UC-San Diego, Psychiatry, 3350 La Jolla Village Dr,, Psychiatry 116-A, San Diego, CA, 92161*

SUMMARY:

The number of mental disorders has grown from one (Greisinger) to a few (Pinel, Kraepelin) to 12 (Washington University criteria) to several hundred (DSM-IV-TR and ICD-10). This expansion represents either conditions of clinical relevance or those that require further study. They are lumped in about 10 chapters based on some organizing principle typically related to the type of mental function presumed to be the substrate of the disorder, i.e. mood, personality, cognition, sleep. In this presentation, I will argue that better principles are needed to split mental conditions in order to better lump them in more coherent categories. Our group has expanded bipolar disorder to include six subtypes beyond our formal nosology. Some of these subtypes such as BP II-½ might be classified as personality disorders and III-½ as substance use disorders by others. I further submit that recurrent depressions, atypical and seasonal depressions, anxiety comorbidity, bulimia nervosa, impulse control disorders, refractory depressions, depression with migraine attacks could also belong to a broad bipolar spectrum. In other words, the splitting in our classification efforts should ultimately serve to define spectra, in this instance, a putative bipolar spectrum tied together by course, familial-genetic, temperamental, and neurophysiologic affinities.

No. 38D
LUMPING IN ORDER TO BETTER SPLITT

Juan J. López-Ibor, Jr., Ph.D. *Hospital Clínico San Carlos. Complutense University, Institute of Psychiatry and Mental Health, Martín Lagos s/n, Madrid, E-28040, Spain*

SUMMARY:

Contrary to what is common in other medical specialties, nosology is a main and constant concern of psychiatry and there is a constant return to a few set of paradigms. Emil Kraepelin himself in his last publication, ecoes this disenchantment abandons his former principles and yields to Hoche's functional approach to define and classify psychiatric disorders.

Nowere in the rest of medicine there are such different perspectives as the ones of the so called splitters and lumpers. The first group is represented by the concept of unique-psychosis (*Einheitspsychose*), and authors like Griesinger (1872) and Janzarik (1968). In Spain, Llopis (1954) studied the psychiatric disorders secondary to pellagra after the 1936-39 Spanish Civil War.

Another big schism in psychiatric nosology is represented by generalisation vs. individualisation. Schizophrenia was descibed by Kraepelin as a nosological entity, taking a strong natural scientific perspective, while other auhors descibed more the personal aspects of the disease. There are two trends within philosophy of knowledge (Gadamer, 1990), positivism and hermeneutic knowledge. The first entails understanding the facts of the world, while hermeneutic knowledge entails subjective understanding. But a synthesis is also possible (Bhaskar, 1994). Before starting splitting, we need to understand what means to suffer fom a mental disease, how it happens that the mind of somebody can turn upside down, or that a persons losses what is more precious in our nature. The disentchantment of the last Kraepelin and of many others is s the consequence of having become splitteres too early.

No. 38E
THE NEED FOR AN ECLECTIC APPROACH TO THE CLASSIFICATION OF MENTAL DISORDERS

Norman H. Sartorius, M.D. *Chemin Colladon 14, Geneva, CH 1209, Switzerland*

SUMMARY:

The recent hesitation in the selection of the strategy for the revision of the international and other classifications of mental disorders – between putting together categories of the psychiatric classifications (''lumping'') and ''splitting'' them further – is healthy and it is to be hoped that neither of the two approaches will be comprehensively applied in the development of proposals for the new classifications. In the current classifications there are many categories that have been created on the basis of insufficient evidence available at the time of their formulation. These (and others) will have to be examined and, wherever there is sufficient and relevant new evidence, revised: some will have to be lumped with others, others split further: no general rule can be made at present for all the categories. While in the process of doing this it will be important to keep in mind the possible uses of classifications – for clinical practice, for statistical purposes, for research and for training – and undertake changes only when necessary and always with the intention to make them serve the purposes for which they are **made.**

REFERENCES:

1. Kupfer D., First M and Regier D : A research Agenda for DSM-V. American Psychiatric Association, Washington, D.C. (2002).
2. Kendell RE: The distinction between mental and physical illness. British Journal of Psychiatry 2001; 178:490-493.
3. Akiskal et al: Validating the bipolar spectrum in the French National EPIDEP study: overview of the phenomenology and relative prevalence of its clinical prototypes. J Affect Disord 2006, in press.
4. López-Ibor JJ.: Kraepelin and the New Trends in Psychiatric Nosology. In: H.J. Möller (Ed.), in press.
5. Maj M, Gaebel W, Lopez Ibor JJ, Sartorius N: Psychiatric diagnosis and classification, John Wiley and Sons, Chichester, UK, 2002.

SYMPOSIUM 39—CHOOSING THE RIGHT TREATMENT FOR SUBSTANCE ABUSE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will know the best methods, both pharmacologic and behavioral, for treating the major addictions and when to choose them.

No. 39A
COCAINE DEPENDENCE: CHOOSING THE RIGHT TREATMENT

Adam Bisaga, M.D. *Columbia University College of Physicians and Surgeons, Psychiatry, 1051 Riverside Drive, Unit 120, New York, NY, 10032*

SUMMARY:

Cocaine abuse and dependence remain severe health problems, with treatment difficult, and few successful controlled trials. A combination of pharmacological and behavioral interventions will likely be required for patients to achieve and maintain abstinence. Antidepressants, with desipramine most studied, have yielded inconsistent results. Medications that affect dopaminergic neurotransmission, including dopamine receptor agonists, dopamine transporter inhibitors, and dopamine receptor blockers, have also not been consistently successful. Recently studied medications, including disulfiram, d-amphetamine, tiagabine, and topiramate, are more promising. Current areas of research interest include the use of medications that affect the neurotransmission of excitatory and inhibitory amino acids, and the function of the HPA axis. Strategies to prevent cocaine from entering the brain are also being developed and initial results with a ''cocaine vaccine'' are promising. A new approach in cocaine treatment trials involves the induction of initial abstinence using behavioral methods and medications that may extend abstinence and prevent relapse. Despite the absence of reliable pharmacotherapy, there are several effective psychosocial treatment approaches that should be a part of every treatment effort. Although no single treatment is currently suggested, several treatment combination approaches will be discussed.

No. 39B
CHOOSING THE BEST TREATMENT: MARIJUANA AND CLUB DRUGS

David M. McDowell, M.D. *Department of Psychiatry, Columbia University, 1051 Riverside Dr., Unit 66, New York, NY 10032*

SUMMARY:

Marijuana is the most commonly used substance of abuse in the United States. In addition the use of ''club drugs,'' in particular MDMA, Ketamine and GHB are increasing. Contrary to public perception, ''Club drugs'' cause real and substantial morbidity and mortality along. In addition, chronic and heavy use of marijuana carries with it substantial morbidity as well as the risk of dependence and withdrawal. These issues have far reaching implications for substance abuse treatment and psychiatric treatment both now and in the future. Pharmacological interventions for marijuana dependence have included mood stabilizers and medication focused on withdrawal symptoms. Treatment strategies for these conditions have focused on prevention measures and psychosocial interventions. These conditions are not as well studied as other substance abuse conditions. In recent years a great deal of work has been completed concerning the basic mechanisms of actions, pharmacology and neuro-physiology of marijuana and its endogenous ligand anadamide. Given the increasing knowledge about marijuana, new and potential treatments are being studied and even more can be theorized. Especially promising are various pharmacological interventions for marijuana as well as for co-morbid conditions. This portion of the seminar will focus on the latest developments in the study of marijuana and club drugs as well as treatment strategies. New and potential pharmacological treatments will be emphasized.

No. 39C
TREATMENT OF COMORBID CONDITIONS

Frances R. Levin, M.D., *Department of Psychiatry, Columbia University, State Psychiatric Inst., 722 West 168th Street, Unit 66, New York, NY 10032*

SUMMARY:

Evidence for a link between psychiatric and substance use disorders is strong and converging. Epidemiologic studies have demonstrated that substance abuse is over-represented among individuals with psychiatric conditions. Similarly, numerous prevalence studies among substance abusers seeking treatment have found that the majority of patients have at least one comorbid psychiatric disorder. These psychiatric disorders may include major depression, bipolar disorder, anxiety disorders, attention-deficit hyperactivity disorder, and schizophrenia/schizo-affective illness. Although there are established pharmacologic and nonpharmacologic approaches for each of these psychiatric conditions in non-substance abusing patients, the efficacy of these approaches is substance-abusing patients is not well established. Several questions will be addressed in this presentation: 1) what are the appropriate pharmacologic treatment approaches for specific dually disordered patients? 2) Should medications with abuse potential be avoided? 3) Is substance use reduced if the psychiatric comorbid condition is treated? 4) What are some possible modifications of currently available nonpharmacologic strategies that might

be used for various diagnosed groups? Although there are no definite answers, clinical guidelines will be offered.

No. 39D
INTEGRATING PSYCHOSOCIAL INTERVENTIONS WITH MEDICATIONS IN THE TREATMENT OF SUBSTANCE DEPENDENCE

Edward V. Nunes, Jr., M.D. *Columbia University, Psychiatry, 1051 Riverside Dr, Unit 51 (room 3717), New York, NY, 10032-1007*

SUMMARY:

Psychosocial treatment is the cornerstone of treatment for addictions, either alone or in combination with medications. Several types of psychotherapeutic interventions have been developed and studied, including cognitive behavioral skill-building approaches (e.g., relapse prevention, community reinforcement approach, contingency management, motivational enhancement therapy, and 12-Step facilitation). Such interventions have served as means of achieving abstinence, encouraging lifestyle change, and promoting compliance with medications. Despite encouraging findings in treatment outcome research, many challenges remain. The behavioral interventions are not always successful in securing longer term abstinence and commitment to change. Transferring and integrating such treatment models from research to community treatment settings remains a complex task. An overview of these models will be provided, as well as their known efficacy in working with different substances of choice. Obstacles encountered in the delivery of these approaches, the clinical implication of integrating such models, and the efforts thus far to generalize research findings to community settings will be addressed.

No. 39E
CHOOSING THE RIGHT TREATMENT FOR OPIOID DEPENDENCE

Herbert D. Kleber, M.D. *Columbia University, Psychiatry, 1051 Riverside Dr, Unit 66, New York, NY, 10032-1007*

SUMMARY:

There are more effective pharmacotherapies for the 1 million heroin addicts and 2-3 times more prescription opioid abusers than for any other addiction other than nicotine. Unfortunately, too few physicians use them. The agonist methadone decreases opiate use and improves psychosocial outcome but presents problems such as high rates of concurrent alcohol and cocaine abuse, need for frequent clinic visits, and difficulty in withdrawal. The partial agonist buprenorphine has better psychological effects, easier withdrawal, a ceiling effect on respiratory depression, decreased diversion potential and office-based prescribing. It opens the possibility of mainstreaming addiction treatment and attracting individuals who have not sought help, especially prescription opioid abusers and women. The antagonist naltrexone, while blocking opiate use and decreasing alcohol abuse, has low rates of acceptance and high dropout rates but an injectable 1 month depot form of naltrexone, which can block opioids for up to 4 weeks, came on the market in 2006 to treat alcoholism and can be used off-label for opioid dependence. A 1-month buprenorphine injection, and a 6-month buprenorphine implant are all being tested. New approaches to opiate detoxification, including lofexidine, rapid detoxification using buprenorphine and naltrexone, and the use of NMDA antagonists hold out hope for less discomfort and higher completion rates. In contrast, studies suggest the risk/benefit ratio for anesthesia rapid detoxification methods do not justify their use. Alpha-2 agonists such as lofexidine or clonidine are being tried to treat protracted withdrawal and craving. The paper discusses using available medications in office-based settings including patient selection, treatment, and safety issues.

REFERENCES:

1. Rothenberg JL, Sullivan MA, Church SH, Seracini A, Collins E, Kleber HD, Nunes EV: Behavioral naltrexone therapy: an integrated treatment for opiate dependence. J Subst Abuse Treat 2002; 23(4):351-360.
2. American Psychiatric Association, Practice guideline for the treatment of patients with substance use disorders, 2nd Edition. H.D. Kleber, Chair. Am J Psychiatry, p 72-82. August 2006 (supp).
3. Levin FR, Evans, SM, Kleber, HD: Treatment of substance abusers with adult ADHD: practical guidelines for treatment. Psychiatric Services 50: 1001-1003.
4. Budney, A.J. Hughes, J.R. et al. Marijuana Abstinence Effects in Marijuana Smokers Maintained in their Home Environment. 2001, Archives of Gen Psychiatry 58: 917-924.

SYMPOSIUM 40—ETHICAL ISSUES IN PSYCHIATRIC GENETICS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will understand the current state of psychiatric genetics and the current and future ethical issues in the field.

No. 40A
WHAT CAN PSYCHIATRIC GENETICS TELL THE CLINICIAN?

John R. Kelsoe, M.D. *Univ Calif, San Diego, Psychiatry, 9500 Gilman Drive, mail code 0603, La Jolla, CA, 92093-0603*, Thomas B. Barrett, M.D., Xianjin Zhou, Ph.D., Nicholas Schork, Ph.D.

SUMMARY:

Several psychiatric disorders have been shown to display significant heritability, with genes explaining 30-70% of the risk for illness. Recently, molecular genetic mapping methods have identified several genes for both schizophrenia and bipolar disorder which show reasonably convincing evidence for association. Studies of the cell biology of these proteins are beginning to provide new insights into disease mechanism. Whole genome association methods that are just beginning, promise to detect genes with even greater power. The identification of specific mutations or well defined markers in these genes opens the prospect of DNA testing in psychiatry. To inform a discussion of relevant ethical and legal issues, the status of psychiatric genetics will be reviewed. What genes have been found? How large an effect do they display? How many genes likely explain most of the genetic variance? What could a DNA test panel tell clinicians about diagnosis or risk for illness in unaffected individuals? Data to date suggests that the relationship between genes and diagnosis is more complex than suspected. At least half of identified genes and chromosomal loci seem to play a role in both bipolar disorder and schizophrenia. Alternatively, some specific symptoms may show specific gene associations across diagnosis. To illustrate mapping methods and as an example of gene effect size, data will be presented regarding our examination of the gene, GRK3, in bipolar disorder. These and numerous other data suggest that at least several dozen genes are significantly involved genetic etiology. In the relatively near future, it may be possible to employ a panel of DNA tests interrogating many mutations in many genes that will provide probabilistic information to aid in diagnosis. This may in turn lead to new biology based diagnoses, made using both DNA and symptom data that transcends current diagnostic boundaries.

No. 40B
ETHICAL ISSUES INVOLVED IN DECISION MAKING ABOUT GENETIC TESTING, DISCLOSURE AND REPRODUCTIVE CHOICES AMONG INDIVIDAULS AT RISK FOR HUNTINGTON'S DISEASE

Robert L. Klitzman, M.D. *Columbia University, Dept. of Psychiatry, 410 Central Park W # 16F, New York, NY, 10025-4848*

SUMMARY:

Purpose: To understand ethical, psychological and social issues confronted by individuals at risk for Huntington's Disease (HD) in decision making; and potential implications for other psychiatric disorders.

Methods: 21 individuals (8 gene positive, 4 gene negative, and 9 not tested) were interviewed for 2 hours each.

Results: These individuals wrestled with difficult ethical issues concerning whether to undergo genetic testing, whether to disclose results to family members, and if so, when, what and whom to tell; and how to make reproductive decisions. Individuals confronted difficult psychological issues in contemplating testing, and experienced anxiety and depression in confronting their risk, and possibilities of carrying the HD mutation. Individuals disclosed because of perceived duty to family members, yet the information could burden these members, who also have rights to remain 'in denial' if they wish and not discuss the topic or pursue testing. Differences arose in what is disclosed (i.e., partial, or indirect information), how disclosure occurs (e.g., "blurted out") whether extended family members are told, and whether families are encouraged to test. These individuals balanced their sense of obligations toward others against dilemmas of whether to: get pregnant and deliver, have fetal testing and abort if the fetus is positive, undergo pre-implantation genetic diagnosis, or have no children. Individuals balanced desires for children against broader concerns, and had to imagine how they and their yet unborn offspring will view these decisions in the future.

Conclusions: These data have important implications for at-risk individuals, genetic counselors, psychiatrists and other health care professionals, and for future research and policy, particularly as more genetic tests become available. Psychiatrists and other providers, and at-risk individuals and their families may benefit from increased awareness of these complexities. Future policy and research should examine the specific roles of providers, and mental health issues involved in these decisions.

No. 40C
DISCLOSURE OF GENETIC INFORMATION: PATIENTS, THIRD PARTIES, EMPLOYERS AND INSURERS

Paul S. Appelbaum, M.D. *Columbia University, Department of Psychiatry, 1051 Riverside Dr, Unit 122, New York, NY, 10032-1007*

SUMMARY:

With the growing availability of genetic testing for alleles related to mental disorders, ethical and legal challenges regarding disclosure of the resulting information will be common. When disclosing to patients themselves, problems that will need to be addressed include popular misunderstanding of the consequences of possessing an affected allele and the impact of knowledge of one's genetic make-up on one's sense of self and the future. Physicians may also find that newly available genetic information creates new duties for them, including warning third parties who may share the patient's genetic endowment—arguably a variant of the duty to warn endangered persons of the risk posed by a patient. Other third parties, as well, may be interested in access to genetic information, including insurers—who may compel disclosure—and employers—who may use the information for discriminatory purposes. Although most states have some legislation aimed at preventing discrimination by both insurers and employers, the laws' coverage is spotty and federal rules are lacking. And genetic research itself has raised questions about when to disclose information to subjects and their family members about the genes being studied. Psychiatrists will need to resolve these issues in daily practice in the near future, balancing ethical, legal, and clinical considerations.

No. 40D
PRESENTER ETHICAL ISSUES RELATED TO THE USE OF GENETIC INFORMATION IN THE WORKPLACE - APA SYMPOSIUM ON ETHICS OF PSYCHIATRIC GENETICS

Laura W. Roberts *Medical College of Wisconsin, Dept of Psych & Behav Med, 8701 W Watertown Plank Rd, Milwaukee, WI, 53226-3548*

SUMMARY:

Over 139 million people are employed in the United States, and careful efforts to protect and promote the health of these workers are crucial to our society. In the near future, advances in biomedical science will lead to the development of genetic tests that may be very useful in identifying, monitoring, and preventing many genetically-based health conditions of workers. These tests will not only clarify the presence of disease, but also will help to determine whether individuals have increased susceptibility to health conditions linked to occupational exposures and to illnesses that influence worker productivity or performance.

Use of genetic and related health information in the workplace poses many ethical, legal, and social issues, however, particularly in relation to complex disorders and especially pertaining to stigmatizing conditions (e.g., mental illness, addiction). These concerns have yet to be examined using evidence-based methods.

In a preliminary study funded by the DOE, our research team assessed employee attitudes, preferences, concerns, and decision-making in a sample of 63 workers at Sandia National Laboratories (SNL) and at the University of New Mexico Health Sciences Center (UNMHSC). Results show that workers expressed serious concerns about the possible consequences of genetic testing in the workplace for themselves in four areas: (1) informed consent for genetic testing; (2) handling and retention of genetic samples by employers; (3) safeguards for confidentiality of genetic information gathered in the workplace; and (4) uses of genetic information by employers. In a larger follow up study, we are assessing views of workers stratified by five broad job categories. Findings from the preliminary and follow-up study will be presented as part of this symposium, giving special emphasis to the issues most pertinent to stigmatizing illnesses.

No. 40E
TRAINING PSYCHIATRISTS IN PSYCHIATRIC GENETICS: VIEWS OF PROGRAM DIRECTORS AND RESIDENTS

Laura B. Dunn, M.D. *UC San Diego, Div of Geriatric Psychiatry, 3350 La Jolla Village Dr # 116A-1, San Diego, CA, 92161-0002,* Jinger G. Hoop, M.D., Sidney Zisook, M.D.

SUMMARY:

Understanding the genetic underpinnings of and influences on psychiatric disorders has become an increasingly important research avenue in psychiatry. It is unclear, however, whether and to what degree advances in the field's knowledge of psychiatric genetics have been translated into the training of future psychiatrists. We conducted a web-based survey of psychiatry residency training direc-

tors (including assistant and associate directors) (TDs), as well as of psychiatry residents, to ascertain perspectives on a number of training issues relevant to psychiatric genetics, including importance of such training, availability of faculty expertise, competency among graduating residents in a number of skills related to psychiatric genetics, and potential usefulness of new educational materials on topics in psychiatric genetics. For this analysis, we utilized responses from 101 TDs and 60 residents. A majority of TDs and residents rated training in psychiatric genetics/genomics as very or somewhat important. In terms of faculty expertise in teaching residents about research advances in psychiatric genetics and genomics, only 19% of TDs reported having numerous faculty with such expertise; the remainder reported having some faculty (34%) or few to no faculty (46%) with such expertise. A slight majority (58%) of TDs agreed that graduates could "competently discuss the genetics of psychiatric illness with patients and their families;" 47% of residents agreed that they were able to do so, while 53% disagreed. Half (49%) of TDs agreed that graduates "understand the ethical and legal issues concerning genetic testing for psychiatric illnesses;" 44% of residents themselves felt they understood these issues. Both TDs and residents endorsed the potential usefulness of new educational materials on a variety of topics in psychiatric genetics, with 60% or more in each group rating as "extremely useful" materials on the following topics: overview of pharmacogenetics and overview of ethical and legal issues concerning genetic testing.

REFERENCES:

1. Barrett TB, Hauger RL, Kennedy JL, et al. Evidence that a single nucleotide polymorphism in the promoter of the G protein receptor kinase 3 gene is associated wtih bipolar disorder. Mol Psychiatry 2003; 8:546-57.
2. Klitzman, R. Questions, complexities, and limitations in disclosing individual genetic test results. American Journal of Bioethics, (in press).
3. Appelbaum PS: Ethical issues in psychiatric genetics. Journal of Psychiatric Practice 2004; 10:343-351.
4. Roberts LW, Geppert CMA, et al, "Perspectives on use and protection of genetic information in work settings: results of a preliminary study", Social Science & Medicine 60 (2005) 1855-1858.
5. Insel TR, Quirion R: Psychiatry as a clinical neuroscience discipline. JAMA 2005;294:2221-2224.

SYMPOSIUM 41—WOMEN AND PSYCHIATRY AROUND THE WORLD: THE IMPORTANCE OF GENDER AND CULTURE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will recognize the importance of some of the cultural, national and biological factors that account for differences in rates and presentations of psychiatric disorders in women, specifically the sex of the child in Pakistan, child rearing in Africa, religion in Egypt(?), a new law against spousal abuse in the Caribbean, migration of husbands in Mexico, estrogens in Australia.

No. 41A
GENDER ISSUES IN PSYCHIATRY IN PAKISTAN

Haroon R. Chaudhry, M.D. *Fatima Jinnah Medical College, Department of Psychitry, 83 Shah Jamal Colony, Lahore, 54000, Pakistan*, Saima Niaz, M.D., Mirrat Gul Butt, Nadia Arshad, Amara Shabir, Khalid A. Mufti

SUMMARY:

In Pakistan, women have higher base rates of the common mental disorders, regardless of whether they seek assessment and treatment or not. In childhood and adolescent psychiatric disorders, boys are more likely to display externalizing disorders such as conduct disorder, whilst girls typically show depression, anxiety and conversion symptoms. Similarly, in neuro-physical responses to trauma, boys show hyperarousal in contrast to girls who show conversion symptoms.

Psychosocial explanations for gender differences draw on the inferior status of women in most societies regarding their socioeconomic status, which has been linked to psychiatric disorder and is operationalized through low income, poor-quality housing, nutrition, medical care, contraception and childcare and gender rates a sense of inferiority and low self-esteem. Physical, sexual, and emotional violence are greater problems for women than for men and are non-specific risk factors for a wide range of medical, psychiatric and psychological problems in women.

Considering the diversity of Pakistani society, female empowerment has different meaning for women from different strata. Her status is always lower than the male partner. She is underprivileged in getting education, carrier selection, food, health care and freedom of choice of partner, number of children and other essentials of life. The incidence of postnatal depression is significantly more in females giving birth to female child. Pakistan is among those countries where women live shorter than men do. Mortality rates for women in their twenties are twice as high as those for men. The present presentation will highlight the various gender issues in relation to psychiatric illnesses and the contribution of Islamic principles in the management of psychiatric illnesses.

No. 41B
THE AFRICAN WOMAN IN HEALTH AND DISEASE: CULTURAL ISSUES IN THE MENTAL HEALTH OF WOMEN

Frank G. Njenga, M.B.Ch.B. *Upper Hill Medical Center, PO Box 73749, Nairobi, 00200, Kenya*

SUMMARY:

The African woman occupies a central part in the structure of the family. Though not matriarchal in organization, many mothers in these communities spend long periods of time with their children in education and nurturing. This causes them to influence the thinking of both sons and daughters. This study looks at the effects of mental illness in women in African cultures, and its influence on child rearing.

No. 41C
STRESS AND MENTAL DISORDER AMONG MEXICAN FEMALES

Maria Asuncion Lara, Ph.D., Maria E. Medina-Mora, M.D.

SUMMARY:

Females, especially those living in rural and in poor urban communities, present higher rates of stress and of mental disorders. The problems that negatively affect the mental health of Mexican females are closely associated with the social factors derived from poverty, the lack of opportunities for development in the labour force and traditional gender roles. Important social transitions have affected the well being of females, the most significant international migration to the United States, that has affected the migrants and those left behind – usually females and children; behaviour problems among children and adolescents; and stress and depression among females; have been related to migration. The paper will provide a brief socio

cultural description of the context, will describe local conceptions of mental disorders, prevalence rates, use of services and other coping strategies, will examine impact of migration and will discuss implications for policy.

No. 41D
WOMEN AND PSYCHIATRY AROUND THE WORLD: THE IMPACT OF GENDER AND CULTURE IN THE MIDDLE EASTERN CULTURE

Nasser F. Loza *The Behman Hospital, Helwan, Cairo, 11421, Egypt,* Nael M. Hasan, M.B.Ch.B.

SUMMARY:

The role of women has been well recognized in the Middle Eastern culture. This role is appreciated in our diverse cultures and religions.

Historically Pharonics emphasized the role of women in keeping the home and raising the children. Even women had ruled Egypt in long eras in the Pharonic history. Many pharonic writings stressed on the respect of women, with commandments to women on how to treat her husband and care for her children.

In the Islamic era, women gained more rights such as political rights, inheritance, and even some of them became mentors for religious traditions and commands.

Recently women are still gaining more rights, astonishingly the first who called for empowerment of women to be on equal foot with men were men. The recently achieved goal for women is gaining the right to be a judge.

From the psychiatric perspective, researches reported gender differences in some of psychiatric disorders. As the case in depression, females have higher prevalence of depressive disorders in different age groups.

To conclude: the role of women is changing in our culture along history in the Middle East, this has been shown in the majority of our communities.

No. 41E
CHANGING PATTERNS OF SELF HARM BEHAVIOUR AMONG WOMEN IN TRINIDAD AND TOBAGO. THE EMERGENCE OF SELF MUTILATION

Gerard Hutchinson, M.D. *University of the West Indies, Psychiatry Unit, Faculty of Medical Sciences, Building 67, EWMSC, Mount Hope, Champs Fleurs, Trinidad, 007, Trinidad and Tobago*

SUMMARY:

Deliberate self harm has long been a problem in Trinidad and Tobago with female to male ratios in the range of 4:1. The ratios increase to as much as 10:1 for a new pattern of self harm being seen in the country. Self mutilation or cutting has now become a significant method of self harm behaviour in women and clinicians have noted an exponential increase in young women presenting with self mutilation over the past five years.

I undertook a review of ten cases that have been seen in our service for self mutilation in the past year. They were interviewed to determine the proximal cause of the behaviour and the reasons that they had chosen this means to express their distress.

The mean age was 25 years and the reasons for acting in this way involved feelings of low self worth that were amplified in the context of relationship problems. Seven of them had been sexually abused in childhood. They described developing an 'addiction' for cutting and two women described it as a translation of sexual energy. They all agreed that it was a means of concretizing the psychological distress they felt but could not articulate. Most had decided to do this because of hearing about it through their friends or seeing it on the internet on television. Repeated self mutilation was a feature in eight of the ten women.

This clinical review suggests that young women in response to prompting from international information sources and friends are expressing psychological distress in a relatively new format for the Caribbean and this illustrates the degree to which psychological distress is experienced and how maladaptive responses can be easily incorporated into different cultures.

No. 41F
GENDER DIFFERENCES IN PSYCHIATRY - A BIOPSYCHOSOCIAL APPROACH FROM AUSTRALIA

Jayashri Kulkarni, M.B.B.S. *The Alfred, Alfred Psychiatry Research Centre, Commercial Road, Level 1, Old Baker Building, Melbourne, 3004, Australia*

SUMMARY:

The history of the treatment of women with mental illness is bleak and shameful and currently treatments remain "gender-blind" to a large extent. Using schizophrenia as a paradigm, more work needs to be done to clarify the role of gender and culture in the onset, outcomes and treatments for this severe mental illness. In this presentation, gender differences in the epidemiology and psychopathology will be presented. Gender sensitive drug treatments for schizophrenia, hormone treatments and psychosocial therapies will be explored in the presentation.

The recent shift in recognizing estrogen's effect on the brain has generated interest in its effect on cognition, emotion, and other non reproductive brain functions. It is now accepted that there is a hormonal influence on the pathogenesis of schizophrenia. Women have a considerably less severe course of illness, as demonstrated by fewer hospitalizations, shorter inpatient stays, and better social adaptation compared to men. With respect to treatment response, research has demonstrated that, early in their illness, women respond more quickly and more thoroughly than men to antipsychotic medication. A summary of studies to date demonstrates that adjunctive use of estrogen in premenopausal women with schizophrenia further improves psychotic symptoms. Data will be presented demonstrating efficacy of estradiol in the adjunctive treatment of schizophrenia symptoms in women.

The best treatment for pregnant women with psychotic symptoms is still unclear. Biopsychosocial factors involved in the optimal care of pregnant women with schizophrenia will be discussed. This area is of great importance in preventing mental illness as much as possible in future generations and also in preventing secondary morbidity in women with schizophrenia.

REFERENCES:

1. Chaudhry HR, Awan AS, Akhtar S, Sabir MA, Ali SA, Malik SB: Relationship of female child birth with postpatum psychosis in a given culture setting. Pak J Neurology 1999, pp8-10.
2. Essentials of Clinical Psychiatry in Sub-Sahara Africa. Published by World Psychiatric Association and African Association of Psychiatrists and Allied Professions. Masson. July 2005.
3. Ahdaf Soueif, In the eye of the sun.
4. Ali A, Maharajh HD: Social predictors of suicidal behaviour in adolescents in Trinidad and Tobago. Soc Psychiatry Psychiatr Epidemiol 2005; 40 : 186-191.

5. Kulkarni J, de Castella AR, Riedel A, Taffe J, Fitzgerald P, Burger H (2001) "Estrogen — A Potential New Treatment in Schizophrenia". Schizophrenia Research 48: 137-144.

SYMPOSIUM 42—PSILOCYBIN AND PSYCHIATRY: RECENT RESEARCH

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the historical context and clinical rationale for using hallucinogens in the treatment of late-stage cancer anxiety and be aware of recent efforts to initiate approved research protocols designed to explore the safety and efficacy of psilocybin in this patient population.

No. 42A
PSILOCYBIN IN LATE-STAGE CANCER ANXIETY

Charles S. Grob, M.D. *UCLA David Geffen School of Medicine, Psychiatry and Biobehavioral Science, Harbor-UCLA Medical Center, Torrance, CA, 90509*

SUMMARY:

This talk will examine the rationale, historical foundation and recent research using the hallucinogen treatment model with advanced-stage cancer patients with anxiety. From the early 1960s to early 1970s several medical and psychiatric investigators explored the therapeutic potential of various hallucinogens in patients with terminal cancer who were experiencing reactive depression, demoralization and isolation. Positive preliminary results were observed in improved regulation of mood and anxiety and diminished pain perception and need for narcotic medications. Retrospective examination of variables associated with positive response included powerful psychospiritual experiences during their hallucinogen treatment session, observed in patients with both religious and non-religious backgrounds. Effects on pain control were believed to be associated with an "attenuation of anticipation" that persisted even weeks after treatment. More recently, a pilot investigation of the effects of psilocybin on the existential anxiety in patients with advanced-stage cancer was initiated, allowing for a reopening of this potentially valuable area of medical and psychiatric research.

No. 42B
SAFETY ANDEFFICACY OF PSILOCYBIN IN OCD.

Francisco A. Moreno, M.D. *Univ of Arizona College of Medicine, Psychiatry, 1501 N Campbell Ave, 7-OPC, Tucson, AZ, 85724-5002*

SUMMARY:

Background/Purpose: Anecdotal reports suggest that psychedelic agents may relieve symptoms of Obsessive Compulsive Disorder (OCD). This modified double-blind study investigated the safety, tolerability, and clinical effects of psilocybin, a potent 5-HT-1A, and 2A/2C agonist, in patients with OCD.

Methods: Nine subjects with OCD and no other current major psychiatric disorder participated in up to 4 single-dose exposures to psilocybin in doses ranging from sub-hallucinogenic to frankly hallucinogenic. The Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) and a Visual Analog Scale (VAS) were administered at 0, 4, 8, and 24 hours post-ingestion. The Hallucinogen Rating Scale (HRS) was administered at 8 hours, and vital signs were recorded at 0, 1, 4, 8, and 24 hours after ingestion.

Results: Nine subjects were administered a total of 29 psilocybin doses. One subject experienced transient hypertension without relation to anxiety or somatic symptoms, but no other significant adverse effects were observed. Marked decreases in OCD symptoms of variable degrees were observed in all subjects during one or more of the testing sessions (23 to 100% decrease in Y-BOCS score). Repeated measures ANOVA for all Y-BOCS values revealed a significant main effect of time on Wilks' Lambda ($F= 9.86$, $df= (3,3)$ $p= .046$), but no significant effect of dose ($F= 2.25$, $df= (3,3)$ $p= .261$), or interaction of time and dose ($F= .923$, $df= (9,45)$ $p= .515$). Improvement generally lasted past 24 hours.

Conclusions: Psilocybin is safe and well tolerated in subjects with OCD and may be associated with robust acute reductions in core OCD symptoms.

No. 42C
PSILOCYBIN CAN OCCASION MYSTICAL-TYPE EXPERIENCES HAVING SUBSTANTIAL AND SUSTAINED PERSONAL MEANING AND SPIRITUAL SIGNIFICANCE: 14-MONTH FOLLOW-UP

Roland R. Griffiths, Ph.D. *Johns Hopkins University School of Medicine, Departments of Psychiatry and Neuroscience, 5510 Nathan Shock Drive, Baltimore, MD, 21225*, William A. Richards, Una D. McCann, Robert Jesse

SUMMARY:

Recently we reported the results of a double-blind study evaluating the psychological effects of 30 mg/70 kg psilocybin relative to a comparison compound (methylphenidate, 40 mg/70 kg) administered to 36 hallucinogen-naive adults under comfortable, supportive conditions (Psychopharmacology, 187(3):268-83, 2006). This presentation will review the results of that study, provide a summary of the 14-month follow-up data, and discuss future research directions. Psilocybin produced a range of acute perceptual changes, subjective experiences, and labile moods (e.g. joy, peace/harmony, anxiety, and fear). Thirty-one percent of the volunteers reported strong or extreme fear sometime during their psilocybin session, including 17% who had mild, transient ideas of reference or paranoia. Sixty-one percent met pre-established criteria, as measured on standardized scales, for a full mystical experience. At 2 months after sessions volunteers attributed to the psilocybin experience positive changes in attitudes and behavior that were consistent with changes rated by community observers. At 2 months and 14 months after the session, 69 and 67%, respectively, of volunteers rated the experience as among the five most spiritually significant experiences of their lifetimes. At these same time points, 59 and 58%, respectively, rated the experience as among the five most personally meaningful experiences of their lifetimes, and 72 and 64%, respectively, rated that it had increased their current sense of personal well being or life satisfaction moderately or very much. At the 14-month follow-up, there were no reports of persisting perceptional phenomena sometimes attributed to hallucinogen use, no reports of recreational abuse of hallucinogens, and all participants appeared to continue to be high-functioning, productive members of society. Because of concern about recreational abuse of these compounds, in communicating findings from this study, it is important that the risks hallucinogen-induced panic reaction and the possible precipitation of enduring psychiatric conditions also be emphasized.

REFERENCES:

1. Grob CS: Hallucinogens: A Reader. New York, Tarcher/Putnam, 2002.
2. Moreno FA*, Wiegand C, Taitano K, Delgado PL. Safety, Tolerability, and Efficacy of Psilocybin in 9 Patients with OCD. J Clin Psychiatry (In Press).
3. Griffiths RR, Richards, WA, McCann U, Jesse R Psilocybin can occasion mystical experiences having substantial and sustained

personal meaning and spiritual significance. Psychopharmacology 2006; 187:268-283.
4. Hasler F, Grimberg U, Benz MA, Huber T, Vollenweider FX. Acute psychological and physiological effects of psilocybin in healthy humans: a double-blind, placebo-controlled dose-effect study.Psychopharmacology (Berl). 2004 Mar;172(2):145-56.

SYMPOSIUM 43—HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE: PART 3

EDUCATIONAL OBJECTIVES:

1. Learn factors important to setting up you new office that will enhance your professionalism;
2. Develop the skills to avoid the biggest risks for failure in private practice;
3. Learn how to structure your professional life so that you will be happy, successful and ethical.

No. 43A
PERONAL FACTORS LEADING TO A SUCCESSFUL PRIVATE PRACTICE

William E. Callahan, Jr., M.D. *120 Vantis Ste 540, Aliso Viejo, CA, 92656-2679*

SUMMARY:

Issues to be discussed: the biggest risks for failure, and individual issues that must be accounted for if you are to be successful. Ways to avoid being pulled into unethical behavior are addressed. Having an attorney review your office contracts and avoiding getting taken advantage of in the business and professional world will be detailed. Broad issues for professional success will be covered, including: recognizing your own professional value; developing a business plan; and keeping your financial expectations realistic.

No. 43B
OFFICE LOCATION AND DESIGN FOR EFFICIENCY AND SUCCESS

William E. Callahan, Jr., M.D. *n/a, Aliso Viejo, CA*

SUMMARY:

Issues to be discussed: the details of office location and design. The speaker will provide a checklist of features often not thought about that you will want to consider. Factors that are and are not important in where you locate, and tips on how to make that decision are discussed. References to differences based on rural versus urban will also be addressed. The impact on the office on the success of the practice, as well as how well (or not) it represents you will be presented.

No. 43C
STREAMLINING OVERHEAD AND MANAGING YOUR BUSINESS IN PRIVATE PRACTICE

Keith W. Young, M.D. *10780 Santa Monica Blvd Ste 250, Los Angeles, CA, 90025-4777*

SUMMARY:

The speaker will discuss streamlining all aspects of your practice to limit overhead while maximizing earnings and quality. Tips about minimizing personal and office expenses will be offered. Setting fees, billing, scheduling appointments, missed appointments and other areas are covered.

The speaker will also outline necessary insurance, retirement and banking systems, as well as taxes and areas of potential difficulty for psychiatrists starting a new practice. Finally, the roles of technician, manager and entrepreneur which are essential to success in a small business will be discussed as they apply to psychiatric practice.

No. 43D
MARKETING YOUR UNIQUE PRIVATE PRACTICE

William E. Callahan, M.D. *120 Vantis Ste 540, Aliso Viejo, CA, 92656-2679*

SUMMARY:

The speaker will highlight how to get the right patients through the door. Concepts of branding so that you are distinguishable from the rest of your peers are examined. Marketing also requires persistent visibility and developing name recognition within a region, and then within segments of that region that you are best equipped to serve.

The speaker has developed an extensive list of different ideas and ways to do this, which you can tailor to your own area and strengths. The focus in the start-up phase of practice is on methods that will cost you time, but not money, since time is usually more available than money in this phase.

REFERENCES:

1. Logsdon, L: Establishing a Private Practice, Washington, D.C., American Psychiatric Press, Inc., 1985.
2. Molloy, Patrick, Entering the Practice of Psychiatry: A New Physician's Planning Guide, Roerig and Residents, 1996.
3. Gerber, Michael E. The E-Myth Revisited: Why Most Small Businesses Don't Work and What to Do About it, Harperbusiness, ISBN 0887307280, April 1995.
4. Practice Management for Early Career Psychiatrists, APA Office of Healthcare Systems and Financing, 1998.

SYMPOSIUM 44—UNTITLED SESSION

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will understand the impact of HIV and AIDS among particular patient populations in the U.S. and worldwide, recognize the changing roles of psychiatrists, and understand the significance — and limits — of new biomedical interventions.

No. 44A
NEW CLINICAL DEVELOPMENTS AND OPPORTUNITIES IN COMBATING HIV

Milton L. Wainberg *Columbia University, Columbia University, New York, NY, 10025*

SUMMARY:

Trends in the HIV transmission reinforce the importance of identifying effective, new HIV prevention methods such as vaccines, microbicides, and antiretroviral prophylaxis. HIV vaccines are our best hope to end the HIV pandemic. At present, however, it is not known when a safe and effective vaccine will be developed, or even when such a vaccine will become available. In the interim, nonvaccine prevention methods are needed that can be controlled by women to prevent HIV transmission. Currently, microbicides, defined as antimicrobial products that can be applied topically for the prevention of sexually transmitted diseases (STDs), including HIV, may offer one of the most promising preventive interventions that could be

safe, effective, inexpensive, readily available, and widely acceptable. This session will provide a discussion of

topical microbicides, current vaccine research and development, and other clinical advances in HIV care and treatment.

No. 44B
THE CHANGING FACE OF AIDS AND HIV DISEASE

Francine Cournos , *Bronx, NY, 10471-2868*

SUMMARY:

In the United States, the HIV/AIDS epidemic continues to evolve. Although the incidence of new AIDS cases has declined, attributed largely to expanded use of new antiretroviral therapies, the decline in death rates observed in the late 1990s has leveled off. Further, according to the Centers for Disease Control and Prevention, the rate of new HIV infections has been constant, meaning that the overall epidemic is continuing to expand. In fact, HIV infection rates are continuing to climb in a number of subpopulation groups, including women, racial and ethnic minorities, young adults, and seniors. These data foreshadow an epidemic of even greater magnitude in the coming years here in the U.S.

Globally estimates are nothing less than harrowing. In 2005 HIV/AIDS is thought to have claimed three million lives and spread to an additional five million people, bringing the global total to 40 million people living with HIV/AIDS. According to published reports, HIV prevalence has remained relatively steady_generally at high levels_for the past several years across much of sub-Saharan Africa. Of equal concern are emerging epidemics in Eastern Europe and Central Asia, in Eastern Asia and the Pacific Islands, in South and Southeast Asia, and in Latin American and the Caribbean. Beyond the incidence and prevalence rates are the social and economic consequences of the HIV/AIDS pandemic: loss of life, weakened governments, decreased workforce and productivity, and political and economic strain. Additionally, unchecked HIV infection contributes to increasing crime rates, poverty and starvation, stigmatization and discrimination, and the destruction of families and entire communities.

This session will provide a review of epidemiological trends in HIV/AIDS cases and a discussion of the impact of the epidemic worldwide.

No. 44C
THE ROLE OF THE PSYCHIATRIST: CHANGING WITH THE EPIDEMIC

Marshall Forstein *Harvard, Harvard, Jamaica Plain, MA, 02130-2910*

SUMMARY:

In the past 10 years, there have been dramatic shifts in the fight against HIV and AIDS. We have witnessed significant progress in understanding the mechanisms of HIV transmission and prevention and the development of more sophisticated systems for classifying AIDS and its associated syndromes. The variety of treatments available for HIV-infected individuals has transformed the disease from certain death to a chronic medical illness. Psychiatrists may be asked to play several different roles (e.g. consultant to patients and/or medical providers, pharmacologist, psychotherapist). The range of issues have increased with people living longer: assessing cognitive impairments, adjusting to a chronic medical illness, maintaining adherence over a lifetime of treatment, dealing with changes in role expectations, managing sexual and drug using behaviors, and grief and bereavement when treatments are not successful.

This presentation will discuss the range of issues psychiatrists must prepare for in working with people with or at risk for HIV. Suggestions for practicing psychiatrists to keep current with the latest information will be offered.

REFERENCES:

1. Rosenberg Z, A Session on Microbicide Development, XVI International AIDS Conference Toronto, Canada, August 13-18, 2006.
2. Joint United Nations Programme on HIV/AIDS (UNAIDS). 2006 report on the global AIDS epidemic. Geneva, Switzerland: UNAIDS; 2006.
3. Price S. Goyette J. Role of the Psychiatrist in the Care of Patients with Hepatitis C and HIV/AIDS. Psychiatric Quarterly, Volume 74, Number 3, 2003, pp. 261-276(16).
4. Israelski DM, Prentiss DE, Lubega S, Balmas G, Garcia P, Muhammad M, Cummings S, Koopman C. Psychiatric co-morbidity in vulnerable populations receiving primary care for HIV/AIDS. AIDS Care. 2007 Feb;19(2):220-5.

SYMPOSIUM 45—DSM-V: OBSESSIVE-COMPULSIVE RELATED DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify the disorders within the obsessive-compulsive related disorders (OCRD) spectrum, and understand brain circuitry, genetic and treatment factors that strengthen the relationship between these disorders.

No. 45A
OVERVIEW AND AUTISM

Eric Hollander, M.D. *Mount Sinai School of Medicine, Department of Psychiatry, 380 Orienta Ave, Mamaroneck, NY, 10543-3936*, Ting Wang, Ph.D., Ting Wang, Ph.D., Daphne Simeon, Evdokia Anagnostou, M.D., Jennifer Bartz, Ph.D., Latha Soorya, Ph.D., Andrea Allen, Ph.D.

SUMMARY:

The DSM provides a working model of categories and diagnostic criteria for psychiatric disorders. DSM is constantly evolving and research planning is underway for DSM-V. Changes to DSM-V being considered include the creation of two broad new categories.

A category related to obsessive-compulsive related disorders (OCRD) might include disorders such as obsessive compulsive disorder, obsessive compulsive personality disorder, hoarding, body dysmorphic disorder, eating disorders, hypochondriasis, Tourette's syndrome, Sydenham's chorea or pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS), and pathological grooming disorders, such as trichotillomania, skin picking, and nail biting.

A parallel category under consideration is behavioral and substance addictions, which might include substance-related disorders and several impulse-control disorders (pathological gambling, pyromania, and kleptomania), as well as others currently in the category of impulse-control disorders not otherwise specified (internet addiction, impulsive-compulsive sexual behavior, and compulsive buying).

The repetitive behavior core symptom domain is required for a diagnosis of autism. Additional symptom domains in autism include impairments in communication and reciprocal social interaction, and these influence the expression of repetitive behaviors. The repetitive behavior symptom domain in both autism and obsessive-compulsive disorder (OCD) has considerable overlap, and will be discussed with respect to phenomenology, comorbidity, course of illness, family history and genetics, brain circuitry, animal models, immune function, pharmacological dissection, and treatment.

No. 45B
OCD AND THE LINK WITH SCHIZOPHRENIA

Joseph Zohar, M.D. *Chaim Sheba Medical Center, Department of Psychiatry, Tel Hashomer, Tel Hashomer, 52621, Israel*, Michael Poyurovsky

SUMMARY:

Phenomenologically, "schizo-obsessive" patients represent both typical presentation of schizophrenia and typical presentation of OC symptoms. Overall, reports from research groups around the globe, including more than 2000 patients altogether (with OCD or OC symptoms in schizophrenic patients) provide compelling evidence that the odds of OCD in schizophrenic patients are considerably higher than expected. Since the comorbidity of schizophrenia and OCD is much higher than expected, it might suggest a common underlying pathophysiological linkage between the two disorders. The course of the illness in "schizo-obsessive" patients is distinctly different - poorer - to that of schizophrenia. When morbid risk for OCD, Obsessive compulsive personality disorder (OCPD) and "schizo-obsessive" were grouped together, the significance between-group differences became stronger (p=0.0002). These findings are in line with the hypothesis that "schizo-obsessive" disorders might be familial. Brain circuitry suggests that there is a combination of the relevant circuitry in individuals with "schizo-obsessive" disorder. Neurocognitive tests that were carried out in "schizo-obsessive" and schizophrenic patients without OCD suggest that the best fit of the "schizo-obsessive" patients' results is of a simple combination of schizophrenia and OCD. Pharmacologic or psychological interventions are also in line with the above findings; probably a combination of antipsychotic and antiobsessional medications is better than either alone. Looking at the emerging data, the possibility of recognizing "schizo-obsessive" as a schizophrenia subtype will be presented and discussed.

No. 45C
ARE THE IMPULSE CONTROL DISORDERS RELATED TO OCD?

Lorrin M. Koran, M.D. *Stanford University Medical Center, Psychiatry and Behavioral Sciences, 401 Quarry Road, Room 2363, Stanford, CA, 94305*

SUMMARY:

This presentation will review the evidence for and against including the Impulse Control Disorders (ICDs) in a DSM-V Obsessive-Compulsive spectrum diagnostic category. On the basis of phenomenology, the ICDs can be divided into self-soothing behaviors (trichotillomania, skin picking, nail biting), reward/excitement-seeking behaviors (pathological gambling, kleptomania, pyromania, hypersexuality, compulsive buying), and a problem of anger control (intermittent explosive disorder). With regard to sharing characteristics with OCD, skin picking, for example, is a poor match in that it is pleasurable, associated with dissociation, has a gender ratio of 2:1 (F/M), and responds to a form of psychotherapy (habit reversal) that utilizes treatment elements unlike those that are effective in OCD. Nail biting is a poor match in view of its ego-syntonic nature, lack of comorbidity with OCD, and limited response to serotonin reuptake inhibitors. Pathological gambling is a fair match in that it has some similarity in phenomenology, but is pleasurable, responds to medications ineffective for OCD and involves a differing brain circuitry. Compulsive buying is a poor match in view of differences in phenomenology (e.g., it is pleasurable) and lack of consistent response to SSRIs. Hypersexuality is a poor match because it is focused on pleasurable activities, involves different brain circuits and responds to medications that are ineffective in OCD. Intermittent explosive disorder differs from OCD in phenomenology (e.g., it is episodic and is often ego-syntonic), gender ratio (M/F 3:1), brain circuitry and medication response.

In constructing DSM-V, diagnostic criteria will be needed for ICDs not included in DSM-IV.

No. 45D
GENETICS OF OCD

Gerald Nestadt, M.D. *Johns Hopkins, 1031 W Padonia Rd, Cockys Ht Vly, MD, 21030-1727*, Jack F. Samuels, Ph.D., Mark A. Riddle, M.D., Marco Grados, M.D., Bernadette Cullen, M.D., O. Joseph Bienvenu, M.D., Yin Shugart, Ph.D., Ying Wang

SUMMARY:

The most established risk factor in the etiology of OCD is genetic transmission. This conclusion is based on twin and family studies that have been conducted over many years. The exact mechanism for this transmission has not been established but genetic segregation studies suggest the likelihood of dominant or co-dominant inheritance with a major gene effect. This has prompted two related lines of research: the identification of genomic regions and candidate genes associated with OCD, using genetic linkage and association studies; and the identification of etiologically homogeneous OCD phenotypes, using methods of familial correlation. This presentation will report the findings of linkage to chromosomes 3q, 7p, 1q, 15q, and 6q from the OCD Collaborative Genetics Study. Recent important findings of genetic association of OCD to the SLC1A1/EAAC1 gene will be discussed. From the phenotype perspective, findings from the OCD Family Study will be reported; specifically, the familial correlation of OCD to specific psychiatric syndromes, for example generalized anxiety disorder. This presentation will provide the latest update on the genetic and familial aspects of OCD and their implications for future nosological decisions.

No. 45E
NEUROIMAGING IN OBSESSIVE-COMPULSIVE RELATED DISORDERS

Sanjaya Saxena, M.D. *University of California, San Diego, Psychiatry, VA San Diego Healthcare System, 3350 La Jolla Village Drive, San Diego, CA, 92161-0002*

SUMMARY:

Several neuropsychiatric disorders have been termed "Obsessive-Compulsive Related Disorders," based on similarities in their phenomenology, comorbidity, familial aggregation, genetics, and treatment response. Neuroimaging studies can elucidate the pathophysiology of psychiatric disorders and help determine if they are neurobiologically related. This presentation will review neuroimaging findings in several putative OCD-related disorders, including Compulsive Hoarding, Body Dysmorphic Disorder (BDD), Trichotillomania, and Tourette Syndrome (TS), and compare them to findings in OCD.

Functional neuroimaging studies of OCD have repeatedly found elevated glucose metabolism in the orbitofrontal cortex (OFC), caudate nuclei, and thalamus that normalizes with response to treatment. OCD symptoms provocation increases activity in these same brain regions. These findings have led to the theory that the symptomatic expression of OCD is mediated by hyperactivity along specific, frontal-subcortical circuits connecting the OFC, caudate, globus pallidus, and thalamus. In contrast, compulsive hoarders were found to have significantly lower glucose metabolism in the cingulate cortex than normal controls and non-hoarding OCD patients. The severity of compulsive hoarding was negatively correlated with activity in the dorsal anterior cingulate cortex. These results suggested that

compulsive hoarding is a neurobiologically distinct subtype or variant of OCD.

Neuroimaging findings in BDD include greater white matter volume and abnormal asymmetry in caudate volume, compared with normal controls, and cerebral perfusion asymmetries in temporal, parieto-occipital, and frontal areas. In Trichotillomania, studies have found smaller volumes of the putamen, inferior frontal gyrus, and cerebellum, as well as elevated glucose metabolism in the cerebellum and superior parietal cortex. In TS, various abnormalities in the basal ganglia, prefrontal cortex, and hippocampus have been found. Elevated striatal dopamine transporter and serotonin 2a receptor binding have been found in both OCD and TS. Overall, neuroimaging studies have revealed more neuroanatomical differences than similarities between the putative OCD-related disorders, with the possible exception of TS and OCD.

REFERENCES:

1. Hollander E, Phillips A, Chaplin W, Zagursky K, Novotny S, Wasserman S, Iyengar R. A placebo controlled crossover trial of liquid fluoxetine on repetitive behaviors in childhood and adolescent autism. Neuropsychopharmacology 2005; 30(3):582-9.
2. Zohar J. Is there room for a new diagnostic subtype—the schizo-obsessive subtype? CNS Spectrums 1997; 2(3):49-50.
3. Hollander E, Stein DJ (eds). Clinical Manual of Impulse Control Disorders. Arlington, VA, American Psychiatric Publishing, Inc. 2006.
4. Shugart YY, Samuels J, et al. Genomewide linkage scan for obsessive-compulsive disorder: evidence for susceptibility loci on chromosomes 3q, 7p, 1q, 15q, and 6q. Mol Psychiatry. 2006 Aug;11(8):763-70.
5. Mataix-Cols D, van den Heuvel OA: Common and distinct neural correlates of obsessive-compulsive and related disorders. Psychiatr Clin North Am 2006; 29:391-410.

SYMPOSIUM 46—LEADERSHIP DISCOURSE: AGENTS OF CHANGE IN MENTAL HEALTH
American Association of Psychiatric Administrators

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants will be able to understand the dynamics of system change in mental health from multiple perspectives, including historic, present and future. Agents of change in the field will be reviewed, including the influence of law, the forces of market and finances, the guidance of research and science, the leadership within states and the nation, and the advocacy of professional groups, including the APA.

No. 46A
OVERVIEW OF AGENTS OF CHANGE IN MENTAL HEALTH TRANSFORMATION

Yad M. Jabbarpour, M.D. *Catawba Hospital, Office of Chief of Staff, PO Box 200, Catawba, VA, 24070-0200*

SUMMARY:

Mental Health Transformation has been occurring over the centuries, driven by varying agents of change: science, clinicians, professional groups, policy makers, advocacy groups, the consumer movement, families, the press, politics, market forces and oversight agencies, including the Joint Commission on Accreditation of Healthcare Organizations and the Centers for Medicare & Medicaid Services. A history of mental health transformation can provide a framework on which to understand present system issues and future direction. Three presidential commissions on mental health have existed in the United States with the most recent provided a vision for transformation. Change management provides a set of tools, practices and techniques to help individuals and organizations guide and strategically lead system improvement.

No. 46B
LAW AS AN AGENT OF CHANGE IN THE MENTAL HEALTH SYSTEM

Paul S. Appelbaum, M.D. *Columbia University, Department of Psychiatry, 1051 Riverside Dr # 122, New York, NY, 10032-1007*

SUMMARY:

The courts are often perceived as effective instruments of social change, and litigation in the mid to late 20th century on civil rights and abortion are often cited as examples. Hence, advocacy groups frequently devote substantial resources to litigating issues of concern to their constituencies. The efficacy of the courts in changing the behavior of both governmental and private actors, however, is not at all clear and is probably overrated. Litigation about issues related to the right to mental health treatment offers a good illustration of the limits of judicial power. Patients' right to treatment began to be pursued in the courts in the early 1960s on constitutional grounds. Despite some successes by plaintiffs before the bench, judges often proved impotent to compel states to provide effective treatment, even to committed patients. Legislation subsequently allowed the Department of Justice to pursue remedies against the states, with mutually agreed-to consent decrees probably having more impact than the earlier judicial decisions. Subsequently, the Americans with Disabilities Act has been used a lever to extend a right to treatment into the community, but despite early victories in court, this effort has had equally ambiguous results for mental health systems of care. Such systems have undergone dramatic changes in the decades since the right to treatment litigation began. But the changes have almost always come as the result of financial, organizational, and ideological pressures, and only rarely and to a limited extent because of the decisions of the courts.

No. 46C
FEDERAL PERSPECTIVE: GOVERNMENT AS AN AGENT OF CHANGE

Anita S. Everett, M.D. *US, HHS, SAMHSA, Office of the Administrator, 3563 Cattail Creek Dr, Glenwood, MD, 21738-9607*

SUMMARY:

Abstract: Federal Perspective: Government as an Agent of Change

Currently in the United States, government funding is the single biggest financial resource for mental health care and substance abuse treatment. In order for psychiatrists to become effective advocates, leaders and change agents, it is essential that psychiatrists understand the contribution made by different levels of government. In this session, the most recent National Healthcare Expenditures report will be presented. This is a report conducted by the US HHS, Substance Abuse Services Administration that examines trends in sources for funding from all payors of mental health and substance abuse treatment services.

The Federal Government plays several critical roles in shaping US Mental Health and substance abuse services. Federal programs that fund these services include Medicare, the federal portion of Medicaid, Federal Employees Health Program, the Veterans Administration, Indian Health Services, Mental Health block Grants and Substance Abuse Block Grants. Additionally there are myriad of demonstration projects and services research funding administered

by the NIH through the National Institute of Mental health, the National institute of Drug Abuse and the National Institute of Alcohol Abuse and Alcoholism. The federal government is also involved in several healthcare regulatory activities, primarily through the CMS or Center for Medicare and Medicaid, which are created to enhance quality.

The profession of psychiatry has been changed in the last two decades. Through the rise in managed care approaches as well as the proficiency of other allied professions to provide quality mental health care, our profession is at risk of being left behind in terms of providing valuable influence in the shaping of mental health and substance abuse services at every level. Every Psychiatrist in practice or administration, in private or public settings, has or can create an opportunity to be a positive change agent.

No. 46D
HOW TO LOSE FRIENDS AND INFLUENCE PEOPLE: CHALLENGES IN TRANSFORMING A STATE MENTAL HEALTH AGENCY.

James S. Reinhard, M.D. *Commonwealth of Virginia, Department of Mental Health, PO Box 1797, Richmond, VA, 23218-1797*

SUMMARY:

The Commonwealth of Virginia has historically relied heavily on its state mental health facilities. It ranks near the top of the country in per capita state dollars spent on state inpatient care, yet ranks near the bottom in per capita state dollars spent of community mental health care. Transforming mental health care in Virginia includes determining the right amount of resources to invest in rebuilding and supporting exceptional institutional care while improving the investment in community care alternatives. Sometimes this means re-investing dollars traditionally spent of inpatient care into best practices in the community (crisis stabilization units, PACT, jail diversion, etc.)

Staying on message and promoting a vision that truly embraces community integration and finding alternatives to traditional acute state hospital beds has put this state mental health commissioner at odds with many of his psychiatrist colleagues, not to mention emergency room personnel, family members, local government officials, sheriffs, jail superintendents, and general assembly members.

None-the-less, in Virginia the two most recent Governors with General Assembly approval have supported an unprecedented infusion of state dollars in the mental health system to include both replacement of outdated and inefficient facilities as well as improving community treatment capacity. Challenges, pitfalls, and successes to system transformation in the Commonwealth of Virginia will be examined.

No. 46E
RESEARCH, EVIDENCE, PRACTICE & POLICY: NEW FRONTIERS IN RE-ALIGNMENTS?

Junius J. Gonzales, M.D. *Abt Associates, Inc, 2036 Derby Ridge Lane, Silver Spring, MD, 20910*

SUMMARY:

The complexities of leadership, as related to evidence, practice, and policy making, will be discussed. Special issues related to the connection of research and 'real world' leadership driven change will also be noted.

REFERENCES:

1. Hogan MF: The President's New Freedom Commission: Recommendations to Transform Mental Health Care in America. Psychiatric Services 54:1467-1474, 2003.
2. Appelbaum PS. (1994) Almost a Revolution: Mental Health Law and the Limits of Change. Oxford University Press, New York, NY.
3. Kouzes James M, and Posner, Barry Z: Leadership Challenge, 3rd Edition, B Jossey-Bass, A Wiley Imprint, 2003.
4. Block, P: Stewardship; Choosing Service Over Self Interest. Barrett-Koehler Publishers, Inc., 1993.
5. Tanenbaum S, 'Evidence-Based' Knowledge, Psychotherapeutic Culture, and Managed Mental Health Care in the U.S., International Journal of Knowledge, Culture and Change Management, Volume 4, 2004.

SYMPOSIUM 47—DEPRESSION AND ANXIETY, CONTINUOUS OR CATEGORICAL? A VIEW FROM DIFFERENT ANGLES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize similarities and differences between depression and anxiety from an epidemiological, genetic, neuroimaging and clinical perspective.

No. 47A
EPIDEMIOLOGY OF MOOD AND ANXIETY DISORDERS IN A MULTICULTURAL EUROPEAN CITY

Wilco Tuinebreijer, M.D. *ggd amsterdam, nieuwe achtergracht 100, amsterdam, 1018WT, Netherlands*, matty de wit, Ph.D.

SUMMARY:

The population of Amsterdam, like any big city, consists of people with different cultural backgrounds. In previous epidemiological research, immigrants are often excluded due to the difficulty to reach them as a result of closed subcultures, language barrieres, or limited partication in society. As a result, information on the mental health of these different cultures is lacking. Earlier nation-wide studies (NEMESIS) indicated a higher prevalence in Amsterdam compared to the rest.

Therefore, we initiated a new study on mood and anxiety disorders with special focus on reaching the different cultural groups. By adjusting the design and method of approach to these different cultural groups, a reasonable respons rate was reached and 812 respondents (of which 312 native Dutch and 491 of the three major migrant groups) participated in an extensive interview including the CIDI section on mood and anxiety.

The results show that prevalences of mood and anxiety disorders were highest among the two major migrant groups originating from Turkey and Morocco. Migrants from the former Carribean colonies showed no difference from the native Dutch. In addition, the demographic patterns differed by cultural group, some cultures had higher prevalence rates for men, others for women.

Besides the prevalence of the disorders, several factors were studied that might be associated with the differences in prevalence, such as the influence of socio-economic status, discrimination, and daily hassles. Risk factor patterns also turned out to differ between the cultural groups.

No. 47B
IS COMORBIDITY BETWEEN ANXIETY AND DEPRESSION CAUSED BY SHARED GENES? A GENOME WIDE LINKAGE ANALYSIS.

Christel M. Middeldorp *Vrije Universiteit, Biological Psychology, Van der Boechorststraat 1, Amsterdam, 1081BT, Netherlands*, Jouke-

Jan Hottenga, Eline Slagboom, Patrick F. Sullivan, Leo Beem, Gonneke Willemsen, Dorret I. Boomsma

SUMMARY:

A review on the causes for the frequent comorbidity of anxiety and depression concluded that anxiety disorders and depression are probably distinct entities with shared genes explaining part of the comorbidity. However, it was noted that it is statistically difficult to decide between the different comorbidity models. As a consequence, other models were not conclusively excluded. In this study, a more direct approach is used to investigate whether similar genes influence the vulnerability for anxiety and depression. Separate genome-wide linkage analyses were conducted for anxious (assessed with the Spielberger State-Trait Anxiety Inventory - trait version) and depressive symptoms (assessed with the Young Adult Self Report). These scores are highly correlated (0.61). In addition, they are highly related to categorical anxiety and depressive disorders. The linkage sample consisted of 2488 subjects from 717 families recruited from the Netherlands Twin Register (NTR). As the subjects had participated at least once in a longitudinal survey study, mean scores from 1 to 5 occasions were analyzed in order to stabilize the trait variance. The large sample and the quantitative measure make it a relatively powerful design. For anxiety, evidence for linkage was found on chromosome 14 at 105cM (LOD 2.6). For depression, the highest LOD score was on chromosome 18 at 127cM (LOD 1.4). These results suggest that, although anxiety and depression are phenotypically related, their genetic basis may be distinctive. Therefore, gene-finding studies should be careful when creating composite anxious and depressive phenotypes for genetic analyses.

No. 47C
DIFFERENTIAL NEURAL PATTERNS IN MAJOR DEPRESSIVE DISORDER AND OBSESSIVE-COMPULSIVE DISORDER: AN AFFECTIVE ACTIVATION NEUROIMAGING EXPERIMENT.

Peter L. Remijnse *VU University Medical Center, Psychiatry, Zandstraat 2-H, Amsterdam, 1011 HK, Netherlands*

SUMMARY:

Resting-state neuroimaging studies of patients with major depressive disorder (MDD) have emphasized the implication of 'ventral' and 'dorsal' prefrontal cortical, as well as (para)limbic brain regions in the pathophysiology of this disorder. In patients that suffer from obsessive-compulsive disorder (OCD), resting-state imaging experiments have shown the involvement of cortico-striatal-thalamic circuits. However, OCD and MDD both appear to be characterized by dysfunctional emotion processing, and an imaging experiment with a concomitant affective activation probe in these patients groups would enhance the sensitivity and specificity for elucidating (differential) neural patterns in these disorders. For this reason, we employed an affective activation paradigm in 20 MDD-free unmedicated OCD patients, 20 unmedicated MDD patients without comorbid OCD, and 27 healthy control subjects, during an event-related functional MRI experiment. We used a reversal learning task, that assesses the neural substrates of reward and punishment perception, and of affective switching behaviour. This task has previously shown to recruit prefrontal (including orbitofrontal, dorsolateral cortical and anterior cingulate cortical (ACC)) as well as striatal and paralimbic (insular) regions in healthy subjects (Remijnse et al., 2005). Results of the present experiment included reduced (orbito)frontal and insular activity upon reward and affective switching in patients with OCD compared with control subjects. Furthermore, patients with MDD showed increased activity in striatal and insular areas on emotional feedback, but decreased activity in ACC and prefrontal regions on affective switching, in comparison with control subjects. Contrasting the two patients groups, patients with OCD versus MDD showed blunted activity in prefrontal (including orbitofrontal and dorsolateral) cortical, next to striatal and insular brain areas. In conclusion, the current study implies that OCD and MDD are characterized by differential neural activation patterns, when targeted with an affective neuropsychological task.

No. 47D
OPTIMIZING TREATMENT STRATEGIES IN DEPRESSED PATIENTS WITH COMORBID ANXIETY SYMPTOMS.

Henricus Van, M.D. *Mentrum Mental Health Care, Po Box 75848, Amsterdam, 1070 AV, Netherlands*

SUMMARY:

Comorbid anxiety symptoms are very common in depression. Various studies suggest that anxiety symptoms adversely affects outcome in both pharmacotherapy and psychotherapy for depression. Therefore it is crucial for clinicians to recognize anxiety symptoms in depressed patients. It is recommended to monitor these symptoms carefully during the course of treatment and modify the therapeutic strategy in case of residual anxiety symptoms. However, data regarding the potential influence of anxiety symptoms in selecting the most optimal therapeutic modality for depression after the initial assessment, are relatively scarce. The aim of this presentation is to discuss the differential predictive value of comorbid anxiety symptoms on efficacy in three commonly delivered treatments for depression.

We conducted a *post hoc* analysis of the pooled data of three RCTs in mild to moderate depression. Patients were treated during six months with either an Antidepressant, Short-Term Psychodynamic Supportive Psychotherapy (SPSP) or a combination of these two. Severity of anxiety symptoms was measured with the SCL-90.

Overall, treatment with an antidepressant only appeared to be less efficacious compared to psychotherapy and combined therapy. In psychotherapy, patients with more severe anxiety symptoms showed lower remission rates. In combined therapy however, severity of anxiety was not identified as a negative predictor.

These findings suggests that patients with mild to moderate depression and comorbid anxiety symptoms may be preferable treated with the combination of pharmacotherapy and psychotherapy in order to optimize outcome.

No. 47E
THE RELATIONSHIP BETWEEN GENERALIZED ANXIETY DISORDER, DEPRESSION AND MORTALITY IN OLD AGE

Tjalling Jan Holwerda III, M.D. *Mentrum Mental Health Care/ Vrije Universiteit Amsterdam, Psychiatry, Van der Boechorststraat 7, Institute for research in extramural medicine, Amsterdam, 1081 BT, Netherlands*, Robert A. Schoevers, Sr., Ph.D.

SUMMARY:

Background: The association between depression and an increased risk of death in elderly persons has been established in both clinical and community studies. Co-occurrence of depression and generalized anxiety has been shown to represent more severe and more chronic psychopathology. However little is known about the relation between generalized anxiety disorder, mixed anxiety-depression (generalized anxiety disorder and depression) and excess mortality in the elderly.

Objective: To investigate whether generalized anxiety and mixed anxiety-depression are associated with mortality in older persons.

Method: Generalized anxiety disorder, mixed anxiety-depression and depression were assessed in 4051 older persons with a ten-year follow-up of community death registers. The mortality risk of

generalized anxiety, depression and mixed anxiety-depression was calculated after adjustment for demographic variables, physical illness, functional disabilities and social vulnerability.

Results: In generalized anxiety disorder and mixed anxiety-depression no significant excess mortality was found. In depression a significant excess mortality was found in men (HR 1.44 (1.09–1.89)) but not in women (HR 1.04 (0.87–1.24)) after adjustment for the different variables.

Conclusions: In elderly persons depression increases the risk of death in men. Neither generalized anxiety nor mixed anxiety-depression are associated with excess mortality. Generalized anxiety disorder may even predict less mortality in depressive elderly people. The relation between generalized anxiety disorder and its possibly protective effect on mortality has to be further explored.

No. 47F
MANAGING THE PATIENT WITH COMORBID DEPRESSION AND AN ANXIETY DISORDER

Robert Schoevers, Ph.D. *Mentrum Mental Health Care, 2e Const. Huijgensstraat 37, Amsterdam, 1054 AG, Netherlands*, Henricus Van, Simone Kool, Jack J. Dekker

SUMMARY:

Although depression and anxiety disorder frequently co-occur, current treatment protocols often address single disorders. Research on the treatment of combined disorders is also less elaborate. In this presentation, an overview will be presented of the literature on the treatment of depression and comorbid anxiety.

REFERENCES:

1. Bhugra D. Cultural indentities and cultural congruency: a new model for evaluating mental distress in migrants. Act Psychiatr Scand 2005; 111(2): 84-93.
2. Middeldorp CM, Cath DC, Van Dyck R, Boomsma DI: The comorbidity of anxiety and depression in the perspective of genetic epidemiology. A review of twin and family studies. Psych Med 2005; 35: 611-624.
3. Remijnse PL, Nielen MMA, Uylings HBM, Veltman DJ: Neural correlated of a reversal learning task with an affectively neutral baseline: an event-related fMRI study. NeuroImage 2005; 26:609-618.
4. Fava M, Alpert JE, Carmin CN et al: Clinical correlates and symptom patterns of anxious depression among patienst with major depressive disorder in STAR*D. Psych Med 2004: 34: 1299-1308.
5. Holwerda TJ, Schoevers RA, Dekker J, Deeg DJH, Jonker C, Beekman, ATF: The relationship between generalized anxiety, depression and mortality in old age. International Journal of Geriatric Psychiatry 2006, in press.
6. Fava M, Alpert JE, Carmin CN, et al. Clinical correlates and symptom patterns of anxious depression among patients with major depressive disorder in STAR*D. Psychol Med 2004;34:1299-308.

SYMPOSIUM 48—FROM CLINICAL TRIALS TO REAL WORLD OUTCOMES

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants will be able to better understand clinical significance of comorbid psychiatric conditions in schizophrenia and limitations of clinical trials to incooperate these comorbid conditions common in clinical practice.

No. 48A
SCHIZOPHRENIA WITH COMORBID CONDITIONS IN CLINICAL TRIALS: CLINICAL APPLICABILITY

Michael Y. Hwang, M.D. *East Orange VA Medical Center, Department of Psychiatry, 385 Tremont Ave # 116A, East Orange, NJ, 07018-1023*

SUMMARY:

While the clinical heterogeneity in schizophrenia has well been established over the years it is often regarded as a single disorder entity with similar clinical features, treatment response, and shared underlying pathogenesis. Recent epidemiological and clinical studies have demonstrated substantially greater prevalence rate of comorbid psychiatric conditions such depression, anxiety, and impulsive-aggressive disorders in patients with schizophrenia. Recent evidence also suggests that some of these clinical conditions may reflect specific neurobiological pathogenesis. Such dichotomy between the conventional rules and real world practice often challenge practicing clinicians in their management. Recently emerging clinical and research evidence suggests that subgroup of schizophrenic patients with comorbid disorders require specific assessment and individualized psycho-pharmacological intervention for optimal outcome.

In this symposium presentation we will review the short comings of clinical trials and discuss clinical applicability of the outcome measures utilized in these trials.

No. 48B
GAINING A BETTER UNDERSTANDING OF CLINICAL TRIAL APPLICABILITY THROUGH THE USE OF OUTCOME MEASURES AND ADVERSE EVENT RATING SCALES.

Gabe Goldfeder, M.A. *Advanced Bio-Behavioral Sciences, 5 West Main Street, Suite 206, Elmsford, NY, 10523*

SUMMARY:

Within clinical trials several rating scales are utilized to asses the outcomes of treatment. For each therapeutic area there are one or two "gold standard" rating scales. I will discuss how the results of these scales can be used to inform clinical care. In addition I will discuss how these scales can be used directly in clinical practice. In addition to efficacy rating scales there are side effects scales used to measure adverse events. Again, I will discuss applying these scales to real world clinical practice. I hope to give the audience a better understanding of the scales used in clinical trials and their applicability to real clinical practice.

No. 48C
CLINICAL IMPLICATIONS OF RANDOMIZED CLINICAL TRIAL DESIGNS

Naveed Iqbal, M.D. *Advanced Bio-Behavioral Sciences, Advanced Bio-Behavioral Sciences, Elmsford, NY, 10523*

SUMMARY:

At the conclusion of this presentation, the participant should be able to have a better understanding of the research designs commonly employed in randomized clinical trials. In addition the participant will be able to understand how the study design can affect the applicability of that research to real world clinical practice. To appreciate the efficacy data from randomized clinical trials, a clinician would need to understand the design of that particular study. Different study designs will be described and discussed. The following designs will be discussed: open-label, single-blind, double-blind, placebo controlled, comparator controlled, and active non-comparator controlled. In addition different randomization strategies will also be

discussed. Furthermore, differences between an acute stabilization versus long term maintenance will be discussed. The differences between the various acute stabilization trials in the literature will be highlighted. The importance of a sufficient stabilization period prior to being randomized in a maintenance trial will be highlighted. A better understanding of the designs of the various randomized clinical trials will enhance the clinician's ability to apply these results to their clinical practice in an attempt to optimize the real world clinical outcomes.

REFERENCES:

1. Hwang MY, Bermanzohn PC: Schizophrenia and comorbid conditions: diagnosis and treatment. Washington, DC, American Psychiatric Press, 2001.
2. Bourin M, Lambert O, Guitton B: Treatment of acute mania-from clinical trials to recommendations for clinical practice. Human Psychopharmacology 2004; 20:15-26.
3. Lehman AF, Steinwachs DM: Translating research into practice: the Schizophrenia Patient Outcomes Research Team (PORT) treatment recommendations. Schizophr Bull 1998; 24: 1-10.
4. Pajonk FG. Clinical trial design in schizophrenia: implications for clinical decisions. Curr Opin Psychiatry. 2005 Nov;18(6):692-9.

SYMPOSIUM 49—INVENTORY OF STIGMATIZING EXPERIENCES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to:

1. Recognize stigma associated with mental illness.
2. Have knowledge of the inventory of stigmatizing experiences.
3. Demonstrate awareness of the specific issues of stigma in Depressive and Bipolar Disorders.
4. Be aware of the development of the psychoeducational and behavioural modification program to treat patients experiences of stigma.

No. 49A
STIGMA OF MENTAL ILLNESS: FROM THEORY TO PRACTICE

Julio E. Arboleda-Florez, Ph.D. *Queen's University, PCCC-Mental Health Services, 752 King Street West, Room 1077, Kingston, ON, K7L 4X3, Canada*

SUMMARY:

While stigmatization has been written about since the 1950s, it is only over the past 20 years that there has been a growing realization that stigmatizing attitudes and their behavioural counterpart of discrimination against the mentally ill have massive negative and deleterious effects on mental patients, their families and even on their clinical caregivers. It is even more recently that those stigmatizing negative attitudes have been known to lead to discriminatory practices that impinge on the normal enjoyment of rights and entitlements that other citizens enjoy. This presentation will contain a review of theoretical issues of stigma and discrimination, how they develop and impact on patients and caregivers, and how better knowledge of their origins and impacts have led to programs and interventions to combat them. The presentation will also review effectiveness of these interventions and sketch a program of evaluation conducive to best practices on stigma reduction and on fighting discrimination.

No. 49B
THE INVENTORY OF STIGMA EXPERIENCES: DEVELOPMENT AND RELIABILITY

Michelle Koller, M.A. *Queen's University, Community Health & Epidemiology, 21 Arch Street, Kingston, ON, K7L 3N6, Canada*, Heather Stuart, Ph.D., Roumen V. Milev, Ph.D.

SUMMARY:

We report on the development and reliability of two new inventories designed to capture experiences of stigma from the perspective of those who are being stigmatized—consumers and family members. Both are composed of two sub-scales: one measuring the scope of experiences, and one measuring their psych-social impacts. Field testing was done on 88 consumers and 66 family members. Consumers came from hospital, community mental health, and advocacy agencies. They reported a range of serious and persistent mental disorders, most with past hospital admissions. A significant proportion were also actively involved in outpatient community mental health programs at the time of the survey. However, less than half reported that their mental health had improved over the past year. Reliability coefficients were strong for both sub-scales: .83 for the Consumer Stigma Experiences Scale and .91 for the Consumer Stigma Impact Scale indicating high internal consistency. A statistically significant but moderate correlation between the sub-scales (.47) indicated that they were measuring different but related phenomena. Family members were recruited from hospital-based outpatient programs and mental health advocacy groups. They were predominantly female with over half being mothers of someone with schizophrenia with disease onset during adolescence or early adulthood. Half reported that their relative had been ill for 10 years or more, and three quarters reported at least one previous hospitalization for treatment of a mental illness or suicide attempt. Reliability coefficients were also strong for both sub-scales: .76 for the Family Stigma Experiences Scale and .92 for the Family Stigma Impact Scale. The sub-scales were also moderately correlated (.65). Together these inventories provide the first battery of psychometrically tested instruments to measure the scope and psychosocial impact of stigma on those who are most victimized by it. Potential applications will be discussed.

No. 49C
STIGMA AND DISCRIMINATION IN PATIENTS WITH DEPRESSION AND BIPOLAR DISORDERS AS CAPTURED BY THE INVENTORY OF STIGMATIZING EXPERIENCES

Roumen V. Milev, M.D. *Queen's University, PCCC, Mental Health Services, 752 King Street West, Postal Bag 603, Kingston, ON, K7L 4X3, Canada*, Heather Stuart, Ph.D.

SUMMARY:

Background: Depression and Bipolar Disorders are amongst the most common and disabling psychiatric conditions. They usually run a chronic course with their symptoms waxing and waning. They are associated with significant burden of disease. Patients with Depression and Bipolar Disorders experience a significant amount of stigmatizing and discrimination because of their mental illness.

Method: We have developed an Inventory of Stigmatizing Experiences (see reference). It is a questionnaire, which includes both a frequency and an intensity scale, and measures the prevalence and frequency of stigma experiences, with the underlying assumption being that the total score reflects the pervasiveness of stigma experienced across different life domains.

Results: Over 150 patients attending a specialized tertiary service for patients with Depression and Bipolar Disorders were screened with the Inventory of Stigmatizing Experiences. The results show

that the experience of stigmatizing events and discrimination because of mental illness is very high and occurs almost universally. Some further analysis based on age, gender and diagnosis is given. The descriptive part of the questionaire captured range of experiences, summarized in this presentation. The need for further study in this population is emphasized.

Conclusion: Stigmatizing experiences and discrimination is common in patients with Depression and Bipolar Disorders, and requires further studying and work towards reducing it.

No. 49D
STIGMA AND RECOVERY

Heather Stuart, Ph.D. *Queen's University, Community Health & Epidemiology, 21 Arch Street, Kingston, ON, K7L 3N6, Canada*, Roumen V. Milev, Ph.D.

SUMMARY:

Most anti-stigma efforts focus on removing negative public views of mental illness. However, removing prejudices and changing social attitudes is a difficult and long-term task. In the mean time, stigmatized individuals must find way to rise above these conditions and live healthy and productive lives. The recovery paradigm has emphasized the importance of looking beyond symptom management to recovery, where recovery is typically defined as some combination of improved functioning, enhanced quality of life, and empowerment. Stigma is a major barrier to recovery at every level. It reduces self-efficacy, self-esteem, medication adherence, and social participation.. Helping people with mental disorders learn to overcome stigma is an important therapeutic aim. We will discuss the impact of stigma on recovery principles and best practices of stigma management based on our experiences with a new stigma management program for people with mood and anxiety disorders.

REFERENCES:

1. Sartorius N and Schulze H: Reducing the Stigma of Mental Illness. Cambridge: Cambridge University Press, 2005.
2. Stuart H, Milev R, Koller M. (2005) The Inventory of Stigma Experiences: Development and Reliability. World Psychiatry, Vol. 4(Supplement 1): 33-37.
3. Stuart H, Milev R, Koller M. The Inventory of Stigmatizing Experience: its development and reliability. World Psychiatry 2005; 4:S1, 35-39.
4. Stuart H. (2006) Media Portrayals of Mental Illness and its Treatments. What Effect Does it have on Patient Outcomes? (Invited Lead Article) CNS Drugs, 20(2): 1-8.

SYMPOSIUM 50—CONSUMER PROVIDER TRAINING: INCORPORATING INDIVIDUALS IN RECOVERY INTO THE BEHAVIORAL WORKFORCE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) demonstrate increased knowledge about the recovery movement in psychiatry; (2) recognize the critical components of consumer provider training programs; and (3) recognize the benefits of incorporating consumer providers into the behavioral health workforce.

No. 50A
THE UNIVERSITY OF KANSAS CONSUMERS AS PROVIDERS PROGRAM: OVERVIEW OF THE NATIONAL AWARD WINNING TRAINING, INTERNSHIP & RESEARCH PROGRAM UTILIZING BEST PRACTICES

Diane McDiarmid *University of Kansas, Education, Lawrence, KS*

SUMMARY:

Despite increased attention to consumer-providers, there remains a lack of models that prepare, support, and sustain consumers in provider roles. This presentation will describe the award-wining Consumer as Provider (CAP) Training program at the University of Kansas School of Social Welfare, which creates opportunities for individuals with severe psychiatric disabilities to develop knowledge and skills to be effective as human service providers. CAP fosters a partnership between colleges and community mental health centers where students experience classroom and internship activities.

No. 50B
THE IMPLEMENTATION AND BENEFITS OF INCORPORATING SELF-IDENTIFIED CLIENT EMPLOYEES IN THE SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

Katherine M. Roberts, M.P.H., *South Caroline Department of Mental Health, 2414 Bull Street Columbia, South Carolina 29202*

SUMMARY:

Goal 2.2 of the Presidential Freedom Commission report recommends that consumers and families be involved in planning, evaluation, and services that orientate mental health systems toward recovery. Today a growing array of innovative of consumer-run peer support services have emerged to assist people with mental illnesses, with hope, empowerment and the recovery skills needed to live a self-determined life. The focus of this presentation is to describe the implementation of the Medicaid reimbursable peer support service at the South Carolina Department of Mental Health and the benefits this services has not only to the clients served but also to our workforce.

The presentation will include: 1) a description of how peer support services were implemented at the department of mental health, including a.history of events in South Carolina Leading to the CPSS Initiative, a definition of peer support, and the Medicaid regulation as it applies to the service; 2) a discussion of the peer support certification training program and continuing education requirements, including qualities and characteristics of a peer support specialist, position descriptions, training curriculum, and testing and continuing education requirements; 3) a discussion of the service benefits to clients served and our workforce based on service evaluation results; and 4) next steps in implementation and evaluation.

No. 50C
DEVELOPING NEEDED COMPETENCIES TO MEET WORKFORCE DEMANDS: THE ROLE OF TRAINING, SUPERVISION AND MENTORING

Cheryl Gagne, Sc.D *Boston University, Center for Psychiatric Rehabilitation, 940 Commonwealth Avenue, West, Boston, MA, 02115*

SUMMARY:

Using psychiatric rehabilitation technology, the Center for Psychiatric Rehabilitation has recruited, trained and supervised people in recovery from mental illness to assume roles in the behavioral health workforce. This presentation will lead participants through the processes of functional assessment to determine the critical skills neces-

sary for specific roles, training and supporting the acquisition of interpersonal skills, and strategies to support role performance.

No. 50D
ADDING PEOPLE IN RECOVERY TO THE BEHAVIORAL HEALTH WORKFORCE

Lori Ashcraft, Psy.D. *META Services, Inc., Recovery Education Center, 2701 N. 16th St., Phoenix, AZ, 85006*

SUMMARY:

This presentation will cover the latesst information on the intergration of peers (people who have been diagnosed with a mental illness and have joined the behavioral health work force) into the work force. It will highlight the contributions they are making and the complimentary nature of their work when combined with clinical staff work. Various sites from across the nation will be described, solutions to problems will be identified, and the future options and opportunities will be dis cussed.

Whilet he use of peers has been a significant part of the substance use programs over t he years, this is a rerlatively new venture in the behavioral health field. It has grown in popularity over the past five years and is now being used as a way of complimenting ans extending professional services in many parts of the country. A fey to having sucessful outocmes has been the use of effective training programs that train peers to share thier own personal experience in ways that inspire hope for recovery in others. those training programs will be discussed and curriculums will be comared and shared

No. 50E
CPSA'S RECOVERY SUPPORT SPECIALIST INITIATIVE: EVALUATION RESULTS OF A CONSUMER PROVIDER TRAINING PROGRAM

Jason Malfait *Community Partnership of Southern AZ, System Development and Evaluation, 4575 E. Broadway Blvd., Tucson, AZ, 85711*

SUMMARY:

The Community Partnership of Southern Arizona and the University of Arizona developed a peer support provider training program. The 60-hour Recovery Support Specialist (RSS) Institute recruited individuals in recovery from Psychiatric Disorders (90%) and/or Substance Use Disorders (40%). The curriculum included a multitude of topics, including the recovery philosophy, documentation, ethics, cultural awareness, professionalism, and an overview of the Arizona Behavioral Health System. In addition to the Institute, certified RSSs attended weekly practicum meetings for three months to supplement the knowledge learned at the Institute. A satisfactory supervisor evaluation was also required for RSS Certification.

There were three primary goals examined in the evaluation: 1) workforce development, 2) system enhancement, and 3) increased satisfaction. To assess these goals, survey data were collected from RSS Institute participants as well as consumers who received peer support services from the RSSs. In addition, focus groups were held with the non-consumer staff members. In terms of the 1st goal, workforce development, thus far 124 individuals have completed the RSS Institute, 50 have received RSS Certification, and 65 are currently employed (69% female, mean age=43). Employees averaged 32 hours per week (range 8-40) and held many responsibilities, including peer support, group facilitation, and increasing access and awareness to community resources. Regarding the 2nd goal, system enhancement, consumers (N=55) who received peer support services self-reported significantly better outcomes ($p<.05$) and higher satisfaction ($p<.10$) than a randomized sample of consumers (N=550) who had not received peer support services. The non-RSS staff highlighted several changes in their agencies due to the presence of consumer providers: increased focus on recovery, greater engagement of clients, improved outcomes, and enhanced awareness of wellness needs of all staff. Finally, despite initial ambivalence from some of the non-RSS staff, the 3rd goal of increased satisfaction was widely reported across all respondents.

REFERENCES:

1. Anthony, A., Cohen, M., Farkas, M., & Gagne, C. Psychiatric Rehabilitation. Boston University, 2002.
2. Prochaska, J.O., J.C. Norcross, et al. (1994). Changing for Good. NY, William Morrow and Company,Inc.
3. Davidson L, Chinman M, Sells D, & Rowe M: Peer Support Among Adults With Serious Mental Illness: A Report From the Field. Schizophrenia Bulletin 2006; 443-450.
4. McDiarmid D, Rapp C, Ratzlaff S. Design and initial results from a supported education initiative: the Kansas Consumer as Provider program. Psychiatr Rehabil J. 2005 Summer;29(1):3-9.

SYMPOSIUM 51—WHEN USUAL TREATMENTS FAIL: AUGMENTATION STRATEGIES FOR REFRACTORY SCHIZOPHRENIA

EDUCATIONAL OBJECTIVES:

1. Hypofunction of N-Methyl-D-Aspartate (NMDA) neurotransmission is an alternative hypothesis of schizophrenia.

2. Agonist/partial agonist of the glycine-coagonist site of the NMDA receptors or inhibitor of glycine transporter-1 enhance NMDA function and improve key symptom domains of schizophrenia including positive, negative, cognitive and depressive symptoms.

3. Large series confirmation trials exploiting the optimal doses are required to determine the efficacy and limitation for the NMDA-enhancing treatments of schizophrenia.

4. In theory, innovative application to enhance NMDA neurotransmission can bring benefits not only to schizophrenia but to other neuropsychiatric condition that has a component of attenuated NMDA function as well.

No. 51A
NEW TREATMENT OF SCHIZOPHRENIA BY ENHANCING N-METHYL-D-ASPARTATE NEUROTRANSMISSION

Guochuan E. Tsai, M.D. *Harbor-UCLA Medical Center, Psychiatry, F9, 1000 West Carson Street, Torrance, CA, 90502*

SUMMARY:

There is a great need to develop new antipsychotic agents. In addition to dopaminergic neurotransmission, glutamatergic neurotransmission has been implicated in the pathophysiology of schizophrenia. The most compelling link between the glutamatergic N-methyl-D-aspartate (NMDA) system and schizophrenia concerns the mechanism of action of the psychotomimetic drug phencyclidine and the dissociative anesthetic, ketamine; both are NMDA antagonists. The psychosis induced by the NMDA antagonists causes not only positive symptoms similar to the action of dopaminergic agonists but also negative symptoms and cognitive deficits associated with schizophrenia in normal volunteers and worsening of the psychotic symptoms in patients with schizophrenia. When taking together all the double-blind, placebo-controlled studies of NMDA-enhancing agents in patients with chronic schizophrenia receiving stable dose of antipsychotics, the NMDA-enhancing agents, glycine, D-serine, D-alanine, D-cycloserine and sarcosine, were effective in the symptom domains of negative, cognitive, depressive, positive symptom, and general psychopathology. The agents also significantly

improved the extrapyramidal symptoms. No significant side effect or safety concern was noted. In addition to testing more lead compounds, dose-finding and long-term trials are required to determine the optimal dose and functional improvement capacity. The agents can also be applied to prevention and the treatment for prodromal phase of the illness.

No. 51B
TREATMENT-REFRACTORY SCHIZOPHRENIA: USE OF HIGH DOSES OF ANTIPSYCHOTICS

Peter F. Buckley, M.D. *Medical College of Georgia, Psychiatry & Health Behavior, 1515 Pope Avenue, Augusta, GA, 30912*

SUMMARY:

Appreciate the complexity of decision making between the patient and clinician when considering the use of antipsychotic medications at high doses.

Understand the available evidence on use of high doses of antipsychotic medications and how best to compare these drugs in practice.

Abstract:

The treatment of patients with treatment refractory schizophrenia has (paradoxically) become increasingly complex with increasing switching and combining of medications.

For patients and clinicians, then, the question of what to do next when several have failed before is now very challenging. The option of staying on current medicine and optimizing its dose is certainly appealing. Available evidence for this approach will be reviewed in this presentation and we will address the decision making process for considering which drug to use a high doses.

No. 51C
NATURAL AND ALTERNATIVE TREATMENTS IN SCHIZOPHRENIA

Richard P. Brown, M.D. *Columbia University College of Physicians and Surgeons, Psychiatry, 86 Sherry Ln, Kingston, NY, 12401-4724*

SUMMARY:

This lecture reviews the evidence for the use of natural and alternative treatments for negative symptoms, tardive dyskinesia, and social deficits in refractory schizophrenia. We will cover ginkgo, piracetam, essential fatty acids, melatonin, vitamins, yoga breathing and other alternative treatments.

No. 51D
CLOZAPINE AUGMENTATION STRATEGIES

Joseph I. Friedman, M.D., *Psychiatry, Mount Sinai School of Medicine, One Gustave L. Levy Place, Box 1230, New York, NY 10029*

SUMMARY:

A significant number of persons with schizophrenia will show partial or no response to "typical" antipsychotic medications such as haloperidol or chlorpromazine. The introduction of clozapine provided an option for these refractory patients because of its increased efficacy over typical antipsychotic medications. However, it is estimated that only 30%-60% of schizophrenic patients who are non-responsive to "typical" antipsychotics will respond to treatment with clozapine. This lack of complete success has prompted the frequent use of various clozapine augmenting strategies with agents such as additional antipsychotics, benzodiazepines, antidepressants and mood stabilizers, despite a lack of controlled trials demonstrating the clinical usefulness or safety of such strategies. To date, several prospective clinical trials of several clozpine augmentation strategies have been undertaken. This presentation will review the results of these studies, their strengths and weaknesses and any recommendations which can be made based on these findings.

REFERENCES:

1. Tsai G, Coyle JT. Glutamatergic mechanisms in schizophrenia. Annu Rev Pharmacol Toxico. 2001; 42:165-179.
2. Buckley PF, Shendarkar N. Treatment refractory schizophrenia. Current Opinion in Psychiatry 2005; 18:165-173.
3. Zhang XY, Zhou DF, Zhang PY, et al. A double-blind, placebo-controlled trial of extract of Ginkgo biloba added to haloperidol in treatment-resistant patients with schizophrenia. J Clin Psychiatry. 2001 Nov;62(11):878-83.
4. Clarke LA, Lindenmayer JP, Kaushik S. Clozapine augmentation with aripiprazole for negative symptoms. J Clin Psychiatry. 2006 Apr;67(4):675-6.

WEDNESDAY, MAY 23, 2:00 PM - 5:00 PM

SYMPOSIUM 52—BEHAVIORAL AND SUBSTANCE ADDICTIONS IN MINORITY POPULATIONS

EDUCATIONAL OBJECTIVES:

At the end of the presentation, attendees should be able to: 1) understand the need for considering race, ethnicity and culture in addictive disorders; 2) recognize the clinical characteristics of African Americans with gambling problems; and 3) formulate prevention and treatment considerations that incorporate consideration of race, ethnicity and culture.

No. 52A
IMPLICATIONS OF BLACK/AFRICAN AMERICAN RACE, ETHNICITY, AND CULTURE FOR ADDICTION

Marc N. Potenza, M.D. *Yale University, Psychiatry, 34 Park Street, New Haven, CT, 06519*, Marvin Steinberg, Ph.D., Ran Wu, M.S., Declan Barry, Ph.D.

SUMMARY:

Background: Individuals of African American or black race are amongst those afflicted with addiction, although the impact of race per se is often difficult to disentangle from other sociodemographic factors. Although drug addiction has been examined extensively amongst groups of African Americans, relatively little is known regarding how the characteristics of African American problem gamblers.

Methods: Callers to the Connecticut Council on Problem Gambling helpline were queried from January 1, 2000 through December 31, 2003, inclusive, regarding their racial identities. Individuals acknowledging African American (n=153) race and those acknowledging other racial origin (e.g., Caucasian, Asian/Asian American, or Native American; n=1658) were included in analyses.

Results: Preliminary analyses indicate between-group differences in multiple domains. African American as compared to callers of other racial identities were on average less likely to be married, have received post-high-school education education, report gambling-related psychiatric symptomatology (depression, anxiety, or suicidality), acknowledge problems with poker or sports betting, and have attended gamblers anonymous meetings. African American callers were more likely report an earlier age at gambling onset and acknowledge problems with lottery gambling.

Conclusions: Differences in types of problematic gambling, gambling-related psychiatric symptoms and gambling treatment accessed were observed between African American problem gamblers and problem gamblers of other racial identities. These differences suggest the need for prevention and treatment strategies for problem gambling that consider racial, ethnic and related cultural differences. Additional research is needed to investigate the extent to which the current findings apply to other addictive disorders.

No. 52B
NATIVE AMERICAN AND HISPANIC VETERANS WITH ADDICTIVE DISORDERS: COMORBIDITY WITH "INTERNALIZING" AND "EXTERNALIZING" DISORDERS

Joseph J. Westermeyer, M.D., M.P.H., Ph.D., *Psychiatry, University of Minnesota, 1935 Summit Ave., Saint Paul, MN 55105-1430*

SUMMARY:

The primary goal was to assess the lifetime comorbidity associated with Substance Use Disorders, comparing "internalizing disorders" (Mood and Anxiety Disorders) versus "externalizing disorders" (Substance Use Disorder, Antisocial Personality Disorder, and Pathological Gambling). Study participants consisted of 834 veterans from two groups with high rates of Substance Use Disorder, i.e., American Indian and Hispanic veterans. The community sample was structured to include 1:1 ratio of rural-to-urban veterans and over sampled for women (10% of sample). Sampling frame was based on targeted sampling in the catchment area of the Minneapolis VA Medical Center, designed to produce a representative sample (compared with 2000 Census). Diagnoses were based on the Diagnostic Interview Schedule – Quick Version, DSM-III-R, using an algorithmic computer-based format.

Findings: As expected, bivariate analyses revealed high rates of comorbidity between "internalizing" and "externalizing" disorders. However, regression analyses showed some unexpected findings. For example, PTSD showed an independent association with the "internalizing disorders" (Mood and Anxiety Disorders), but not with the "externalizing disorders" (Substance Use Disorder, Antisocial Personality Disorder, and Pathological Gambling). Pathological Gambling demonstrated a stronger comorbidity with the "internalizing disorders" as compared to the other "externalizing disorders." Other expected and unexpected associations will be presented.

Conclusion: High comorbidity of certain disorders can lead to false "conventional wisdom" regarding common comorbidity patterns. "Internalizing" and "externalizing" disorders can show comorbidity patterns that quite unexpected.

No. 52C
ASIAN-AMERICANS, ADDICTIONS, AND BARRIERS TO TREATMENT

Timothy W. Fong, M.D. *Semel Institute For Neuroscience and Human Behavior at UCLA, Psychiatry, 760 Westwood Ave., Room C8-887, Los Angeles, CA, 90024*

SUMMARY:

Behavioral and Substance Addictions in Minority Populations
Asian-Americans, Addictions, and Barriers to Treatment
Timothy W. Fong MD

Asian Pacific Islanders are one of the fastest growing segments of the United States population (APIs). Recent reports suggest that rates of substance use disorders among APIs are growing but utilization of services remains fairly low. This presentation will focus on the biological, psychological and cultural factors that impact rates of behavioral addictions and substance abuse among Asian Pacific Islanders (APIs). Biological factors such as drug/alcohol metabolism and genetic variants will be explored. Cultural factors such as the immigration experience, reliance on the family, shame and peer behaviors will be presented. Finally, barriers to treatment such as stigma, language, financial resources and transportation will be discussed.

No. 52D
ADDICTIONS WITHIN THE GAY AND LESBIAN COMMUNITY

Jon E. Grant, M.D. *University of Minnesota, Psychiatry, 2450 Riverside Ave, Minneapolis, MN, 55454-1512*

SUMMARY:

Adolescent and young adult gay men and lesbians appear particularly prone to substance abuse and dependence, and such substance use has important consequences for their long term health. Given the association between substance use disorders and a variety of serious health consequences of which young gay men are at increased risk, including HIV infection and suicide, there is a need for improved prevention and treatment of substance abuse and dependence. Several epidemiological studies report that gay men are more likely than heterosexual men to use recreational drugs and abuse them. Among gay and bisexual people, lesbian women appear to be at greatest risk. Although substance abuse is 1.47 times more common in gay than heterosexual individuals, it is less clear whether gay men and lesbians are at increased risk for alcohol abuse or dependence. Rates of tobacco use among gay men exceed those of the general population, ultimately leading to increased rates of tobacco-related disease. Adolescent gay men and lesbians are more likely to smoke tobacco than are their heterosexual peers, and higher numbers of male sexual partners correlate with higher rates of tobacco use in gay men (as well as drug use, victimisation, and the use of violence). Pathological gambling may also be higher among gay men and there is evidence that gay men who gamble also have higher rates of compulsive sexual behaviour. Treatment for gay men and lesbians includes a focus on internalized homophobia as well as more traditional addiction treatment approaches.

No. 52E
CLINICAL CHALLENGES TO ADDICTION TREATMENT WITHIN THE LATINO COMMUNITY

Carlos Blanco-Jerez *504 W 110th St Apt 5D, New York, NY, 10025-2008*

SUMMARY:

An estimated 37.4 million Hispanic people live in the US and the population is growing rapidly due to high birth and immigra[[Unsupported Character - Codename]]tion rates. In addition, Hispanics are a young population (with 40% under the age of 21 years), have disproportionately low incomes, and have low levels of education (more than 50% of those under the age of 25 have not graduated from high school). Together, these sociodemographic characteristics portend increases in drug abuse. Cultural influences and high rates of foreign-born Hispanics, which lower the risk for substance use disorders, may create countervailing influences that limit the rate of increase of drug abuse. At the same time, cultural influences may also be related to observed delays in treatment-seeking by Hispanics.

This presentation will review the factors related to prevalence rates and treatment-seeking behavior in Hispanics. Particular emphasis will be placed on findings from recent, large national datasets such as the National Epidemiologic Study on Alcoholism and Related Conditions (NESARC) and the National Comorbidity Study (NCS). The presentation will used to stimulate a discussion on how to

generate more refined approaches to the relationship between ethnocultural factors and SUD and how to translate those approaches into treatment interventions.

REFERENCES:

1. Potenza MN, Steinberg MA, McLaughlin SD, Wu R, Rounsaville BJ, O'Malley SS (2001) Gender-related differences in the characteristics of problem gamblers using a gambling helpline. Am J Psychiatry 158: 1500-1505.
2. Sue S: Use and abuse of alcohol by Asian Americans. Journal of Psychoactive Drugs, 1987; 19:57-66.
3. Gilman S E, Cochran S D, Mays V M, Hughes M, Ostrow D, Kessler D. Riskof psychiatric disorders among individuals reporting same-sex sexual partners in the national comorbidity survey. Am J Pub Health 91:933-939, 2001.
4. Ortega AN, Rosenheck R, Alegría M, Desai RA. Acculturation and the lifetime risk of psychiatric and substance use disorders among Hispanics. J Nerv Ment Dis 2000; 188:728-735.

SYMPOSIUM 53—TREATMENT OF DEPRESSION IN THE MEDICALLY ILL: AN UPDATE FROM RECENT CLINICAL TRIALS

EDUCATIONAL OBJECTIVES:

At the end of this presentation the participant should understand the benefits of two by two factorial designs, centralized ratings and adequate control conditions in evaluating psychotherapy and medication for depression

No. 53A
THE CREATE TRIAL: BACKGROUND AND DESIGN OF A 2 BY 2 FACTORIAL RANDOMIZED TRIAL OF CITALOPRAM AND IPT FOR MAJOR DEPRESSION IN PATIENTS WITH CORONARY ARTERY DISEASE

Nancy Frasure-Smith *McGill University, Department of Psychiatry, 1560 Sherbrooke E, Montreal, PQ, H2L 4M1, Canada*, François Lespérance, M.D., Diana Koszycki, Ph.D., John R. Swenson, M.D., Brian Baker, M.B.Ch.B., Louis T. van Zyl, M.D., Marc-André Laliberté, M.D., Beth L. Abramson, M.D., Marie-Claude Guertin

SUMMARY:

Using a two by two factorial design, we evaluated the efficacy, safety and tolerability of 12 weeks of citalopram and interpersonal psychotherapy (IPT) for the treatment of major depression in 284 outpatients with coronary artery disease (CAD) in 9 academic centers across Canada. The primary aim was to determine the efficacy of citalopram in comparison to matched-placebo and IPT in comparison to clinical management (CM) in reducing depressive symptoms. IPT is a short-term, semi-structured psychotherapy dealing with interpersonal conflicts, life transitions, grief, and deficient social supports. Neither citalopram nor IPT have ever been evaluated before in CAD patients. To be eligible participants had to have current unipolar major depression of ≥ 4 weeks duration, a baseline score of ≥ 20 on the 24 item Hamilton Depression Rating Scale (HAM-D), a lifetime history of myocardial infarction, bypass surgery or angioplasty, and stable CAD based on clinical judgment. Patients were randomized twice: once to 20-40 mg per day of citalopram or pill placebo, and once to participate in 12 weekly sessions of IPT or 12 weekly sessions of CM. The IPT and CM sessions were delivered by trained, IPT therapists. Patients began taking 10 mg per day of citalopram/placaebo for 1 week and then increased to 20 mg. If the 6-week, centralized 24-item HAM-D was not ≤ 8, the dose was increased to 40 mg if tolerated. The primary outcome was the HAM-D rated centrally by phone at baseline, 6 and 12 weeks, by a trained psychologist, blind to treatment allocation. The secondary outcome was the Beck Depression Inventory (BDI-II). Safety and tolerability evaluation included ECGs and blood pressure changes over 12 weeks and incidence of adverse events.

No. 53B
THE CREATE TRIAL: RESULTS OF A 2 BY 2 FACTORIAL RANDOMIZED TRIAL OF CITALOPRAM AND IPT FOR MAJOR DEPRESSION IN PATIENTS WITH CORONARY ARTERY DISEASE

François Lespérance, M.D. *Université de Montréal, Department of Psychiatry, 1560 Sherbrooke E, M-3234, Montreal, PQ, H2L4M1, Canada*, Nancy Frasure-Smith, Ph.D., Diana Koszycki, Marc-André Laliberté, M.D., Louis T. vanZyl, M.D., Brian Baker, M.D., John Robert Swenson, M.D., Kayhan Ghatavi, M.D., Beth L. Abramson, M.D.

SUMMARY:

All 284 patients had at ≥1 dose of study medication and ≥1 CM/IPT session. One-quarter were women, 43% had a prior episode of major depression and 25% had a co-morbid anxiety disorder. All 12 weekly sessions were completed by 84% of those assigned to IPT and 85% of those assigned to CM. Mean duration of CM sessions was 20 minutes and mean duration of IPT sessions was 48 minutes. 94% of patients completed the final HAM-D rating. The target dose of 40 mg was reached for 70% with a mean final dose of citalopram of 33.1 mg (SD=10.82), not different from the average final placebo dose (34.2 mg; SD=9.91; P=.38). Last observation carried forwards analyses showed that citalopram was superior to placebo in reducing depression severity over 12 weeks with a HAM-D difference of 3.3 points (96.7% CI, .80 to 5.85; P =.005), an effect that was apparent by 6 weeks. In addition, citalopram was particularly efficacious for recurrent depression. In contrast, there was no additional benefit of adding IPT to CM (HAM-D difference -2.3 points; 96.7% CI, -4.78 to .27; P =.06). In fact, subgroup analyses suggest that CM was superior to IPT for patients with low levels of social support and those with low levels of functional performance. There were 35 serious adverse events including 12 classified as cardiovascular by a committee blind to treatment group. There was no impact of citalopram on blood pressure or ECG measures, including QTc intervals. In summary, citalopram should be considered as a first-line antidepressant treatment for the acute phase treatment of major depression in CAD. It remains to be established whether any forms of short-term psychotherapy is indicated, in addition to CM, for these patients.

No. 53C
RANDOMIZED CONTROLLED TRIAL OF TREATMENTS FOR DEPRESSION AFTER CORONARY BYPASS SURGERY

Kenneth E. Freedland, Ph.D. *Washington University School of Medicine, Department of Psychiatry, 4625 Lindell Blvd., Suite 420, St Louis, MO, 63108*

SUMMARY:

Depression is a common problem after coronary artery bypass graft (CABG) surgery, but there has been almost no treatment research. We randomly assigned 123 patients (50% female, 20% minority, mean age 60+10 years, 66% with DSM-IV major depression, 34% with minor depression) to 12 weeks of cognitive behavior therapy (CBT), supportive stress management (SSM), or usual care (UC) for depression. Approximately 50% of the patients in all three arms received non-study antidepressants. The participants completed the Beck Depression Inventory (BDI) once per week between the baseline and

3-month post-treatment evaluations. A random coefficients mixed model with random slopes and intercepts was used to determine whether the trajectories of change in depression differed among the three groups. The fixed effects were significant for time ($p<.0001$) and the group X time interaction ($p<.0001$), indicating group differences in the rate of change. Depression improved significantly more rapidly in the CBT and SSM groups than in the UC group ($p<.0001$), but there was no difference in the rate of change between the two active intervention arms, and no effect for antidepressant use. The random effects revealed significant variability in individual patient intercepts ($p<.0001$) and slopes ($p<.0001$), but not covariance of intercepts and slopes ($p=.91$). This indicates that there were individual differences in the intial severity of depression and in the rate of change, but that the rate of change did not depend upon the initial severity. In conclusion, depression improved more rapidly in both treatment groups than in usual care, and neither the initial severity of depression nor the use of non-study antidepressants affected the rate of change.

No. 53D
COST-EFFECTIVENESS OR IMPROVING DEPRESSION OUTCOMES IN PATIENTS WITH DIABETES AND DEPRESSION

Wayne J. Katon, M.D. *University of Washington, Department of Psychiatry, 1959 NE Pacific St,. Box 356560, Seattle, WA, 98195-6560*, Gregory E. Simon, M.D., Jurgen Unutzer, M.D., Ming-Yu Fan, Ph.D., Michael Schoenbaum, Ph.D., Michael Von Korff, Sc.D, John W. Williams, Jr., M.D., Carolyn Rutter, Ph.D., Paul S. Ciechanowski, M.D.

SUMMARY:

Patients with diabetes have a high prevalence of major depression, estimated at up to 15%. These research projects tested the effect on depressive outcomes and costs of a quality improvement depression intervention for patients with diabetes and depression.

We will describe the 2-year incremental cost-effectiveness of two trials that randomized 414 older adults with diabetes and depression (IMPACT) and 329 mixed-aged patients with diabetes and depression (Pathways Trial), respectively, to a collaborative stepped care intervention versus usual care. The stepped care intervention in each trial provided patients with a choice of problem-solving therapy, antidepressant medication and behavioral activation with potential augmentation of initial choice of treatment based on persistent depressive symptoms.

In the IMPACT trial, the two-year total ambulatory costs were $25 (95% CI -1638, 1689) higher in intervention versus usual care patients over a 2-year period and the incremental number of depression-free days associated with the intervention was 115 (95% CI 72, 159). The incremental cost per depression-free day was -$0.25 (95% CI -14, 15). A bootstrap analysis suggested a 50% chance of dominance of the intervention (the total ambulatory costs were less with greater clinical benefit).

In the Pathways trial, the two-year total ambulatory costs were $605 (95% CI -1767, 556) less in intervention versus usual care patients and the incremental number of depression-free days associated with the intervention was 70 (95% CI 26, 114). The incremental cost per depression-free day in Pathways was -$9.7 (95% CI -31, 14). The results of the two trials suggests in patients with diabetes and depression that for no greater costs the depression stepped care intervention compared to usual primary care was associated with a marked increase in depression-free days and health care benefits in primary care patients with comorbid diabetes and depression.

No. 53E
EFFICACY OF SERTRALINE FOR PREVENTION OF DEPRESSION RECURRENCE IN OLDER VERSUS YOUNGER ADULTS WITH DIABETES

Patrick J. Lustman, Ph.D. *Washington University School of Medicine, Department of Psychiatry, 660 S. Euclid, Medical Box 8134, Saint Louis, MO, 63110*, Ray E. Clouse, M.D., Billy D. Nix, Monique M. Williams, M.D.

SUMMARY:

Objective: Sertraline maintenance therapy effectively delays recurrence of major depressive disorder in adult diabetic patients when data are examined across all age groups. A secondary analysis was performed to assess this effect in younger and older subsets of patients.

Research Design and Methods: Younger (age <55 yr, n=85) and older (age ≥55 yr, n=67) subsets were identified from a multi-center, double-blind, placebo-controlled, maintenance treatment trial of sertraline in diabetic participants who achieved depression recovery with open-label sertraline treatment. Cox proportional hazards models were used to determine differences in time to depression recurrence between treatment arms (sertraline or placebo) for each age subset and between age subsets for each treatment.

Results: In younger subjects, sertraline conferred significantly greater prophylaxis against depression recurrence than placebo (HR 0.37, 95%CI 0.20 - 0.71; $p = 0.003$). Benefits of sertraline maintenance therapy were lost in older participants (HR 0.94, 95%CI 0.39 - 2.29; $p = 0.89$). There was no difference in time to recurrence for sertraline-treated subjects between age subsets ($p = 0.65$), but elderly subjects had a significantly longer time to recurrence on placebo than younger subjects ($p = 0.03$).

Conclusions: While sertraline significantly increased the time to depression recurrence in the younger diabetic participants, there was no treatment effect in those aged 55 years and older because of a high placebo response rate. Depression maintenance strategies should be developed that are specific for elderly subjects with diabetes.

REFERENCES:

1. Frasure-Smith N, Koszycki D, Swenson JR et al. Design and rationale for a randomized, controlled trial of interpersonal psychotherapy and citalopram for depression in coronary artery disease (CREATE). Psychosom Med. 2006;68:87-93.
2. Glassman AH, O'Connor CM, Califf R et al. Sertraline treatment of major depression in patients with acute MI or unstable angina. JAMA. 2002;288:701-709.
3. Blumenthal JA, et al: Depression as a risk factor for mortality after coronary artery bypass surgery. Lancet 2003; 362:604-609.
4. Katon W, Unützer J, Fan MY, Williams Jr JW, Schoenbaum M, Lin EHB, Hunkeler EM: Cost-effectiveness and net benefit of enhanced treatment of depression for older adults with diabetes and depression. Diabetes Care 2006; 29:265-270.
5. Lustman PJ, Clouse RE, Nix BD et al. Sertraline for prevention of depression recurrence in diabetes: A randomized, double-blind, placebo-controlled trial. Archives of General Psychiatry, 63(5):521-529, 2006.

SYMPOSIUM 54—DRUG ABUSE TREATMENT WITHIN THE CRIMINAL JUSTICE SYSTEM: ADDRESSING OUR NATION'S PUBLIC HEALTH NEEDS
National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

1. To learn about the nature of health and substance abuse treatment services offered to drug-involved offenders, both adults and juveniles.

2. To discuss organizational characteristics that affect the type of programs and services offered to offenders.
3. To identify organizational characteristics that affect the prevalence of programs and servcies provided to offenders.
4. To identify organizational characteristics that affect the access to quality services and programs by offenders.

No. 54A
FINDINGS FROM A NATIONAL SURVEY OF CORRECTIONAL AGENCIES ON SUBSTANCE ABUSE TREATMENT AND HEALTH SERVICES: WHO CAN GET SERVED?

Faye S. Taxman, Ph.D. *Virginia Commonwealth University, Wilder School of Government and Pulic Affairs, 923 W. Franklin Street, Suite 501, Richmond, VA, 23284*

SUMMARY:

A recent survey of adult and juvenile correctional systems to ascertain the nature and type of programs and services offered to offenders. The study includes a census of state systems and a representative sample of prisons, jails, probation and/or parole offices. Survey findings will be presented regarding the prevalence of medical, substance abuse, and mental health services for offenders in correctional settings we well as the access to such services. The difference between the prevalence and access rates for programs and services will be discussed, and the consequences on the adoption and sustaining effective health services practices in correctional settings. The survey also characterized the health and treatment delivery systems in place including substance abuse treatment programs. The paper will dicusss the adoption of evidence-based pratices in the substance abuse treatment programs for offenders, and the organizational characteristics that affect the adoption of evidence-based practices. Survey findings will be provide a better apprecaition of structural and leadership issues that affect the likelihood that correctonal organizations will offer quality services.

No. 54B
THE LONG-TERM EFFECTIVENESS OF CORRECTIONS-BASED TREATMENT FOR DRUG-INVOLVED OFFENDERS

James A. Inciardi, Ph.D. *University of Delware, Center for Drug & Alcohol Studies, 77 E. Main St., Newark, DE, 19716*

SUMMARY:

With growing numbers of drug-involved offenders coming to the attention of the criminal justice system, substance abuse treatment has become a critical part of the overall correctional process. The therapeutic community appears to be a treatment modality especially well suited for correctional clients because its intensive nature addresses their long-term treatment needs. A multistage therapeutic community treatment system has been implemented in the Delaware correctional system. The centerpiece of the treatment process occurs during work release - the transitional stage between prison and the free community. When evaluating this program, 690 individuals in four research groups were followed: treatment graduates with and without aftercare, treatment dropouts, and a "no treatment" comparison group. At 5 years after release, treatment graduates, with or without aftercare, had significantly greater probabilities of remaining both arrest-free and drug-free than did those without treatment. Treatment dropouts were slightly, though not significantly, less likely to be arrested on a new charge as those without treatment, but were significantly more likely to be drug free. These outcome data suggest that the widespread implementation of such treatment programs would bring about significant reductions in both drug use and drug-related crime.

No. 54C
MENTAL HEALTH AND CO-OCCURRING TREATMENT NEEDS OF INDIVIDUALS IN THE CRIMINAL JUSTICE SYSTEM

Roger H. Peters, Ph.D. *University of South Florida, Department of Mental Health Law & Policy, 13301 N. Bruce B. Downs Blvd., Tampa, FL, 33612*

SUMMARY:

Offenders with co-occurring mental health and substance use disorders present numerous challenges, and often cycle repeatedly through the justice system. This presentation will examine features of co-occurring disorders that influence program outcomes, and specialized screening and assessment strategies for this population. Several new screening and assessment instruments related to co-occurring disorders will be reviewed.

No. 54D
MEETING THE MEDICAL NEEDS OF OFFENDERS

Peter D. Friedmann, M.D. *Rhode Island Hospital, Division of General Internal Medicine, 593 Eddy Street, Providence, RI, 02903*, Jennifer G. Clarke, M.D., Lynn E. Taylor, M.D., Michael Poshkus, M.D., Josiah D. Rich, M.D.

SUMMARY:

Drug-involved offenders have a high prevalence of medical problems. These medical conditions can be toxic effects of illicit drugs or their impurities, sequellae of drug injection or other routes of administration, infectious complications of high risk behaviors (such as hepatitis C, HIV/AIDS or sexually transmitted infections) or poor living conditions (such as tuberculosis). Furthermore, drug users commonly forgo primary or preventive care in the community. Health care professionals working in corrections or addiction treatment settings have a 'treatable moment,' an opportunity to screen for common medical conditions and link drug-using patients to needed medical care. In addition to positive effects on physical health, some evidence suggests that linkages to medical care might improve compliance with addiction treatment and criminal justice outcomes. Finally, given the overrepresentation of African-Americans among correctional populations, such linkages might help to reduce racial disparities in health.

No. 54E
PHARMACOTHERAPY IN CORRECTIONAL SETTINGS FOR ADDICTIVE AND OTHER MENTAL DISORDERS

Robert P. Schwartz, M.D. *Friends Research Institute, 1040 Park Avenue, Suite 1300, Baltimore, MD, 21201*

SUMMARY:

The majority of the prisoners in the United States have substance use disorders and a significant minority have severe mental illness. Pharmacotherapy is often indicated for the treatment of these disorders. The purpose of this presentation is to discuss specific challenges associated with the use of medications to treat mental and substance use disorders in jails and prisons. The limited literature addressing this important area will be reviewed. Challenges to providing pharmacotherapy will be presented including: patient assessment; medication and outcomes monitoring; integration of pharmacotherapy with concurrent medical care, psychosocial and prison activities;

cost-constraints and, aftercare planning. The Forensic Algorithm Project for the treatment of schizophrenia in prisons and a randomized clinical trial of methadone treatment for pre-release prisoners will be presented to illustrate effective approaches to the significant challenges of providing psychiatric and substance abuse treatment in prisons. Ethical principles and dilemmas in practicing in prisons will be presented. In summary, this presentation will offer a timely review of clinical and ethical issues related to the practice of psychopharmacology in jail and prison settings.

REFERENCES:

1. Taxman, FS, et al. The State of the STate of Substance Abuse Treatment Services for Offenders. Journal of Substance ABuse Treatment, forthcoming.
2. Inciardi JA, Martin SS, Butzin CA: Five-year outcomes of Therapeutic Community treatment of drug-involved offenders after release from prison. Crime & Delinquency 2004; 50:88-107.
3. Friedmann, PD, Saitz R, Samet JH. Linking addiction treatment with other medical and psychiatric treatment systems. In Principles of Addiction Medicine, 3rd Edition. Chevy Chase, MD, American Society of Addiction Medicine, 2003, pp. 497-507.
4. Weinstein H, Zil JS, Burns KA: Psyhchiatric Services in Jails and Prisons, 2nd Edition, APA Publishing, 2000.

SYMPOSIUM 55—IMPROVING CROSS-CULTURAL COMPETENCY IN PSYCHIATRIC PRACTICE

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to:

1. Understand the concept and components of cultural competence
2. Recognize cultural characteristics of African American, Latino, South Asian, South East Asian communities
3. Demonstrate understanding of effective race and ethnically compatible psychiatric interventions.

No. 55A
SOUTH ASIAN PSYCHITRIST-PROVIDING CULTURALLY SENSITIVE TREATMENT

Rama Rao Gogineni, M.D. *Robertwood Johnson Medical School, Psychiatry Department, One Bala Avenue,suite#118, BalaCynwyd, PA, 19004*

SUMMARY:

About half of 25% of IMGs in APA are of South Asian origin.Many of them work in public sector,so they provide psychitric treatment to many native born and immigrant patients.

Propose a four step model to provide a culturally sensitive comprehensive biopsychosocial treatment.1.Understand oneself by learning/ understanding Soth Asian upbringing,religion,caste system,sociocultural values that shape one's identity,values etc.2.Understand one's immigration,acculturation processes and establishment of bicultural idendity.3.Learn about American born,immigrants culture,ethnicity,-vaue system etc.4.Pay attention to/address cross cultural issues,resistances that influence thearaputicalliance,tranference,counter tranference etc.

This 4 step model can/will help to provide good treatment

No. 55B
CULTURAL COMPETENCY IN PSYCHIATRY AND AFRICAN-AMERICANS

Altha J. Stewart, M.D. *111 South Highland, #180, Memphis, TN, 38111*

SUMMARY:

In the twenty-five years since publication of Adebimpe's landmark paper, "Overview: White Norms and Psychiatric Diagnosis of Black Patients" much has been written about the barriers to achieving a level of competence in the practice of psychiatry that will positively influence access to and quality of mental health care received by African-Americans in the US. Unfortunately, work related to overcoming those barriers has not changed the outcome he identified then — Black patients run a higher risk of being misdiagnosed and undertreated than white patients. The expert consensus, reported in numerous national reports, is that we have fallen short of achieving the goal of cultural competence when treating African-Americans.

This presentation will provide a brief review of literature of the last few decades, highlighting interventions that have demonstrated effectiveness in reducing the stigma and isolation that continue to prevent African-Americans from seeking treatment. In addition, it will include a discussion of the shift, by publicly funded systems serving significant African-American populations, to integrated models of care and the impact on access to and quality of care provided to African-Americans. It will conclude with a discussion of a rationale and strategy for involving the community's natural support systems to improve treatment adherence and outcomes, and recommendations for policy and funding changes needed to achieve the goal of improving mental health care and outcomes for African-Americans.

No. 55C
FILIPINO FAMILIES AND MENTAL HEALTH: UNDERSTANDING THEIR PERSPECTIVES

Consuelo Cagande, M.D. *The Cooper Health System RWJMS/ UMDNJ, Psychiatry Department, 401 Haddon Ave, Camden, NJ, 08103*

SUMMARY:

Filipinos are one of the largest growing population in the United States. Their background is one of a complex mosaic of influences; from the Spaniards to the Chinese. Mental health issues are still a "taboo" despite their culture becoming more modernized and westernized. As a filipina immigrant myself, the same cultural factors that affect any migrating ethnic group are relevant. This presentation will present these factors that mental health providers should be attuned to when evaluating and treating Filipinos.

No. 55D
LATINOS IN THE UNITED STATES, CROSS-CULTURAL ISSUES

Maria Velazquez, M.D. *The Reading Hospital and Medical Center, Psychiatry Department, Six Avenue and Spruce Street, Reading, PA, 19611*

SUMMARY:

The Latino population in the United States is the fastest growing minority. Puertoricans share many cultural characteristics with other hispanic groups, however discussion will focus on specific issues that affect puertorican population in the United States. Also, will review access to mental health services and general attitudes regarding psychiatrict treatment .

REFERENCES:

1. Sudhir Kakar-Identity and adulthood,oxford university press,1979.
2. Adebimpe VR: Overview: white norms and psychiatric diagnosis of black patients. Am J Psychiatry 1981; 138:279-285.

3. McGoldrick M, et al: Filipino Families. In Ethnicity & Family Therapy, edited by McGoldrick M, Giordano J, Garcia-Preto N, New York, The Guilford Press,, pp 319 - 331.
4. Canino GJ, Bird HR, Shrout PE, Rubio-Stipec M, Bravo M, Martinez R, Sesman M, Guevara LM: The prevalence of specific psychiatric disorders in Puerto Rico. Arch Gen Psychiatry 1987; 44:7 27-735.

SYMPOSIUM 56—EATING BEHAVIOR IN SCHIZOPHRENIA: BIOLOGICAL AND CLINICAL IMPLICATIONS

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to have an increased knowledge of the medical co-morbidity in schizophrenics. The participant will also get increased awareness of selection of treatments with lower potential for these side effects. The optimal management of weight gain and metabolic syndromes will be made clearer thereby allowing the participant the ability to enhance patient quality of life.

No. 56A
OBESITY AND METABOLIC DISORDERS IN SCHIZOPHRENIA

Naveed Iqbal, M.D. *Advance Bio Behavioral Sciences Inc, 5 W Main St Ste 206, Elmsford, NY, 10523-2448*

SUMMARY:

Schizophrenic patients have increased weight as compared to the general population. This may be due to the illness or the inability of these patients to follow a proper diet and exercise regimen. The problem of increased weight gain in schizophrenic patients is compounded several folds more secondary to the treatments they receive for their chronic illness. Most of the antipsychotic medications have moderate to significant potential towards increasing weight. Furthermore, schizophrenic patients treated with these medications also are more predisposed towards developing dyslipidemias, metabolic syndrome, and non insulin dependent diabetes mellitus. The increase in weight gain and worsening of metabolic parameters increase the medical, including cardiac, morbidity and mortality in these patients. Optimizing the treatment of these schizophrenic patients requires minimizing the potential of the serious side effects while maintaining the therapeutic efficacy of the treatment.

No. 56B
EATING DISORDERS IN SCHIZOPHRENIA: CONCEPTUAL AND CLINICAL ISSUES

Michael Y. Hwang, M.D. *East Orange VA Medical Center, Department of Psychiatry, 385 Tremont Ave # 116A, East Orange, NJ, 07018-1023*

SUMMARY:

Abnormal eating behavior in pateints with schizophrneia is has long been considered to be a part of the psychotic phenomena and that eating disorders has not been an acceptable comorbid disorder. Consequently eating disorder and schizophrenia has been generally thought to be mutually exclusive. Furthermore, when significant eating disturbance is clinically observed, there is often unsubstantiated belief that eating-related symptoms will resolve as psychosis abates. Else, clinicians may have a speculative skepticism, regarding schizophrenia as encompassing an inability to comply with a normal prescribed ways of living. This may reflect emphasis on overt behaviors in the clinical management of schizophrenia, with less concern about the cognitive drives behind them. Distortions of body image and a deficient sense of self are commonly recognized in schizophrenia. Such cognitive processes may predispose patients with schizophrenia to eating disorders, especially in a cultural context in which thinness is revered and valued. Clinicians may argue that in patients with schizophrenia, insight about their eating behaviors or the motives behind them may be lost whereas it is preserved in conventional eating disorders. However, the insight fluctuates on a continuum and the insight is not consistently present in eating disorders. One of the most distinctive characteristics of anorexia nervosa is a lack of appropriate concern about or denial of the seriousness of low body weight. Anorexic behaviors are often ego-syntonic with denial of illness, little motivation to change behavior, fear of changing behavior. Similarly, in bulimia nervosa, the ICD-10 criterion of "intrusive dread of fatness" and the *DSM*-IV criterion of "self-evaluation unduly influenced by body shape and weight" are also reflective of disturbed insight.

This symopsoium presetation will examine the conceptual issues of diagnosing eating disorder in the context of recently emerging clincal and neurobiological basis of other comorbid disorders in schizophrenia.

No. 56C
PHENOMENOLOGICAL AND CLINICAL PROFILES OF EATING BEHAVIOR IN SCHIZOPHRENIA

Sun Young Yum, M.D. *NJVAHCS / UMDNJ NJMS, Psychiatry, 183 South Orange Ave, E-1428, Newark, NJ, 07101*, Michael Y. Hwang, M.D.

SUMMARY:

There is a prevailing cultural idealization of thinness and disparagement of bigness. Patients with schizophrenia are just as vulnerable, if not more so to cultural standards. In fact, patients with schizophrenia very frequently have body-image preoccupations and associated ritualistic behaviors to control body weight and size. This presentation will discuss how eating disorders present in schizophrenia, and share experiences with cognitive therapies adopted from eating disorders in a group of patients with schizophrenia.

In our clinical observation of eating behaviors in schizophrenia, eating-related cognitive dimensions do not seem to correlate with clinicians' objective measures of severity of overt psychotic symptoms, but correlate strongly with patients' subjective perception of distress associated with psychiatric symptoms. Just as individual subjectivity is not always accurately incorporated into a clinician's assessment, variable cognitive drives for similar behaviors may not be adequately evaluated.

Quite commonly, patients will not readily disclose behaviors such as food restrictions, purging, excessive exercise, binging, or use of diet products even upon questioning. Patients with schizophrenia also often tend to make selective disclosures, even about rather obvious positive psychotic symptoms. Such discretion might be based on the patient's perception of the interviewer's capacity to address the endorsed symptoms. In regards to eating behaviors, it helps to inquire about the cognitive drives before assessing the behaviors. It is essential to have non-judgmental, non-authoritarian attitudes about patients' weight and eating behaviors. It is also important to recognize the ego-syntonic nature of self-control whether that control means staying thin or big, and the difficulties in changing.

No. 56D
EFFECT OF ATYPICAL ANTIPSYCHOTICS ON OBESITY AND METABOLISM IN SCHIZOPHRENIA

Palmiero Monteleone, M.D. *University of Naples SUN, Psychiatry, Largo Madonna delle Grazie, Naples, 80138, Italy*, Michele Fabrazzo, M.D., Alfonso Tortorella, M.D., Mario Maj, M.D.

SUMMARY:

Over the last decade, profound metabolic side effects have been described with several of the atypical antipsychotics. In particular, it has been claimed that this class of drugs is associated to the development of glucose intolerance and diabetes mellitus as well as to profound body weight gain. These side effects are associated with increased risk of coronary heart disease, hypertension, osteoarthritis, cancers, thus impairing the quality of life of patients taking those drugs. Moreover, antipsychotic induced weight gain may impair the patient's compliance to treatment, increasing the likelihood of relapse. Therefore, the identification of factors predicting such untoward effects may be important in order to prevent or minimize them adequately. We investigated whether pre-treatment values of circulating leptin or its early change during clozapine administration could predict the long term weight gain induced by the drug. We found that after 2 weeks of clozapine administration, plasma leptin levels increased much more than the amount of weight gained by patients and this increase negatively correlated with the patients' percent increases of BW after 6 and 8 months of treatment. We hypothesized that, in the first phase of clozapine treatment, the marked rise in circulating leptin independently of total BW changes could theoretically signal to the brain the immediate need for appetite suppression and/or increase in the energy expenditure to counteract the incoming disturbance of the metabolic state induced by clozapine. This acute signaling function of leptin likely has long term effects, since the higher the increase in the fat hormone plasma levels after 2 weeks of treatment, the lower the weight increase gained by clozapine-treated patients after 6 and 8 months of treatment.

REFERENCES:

1. Allison DB, Mentore JL, Heo M, et al.: Antipsychotic-induced weight gain: a comprehensive research synthesis. Am J Psychiatry.
2. Hwang MY, Bermanzohn PC: Schizophrenia and comorbid conditions. Washington, DC, American Psychiatric Press, 2001.
3. Yum YS, Hwang MY, Lee YH, Halmi KA. Non-dieting approaches to the management of obesity in schizophrenia. Paradigm 2006; Oct Fall issue [in press].
4. Nasrallah HA,, Newcomer JW: Atypical antipsychotics and metabolic dysregulation. J Clin Psychopharmacol 2004; 24:S7-S14.

SYMPOSIUM 57—SIMPLE TECHNOLOGIES TO IMPROVE PSYCHOTHERAPY

EDUCATIONAL OBJECTIVES:

1. Participants will learn how to use web-based technology to teach and learn psychotherapy.

No. 57A
WEB-BASED LEARNING IN PSYCHOTHERAPY: A DEMONSTRATION!

Priyanthy Weerasekera, M.D. *McMaster University, Psychiatry & Behavioural Neurosciences, St. Joseph's Hospital 301 James S Fontbonne F415, Hamilton, ON, L8P 3B6, Canada*

SUMMARY:

The past 10 years has witnessed a significant increase in the use of technology in medical education. Web-based learning (WBL) offers numerous advantages with universal accessibility, ease in updating content, and hyperlink functions that permit cross-referencing to other resources. Proponents of WBL consider this method of learning superior to more traditional forms given that the learner is actively searching out and enhancing his/her knowledge base through hyperlink functions. Application of this technology to psychotherapy training suggests potential benefits to various components of training such as demonstration of therapy specific skills through clinical vignettes, interactive learning experiences, and testing of knowledge base.

The purpose of this paper is to present a demonstration of a web-based psychotherapy program developed at McMaster University. Each psychotherapy module is organized into a web module with content information being presented in multiple forms including clinical vignettes so as to demonstrate expert modeling of clinical skills, essential to learning. Pre-post test are also presented in each module and resident performance is monitored throughout training. WBL is integrated with traditional methods so that this knowledge can be applied and tested in classroom sessions with an instructor. This permits multiple methods of evaluation. This program was developed to provide residents with an innovative, efficient means to learning the psychological treatments for patients with psychiatric disorders.

No. 57B
SEEING IS BELIEVING: WEB-CAMS IN PSYCHOTHERAPY SUPERVISION

John Manring, M.D. *SUNY Upstate Medical University, Department of Psychiatry, 750 E Adams St, Syracuse, NY, 13210-2306*

SUMMARY:

The past 10 years have witnessed a significant increase in the use of technology in medical education. Updated electronic equipment can facilitate various aspects of learning to enhance competence. After presenting a review of the empirical literature on learning in psychotherapy, I will demonstrate how web-cams can be creatively utilized to routinely record therapy sessions. The digital files created can then be reviewed by the resident and supervisor, separately and together, stopping and focusing on specific aspects of the session without disrupting the flow of the actual patient-therapist interactions. This permits detailed dissection of the session and more accurate feedback to be shared with the resident about the process, content, feeling states and specific therapeutic interventions of the therapy session. It also permits accumulation of a therapist portfolio of competence in psychotherapy. I will discuss how this technology has been incorporated into our psychotherapy training program at SUNY-Upstate Medical University.

No. 57C
EVIDENCE FOR MEASURING, MONITORING, AND FEEDING BACK PROGRESS INFORMATION TO PROVIDERS: TECHNOLOGY IN THE SERVICE OF IMPROVING PATIENT OUTCOME.

Michael J. Lambert, Ph.D. *Brigham Young University, Psychology, 272 TLRB, Provo, UT, 84602*

SUMMARY:

Approximately 40% to 60% of patients are expected to be unresponsive to treatment in routine care, outpatient settings, and an addition 5% to 10% reliably worsen. If these patients can be identified early in the treatment process, and clinicians are made aware of their status the patients', eventual treatment response can be enhanced. A measure of symptomatic states, interpersonal, and social role functioning was developed to monitor patient treatment response on a weekly basis. The patient's response to treatment after each session of psychotherapy or medication is compared with average response curves derived from a data base with repeated measures on over 10,000 patients. Large deviations from the expected treatment response reliably identify treatment failures and do so with much

greater accuracy than treating clinicians. The results of five clinical trials in which treatment as usual was compared with treatment that included weekly progress feedback to providers are summarized. The effects of this outcomes management procedure were shown to persistently enhance outcomes for the poorly responding patients.

The addition of a Clinical Support Tool Manual that included a problem solving decision tree for analyzing what is going wrong in a particular case, measures of important patient variables to focus problem solving, and suggestions for appropriate future actions was also evaluated. The effects of this intervention were of even greater magnitude than progress feedback alone, reducing treatment as usual deterioration rates from 21% to 8%, and doubling the percent of patients who recovered/reliably improved.

The use of outcomes management practices based on progress feedback relative to expected response can be easily achieved through the use of handheld computers linked to software (OQ-Analyst) that scores the measure and interfaces with the clinician's computer, providing instantaneous feedback to clinicians.

No. 57D
USING TECHNOLOGY IN COGNITIVE THERAPY

Judith Beck *Beck Inst for Cognitive Therapy, One Belmont Avenue, Bala Cynwyd, PA, 19004-1610*

SUMMARY:

Research has shown that cognitive therapy has been effective when delivered by individual and group telephone counseling. It has also been shown to be effective when delivered through computer programs, either as a stand-alone treatment for patients with mild symptoms or in conjunction with face-to-face counseling for patients with moderate symptoms. PDAs (personal digital assistants) are also used for a variety of tasks, including helping patients monitor symptoms, schedule and monitor activities, and prompt adaptive behavior.

REFERENCES:

1. Chumley-Jones H, Dobbie A, Alford C: Web-based Learning: Sound Educational Method or Hype? A Review of the Evaluation Literature. Academic Medicine 2002; 77 (10): S86-S93.
2. Miller WR, Yahne CE, Moyers TB, Martinez J, Pirritano M: A randomized trial of methods to help cinicians learn motivational interviewing. J of Consulting and Clinical Psychology 2004; 72(6): 1050-1062.
3. Lambert MJ, Whipple JL, Hawkins EJ, Vermeersch,DA, Nielsen SL, Smart DW: Is it time for clinicians to routinely track patient outcome?: A meta-analysis. Clinical Psychology: Science & Practice 2003; 10:288-301.
4. Wright JH et al Computer-assisted cognitive therapy for depression: maintaining effficacy while reducing therapist time. Am Journal Psychiatry, 2005; 162:1158--1164.

SYMPOSIUM 58—PSYCHIATRIC TRAINING ACROSS THE CONTINENTS: INTERNATIONAL YOUNG PSYCHIATRIST PERSPECTIVES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium the participant shoulde be able to demostrate an understanding of:

- psychiatric training programs in North America, South America, Europe, Middle East, Asia and Africa
- variation and similarities across these programs
- common educational challenges
- trends in the development of these programs.

No. 58A
FROM THE OLD TO THE NEW: CHANGES TO POSTGRADUATE PSYCHIATRIC TRAINING IN THE UK

Amit Malik, M.B.B.S. *Queens Medical Centre, Department of Psychological Medicine, South Block, B Floor, Psychiatric Outpatients, Nottingham, NG7 2UH, United Kingdom*

SUMMARY:

Postgraduate Psychiatric training in the UK is undergoing a massive change. There is a major shift in both postgraduate psychiatric training and assessments from the more traditional models towards the competency based models. The new training model will be driven by a competency-based curriculum. The emphasis of assessments will change from 'what residents know' to 'what residents can do' and these will increasingly occur in the workplace. This compounded with the changes to structure of training including foundation training before the start of specialty training and run-through specialist training will change the face of a decade old system.

This presentation will outline some of these changes relating to selection into postgraduate training, delivery of training and context and methodology of assessments. These changes will be presented as a contrast to the existing system. The presentation will also discuss some of the contemporary academic perspectives in postgraduate medical education as applicable to these changes.

No. 58B
PSYCHIATRIC TRAINING IN KENYA: AN AFRICAN PERSPECTIVE

Violet A. Okech, M.Med. *P O Box 2308, Nairobi, KNH 00202, Kenya*

SUMMARY:

Overall, the African psychiatrist is often one in a million, in terms of psychiatrist-to-population ratio in East Africa. General doctors recognize that psychiatric disorders are common among their patients but they have major obstacles in managing them. Among specific obstacles frequently cited by the doctors were the patients' resistance to referral, lack of coordination and insufficient knowledge to treat the disorders. In the year 2002, 598,119 patients were treated at Kenyatta National Hospital out of which 6,878 (1.15%) were seen in the psychiatric clinics: 1,709 adults and 1,412 children were referred to the various psychiatric clinics. At the hospital's Patient Support Centre (PSC) 3,454 patients were seen, mostly for pre and post-HIV test counseling. Consultations from the wards accounted for 332 (9.6%) of the cases referred to PSC. It is within this context that the challenges and opportunities for psychiatric training in Kenya will be discussed.

No. 58C
THE SPECIALIST TRAINING IN PSYCHIATRY IN BOLIVIA AND LATIN AMERICA

Guillermo C. Rivera Arroyo, Sr., Ph.D. *Bolivian Catholic University, Mental Health, Franz Ruck 101, 101, Sucre, 479, Bolivia*

SUMMARY:

This presentation will provide an overview of the key features, issues and trends relating to psychiatric residency training in Bolivia.

No. 58D
PSYCHIATRIC TRAINING PROGRAM IN JAPAN

Atsuo Nakagawa, M.D. *Keio University School of Medicine, Psychiatry, Shinanomachi 35, Shinjuku-ku, Tokyo, 160-8582, Japan*, Ryoko Sato, M.D.

SUMMARY:

Objective: In Japan, a mandatory postgraduate two-year primary care training program was implemented in 2004. In this program, psychiatric training became mandatory requiring minimum of 4 weeks for each resident. We investigated the residents' perception of the content and adequacy of their psychiatric training program.

Methods: Residents of the 26 institutes (15 universities, 4 general hospitals and 7 psychiatric hospitals) in Japan were surveyed prospectively by self-report questionnaire (pre-program: n=247; post: n= 241). Demographic and program information, perception of the content and adequacy of their psychiatric training program, concerns about interview with psychiatric patients and knowledge of clinical psychiatry were collected.

Results: More than 90% of the residents admired the necessity of psychiatric training in the mandatory residency program. Nearly 70% of the residents reported a reduction in concerns about interview with psychiatric patients and lack of their knowledge of clinical psychiatry. Although 40-50% of the residents reported having interest on primary mental health care, psychopharmacotherapy, psychiatric emergency and consultation liaison psychiatry before the program, approximately 40% of the residents revealed that the program was inadequate in experiencing psychiatric emergency and consultation liaison psychiatry. The proportion of residents achieving confidence in diagnostic and treatment skills of insomnia, depression, delirium and psychosis increased up to 20% from 70% after the program.

Conclusions: The majority of resident acknowledges the importance of psychiatry in clinical practice, and has improved their knowledge and skills of common mental disorders. These results imply that receiving psychiatric training has positive effects on the acquisition of primary care skills. Due to limited training period, standardize training program is needed.

No. 58E
THE INTERFACE BETWEEN EAST AND WEST: PSYCHIATRIC TRAINING IN TURKEY

Ozgur Ozturk, M.D. *Balikli Greek Foundation Hospital, Zeytinburnu, Istanbul, 34020, Turkey*

SUMMARY:

Psychiatric training in Turkey is at the treshhold of a great progress. The duration of residency programs has recently been extended to minimum of five years of which the trainees have to spend 9 months in neurology rotation, 3 months in internal medicine and 4 months in child and adolescent psychiatry (CAP)rotation. CAP is another branch of specialization since the beginning of 1990's. Log-book has begun to be used in some training institutions and its usage is recommended by Psychiatric Association of Turkey.Psychotherapy education is not included in standard education process and young trainees have to afford their own education. Neverthless many trainees can not find this opportunity in small university cities. With the rapid urbanization of the country for the last 20 years,psychiatric care and services emerged as an urgent necessity of the society as the cultural prejudices against psychiatric treatment weakens. Thus these novel developments made psychiatry a specialization of choice among young medical graduates in Turkey.

No. 58F
A REVIEW OF PSYCHIATRIC TRAINING IN THE UNITED STATES

Abigail L. Donovan, M.D. *55 Fruit Street, Yawkey 6A, Boston, MA, 02114*

SUMMARY:

Psychiatric training in the US has undergone an evolution over the past several decades. As psychiatric research and treatment become increasingly biologically based, psychiatric training has expanded to include more advanced scientific methodology, neuroimaging, genetics and psychopharmacology. This talk will describe a few key issues and trends affecting psychiatry residency training in the US, including an emerging focus on evidence based medicine and biologically based psychiatry.

REFERENCES:

1. Brown N, Desai M: Assessing professional and clinical competenc: the way forward. Advances in Psychiatric Treatment 2006; 12: 81'91.
2. Vidal - Alarcón - Lolas Stepke & col: Enciclopedia iberoamericana de psiquiatría Buenos Aires, Argentina, Editorial Panamericana, 1995.
3. Sato R, Kawanishi C, Hirayasu Y. Proposal for new postgraduate educational rotation system in Japan. Seishin Shinkeigaku Zasshi 2005;107:593-598.
4. Ozturk O, Eraslan D, Kayahan B: Scientific evaluation of the annual Turkish Psychiatry European international meetings continuously from 1996-2005Turk Psikiyatri Derg. 2006 Spring;17(1):77-9].
5. Pardes H: A look at psychiatric education. Acad Psychiatry 2006; 30:98-100.

SYMPOSIUM 59—AMERICAN PSYCHIATRY VIEWED FROM THE OUTSIDE: A GLOBAL PERSPECTIVE ON THE DSMS AND PSYCHOPHARMACOLOGY

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will appreciate view points from Latin America, Middle East and Europe regarding psychiatric diagnosis and treatment, become familiar with non-US psychiatric traditions that may be under appreciated in American psychiatry, specifically relating to DSM-IV nosology and current psychopharmacology practice.

No. 59A
THE VIEW FROM SOUTH AMERICA: A CHILEAN PERSPECTIVE

Eduardo A. Correa, M.D., *Psiquiatria, Universidad de Chile*

SUMMARY:

In Chile the changes in psychiatry seen since the 1980s have been immense. Traditionally, Chilean psychiatry had always experienced a strong European —especially German— influence, including the psychopathological tradition of Karl Jaspers. As a result, post-DSM-III nosology resulted in a major change in the approach to diagnosing patients, with more of a checklist mentality prevailing. Further, the impact of "the decade of the brain' and the neurosciences advances led to more psychopharmacological orientation in psychiatry, as the pharmaceutical industry became more prominent, and as Chilean psychiatry became more exposed to the biological emphasis of American psychiatry. This process has led to discontent among esteemed teachers within academic circles, and concerns about an excessively biological and extremely superficial clinical orientation in academic programs and current practice. Phenomenology was reduced to symptomatology. DSMs made possible a wide communication between psychiatrists through a language that could be understood all over the world. It now appears to be demonstrating its limitations, perhaps

representing just other "American dream" if thought of as the final word in nosology. In our experience, its use by no means replaces the study of the classical treaties of psychopathology, psychology and phenomenology, nor clinical experience and practice. In mood disorders, especially, emerging data suggest that the DSMs should not be seen as definitive. We South American psychiatrists have had to re-examine our own traditions in the face of the changes in American psychiatry after DSM-III. Especially in Chile we have a unique opportunity to evaluate the complex integration between European and American psychiatry.

No. 59B
US INFLUENCE ON THE EVOLUTION OF EUROPEAN PSYCHIATRY

Athanasios Koukopoulos *Centro Lucio Bini, 42, Via Crescenzio, Rome, 00193, Italy*

SUMMARY:

In the last decades, European practice has been more and more influenced by developments in American psychiatry. My comments will focus on Italy, based on over 40 years of active clinical practice as well as intimate contact with academic psychiatry throughout Europe and America. In particular, the use of psychotropic medications, especially antidepressants, has markedly increased; yet this massive increase in antidepressant usage has not coincided with marked decline in suicide rates in Italy or, in my clinical experience, with major improvements in patients' outcomes compared to the past. Many of the nosological achievements of the European tradition, such as Kraepelin's views on manic-depressive illness or 19th century perspectives on a broad definition of mania, have been swept away after DSM-III without any strong scientific basis, to the detriment, in my view, of patient care. The important achievements of American psychiatry notwithstanding, a single-minded view of nosology and psychopharmacology ignoring previous European views has been detrimental both in Europe and in the US.

No. 59C
PRESENTER THE VIEW FROM THE MIDDLE EAST

Kemal Sayar, M.D. *Bakirkoy Mental Health Training Hospital, Psychiatry, Bagdat Caddesi, 162/13 Hisar Apt., Selamicesme Kadikoy Istanbul, 81090, Turkey*

SUMMARY:

In Turkey and the Middle East, American psychiatry has had more and more influence over the past decades. The most prominent textbooks remain the major American textbooks and American psychiatric journals are studied carefully. Post-DSM-III nosology is used widely and treatment with psychiatric medications has increased markedly. Psychotherapies have always had limited usage in the Middle East, partly due to stigma, partly due to cultural differences with the West. For instance, in Islamic countries, intimate discussion of one's sexual and private life is more avoided than in the West. As Middle Eastern countries have become gradually more influenced by Western culture, however, psychiatric practice has also become gradually more open to Western methods, such as psychotherapies, particularly cognitive behavioral therapy. Yet, various aspects of Western nosology seem limited: for instance, major depression does not tend to present in the Middle East with the DSM criteria, which are mostly psychological, but rather with somatic symptoms. The DSMs represent, in many ways, the nosology of mental illness in the Western hemisphere, but not the nosology of mental illness in general for all humanity. Further, the religious aspect of life is mostly left out of both nosology and treatment in Western psychiatry, whereas it is difficult to avoid in the Middle East.

No. 59D
THE RISE AND FALL OF AMERICAN PSYCHIATRY

Nassir Ghaemi *The Emory Clinic Building B, 6th Flloor Suite 6100, 1365 Clifton Road, Atlanta, GA, 30322*

SUMMARY:

Major advances in neuroscience, and achievements in psychopharmacology, have given many in US psychiatry the impression that today is clearly better than the past, and the future need not involve anything but more of the same. Yet our nosology is still quite limited; much of DSM-IV is still poorly validated scientifically, and the checklist approach to diagnosis has led to an impoverishment of the process of identifying and appreciating signs and symptoms as well as the overall course of illness. In other words, psychopathology is weak in US psychiatry, and as a consequence our nosological practice has weakened. The success of psychopharmacology, and the cultural impact of the pharmaceutical industry, has led to widespread use of psychotropic medications, often without strong scientific backing. These two factors have coalesced into the common practice of frequent medication treatment of psychiatric symptoms, rather than careful matching of proven medication treatments for carefully identified diagnoses (rather than simply symptoms). The progress of the past is leading to a new stagnation. One route out may be a reconnection with lost European traditions such as schools of psychopathology informed by later developments.

REFERENCES:

1. Kraepelin E: Psychiatrie. 8. ed. Leipzig, JA Barth, 1913.
2. Sayar K. Culture and Psychiatry . Istanbul, Insan Publications, 2000. (In Turkish).
3. Ghaemi SN. The concepts of psychiatry: A pluralistic approach to the mind and mental illness. The Johns Hopkins University Press. Balitmore, MD. 2003.
4. Correa E, Silva H, Risco L. Trastornos Bipolares. Editorial Mediterráneo. Santiago de Chile, 2006

SYMPOSIUM 60—THE END, MIDDLE, AND BEGINNING OF THE AFFAIR: INFIDELITY IN FILM AND TELEVISION

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant should be able to recognize cultural attitudes and expectations regarding infidelity. Monogamy is highly valued in our society, and yet a good deal of popular literature and media is devoted to the portrayal of infidelity. These portrayals reflect many values, attitudes and assumptions. Understanding infidelity in this wider sense can help up in better appreciate the relationship dilemmas that our patients present to us.

No. 60A
DO MARRIED PEOPLE HAVE AFFAIRS BECAUSE THEY CAN'T HELP IT? LESSONS FROM THE HISTORY OF MARRIAGE

Anton C. Trinidad, M.D. *The George Washington University, Psychiatry and Behavioral Sciences, 2150 Pennsylvania Ave NW, Washington, DC, 20037-3201*

SUMMARY:

In Western cultures, it has been argued that the idea of romance and monogamous partnering attached to the institution of marriage is a historically recent phenomenon. Indeed, extra-marital affairs transcend many cultures and many centuries and it is then a legitimate question whether affairs are in fact the default mode. In this part of the symposium, we will explore the idea that faithfulness is a

developmental and psychological milestone, achieved painstakingly over a period of relational adjustment with one's significant other. As such, it is akin to an epigenetic process. Some individuals stumble along this difficult process and default to having extra-marital affairs. To highlight this exploration, we will discuss the film Mr. and Mrs. Bridge and other recent films.

No. 60B
WHY WE THINK PEOPLE CHEAT

Robert J. Boland, M.D. *Brown University, Psychiatry and Human Behavior, 345 Blackstone Blvd, Providence, RI, 02906-4800*

SUMMARY:

Why do men cheat? Why do women cheat? Similar to our previous symposia, this presentation will look to popular media, particularly serialized television programs, to explore biases regarding reasons for infidelity. In its role as reflection and reflector, television offers several cheating "scenarios" which tend to be divided by gender. Thus, when a woman protagonist has an affair, it is most often a result of disenchantment towards a relationship. Such disenchantment can be a realistic response to a dysfunctional relationship, or a more existential response to a passionless relationship. For men, the issue is usually one of ego: lacking attention at home, the protagonist meets an idealized woman. Less idealistically, the affair is sometimes simply presented as a sign of the man's social status. The Television examples will focus on the affairs and near-affairs of main characters from television series-given television's reluctance to change, it is these affairs that are the most meaningful. Examples will be drawn from such shows as *The Sopranos, Sex and the City, The Simpsons, The Mind of the Married Man, The Job, Grey's Anatomy, Coupling* and other related shows.

REFERENCES:

1. Coontz S. Marriage, A History: How Love Conquered Marriage. New York, Penguin Press,2005.
2. Haltzman SH and DiGeronima TF: The Secrets of Happily Married Men. Jossey-Bass/Wiley, 2006.
3. Atkins DC, Yi J, Baucom DH, Christensen A. Infidelity in couples seeking marital therapy. J Fam Psychol. 2005 Sep;19(3):470-3.
4. Atkins DC, Baucom DH, Jacobson NS. Understanding infidelity: correlates in a national random sample. J Fam Psychol. 2001 Dec;15(4):735-49.

SYMPOSIUM 61—CONNECTIONS TO MEDICAL INFORMATION:

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will learn about the various tools available for mobile computing. They will learn to master the basic devices used in psychiatric practice as well as establish connectivity to Internet based content in the field.Participants will learn to utilize the available tools and electronic information available on the personal digital assistant (PDA). They will will learn how to capture, convert, and access electronic content from the Internet, including CME audio MP3 and video podcasts. In addition, participants will learn how to establish Internet connection over various wireless devices using portable computers, Wi-Fi, Wireless Wide Area Network (WWAN), and Bluetooth. Participants will learn how to establish remote connections to various online medical content as well as information resources in the office.

No. 61A
MEDICAL INFORMATION DEVICES: THE TECHNOLOGY TO CONNECT

John Luo, M.D., *Psychiatry, UCLA Semel Institute*

SUMMARY:

There are a number of technologies that offer the clinician access to valuable medical information. Today information can be easily accessed on small handheld devices such as personal digital assistants, mobile phones, and devices such as the Blackberry. The advantages and disadvantages of portable devices is an important consideration.

No. 61B
CONNECTIVITY AND INTERACTIVITY

Britton A. Arey, M.D., *Psychiatry, UCLA Semel Institute*

SUMMARY:

Technology has evolved to the point where connectivity is virtually ubiquitous and the various ways to connect are numerous. Connecting and collaborating with colleagues through e-mail, listserves, discussion groups, webinars, instant messaging and social networking sites has changed our definition of being connected. For many clinicians, connecting with patients has also changed to include technology in the doctor-patient relationship.

No. 61C
INFORMATION RESOURCES

Carlyle H. Chan, M.D., *Medical College of Wisconsin, Milwaukee, WI*

SUMMARY:

The online world has opened up a world of opportunities to clinicians and researchers that has changed the way we view and access information. Traditional books and journals are becoming available online as well as new forms of publishing that are only online. There are a variety of ways to find and access valuable and timely information. Evaluating the quality of information is important for ourselves and our patients.

No. 61D
CONNECTIONS: THE PRESENT AND THE FUTURE

Robert Kennedy, M.D., *Department of Psychiatry, P.O. Box 155, Bronx, NY*, Britton A. Arey, M.D., Carlyle H. Chan, M.D., John Luo, M.D.

SUMMARY:

Just as education is a continual process in the field of psychiatry and medicine, the technology to facilitate the learning process is an evolving challenge. What are the advantages; and disadvantages to the current technologies? What are the new directions for technology that can impact medical education and clinical practice?

REFERENCES:

1. Luo JS, Ton H. Personal Digital Assistants in Psychiatric Education. Acad Psychiatry 2006 30: 516-521
2. Chan CH, Robbins LI. E-Learning Systems: Promises and Pitfalls. Acad Psychiatry 2006 30: 491-497
3. Kennedy RS, Kramer TA. Reshaping Our Educational Experiences. Acad Psychiatry 2006 30: 442-443
4. Luo JS. Portable computing in psychiatry. Can J Psychiatry. 2004 Jan;49(1):24-30.

SYMPOSIUM 62—PRESCRIBING PATTERNS, PREDICTORS, AND COSTS FOR ANTIDEPRESSANT MEDICATIONS:

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, participants will:

1. understand the differences in SSRI/SNRI prescribing pattern by psychiatrists verse other prescribers.
2. know some of the changes in SSRI/SNRI use resulting from Medicaid prior authorization of branded SSRIs
3. understand patterns in SSRI prescribing when a company introduces a new branded product in competition with a similar generic medication marketed by same company.

No. 62A
CHANGES IN PRESCRIBING WHEN ANTIDEPRESSANTS BECOME GENERIC

Ronald J. Diamond, M.D. *University of Wisconsin, Dept of Psychiatry, 6001 Research Park Blvd, Madison, WI, 53719-1176*, Michael Mergener, Pharm.D., Theodore M. Collins, Pharm.D.

SUMMARY:

There is surprisingly little information about changes in prescribing practice when medications become generic. There are attempts by payers to increase or maintain the market share of generics over similar medications that are still on patent and much more expensive. This is countered by the attempts of pharmaceutical companies to present newer medications as more effective or having fewer side effects. Different companies have used different marketing strategies in the face of generic competition. Primary care physicians and psychiatrists may be differentially affected by these strategies. Initial analysis of the experience of the fee-for-service Wisconsin Medicaid system is that, despite the attempts of pharmaceutical companies to maintain market share for branded medication, generic medication use has expanded as more generic options have become available. Since it became generic, fluoxetine has gone from 21% to 34% of SSRI prescriptions. Once citalopram became available as a generic, its use increased by 20%, while its enantiomer, escitalopram, decreased by 20%. This suggests that prescribers may be less susceptible to pharmaceutical company promotion than sometimes feared. It also suggests that payers can use various strategies to counter the effects of pharmaceutical marketing.

No. 62B
PATTERNS OF PHARMACOTHERAPY FOR MAJOR DEPRESSIVE DISORDER

Marion A. Becker, Ph.D., *Department of Mental Health Law & Policy, University of South Florida*

SUMMARY:

Background: Although major depressive disorder (MDD) is recognized as a serious condition requiring treatment, research data show that MDD often goes unrecognized and untreated. Current data on patterns, predictors and outcomes of antidepressant medication provided to patients with MDD are important to understanding the current care provided, promoting optimal clinical practice and quality of care improvement efforts.

Study Objective: While controlling for a myriad of possible confounding historical variables we examined antidepressant treatment patterns for Florida Medicaid recipients with a diagnosis of MDD. Our objective was to identify the types of antidepressant medication currently being prescribed including all TCAs, all SSRIs, Bupropion, Venlafaxine and Duloxetine and the factors that predict service use and costs among recipients of antidepressant therapy.

Methods: The sample included 25.306 patients with a diagnosis of MDD who were enrolled in the Florida Medicaid Program during FY03-05. The research used three years of Medicaid claims data to compare patient demographics, diagnostic characteristics, antidepressant medication use, and service expenditure patterns 6 months prior to and one year after the index prescription event for antidepressant medication users.

Findings: Among those persons diagnosed with MDD, the majority (84.5%) received selective serotonin reuptake inhibitors (SSRIs) alone or in combination with other drugs 29.2% received a serotonin and nor-epinephrine reuptake inhibitor (SNRIs) alone or in combination with other antidepressants and 15.3% received tricyclic antidepressants (TCAs) alone or in combination with other antidepressant medication. A large majority (86.5%), were also receiving prescription pain medication. Of these, more than half were receiving prescription narcotics. Predictors of increased service use and cost following initiation of antidepressant treatment included older age, female sex, and pre-index prescription costs.

No. 62C
RETROSPECTIVE ANALYSIS OF PUBLIC PAYER HEALTHCARE COSTS ASSOCIATED WITH SPECIFIC TYPES OF ANTIDEPRESSANT TREATMENT FOR MDD.

Paul Stiles, Ph.D. *University of S Florida, Department of Mental Health Law & Policy, 13301 Bruce B. Downs Blvd., Tampa, FL, 33612*

SUMMARY:

Background: One justification for the high relative cost of some newer anti-depressants has been the assertion that they can reduce behavioral health service expenditures and healthcare costs in general. Examination of the relative healthcare cost of persons taking various antidepressants is important to support of dispute these assertions.

Study Objective: To examine per user per month service and medication expenditures of Medicaid recipients who were prescribed a newer SNRI (Duloxetine) compared to other types of antidepressants.

Methods: Over 10,700 Medicaid recipients with a diagnosis of MDD who were enrolled in the Florida Medicaid Program during FY03-05 were included in the sample. The sample was examined across time to assess per user per month costs 4-months before and after an index medication change event (either change to Duloxetine or to another antidepressant).

Findings: For those persons diagnosed with MDD only, general health care costs increased after switching to any antidepressant, however behavioral health costs tended to decrease overall with the most dramatic decreases occurring in inpatient services for the "non-duloxetine" group. Although there was a general increase in pharmacy costs for both groups (duloxetine and non-duloxetine), overall healthcare costs did not change substantially (i.e, they were cost neutral). Examining a cohort of persons with MDD who also experienced significant pain (that is, also had a diagnosis of diabetic peripheral neuropathy), differences between Duloxetine and non-Duloxetine groups were apparent. There were clear decreases in both general health and behavioral health service costs in the Duloxetine group compared to the non-duloxetine group (which actually showed an increase in behavioral health costs).

No. 62D
RECENT PATTERNS AND PREDICTORS OF ANTIDEPRESSANT MEDICATION REGIMENS USED TO TREAT MAJOR DEPRESSIVE DISORDER (MDD)

M. Scott Young, Ph.D. *University of South Florida, Dept. of Mental Health Law and Policy, 13301 Bruce B. Downs Blvd., MHC 2603, Tampa, FL, 336612*, Marion Becker, Ph.D., Lodi Rohrer, M.P.H.

SUMMARY:

Background: Numerous studies have documented high rates of depression among chronic pain patients, often noting that physical symptoms are the primary reason these persons visit their physician. The dual reuptake inhibitor Duloxetine is a new antidepressant medication that has been shown to be safe and effective in the acute treatment of pain associated with diabetic neuropathy (DNP). Duloxetine has FDA approval for treatment of both MDD and DNP.

Study Objective: To examine the patterns of comorbid pain and pain medication use among Florida Medicaid beneficiaries with MDD, and to compare the associated service use and cost outcomes among those receiving Duloxetine versus other antidepressant medications.

Methods: Using a sample of adult Florida Medicaid beneficiaries diagnosed with MDD, this study identified persons with comorbid pain. Physical, behavioral, and pharmacy service use and cost outcomes were compared between those prescribed Duloxetine versus other antidepressant medications.

Findings: Nearly half (48%) of participants with MDD were diagnosed with at least one comorbid pain condition, including muscle pain (24.4%), chest pain (14.9%), back pain (14.4%), head pain (9.9%), neurological pain (1.8%), or another pain condition (16.7%). Consistent with these elevated rates of comorbid pain, most participants were taking at least one type of prescription pain medication in addition to an antidepressant, including narcotics (52.0%), non-narcotics (65.6%), or anticonvulsants (40.5%). Longitudinal analyses indicated that patients prescribed Duloxetine demonstrated reduced use of these pain medications over a four-month period following the initial Duloxetine prescription, compared to increased use of these medications among persons prescribed antidepressants other than Duloxetine. This same pattern of findings favoring Duloxetine was found for outpatient behavioral health physician visits and costs, other outpatient behavioral health visits, and emergency room expenditures. Findings suggest that prescribing Duloxetine to persons with MDD may result in reduced use of narcotics, behavioral health services, and emergency room services.

REFERENCES:

1. Dunn JD, Cannon HE, Mitchell MP and Curtiss, FR Utilization and Drug Cost Outcomes of a Step-Therapy Edit for Antidepressants in an HMO in an Integrated Health System J of Managed Care Pharmacy May 2006 12(4) 294-302.
2. Simon GE, Von Korff M, Barlow W, et al: Health care costs of primary care patients with recognized depression. Arch Gen Psychiatry 1995; 52:850-856.
3. Simon GE, Von Korff M, Piccinelli M, et al.: An international study of the relation between somatic symptoms and depression. New England Journal of Medicine 1999; 341: 1329-1335.
4. Cabana, MD, Rushton, JL & Rush, AJ: Implementing practice guidelines for depression. Applying a new framework to an old problem, General Hospital Psychiatry 2003; 24:35-42.

SYMPOSIUM 63—NEUROBIOLOGY OF THE UNCONSCIOUS: IMPLICATIONS FOR PSYCHOTHERAPEUTIC UNDERSTANDING AND TECHNIQUE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium attendees will gain an overview of the concept of the unconscious in psychiatric and psychoanalytic theory and practice. Following a review of the neurobiology of affect and memory upon awareness, attendees will learn of critical psychotherapeutic processes: empathy, action, and relational communication and their determinants in the mirror neuron system, unconscious enactments, and covert metacommunications. The role of unconcious processes in motivation, behavior and psychotherapeutic change will be understood in proper persective. Implications for psychotherapeutic understanding and technique will be a major focus throughout the presentations and discussion.

No. 63A
HISTORICAL OVERVIEW OF THE CONCEPT UNCONSCIOUS

Barton J. Blinder, M.D. *UC Irvine,School of Medicine, Psychiatry and Human Behavior, 400 Newport Center Dr, 706, Newport Beach, CA, 92660-7661*

SUMMARY:

Rooted in concepts of self,will,and behavior,the notion of mental phenomenona outside of awareness is deeply embedded in philiosophical tradition from Plato to Kant

Operations at the borderline of conciousness such as sensory threholds,rapid cognitions, and subliminal perceptions are indicators of a complex dynamic flow of information,encoding and subsequent impact on affect and behavior

The psychological unconscious refers now to those mental states and processes which influence our experience,thought, and action outside of phenomenal awarenes and independant of voluntary control

The Freud-Breuer hypothesis that hysterical symptoms were produced by unconcious memories of traumatic events extended clinical observation to an evolving theory of psychodynamics accounting for biologic need,affect,memory,and behavior--their expression,repression,and appearance directly and indirectly in symptoms,dreams,and everyday life. However there is limited evidence that the unconscious is a repository of primitive,infantile,irrational,sexual or aggressive impulses which have been defensively compartmentalized to avoid conflict and anxiety

In the past 40 years the evidence from cognitive neuroscience,sophisticated methodologic experimental design,and most recently functional neuroimaging has demonstrated that there are automatic,implicit,and procedural content and processes in our perception,cognition,and behavior inaccessable to our awareness and demonstrated only by inferences from our performance.

Emerging is a concept of a cognitive unconscious[implicit memory,learning and thought],an affective unconscious[implicit emotion] and a motivational unconscious[implicit motives,attitudes]

Cumulative research findings are placing unconscious processes in proper perspective to ultimately understand their complex role in motivation,behavior,and psychotherapeutic transformation. The unconscious has recently become re-established as a respectable, necessary, and essential concept.

No. 63B
MAPPING THE UNCONSCIOUS IN THE BRAIN

George I. Viamontes, M.D. *Regional Medical Director, United Behavioral Health Inc, 165 Plantation Dr, Saint Louis, MO, 63141-8352*

SUMMARY:

The neurobiological foundation of the unconscious is the neural representation of information that does not reach consciousness but nevertheless triggers physical changes in body and brain. Information below the level of consciousness is used continuously to make predictions about the future. Some of these predictions, such as the ones that control ocular saccades, are made by genetically hard-wired systems, while others, which can have clinical implications, are determined by learned connections between sensory data and their likely consequences. Thus, the smell of a pie will redirect blood flow to the salivary glands and GI tract when one is hungry, whereas

in the context of a GI infection, it may trigger brainstem nausea centers. From a more clinical perspective, the sight of two strangers talking, which would not normally cause a specific reaction, could elicit severe anxiety in a paranoid person, and trigger a "fight or flight" response. Unconscious representations and their learned meanings redirect blood flow and cause release of neurotransmitters and hormones that prepare the body for anticipated challenges. At times, the elicited body states are incongruous with conscious information, or even maladaptive. This presentation will elucidate the neural substrates of the unconscious by reviewing how non-conscious information is represented and processed in the brain, with emphasis on pattern recognition by systems such as the brainstem, amygdala, orbitofrontal cortex, nucleus accumbens, and cingulate gyrus, which independently modulate neurotransmitter flows and the autonomic nervous system.

No. 63C
THE MIRROR NEURON SYSTEM

Marco Iacoboni, M.D. *DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA, Psychiatry and Biobehavioral Sciences, 660 Charles E. Young Drive South, Los Angeles, CA, 90095*

SUMMARY:

Mirror neurons are cells originally discovered in the macaque premotor cortex that fire during goal-oriented actions such as grasping, and also during the observation of the same action performed by somebody else. These cells are thought to provide a key mechanism for recognizing the actions of other people and for understanding the mental states - intentions, emotions - associated with those actions. in the macaque brain, two cortical areas contain mirror neurons, area F5 in the posterior inferior frontal cortex and area PF/PFG in the anterior inferior parietal lobule. Similarly in humans there exists a fronto-parietal mirror neuron system composed of posterior inferior frontal gyrus and adjacent ventral premotor cortex, and also composed of the rostral part of the posterior parietal cortex. The human mirror neuron system has been studied with a variety of brain imaging techniques and has been strongly associated with imitation and empathy in humans. A deficit in mirror neuron activity has been demonstrated in patients with autism spectrum disorder. During a task of social mirroring - the observation and imitation of facial emotional expressions - reduced activity in the mirror neuron system correlated with severity of disease in ASD as assessed by widely used clinical scales. The more reduced was the activity in mirror neuron areas, the more impaired was the subject with ASD. The mirror neuron system seems a key neural system for social cognition and promises to be a viable biological marker of social behavior and its dysfunction.

No. 63D
UNCONSCIOUS ENACTMENTS IN PSYCHOTHERAPY

Glen O. Gabbard, M.D. *Baylor School of Medicine, Dept of Psychiatry, 6655 Travis, Suite 500, Houston, TX, 77030-3411*

SUMMARY:

Freud noted in 1914 that what patients don't remember will be repeated in their actions. This notion that the unconscious is manifested in enactments was largely ignored in the psychoanalytic/psychodynamic literature for decades. The emphasis instead was placed on dreams and parapraxes as the major avenues to the unconscious. In recent years, much work on nonverbal behavior, procedural memory, transference, and countertransference has brought back Freud's emphasis on enactments. Our growing knowledge of development and the neurobiology of memory has also been helpful in broadening our understanding of the meanings of action in dynamic psychotherapy. Infant research has shown that memories are stored in the early weeks of infancy in representations that do not involve words or images. The Boston Change Process Study Group has noted that there is an implicit relational knowing that is based in affect and action rather than in word and symbol. Similarly, much research shows that behavioral routines become stored as procedural memory early in life in the basal ganglia. These operate largely as modes of object relatedness that are nonconscious and automatic. These principles have implications for both understanding and technique in dynamic therapy.

No. 63E
METACOMMUNICATION, PSYCHOTHERAPY AND THE BRAIN

Bernard D. Beitman *University of Missouri at Columbia, Dept of Psych and Neurology, 3 Hospital Dr, Columbia, MO, 65201-5276,* Jessica R. Nittler, M.D.

SUMMARY:

Unconscious processing predicts the future at any moment and prepares the body to respond. When two people enter into a dialogue, they use *metacommunication* to shape the responses of the other. *Metacommunication* refers to comments upon or about communication with the intention of transforming the communication. It may take two forms: *covert* and *overt*. The *covert* form works through non-verbal means including gestures, voice tone and facial expressions; the speaker non-verbally requests that the listener assume a certain role while being presented word-based information. The request for a role relationship from the listener is an indirect comment on the relationship or a *covert* meta-communication. On the other hand, the nature of the role being requested may be directly commented upon by the listener as an *overt* metacommunication. This form of feedback during psychotherapy can be helpful in demonstrating to patients how they are unconsciously attempting to influence others. Both forms of metacommunication are attempts by the speaker to switch neural circuits in the listener. The covert form operates through subconscious circuits while the overt form activates self-awareness circuits offering the possibility of conscious change.

REFERENCES:

1. Kihlstrom, J.F. The rediscovery of the unconscious. In The mind, the brain, and complex adaptive systems edited by H. Morowitz & J. Singer Reading, Ma.: Addison-Wesley 1995, pp. 123-143.
2. Viamontes GI, Beitman BD. Neural substrates of psychotherapeutic change. Part I: the default brain. Psychiatric Annals. April, 2006;36(4):225-236.
3. Dapretto M, Davies MS, Pfeifer JH, Scott AA, Sigman M, Bookheimer SY, Iacoboni M (2006) Understanding emotions in others: mirror neuron dysfunction in children with autism spectrum disorders. Nat Neurosci 9:28-30.
4. Gabbard GO, Westen D: Rethinking therapeutic action. International Journal of Psychoanalysis 84:823-844, 2003.
5. Watzlawick, P., Bavelas, J.B., Jackson, D.D.. Pragmatics of human communication. New York: WW Norton, 1967.

SYMPOSIUM 64—UPDATE ON THE BIOLOGY OF PERSONALITY DISORDERS

EDUCATIONAL OBJECTIVES:

1. To update clinicians on latest advances in molecular genetics, imaging, and neuropharmacology of personality disorders
2. To teach clinicians role of neuromodulators and neurocircuits in personality disorders
3. To discuss clinical implications of these findings

No. 64A
NEW DEVELOPMENTS IN NEUROCIRCUITS AND NEUROTRANSMITTERS IN THE PERSONALITY DISORDERS

Larry J. Siever, M.D. *Mount Sinai School of Medicine, Psychiatry, 24 Manor Pond Ln, Irvington, NY, 10533-2416*

SUMMARY:

Advances in molecular genetics, imaging, and neuropharmacology have made it possible to identify critical circuits altered in the key dimensions of personality disorders and how these circuits are modulated by neurotransmitters. Thus, prefrontal cortical inhibition of amygdala and other limbic structures may be important for impulse and affective regulation with serotonin facilitating or modulating the topdown control of these domains through structures like anterior cingulate and orbital frontal cortex. Serotonergic probes show alterations in the serotonergic modulations of these areas and components of the serotonergic system like the serotonin transporter are associated with impulsivity (reduced transporter with impulsive aggression and increased $5HT_{2A}$ receptor with impulsive aggression). Candidate genes in the serotonin system including the serotonin transporter and the $5HT_{2A}$ receptor have been associated with dimensions of impulsivity and/or specific diagnosis such as borderline personality disorders, although reports in this area are not consistent. Dopaminergic neurotransmission modulates efficiency of more lateral prefrontal cortical structures implicated in the organization of cognition. Agents which enhance dopamine release may be associated with improved cognitive performance in schizotypal personality disorder (SPD) and new studies identify potential abnormalities in D_1 receptor binding and amphetamine displacement of raclopride. Implications of these neurotransmitter/neuroncircuit studies for pharmacologic treatment interventions will be discussed.

No. 64B
BIOLOGY AND TREATMENT OF IMPULSIVE AGGRESSION IN PERSONALITY DISORDER

Emil F. Coccaro, M.D. *University of Chicago, Psychiatry, 5841 S Maryland Ave Ste 3077, MC #3077, Chicago, IL, 60637-1448*

SUMMARY:

Research into the biological correlates of impulsive aggression include data related to familial/genetic, neurotransmitter based, and neurocognitive and neuroimaging characteristics of patients with impulsive aggression. Familial/genetic studies strongly suggest that impulsivity and aggression is transmitted in families and has a significant constitutional component that suggests a biological underpinning. For example, impulsive aggression appears to be is correlated inversely with central serotonin (5-HT) function and correlated directly with other (e.g, vasopressin) facilitory neurotransmitters. This presentation will review the current state of the field regarding the biological and treatment aspects of impulsive aggression in personality disordered individuals. This includes reviewing data from family, genetic, neurochemical, neuroendocrine, and neurocognitive/neuroimaging studies of impulsive aggressive individuals. Data from clinical psychopharmacological trials will also be presented to highlight the relevance of biology in the treatment of impulsive aggression.

No. 64C
NMDA NEUROTRANSMISSION AND THE NEUROBIOLOGY OF BPD

Bernadette M. Grosjean, M.D. *Harbor UCLA, Psychiatry, 1000 West carson Street, box 497, Los Angeles, CA, 90509*

SUMMARY:

Introduction: Studies of the neurobehavioral components of borderline personality disorder (BPD) have shown that symptoms and behaviors of BPD are, in part, associated with disruptions in basic neurocognitive processes, in particular in the executive neurocognition and memory systems. Recently, a growing body of data indicates that the glutamatergic system, in particular the N-methyl-D-aspartate (NMDA) subtype receptor, plays a major role in neuronal plasticity, cognition and memory, and may underlie the pathophysiology of multiple psychiatric disorders.

Method: This presentation reviews and articulates recent neurobiological data in dysfunctions of NMDA receptor-mediated neurotransmission in the etiopathology and symptomatology of BPD.

Result: Multiple cognitive dysfunctions and symptom presentations like dissociation, psychosis and impaired nociception in BPD may result from the dysregulation of the NMDA neurotransmission. This impairment may be the result of the combination of biological vulnerability and environmental influences mediated by the NMDA neurotransmission.

Conclusion: The role of NMDA neurotransmission as a critical modulator for neuroplasticity is well recognized. Dysfunctions of the NMDA neurotransmission by environmental factors, in particular by stress, trauma, or neglect, impacts cognition, emotion, affect, motivation, appraisal and evaluation of environmental stimuli. These may be particularly evident in the psychopathology of BPD and could suggest a new therapeutic approach for BPD.

No. 64D
PAIN PROCESSING IN BORDERLINE PERSONALITY DISORDER

Christian Schmahl *Central Institute of Mental Health, Psychosomatic Medicine, J5, Mannheim, 68159, Germany*, Anja Jochims, M.A., Petra Ludaescher, M.A., Martin Bohus, M.D.

SUMMARY:

Borderline Personality Disorder is characterized by affective dysregulation and self-injurious behavior. Several experimental studies revealed reduced pain sensitivity in BPD as well as significant correlations between pain perception, aversive inner tension and dissociation. Psychophysiological experiments revealed no deficit in the sensory-discriminative pain component in BPD. However, neurofunctional investigations point at alterations of the affective-motivational and the cognitive pain component in BPD. Preliminary evidence suggests that disturbed pain processing normalizes when patients stop self-injurious beahvior after successful psychotherapeutic treatment.

No. 64E
5HT2A RECEPTOR BINDING IN BORDERLINE PERSONALITY DISORDER

Paul H. Soloff, M.D. *Univ. of Pittsburgh, Psychiatry, 3811 O'Hara St., Pittsburgh, PA, 15213*, Julie C. Price, Ph.D., Carolyn C. Meltzer, M.D., Anthony Fabio, Ph.D., Guido Frank, M.D., Walter H. Kaye, M.D.

SUMMARY:

Background: Post-mortem studies in suicide victims demonstrate an increase in the number of post-synaptic 5HT2a receptor binding sites in areas of prefrontal cortex (PFC). Impulsive subjects with BPD, a group at high risk for suicidal behaviors, have diminished metabolic responses to serotonergic activation in areas of PFC.

Methods: 19 BPD subjects (14F,5M), defined by DIB and IPDE interviews, were compared to 21 healthy controls (11F,10M). [^{18}F] altanserin was used with PET neuroimaging to assess 5HT2a receptor

binding potential (BP) across 10 pre-defined Regions-of-Interest (ROIs). Subjects were also assessed for Axis I co-morbidity, depressed mood, impulsivity, aggression, suicidality and childhood abuse.

Results: Non-depressed female BPD subjects had significantly increased BP values in the hippocampus (HIP) compared to depressed female BPD and control subjects. Male BPD subjects had decreased BP values in PFC and HIP compared to male controls. Control males had significantly greater BP than control females in HIP and lateral orbital frontal cortex (LOF). Impulsivity was directly related to BP in HIP and LOF in control subjects. 5HT2a receptor function in HIP may play a role in dysregulated behavior in BPD.

Conclusions: Gender differences in 5HT2a receptor function may mediate different behaviors in male and female subjects.

No. 64F
A NEURODEVELOPMENTAL MODEL OF BORDERLINE PERSONALITY DISORDER

Kenneth R. Silk, M.D. *University of Michigan Health System, Dept of Psychiatry, MCHC Box 0295, 1500 East Medical Center Drive, Ann Arbor, MI, 48109*, Katherine Putnam, Ph.D.

SUMMARY:

A neurobiological model of borderline personality disorder (BPD) is presented that involves disturbances on four different levels. On the first level we have primary etiologic factors that involve a biological predisposition to emotionality combined with an environment that is unable to adequately respond to the subject's emotionality. Such environmental issues can include exposure to early trauma or to repeated inadequate responses or inflexibility in response or posture of the caregiver. At the next level we have the developmental sequella of the interaction of the two factors on the first level. Thus we have a lack of the development of the ability to adequately regulate one's emotions. The third level looks at the domains where this lack of emotional regulation abilities manifests itself. These domains involve continued compromise of neurophysiological function as well as disturbances in the cognitive/affective, social interpersonal and behavioral realms. At the final level, we have the neuroanatomical region that is impacted by and thus in turn contributes to the dysfunction. Thus we can find disruptions of the amygdala and orbitofrontal cortex which can impact the individual's ability to appraise a given situation and respond in appropriate and non-impulsive ways (in the cognitive/affective realm). This failure to respond appropriately can then lead to impairments in emotional communication (in the social/interpersonal realm), and to a poor response in modulating affect and in utilizing coping abilities (in the behavioral realm). This presentation will describe the empirical support for this model as well as expand upon the model to include other areas of dysfunction in patients with BPD.

REFERENCES:

1. Siever LJ, Torgersen S, Gunderson JG, Livesley WJ, Kendler KS: The borderline diagnosis III: Identifying endophenotypes for genetic studies. Biol Psychiatry 2002; 51:964-968.
2. Coccaro EF, Siever LJ. Neurobiology; In JM Oldham, AE Skodol, DS Bender (Eds), Textbook of Personality Disorders, pp. 155-169, American Psychiatric Press, Arlington, VA, 2005.
3. Fertuck, E.A., M.F. Lenzenweger, and J.F. Clarkin, The association between attentional and executive controls in the expression of borderline personality disorder features: a preliminary study. Psychopathology, 2005. 38(2): p. 75-81.
4. Schmahl C et al.: Neural correlates of antinociception in borderline personality disorder. Arch Gen Psychiatry 2006; 63:659-667.
5. Arango V, Underwood MD, Mann JJ : Postmortem findings in suicide victims. Im,plications for in vivo studies. Ann.N.Y.Acad.-Sci.1997;836:269-287.
6. Putnam K, Silk KR: Emotion dysregulation and the development of borderline personality disorder. Development and Psychopathology, 2005;17: 899-925.

SYMPOSIUM 65—A PICTURE OF THE DEVELOPMENT OF THE ADOLESCENT BRAIN: A STRUCTURAL AND FUNCTIONAL ASSESSMENT
National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand that structural and functional brain development during childhood and adolescence is dynamic with spatial and temporal patterns emerging.

No. 65A
MAPPING ADOLESCENT BRAIN MATURATION WITH STRUCTURAL MAGNETIC RESONANCE IMAGING

Elizabeth R. Sowell, Ph.D. *University of California, Los Angeles, Department of Neurology, 635 Charles Young Drive, Suite 225, Los Angeles, CA, 90095-1769*

SUMMARY:

This talk will highlight our recent work evaluating maturational change in brain structure during the childhood and adolescent years and how these structural changes relate to changing cognitive abilities and brain activation. The primary focus of this talk is on recent studies using cortical pattern matching (CPM) techniques to assess age-related changes in gray matter distribution and brain growth during the childhood and adolescent years. Specifically, we have found cortical thinning over large regions of the dorsal frontal and parietal lobes and increased cortical thickness in primary language cortices in 3 independent samples of normal individuals studied both cross-sectionally and longitudinally. The spatial and temporal pattern of results, with incomplete development of frontal cortices during adolescence, is consistent with observations of increased risk taking behaviors during this period. We have also used CPM methods to assess relationships between cortical thickness and cognitive function on tests of general verbal intellectual functioning and have recently found cortical dissociations between improved phonological processing and motor skills within children studied longitudinally. Finally, findings of relationships between cortical thickness and brain activation on tests of language and executive function in normally developing children and adolescents with combined functional and structural MRI will be discussed. An integration of these findings will highlight the great variability in brain structure and function that occur during normative adolescent development and how brain structure may be a better predictor of cognitive function and brain activation than chronological age.

No. 65B
THE USEFULNESS OF DIFFUSION TENSOR IMAGING FOR THE STUDY OF BRAIN DEVELOPMENT IN CHILDREN

Michael J. Rivkin, M.D. *Children's Hospital Boston and Harvard Medical School, Department of Neurology, 300 Longwood Avenue, Pavilion 154, Boston, MA, 02115*

SUMMARY:

Diffusion tensor imaging (DTI) offers a non-invasive view of white matter organization and microstructure through the information it provides about water movement within the brain. This presentation will focus on three facets of this rapidly developing imaging technique and its application to children. First, the relevant aspects of the diffusion tensor and its use for the purpose of brain imaging will be discussed. The means by which this imaging technique provides a unique view of white matter organization of the central nervous system will be examined. Second, methods by which this imaging technique may be harnessed to gather novel information about white matter development during childhood will be explored. Specifically, tensor-derived maps of fractional anisotropy and mean diffusivity can provide novel views of white matter maturation from the neonatal period through adolescence. Currently, longitudinal DTI data are being gathered from children throughout the United States. These data, in association with additional MRI, neurobehavioral and neurologic data, will be assembled to constitute a database that characterizes brain development of typically developing children in the United States. Finally, applications of this imaging technique to study the adolescent brain will be presented. Both DTI and its methodologic extension - diffusion tensor tractography - can be used to interrogate the white matter organization of the adolescent brain. Both investigational and clinical examples will be provided.

No. 65C
MAGNETIC RESONANCE SPECTROSCOPY STUDIES OF HUMAN BRAIN DEVELOPMENT

Perry F. Renshaw, M.D. *McLean Hospital, BRAIN IMAGING CENTER, 115 Mill St, Belmont, MA, 02478-9106*, Young Hoon H. Sung, M.D.

SUMMARY:

Magnetic Resonance Spectroscopy (MRS) provides a unique *in vivo* assessment of the chemistry of the human brain. In addition, the role of MRS as a tool for characterizing human brain development has become more significant due to recent technical advances. Proton (1H) and phosphorus (31P) MRS detectable metabolites provide information with respect to neuronal viability from N-acetyl aspartate (NAA), membrane metabolism from choline containing compounds (Cho), phospholipid metabolism from anabolites (phosphomonoesters; PME) and catabolites (phosphodiesters; PDE), and bioenergetics from high energy phosphate metabolites.

A MEDLINE literature search was done from 1989 to 2006 and initially 54 articles relevant to human brain development were identified. A much smaller number of these articles described changes occurring during adolescence.

White matter NAA levels, which reflect axonal development and myelination, increase steeply throughout the first decade of life and reach a peak around adolescence. Gray matter NAA levels decrease in adolescence relative to childhood, perhaps due to synaptic/neuronal pruning that mainly occurs in adolescence.

The Cho resonance shows a decreasing concentration with age early in life, but not during adolescence. Cho serves as an intermediate for cell membrane formation. PME and PDE levels generally reflect anabolic and catabolic state of freely mobile membrane phospholipids, respectively. Several study results suggest increasing PME levels or phospholipid turnover in adolescent brain white matter. This finding may reflect both increased glial and neuronal membrane synthesis.

MRS is a useful tool for exploring maturational process and provides valuable *in vivo* information for further investigating the developmental and diseased human brain. Knowledge of dynamic metabolite changes with age using MRS, especially adolescent period, is important for monitoring and evaluating normal brain maturation.

No. 65D
RISK TAKING AND THE ADOLESCENT BRAIN: WHO IS AT RISK?

BJ Casey, Ph.D. *Weill Medical College of Cornell Univers, Sackler Institute, 1300 York Ave., Box 140, New York, NY, 10021*

SUMMARY:

Relative to other ages, adolescence is described as a period of increased impulsive and risk-taking behavior that has been associated with an increased risk for suicide, substance abuse, HIV and accidental death. A recent series of studies was designed to examine neural correlates of risk taking behavior in adolescents, relative to children and adults, in order to predict who may be at greatest risk. Activity in reward-related neural circuitry in anticipation of a large monetary reward was measured with functional magnetic resonance imaging and anonymous self-report rating scales of risky behavior, risk perception and impulsivity were acquired in approximately 40 individuals between the ages of 7 and 29 years. The results show exaggerated accumbens activity, relative to prefrontal activity in adolescents, compared to children and adults, which appeared to be driven by different time courses of development for these two brain regions. Accumbens activity in adolescents looked like adults in both extent of activity and sensitivity to reward values, although the magnitude of activity was exaggerated. In contrast, the extent of OFC activity in adolescents looked more like children, than adults, with less focal patterns of activity. Further, there was a positive association between accumbens activity and the likelihood of engaging in risky behavior across development. The findings suggest that maturing subcortical systems become disproportionately activated relative to later maturing top-down control systems, biasing the adolescent's action toward immediate over long-term gains. Some adolescents may be especially prone to engage in risky behaviors due to these developmental changes in concert with variability in a given individual's predisposition to engage in risky behavior.

REFERENCES:

1. Sowell ER, Thompson PM, Holmes CJ, Jernigan TL, Toga AW (1999) In vivo evidence for post-adolescent brain maturation in frontal and striatal regions. Nature Neuroscience 2:859–861.
2. Almli CR, Rivkin MJ, McKinstry RC and the Brain Development Cooperative Group. The NIH MRI study of normal brain development: Newborns, infants, toddlers, and preschoolers. NeuroImage, 2007.
3. Horska A, Kaufmann WE, Brant LJ, Naidu S, Harris JC, Barker PB: In vivo quantitative proton MRSI study of brain development from childhood to adolescence. J Magn Reson Imaging 2002; 15(2):137–43.
4. Galvan, A, Hare, T, Parra, CE, Penn, J, Voss, HGlover, G & Casey, B.J. Earlier development of the accumbens relative to Orbitofrontal cortex may underlie risk taking in adolescence. Journal of Neuroscience 2006; 26(25):6885–6892.

SYMPOSIUM 66—AN UPDATE ON CROSS-CULTURAL, ETHNIC, AND ETHNOPSYCHOPHARMACOLOGICAL ASPECTS OF MOOD DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant should be able to appreciate the extent to which culture and ethnicity interact to influence the phenomenology and response to treatment in mood disorders; understand the principles and application of ethnopsychopharmacology and recognize cross-cultural issues in the psychopharmacological and psychotherapeutic treatment of mood disorders.

No. 66A
ETHNOPSYCHOPHARMACOLOGY

David C. Henderson, M.D. *Massachusetts General Hospital, Psychiatry, Freedom Trail Clinic, 25 Staniford Street, 2nd floor, Boston, MA, 02114*

SUMMARY:

Understanding basic psychopharmacology principles and the impact of race, sex, and culture on metabolism, response, adverse events, medication interactions and medication compliance. Ethnopsychopharmacology examines biological and non-biological differences across race, ethnicity, sex and culture and is critical for safe prescribing practices. A growing body of published evidence is documenting important inter- and intra-group differences in how patients from diverse racial and ethnic backgrounds experience health and illness, and is affected by pharmacologic treatment. Recommendations will be provided to improve compliance, reduce adverse events and medication interactions, and to improve clinical outcomes. Depression and anxiety are one of the most common medical/psychiatric disorders and occur across all populations, though symptom clusters may vary greatly. Pharmacologic interventions are critical in the treatment of depression. An expanded understanding of the interactions between psychopharmacological treatment and gender, ethnic and cultural diversity informs conceptualizations of psychopharmacological treatments of various populations. Differences in cytochrome P450 enzymes such as the 2D6, 2A6, 2C9/2C19 metabolism rates and their implications for prescribing psychotropic medications will be reviewed. This lecture will also review principles of ethnopsychopharmacology and highlight issues influenced by race, gender, and culture in the pharmacologic treatment of depressive disorders and anxiety disorders. The role of genetic screening for poor and slow metabolizers will be discussed.

No. 66B
PSYCHIATRIC MANAGEMENT OF HISPANIC PATIENTS: CROSS-CULTURAL ISSUES AND ETHNOPSYCHOPHARMACOLOGY

David Mischoulon, M.D. *Massachusetts General Hospital, Psychiatry, 15 Parkman St, WAC-812, Boston, MA, 02114-3117*

SUMMARY:

Increasing numbers of psychiatrists nowadays work with Hispanic patients, either on a regular basis through their outpatient clinic, or by serving as consultants to general internists who are called upon to manage psychiatric disorders in patients seen in the primary care setting. This session will review the demographics of the Hispanic-American population; discuss the different challenges and obstacles faced by clinicians who work with Hispanics, including the language barrier, cultural and interpersonal factors, gender roles, and differing beliefs and attitudes about mental health; review difficulties in diagnosis, including the impact of culture-bound syndromes (such as "ataque de nervios", and "susto") on assessment; and review different approaches to treatment, including relevant principles of ethnopsychopharmacology, and the role of natural remedies and folk healing. The topics covered should allow the clinician to effectively diagnose and treat psychiatric disorders in Hispanic patients and communicate more effectively with these patients in the clinical setting.

No. 66C
CULTURALLY SENSITIVE COLLABORATIVE TREATMENT OF DEPRESSED CHINESE AMERICANS IN PRIMARY CARE

Albert S. Yeung *Massachusetts General Hospital, Psychiatry, 50 Staniford St Ste 401, Boston, MA, 02114-2541*, Lauren Fisher, Anna M. Agoston, B.A., Wan-Chen Weng, M.A., Yantao Ma, M.D., Shamsah B. Sonawalla, M.D., Maurizio Fava, M.D.

SUMMARY:

Objective: To examine the effectiveness of treating less acculturated depressed Chinese Americans in primary care using culturally sensitive collaborative treatment (CSCT).

Method: Between March 2004 to December 2005, depressed Chinese American patients in a primary care clinic were identified through screening using the Chinese version of Patient Health Questionnaire (PHQ-9). Patients who screened positive (PHQ-9≥15) were interviewed using the Engagement Interview Protocol (EIP), designed for communicating psychiatric diagnoses and for negotiating treatment options attuned to patients' cultural viewpoints. Enrolled depressed patients received medications treatment from their primary care physicians or from a liaison psychiatrist, and were randomized to receive either telephonic care management or usual care. Treatment outcomes were evaluated by blind assessors at 1.5, 3, and 6 months using the 17-item Hamilton Rating Scale for Depression (HAM-D), the Clinical Global Impression Scale (CGI), and the Social Functioning Scale (SF-12).

Results: Sixty depressed Chinese Americans (72% female, mean age 50±15) were enrolled into the study; and 35 (58%) of them were randomized to receive telephonic care management. At the end of the study, 16 (27%) patients achieved remission (> 50% reduction of initial HAM-D score), 25 (42%) patients showed response to treatment (HAM-D score < 7 at last assessment), and 20 (33%) patients were lost to follow-up. Treatment outcomes were not associated with age, gender, duration in the U.S., level of education, stigma score, initial HAM-D score, or care management.

Conclusions: This study demonstrated the feasibility and effectiveness of using culturally sensitive approaches and collaborative treatment to treat less acculturated, depressed Chinese American in primary care. CSCT may be a solution for reducing under-treatment of depression among ethnic minority immigrants. The lack of adherence to treatment is an important barrier in treating depressed Chinese Americans in primary care.

No. 66D
CULTURAL CONSIDERATIONS IN THE DIAGNOSIS AND TREATMENT OF MOOD DISORDERS IN THE ASIAN-INDIAN POPULATION

Rajesh M. Parikh, M.D. *Jaslok Hospital and Research Center, Psychiatry, 15 Dr. G. Deshmukh Marg, Bombay, 400 026, India*

SUMMARY:

Asian-Indians are a growing ethnic group in the U.S. This diverse sub-group of individuals have their own set of cultural norms, social and family traditions, and religious and spiritual belief systems, which may influence manifestation of mood disorders and affect treatment outcome. For instance, pain is a common presenting symptom of psychological distress, and majority of individuals with depression visit their general practitioners with physical symptoms. Mental illness is frequently viewed as an embarrassment or stigma, and mood disorders are under-diagnosed and under-treated in this population The involvement of family is important in all stages of treatment of mental illness, including interactions with the treating physician and compliance with treatment. Asian-Indians use family support and an extended network of relatives, friends and community elders during illness or crises. Herbal remedies and alternative treatments are widely used. Data on ethnopsychopharmacology, although limited, suggests differences in metabolism, dose requirements and adverse event profiles for antidepressant medications in this population. Understanding the complex cultural belief systems may allow clinicians to assess some of the cultural factors in treatment and potentially increase treatment acceptability and compliance, particu-

larly with antidepressant medications. Suggested modifications for managing depression in the Asian-Indian population will be discussed. Findings from cross-cultural studies comparing depression in college students in the India and the U.S. will be discussed.

No. 66E
A CULTURAL PERSPECTIVE ON THE DIAGNOSIS AND TREATMENT OF MOOD DISORDERS IN WOMEN

Shamsah B. Sonawalla, M.D. *Massachusetts General Hospital, Psychiatry, 15 Parkman St WAC 812, Massachusetts General Hospital, Boston, MA, 02114-3117*

SUMMARY:

This presentation will review mood disorders associated with a woman's reproductive life cycle, and will focus on providing a cultural perspective in this area. During periods of increased hormonal changes, women are more prone to depression, e.g. the premenstrual phase, the postpartum and the perimenopausal period. Up to 80% women experience premenstrual symptoms to some extent. The menstrual phase is viewed differently in different cultures, and the experience of premenstrual symptoms is also affected by culture, in addition to biological and psychological factors. Up to 15% of women experience postpartum depression, a potentially serious condition. Researchers have found a relationship between postpartum depression and factors such as a cultural preference for a male child, lack of social organization of postpartum events and a lack of social recognition of the role transition for the new mother. Menopause is a normal transition in a woman's life; however, every woman's experience with menopause is unique and is influenced by several factors, including culture. Up to 80% of women in western societies suffer from physical and psychological difficulties at menopause. Interestingly, women in some non-western cultures appear to be significantly less affected by menopausal ills, e.g., Rajput women in India, who report minimal or no 'symptoms' of menopause. Studies suggest that women experience greater levels of stress, depression and anxiety when seeking treatment for infertility, which is traditionally viewed as a woman's problem, even if a male factor is responsible for the couple's infertility. Findings from a study on couples undergoing in-vitro fertilization in an assisted reproductive clinic in India will be discussed. The importance of understanding the cultural context and a holistic approach in treating women with mood disorders will be discussed.

REFERENCES:

1. Ruiz P, ed. Ethnicity and Psychopharmacology. Washington, DC: American Psychiatric Press, 2001.
2. Mischoulon D. Management of Major Depression in Hispanic Patients. Directions in Psychiatry 2000; 20:275-285.
3. Yeung AS, Yu SC, Fung F, Vorono S, Fava M Recognizing and Engaging Depressed Chinese Americans in Treatment in Primary Care. Int J Geriat Psych (in press).
4. Conrad MM, Pacquiao DF. Manifestation, attribution and coping with depression amonf Asian Indians from the perspectives of health care practitioners. Journal of Transcultural Nursing. Vol. 16. No. 1, 32-40, Jan 2005.
5. Sonawalla SB, Parikh RM, Parikh FR: Coping Mechanisms in patients presenting for in-vitro fertilization. International Journal of Psychiatry and Medicine 1999; 29(2):251-60.

SYMPOSIUM 67—ETHICS OF TREATING SUBSYNDROMAL PSYCHIATRIC DISORDERS

EDUCATIONAL OBJECTIVES:

The participant should be able to recognize the magnitude of disability caused by subsyndromal psychiatric disorders.He should be able to evaluate the ethics behind treating these disorders and the necessity for further longitudinal studies for the outcome and management of such disorders.

No. 67A
SHOULD WE TREAT SUBSYNDROMAL PSYCHIATRIC DISORDERS?

Ahmed M. Okasha, M.D. *Insitute of Psychiatry - Faculty of Medicine, Neuropsyhciatry Department - Ain Shams University - Cairo, 3 El-Shawarby Street - Kasr El Nil, 402, Cairo, 1111, Egypt*

SUMMARY:

Recent data suggest that the impairment and disability caused by subsyndromal disorders are almost equal to the syndromal ones. Our current classifications have no room for such disorders in spite of the suffering of those patients. This creates an ethical dilemma to clinicians who would like to help but restricted by the fact that there are no guidelines for the treatment course, or outcome of these disorders. The objective of this symposium is to discuss the ethics of managing subsyndromal disorders inspite of lack of evidence based information about such a category. We need more scientific data and research studies to evaluate the value of treating such disorders.

No. 67B
SUBTHRESHOLD MOOD STATES ARE NOT SUBSCLINICAL

Hagop S. Akiskal, M.D. *UC-San Diego, Psychiatry, 3350 La Jolla Village Dr, 116A, San Diego, CA, 92161-0002*

SUMMARY:

Our current nosology (APA, WHO) uses at least some impairment in functioning to define clinically relevant categories. It is implied that the "major" categories (e.g. major depression, bipolar disorder type I, to mention disorders on which the present author's group has focused its clinical research attention) have the maximum impairment compared to symptomatolocally attenuated variants such as dysthymia, cyclothymia and bipolar disorder type II; these in turn are expected to be less impairing than the corresponding NOS categories. Sometimes, especially in the media, even in some psychiatric quarters, attempts to treat the "lesser" disorders are viewed as unwarranted, if not ethically problematic. I will present data which demonstrate that the so-called "lesser" conditions are not subclinical because in their own right they produce significant impairment in a variety of domains. Furthermore, these conditions can precede or follow the so-called major disorders and are important for primary and secondary prevention. Finally, work at the University of California at San Diego as part of the NIMH Collaborative Study has show that the structure of affective disorders, whether depressive or bipolar in nature, is typically expressed in fluctuations from syndromal to subsyndromal states, with the latter predominating the longitudinal course of these disorders. The lesser expressions should therefore be the target of therapeutic application.

No. 67C
TREATING SUBSYNDROMAL SCHIZOPHRENIA: WHY THE UPROAR?

Thomas H. Mc Glashan, M.D. *Yale University School of Medicine, Psychiatry, 20 Ridge Rd, Branford, CT, 06405-5715*

SUMMARY:

Early detection and intervention offers a new perspective on the diagnosis and treatment of schizophrenic spectrum disorders. Rele-

vant investigations include studies of efforts to reduce post-onset duration of untreated psychosis and studies of efforts to identify and treat prodromally symptomatic high risk patients in the pre-onset phase of disorder. There appears to be consensus that the benefits outweigh the risks in studies aiming to treat first psychotic patients as soon as possible. In contrast, less consensus exists about pre-onset detection and intervention studies. The author and colleagues have conducted such a study, a randomized double-blind placebo controlled clinical trial of atypical antipsychotic medicine in prodromally at risk patients. Among the ethical issues raised, the following are paramount: The false positive rate of case identification, the evidence of benefit, the side effects of treatment, the potential harm from hearing that one is at risk for psychosis, the false negative rate of case identification, and the inclusion of adolescents. Each of these issues is elaborated and discussed in terms of the existing studies informing risk and benefit, including our own clinical experience conducting this research. It is concluded that we do not have enough data yet to justify pre-onset drug intervention as standard practice but we do have enough data concerning risk and benefit to justify proceeding with such research without delay.

No. 67D
DEFINING THE "THRESHOLD" FOR THE DIAGNOSIS OF MENTAL DISORDER: SOME CURRENT APPROACHES

Mario Maj, M.D. *University of Naples SUN, Department of Psychiatry, Largo Madonna delle Grazie, Napoli, 80138, Italy*

SUMMARY:

The issue of the "threshold" for the diagnosis of mental disorder (or, more precisely, of how to distinguish some mental disorders from homeostatic reactions to adverse life events) is becoming more and more visible, due to several factors: a) the broadening of the scope of psychiatric intervention from traditional hospital to community settings; b) the increased presence in the mental health field of several other professionals, whose perception of mental health problems is often different from that of psychiatrists; c) the higher level of awareness of users, families and the public opinion; d) the translation of traditional descriptive definitions (which tended to convey a "gestalt" of the various mental disorders) into current operational diagnostic criteria (which are more precise, concise and reliable, but apparently less able to convey that "gestalt"). There are at least three different approaches to this problem: a) the one emphasizing the context in which the symptoms occur (the DSM-III and its successors have deliberately tried to exclude the assessment of the context from the diagnostic process, but the context in which the symptoms occur may be crucial for the distinction between a true mental disorder and a homeostatic reaction); b) the one emphasizing "qualitative" differences between true mental disorders and homeostatic reactions (for instance, there is some empirical evidence suggesting that depressed mood is something intrinsically different from "normal" forms of negative mood such as despair or sadness); c) the one acknowledging that the boundary between some mental disorders and homeostatic reactions is unavoidably arbitrary and has to be decided on pragmatic grounds (e.g., on the basis of need for treatment). Each of these approaches has its weaknesses and its strengths. Further empirical evidence in this area is urgently needed, because the current situation of uncertainty may damage the credibility of our discipline and our profession.

REFERENCES:

1. Pincus, H, Macqueen .L. and Elinson, L: Subthreshold mental disorders : nosological and research considerations . In advancing DSM Dilemmas, edited by Phillips, K, First, M and Pincus, H American Psychiatric Association . Washington, D.C. (2003).
2. Akiskal HS: Dysthymia and cyclothymia in psychiatric practice a century after Kraepelin. J Affect Disord 62:17-31, 2001.
3. McGlashan TH: Psychosis treatment prior to psychosis onset: ethical issues. Schiz Research 2001; 51:47-54.
4. Wakefield JC. Philosophy of science and the progressiveness of the DSM's theory-neutral nosology: response to Follette and Houts, Part 1. Behav Res Ther 1999; 37:963-999.

SYMPOSIUM 68—INNOVATIONS IN THE TREATMENT OF ADOLESCENT SUBSTANCE USE DISORDERS
National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the end of this symposium, persons in attendance will have an understanding of adolescent substance abuse treatment: (1) research methodologies; (2) useful techniques that are empirically validated.

No. 68A
FLUOXETINE IN ADOLESCENTS WITH COMORBID MAJOR DEPRESSIVE DISORDER AND AN ALCOHOL USE DISORDER: A RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED TRIAL

Jack R. Cornelius, M.D. *WPIC, University of Pittsburgh School of Medicine, Psychiatry, 3811 O' Hara St, PAARC Suite, Pittsburgh, PA, 15213-2593*

SUMMARY:

Background/Objective: We are currently conducting a first double-blind, placebo-controlled trial of fluoxetine (20 mg) in adolescents with comorbid major depressive disorder and an alcohol use disorder (R01 AA13370).

Method: All subjects also receive motivational and cognitive behavioral psychotherapy. That study remains ongoing.

Results: Certain preliminary data are now available, based on data from the first 41 subjects. No subject has complained of serious or persistent side effects, and none has been discontinued from medications because of side effects. A preliminary "blinded" analysis was conducted including all subjects, including both those receiving fluoxetine and those receiving placebo, because the medication blind has not yet been broken. When comparing baseline to end of trial (week 12), a significant improvement (decrease) was noted in depressive symptoms (BDI and SIGH), suicidal ideations (BDI #9), drinks in the last 2 weeks (TLFB), and days of intoxication (ACQ).

Conclusions: These findings suggest that fluoxetine is safe and well tolerated in this comorbid adolescent population. These findings also suggest that subjects who participate in the study generally show clinical improvement. By May, 2007, the study will be complete, the medication blind will have been broken, and comparisons of the efficacy of fluoxetine vs. placebo will be available. An overview of adolescent treatment findings from other investigators will also be presented.

No. 68B
EVIDENCE FOR ADOLESCENT PARTICIPATION IN ALCOHOLICS ANONYMOUS AND NARCOTICS ANONYMOUS: FURTHER STEPS NEEDED

John F. Kelly, Ph.D. *Mass. General Hospital/Harvard Medical School, Psychiatry, 55 Fruit Street, Addiction Research Program, Boston, MA, 02114*

SUMMARY:

During the past 10 years considerable effort and resources have been directed toward developing and testing appropriate interventions for substance use disorders and related problems among youth. Rigorous treatment implementation and evaluation studies have revealed promising evidence-based approaches to addressing these endemic problems. However, despite significant advances in the field, relapse following treatment is still too common. In the United States, addiction mutual-help organizations, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), play an influential role in individuals' formal and informal substance-related change efforts and preventing relapse. Recent evidence suggests professional 12-step-influenced treatment approaches and related referrals to community AA and NA groups are prevalent among both adult and adolescent substance use disorder treatment programs and providers. The potential benefits of participation in 12-step support groups for youth may be similar to adults (e.g., recovery-focused social network, wide availability at no cost, flexible accessibility - notably at times of high relapse risk, such as evenings/weekends). However, several issues linked to adolescents' developmental status raises skepticism regarding the relative fit and merits of 12-step fellowships for youth in helping prevent relapse. This talk will present and evaluate the empirical evidence pertaining to youth participation in AA and NA including the influence of 12-step group involvement on treatment outcomes. As a result, knowledge gaps will be identified and outlined and clinical practice guidelines offered, along with information about current research underway to address knowledge gaps.

No. 68C
DOES SMOKING CESSATION INTERVENTION INFLUENCE ADOLESCENT ALCOHOL AND OTHER DRUG ABUSE TREATMENT OUTCOME?

Mark G. Myers, Ph.D. *University of California, San Diego, Psychiatry, 3350 La Jolla Village Drive, VASDHS 116B, San Diego, CA, 92161*

SUMMARY:

Youth treated for alcohol and other drug use disorders smoke cigarettes at very high rates, incur tobacco-related health problems during adolescence and frequently attempt to quit smoking. Despite the potential value of addressing tobacco use in the context of adolescent substance abuse treatment few studies have investigated this issue. The current presentation will review 1) smoking by adolescents treated for substance abuse, 2) smoking cessation treatment for substance abusing adolescents, and 3) obstacles to implementing smoking interventions. In addition, original data will be presented that examine whether participation in a smoking cessation intervention has a negative effect on alcohol and other drug use treatment outcomes.

Data were analyzed for 55 adolescent participants in a controlled trial of a cigarette smoking cessation intervention delivered during outpatient substance abuse treatment. The sample was composed of 24% females, averaged 16.1 years of age, was 67% white and 26% Hispanic. Adolescents were assigned either to a 6-session course of intensive motivational smoking cessation treatment (n=27) or to a no-treatment condition (n=28) and reassessed 3 and 6-months after treatment completion.

Examination of experimental group in relation to substance use outcomes revealed that at 3-month follow-up 50% of active intervention participants and 31% of controls were abstinent from alcohol or drug use. At 6-month follow-up the proportions abstinent were 56% and 31% respectively. Similarly, a repeated measures ANOVA examined substance use severity scores (Personal Involvement Scale) across time-points, and revealed no group differences. Overall, participation in the smoking cessation intervention had no statistically significant association with post-treatment substance use.

The present findings provide evidence that adolescent participation in a smoking cessation intervention during the course of substance abuse treatment has no detrimental influence on alcohol and drug use outcomes. These data provide additional support for addressing cigarette use in the context of adolescent substance abuse treatment.

No. 68D
AFTERCARE FOR ADOLESCENT ALCOHOL USE DISORDERS

Yifrah Kaminer, M.D. *University of Connecticut Health Center, Psychiatry, 263 Farmington Avenue, Farmington, CT, 06030-2103*

SUMMARY:

Objective: The purpose of this randomized controlled study is to test the hypothesis that aftercare may improve relapse prevention in youth with AUD.

Methods: A total of 177 adolescents, 13-18 years of age, meeting eligibility criteria including primarily DSM-IV AUD participated in this study. Completers (N=146) of the treatment phase were randomized into either a no-active after (NAA) or to active aftercare conditions composed of 5-session manualized curriculum for a period of 12 weeks of either brief individual phone intervention (BPI) or in-person individual therapy (IPT). A 3, 6, and 12-month follow-up assessments concluded the study. Series of analyses hypothesized two orthogonal a priori contrasts for the three-level intervention: (1) Active Aftercare (IPT plus BPI) versus NAA, and (2) IPT versus BPI. Number of Drinking Days, Days of Heavy Drinking, Drug Urinalysis, and Readiness for Change in Marijuana Use were the main outcome measures selected to test the hypothesis that Active Aftercare was associated with better changes than NAA.

Results: There was a significant reduction for both number of drinking days and days of heavy drinking, in readiness to change in marijuana use, and a trend toward significance for positive change in drug urinalysis status as a function of active aftercare versus the control condition. There was no significant difference in the reduction in number of drinking days or days of heavy drinking between the active conditions. Accounting for age, gender and race/ethnicity did not alter the findings. However, these findings were not maintained at 3, 6, and 12-month follow-up assessments.

Conclusion: Aftercare for adolescents with AUD shows promise in enhancing short-term relapse prevention and should be implemented in every treatment discharge plan. Continued efforts to improve long-term relapse prevention are warranted.

REFERENCES:

1. Cornelius JR, Clark, DB, Bukstein OG, Birmaher B, Salloum IM, Brown SA; Acute phase and five-year follow-up study of fluoxetine in adolescents with major depression and a comorbid substance use disorder: a review. Addict Behav 2005; 30:1824-1833.
2. Kelly, J.F., Myers, M.G., & Brown, S.A: Do Adolescents Affiliate with 12-Step Groups? A Multivariate Process Model of Effects. Journal of Studies on Alcohol, 2002, 63, 3, 293-304.
3. Myers MG:Cigarette smoking treatment for substance abusing adolescents. In Innovations in Adolescent Substance Abuse Intervention, edited by Wagner EF, Waldron H, Oxford, England, Elsevier Science, 2001, pp731-777.
4. Kaminer Y, Napolitano C: Dial for therapy: Aftercare for adolescent substance use disorders. J Am Acad ChildAdolesc psychiatry 2004;43:1171-1174.

SYMPOSIUM 69—SEXUALITY IN LONG-TERM CARE FACILITY RESIDENTS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize:

1. how normal aging affects sexual behavior in elderly women and men;
2. how psychiatric illnesses and their treatments impact elderly patients' sexual functioning;
3. how to assess and manage inappropriate sexual behaviors of patients in long-term care (LTC) facilities;
4. issues regarding LTC facility patients' rights vs. concerns over patient exploitation/abuse when sex between adults with cognitive impairment occurs;
5. and effects of attitudes of patients, family, and professional caregivers.

No. 69A
NORMAL AGING AND SEXUALITY IN LATER LIFE

Shunda M. McGahee, M.D., *Harvard Medical School, McLean Division of Massachusetts General Hospital, 115 Mill Street, Belmont, MA, 02478*

SUMMARY:

Sexuality is a vital part of health, well-being and quality of life throughout the ages. It may include touching, caressing, physical closeness and emotional warmth. Although the frequency of intimacy and intercourse tends to decline with age, fulfillment with sexuality continues, and many elderly engage in sexual behavior until their eighties or nineties. People with active sex lives and interests in their youth are more likely to remain sexually active later in life. Factors that influence a decline in sexuality include normal physiological changes in sex organs, medication use, illness, physical difficulties, negative body image, mental disorders, psychosocial stressors, and ageism. Gott and Hinchliff (2003) studied how much elderly valued sex. They reported that sex was seen as a component of a close emotional relationship. Without a close emotional relationship, sex was less important. And if illness hindered sex within the context of a significant emotional relationship, then again, sex was less important. They also reported that factors related to aging, such as illness or loss of a partner, but not age itself, had a direct impact on how sex was viewed.

In this presentation, we will discuss (1) how aging causes normal physiological changes which affect sexual behavior in elderly women and men, (2) how health status influences preferences for sexual activity, (3) the impact of ageist attitudes on sexuality in the elderly, and (4) how to overcome barriers to sexual experiences among elderly women and men.

No. 69B
THE IMPACT OF PSYCHIATRIC ILLNESS ON SEXUAL FUNCTION IN ELDERLY LONG TERM CARE FACILITY RESIDENTS

Robert K. Dolgoff, M.D., *Psychiatry, University of California San Francisco, 1749 Martin Luther King Jr Way, Berkeley, CA 94709-2139*

SUMMARY:

Few elderly people enter a long term care facility with joy or enthusiasm. In our youth-oriented culture such a transition is weighted with meaning, most of it negative. Most individuals who enter these facilities have acute and chronic illnesses and almost by definition lack the social support which, if present, would have allowed them to stay in the community. Some find themselves suddenly single after years of being part of a couple, either because they have been recently widowed or because their spouse is healthy enough to live in the community. Although most people are uncomfortable thinking that people their parents' age think about sex, in fact the desire for emotional and physical intimacy doesn't go away when people age. Rather, freed of work and family responsibilities sexual thoughts may actually loom larger in peoples' minds. LTC residents have sexual thoughts, needs, and desires. Some people liken LTC's to co-ed summer camps or college dorms. Psychiatric illnesses can affect sexuality in many ways. Depression can decrease desire and interest as can the medications that depressed people take. Bipolar mania can cause hypersexuality. Some psychiatric illnesses can cause compulsive masturbation or inappropriate overtures to other patients or to staff, and some neuropsychiatric disorders rob formerly conventional people of the judgment that allowed them to have their sexual experiences in the right place and at the right time. In this talk we'll discuss the psychiatric disorders alluded to above as well as other illnesses which can affect sexuality.

No. 69C
ASSESSMENT AND MANAGEMENT OF INAPPROPRIATE SEXUAL BEHAVIOR IN THE LONG TERM CARE SETTING

David D. Myran, M.Ed. *Baycrest, Psychiatry, 3560 Bathurst St., Toronto, ON, M6A 2E1, Canada*

SUMMARY:

The presentation will discuss the assessment and management of inappropriate sexual behaviour(ISB) on the part of residents in long term care. When psychiatrists and other clinicians who work in the long term care setting are asked to intervene to manage what is perceived to be inapropriate sexual behaviour(ISB) it is often in an atmosphere of crisis where rapid assessment and treatment is demanded. It is particularly important in this context to make a careful assessment of the situation, obtaining a good history of the actual behaviour that is causing the concern.Careful diagnostic assessment of the resident is required to guide intervention. Behavioral environmental and pharmacotherapy approaches to modifying ISB will be reviewed. There will be discussion of of the attitudes on the part of families and staff that set the threshold for the definition of ISB. The presenation will include discussion of how to assess competency to engage in sexual relationships when one or both of the partners suffer from dementia.

No. 69D
SEXUALITY AND RIGHTS OF RESIDENTS IN LONG-TERM CARE FACILITIES

Ken Schwartz, M.D. *Baycrest, Psychiatry, 3560 Bathurst Street, Toronto, ON, M6A 2E1, Canada*

SUMMARY:

Residents of long term care facilities have a right to receive care services, such as nursing and personal assistance. The right of couples to privacy is also mentioned in the "Bill of Rights" for residents of long term care facilities in Ontario, Canada. However, any right to privacy and sexual expression for individual residents is not mentioned. Guided by legal and ethical concerns, nursing homes also have rules and regulations to safeguard residents from being exploited and abused. A model that addresses the situation of residents who lack adequate decision-making capacity because of cognitive impairment and who enter a sexual relationship with another resident is described. The model addresses the obligation of institutions and caregivers to provide not only for the safety and well-being of residents, but also to create an environment to better address the sexual needs of interested residents to further enhance their quality of life. Optimally decisions are guided by the resident's needs, not the home's interests. Clinical material is provided to illustrate the attitudes of residents, family, and health care providers when adults

with various degrees of cognitive impairment develop a romantic and / or sexual relationship.

REFERENCES:

1. Gott M, Hinchliff S. How important is sex in later life? The views of older people. Soc Sci Med 2003; 56:1617–1628.
2. Lothstein LM: Risk Management and Treatment of Sexual Disinhibtion in Geriatric Patients. Connecticut Medicine 1997 ;61:609–618.
3. Berger JT: Sexuality and intimacy in the nursing home: A romantic couple of mixed cognitive capacities. The Journal of Clinical Ethics 2000;11(4):305–317.
4. Blass DM, Steinberg M, Leroi I, Lyketsos CG: Successful Multimodality Treatment of Severe Behavioral Disturbance in a Patient with Advanced Huntington's Disease. Am J Psyciatry 2001;158:1966–1972.

SYMPOSIUM 70—THE SEXUALLY VIOLENT OFFENDER

EDUCATIONAL OBJECTIVES:

Participants should be able to identify the appropriate use of ordinary civil commitment for sex offenders.

No. 70A
CIVIL COMMITMENT OF SEX OFFENDERS

Howard V. Zonana, M.D. *Connecticut Mental Health Center, Yale Univ Dept of Psychiatry, 34 Park St, Rm 153, New Haven, CT, 06519–1109*

SUMMARY:

States without sexual predator statutes are becoming increasingly concerned about the release of sex offenders after the completion of their prison sentences and some governors have been asking prison psychiatrists to civilly commit such offenders at the end of their sentences. The paper will review these trends and problems facing psychiatrists.

No. 70B
THE CIVIL FACILITY EXPERIENCE WITH A PROGRAM FOR SVPS.

Samuel J. Langer *Manhattan Psychiatric Center, Psychiatry, 72 Barrow St., 4 F, New York, NY, 10014*

SUMMARY:

The symposium will review the state of the art of legal issues, treatment issues and outcomes of the treatment of Sexual Violent Predators. In 16 States special Sexual Violent Predator statutes nave been established resulting in a variety of treatment programs, come outside of the prison system, and some in civil psychiatric hospitals. After the supreme court ruling in Kansas vs Hendricks, organized psychiatry was forced to confront the issue of the legal rights of the sex offender. This symposium will present an overview of the current legal controversies of the Sexual Violent Predator statues, the treatment of Sexual Violent Predators in civil psychiatric facilities, the treatment of Sexual Violent Predators under the SVP statute, the biological treatment of Sexual Violent Predators, and finally a review of treatment outcomes.

No. 70C
RISK ASSESSMENT AND TREATMENT ISSUES RELATED TO PARAPHILIC SEX OFFENDERS

Fabian M. Saleh *42 Crosby Rd, Chestnut Hill, MA, 02467–1114*

SUMMARY:

Individuals who engage in sexual offending behavior may present with paraphilic disorders, such as pedophilia or sexual sadism Paraphilias are psychiatric disorders characterized by deviant and culturally non-sanctioned sexual fantasies, thoughts, or behaviors. Though afflicted individuals usually become aware of the unconventionality of their sexual deviancies around the time of puberty, the preponderance of paraphilic patients seeks treatment after being arrested for a sexual offense(s). A small proportion of these individuals may also suffer from symptoms of mental illness that can go unrecognized. Approaches to management involve assessing risk and offering pharmacological treatment if needed. Several pharmacologic agents have been tried to ameliorate paraphilic symptoms, including testosterone-lowering and serotonergic medications. Various modalities have also been proposed and used to assess an individual's risk for engaging in sexual offending behavior. In assessing risk, ethical dilemmas often arise, especially related to the role of mental health professionals in assessing risk, judging the adequacy of consent, and distinguishing between correctional and treatment functions. The purpose of this presentation is to describe pharmacological treatments for adult paraphilic sex offenders and to review basic approaches to sex offender risk assessment.

No. 70D
THE ROLE OF TREATMENT OUTCOME IN THE SVP COURTROOM

Howard E. Barbaree, Ph.D. *University of Toronto, Psychiatry, 250 College Street, 409, Toronto, ON, M5T 1R8, Canada*

SUMMARY:

The presentation will discuss treatment outcome in relation to the Sexually Violent Predator (SVP) legislation and process in three aspects. First, that treatment of sex offenders is efficacious is one pillar of the SVP legislation. Civil commitment of sex offenders is based on the idea that SVPs require treatment not punishment and that treatment will provide for eventual community integration for many sex offenders. The constitutionality of the SVP process is dependent on sex offender treatment resulting in lowered estimates of recidivism risk. Second, the SVP process is dependent on the states providing effective treatment. The present presentation will review the evidence for effective treatment for this population. And third, treatment outcome is critically important in the evaluation of the individual case. During the application process, and at each annual review, sex offenders are evaluated for risk for recidivism. Treatment outcome is relevant to this evaluation with respect to the extent that indices of treatment success are related to the mitigation of risk. The presentation will discuss the empirical evidence for treatment related changes in treatment targets leading to reduced risk for recidivism in the sex offender.

No. 70E
TREATMENT OF SEX OFFENDERS IN A PRISON SETTING

Lawrence A. Siegel, M.D. *PO Box 367, Hastings Hdsn, NY, 10706–0367*

SUMMARY:

Sex offenders are often treated involuntarily in confined settings. The participant will share some of the experiences of working in a sex offender specific prision.

REFERENCES:

1. JANUS, Eric S., LOGAN, Wayne A., Substantive Due Process and the Involuntary Confinement of Sexually Violent Predators, 35 Conn. L. Rev. 319 (2003).
2. Yang SS. Treatability of the sex offender: considerations of etiology, pathology, and treatment in repealing sexually dangerous offender statutes. Med Law. 1989;8(4):319–28.
3. Zonana H, et al.: Task Force Report on Sexually Dangerous Offenders. Washington, DC, American Psychiatric Association, 1999.
4. Marques, J. et al. (2005). Efffects of a relapse prevention program on sexual recidivism: Final results from California's Treatment and Evaluation Project (SOTEP). Sexual Abuse: A Journal of Research and Treatment, 17, 79–107.

SYMPOSIUM 71—PRENATAL NICOTINE EXPOSURE: HOW DOES IT RELATE TO DEVELOPMENTAL VULNERABILITIES? National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) communicate specific associations known to exist between prenatal nicotine exposure and neurobiological and behavioral vulnerabilities from birth into adolescence, (2) identify possible underlying explanations for these associations, and (3) consider and evaluate implications of the findings for clinical practice.

No. 71A
BEYOND DIAGNOSIS: UNPACKING THE ASSOCIATION OF PRENATAL SMOKING AND EXPOSURE ACROSS DEVELOPMENTAL PERIODS

Kimberly A. Espy, Ph.D. *University of Nebraska, Office of research & psychology, 303 CANFIELD ADMINISTRATION, UNL, Lincoln, NE, 68588*, Bennett L. Leventhal, M.D., Gretchen Biesecker, Ph.D., Kate Pickett, Ph.D., Daniel Pine, M.D.

SUMMARY:

Prenatal exposure to cigarettes has been robustly associated with disruptive behavior disorders, with strong evidence for links to antisocial behavior and mixed evidence for association to ADHD. However, such diagnostic categories are broad, reflect a heterogeneous group of behaviors and are adevelopmental. Greater specification of exposure and outcome is crucial to delineation of mechanisms. To this end, we examine the association of exposure and specific components of disruptive behavior in two cohorts at different developmental periods. The studies were specifically designed to examine behavioral effects of prenatal smoking (including oversampling for exposure) and used multi-method assessment of exposure and disruptive behavior components. The Family Health and Development Project (FHDP) is a cohort of 93 mothers and infants followed until age 24 months. The East Boston Family Study (EBFS) is a pregnancy cohort of 272 youth who are now adolescents (mean age=13).

In the FHDP toddlers, exposure was significantly related to observed stubborn defiance (girls and boys), aggression (boys) and lower social competence (girls) but not to dysregulated negative affect. Exposure was also associated with significantly elevated clinical risk at 24 months. In the EBFS, exposure was associated with CD in both girls and boys and ADHD in girls. In terms of component behaviors, exposure was associated with hostile attribution, instrumental anger and problems in anger control but not callousness and impulsivity in boys. Exposure was not significantly associated with any component behaviors in girls, (although we lacked assessment of poor social skills in these adolescents). We will discuss the complex exposure-related pattern suggested by these findings and their implications for understanding mechanisms and an agenda for future research that takes heterotypic continuity across development and individual differences into account.

No. 71B
NEUROIMAGING EVIDENCE OF ALTERED MEDIAL TEMPORAL LOBE FUNCTION IN ADOLESCENT TOBACCO SMOKERS WITH PRENATAL EXPOSURE TO MATERNAL SMOKING.

Leslie K. Jacobsen, M.D. *Yale University School of Medicine, Psychiatry and Pediatrics, 2 Church Street South, 207, New Haven, CT, 06511*, Theodore A. Slotkin, Ph.D., Michael Westerveld, Ph.D., W. Einar Mencl, Ph.D., Kenneth R. Pugh, Ph.D.

SUMMARY:

Active maternal smoking during pregnancy elevates the risk of cognitive deficits and tobacco smoking among offspring. Preclinical work has shown that combined prenatal and adolescent exposure to nicotine produces more pronounced hippocampal damage and greater deficits in cholinergic activity upon nicotine withdrawal than does prenatal or adolescent exposure to nicotine alone. Few prior studies have examined potential modifying effects of gestational exposure to active maternal smoking on cognitive or brain functional response to tobacco smoking or nicotine withdrawal in adolescents. In this presentation, findings from a comparison of 35 adolescent tobacco smokers with prenatal exposure to active maternal smoking and 26 adolescent tobacco smokers with no prenatal exposure to maternal smoking will be described. Subjects were studied during ad libitum smoking and after 24 hours of abstinence from smoking. Adolescent tobacco smokers with prenatal exposure experienced greater nicotine withdrawal related deficits in immediate and delayed visuospatial memory relative to adolescent smokers with no prenatal exposure. Functional magnetic resonance imaging showed that, among adolescent smokers with prenatal exposure, nicotine withdrawal was associated with increased activation of left parahippocampal gyrus during early recall of visuospatial stimuli and increased activation of bilateral hippocampus during delayed recall of visuospatial stimuli. These findings extend prior preclinical work and suggest that, in human adolescent tobacco smokers, prenatal exposure to active maternal smoking is associated with alterations in medial temporal lobe function and concomitant deficits in visuospatial memory.

No. 71C
GESTATIONAL NICOTINE ALTERS BRAIN NICOTINIC CHOLINERGIC RECEPTOR EXPRESSION IN DOPAMINERGIC REGIONS OF ADOLESCENTS AND ADULTS

Burt Sharp, M.D. *University of Tennessee, Pharmacology, 874 Union Ave.*
115 Crowe, Crowe Bldg., Suite 115, Memphis, TN, 38163, H. Chen, S. L. Parker, J. M. McIntosh, S. G. Matta

SUMMARY:

The offspring of women who smoked during pregnancy are at increased risk of becoming dependent on smoking initiated during adolescence. We have previously reported that exposure to gestational nicotine attenuated nucleus accumbens (NAcc) dopamine release induced by nicotine delivered during adolescence. In subse-

quent studies, we determined the effects of gestational nicotine exposure on nicotinic cholinergic receptor (nAChR) expression. Timed pregnant rats received nicotine (2 mg/kg/day) or vehicle via mini-osmotic pumps during gestation. Treatments continued in pups via maternal nursing during postnatal days (PN) 2–14 (equivalent to the human *in utero* third trimester). On PN 22 and PN35, 125I-epibatidine binding to nAChR was measured. The Bmax values (fmol/mg) were significantly reduced in multiple brain regions including NAcc, substantia nigra (SN) and ventral tegmental area (VTA). The expression of nAChR subunit mRNAs was measured using real-time RT-PCR on laser-capture microdissected tissues. In adolescent VTA at PN35, gestational nicotine exposure reduced nAChR subunit mRNAs encoding alpha3 (53%), alpha4 (24%), alpha5 (47%) and beta4 (61%). Additionally, nAChRs were significantly reduced in multiple brain regions from control adults (PN75-90) compared to control adolescents; in adults, gestational nicotine did not further reduce the number of 125I-epibatidine-bound nAChRs. However, alpha6 subunit-containing nAChRs, detected by 125I-conotoxin displaced by E11A, were significantly reduced by gestational nicotine in the NAcc, SN and striatum of both adults and adolescents. These studies indicate that gestational exposure to nicotine induces long-lasting changes in nAChR expression that are age, subunit and brain region specific. These changes may underlie the vulnerability of adolescents to dependence on nicotine.

No. 71D
PRENATAL NICOTINE EXPOSURE INDUCES SEX-DEPENDENT CHANGES IN DOPAMINE PATHWAYS IN ADOLESCENT BRAIN.

Frances Leslie, Ph.D. *University of California, Irvine, Pharmacology, Rm 360, MS2, School of Medicine, Irvine, CA, 92697*, Ryan Franke, Anita Lakatos, Ph.D., James D. Belluzzi, Ph.D.

SUMMARY:

Central dopamine systems serve numerous integrative neural functions and critically regulate action, emotion, motivation, and cognition. Dysregulation of these systems has been implicated in numerous disease states, particularly those in which there are cognitive, emotional, and/or motor deficits. Clinical studies have shown that smoking during pregnancy can lead to long-standing neurobehavioral deficits in the offspring, many of which may result from central dopamine dysfunction, including attention deficit hyperactivity disorder, conduct disorder, cognitive deficits, and substance abuse. Using rat as a model, we have demonstrated that nicotine, the major psychoactive component of tobacco, targets dopamine systems in fetal brain. Chronic prenatal nicotine (PN) exposure, via an osmotic minipump, produces long-lasting changes in the properties of central dopamine neurons. In particular, sex-dependent changes in regional levels of dopamine and dopamine transporter (DAT) are observed in adolescent brain. Cocaine, which mediates many of its effects through blockade of DAT, also exhibits substantial behavioral differences in PN-treated rats, including alterations in drug self-administration, locomotion and stereotypy. The mechanisms underlying these behavioral changes are currently being explored. These findings suggest that not only smoking, but also the use of nicotine patch, during pregnancy may substantially disrupt brain development. Thus, the safety of nicotine replacement therapy as a therapeutic regimen during pregnancy and adolescence must be evaluated more thoroughly. Supported by DA 10612.

REFERENCES:

1. Wakschlag, L., Leventhal, B., Pine, D., Pickett, K. & Carter, A. (2006). Elucidating early mechanisms of developmental psychopathology: The case of prenatal smoking and disruptive behavior. Child Development, 77, 893–906.
2. Slotkin TA (2004). Cholinergic systems in brain development and disruption by neurotoxicants: nicotine, environmental tobacco smoke, organophosphates. Toxicology and Applied Pharmacology 198: 132–151.
3. Chen H, Parker SL, Matta SG, Sharp BM: Gestational nicotine exposure reduces nicotinic cholinergic receptor (nAChR) expression in dopaminergic brain regions of adolescent rats. Eur J Neurosci 2005; 22:380–388.
4. Leslie, F.M., Loughlin, S.E., Wang, R., Perez, L., Lotfipour, S., and Belluzzi, J.D. : Adolescent development of forebrain stimulant responsiveness: Insights from animal studies. Ann. N.Y. Acad. Sci. 2004; 1021:148–159.

SYMPOSIUM 72—THE IOM INFORMS, NAMI STORMS, AND AACP TRANSFORMS: HOW TO MAKE THE GRADE IN RESPONSE TO THE U.S. MENTAL HEALTH'S BAD REPORT CARD

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the key problems of the U.S. mental health system and some of the most relevant responses to those challenges.

No. 72A
CAN COMMUNITY PSYCHIATRY CROSS THE QUALITY CHASM? THE INSTITUTE OF MEDICINE REPORT ON IMPROVING CARE FOR MENTAL AND SUBSTANCE-USE CONDITIONS.

Harold Alan Pincus, M.D. *Columbia University/New York-Presbyterian Hospital, Psychiatry, 1051 Riverside Drive, Unit 9, New York, NY, 10032–1007*

SUMMARY:

In 2001, a seminal Institute of Medicine (IOM) report, *Crossing the Quality Chasm: a New Health System for the 21st* Century, put forth a comprehensive strategy for improving the quality of U.S. health care. This strategy attained considerable traction within the overall U.S. health care system, and subsequent attention in the mental health community as well. A new IOM report, *Improving the Quality of Health Care for Mental and Substance-Use Conditions,* examines the Quality Chasm strategy in light of the distinctive features of mental and substance-use (M/SU) health care, including concerns about patient decision-making abilities and coercion into care; a less developed quality measurement and improvement infrastructure; lagging use of information technology and participation in the development of the National Health Information Infrastructure; greater separations in care delivery accompanied by more restrictions on sharing clinical information; a larger number of provider types licensed to diagnose and treat; more solo practice; and a differently structured marketplace. This presentation summarizes the IOM's analysis of these issues and recommendations for improving M/SU health care, and discusses the implications for psychiatric practice and related policy efforts of psychiatrists, psychiatric organizations, and other leaders in M/SU health care.

No. 72B
WHAT FAMILIES AND CONSUMERS SEE AND WANT IN AMERICAS MENTAL HEALTH SERVICE SYSTEM

Kenneth S. Duckworth, M.D. *National Alliance for Mental Illness, 950 Cambridge St, Cambridge, MA, 02141*

SUMMARY:

NAMI rated state mental health systems for the first time in 17 years. Some states came out solid, yet many states did not fare well. Innovative practices to emulate were seen in every state.

In a transparent and data driven way, NAMI had the results blindly rated by a consumer, a family member and two psychaitrists. The results gained national attention and can be used to continue to advance the casue of improving servcies for individuals living with the most severe illnesses.

One feature of the scoring was a "consumer and family test drive" which took consumers and family members through all 50 states web sites and phone systems to ask basic questions of the system.

NAMI is interested in feedback on this project as will be a reoccurrring biopsy of the servcie system.

REFERENCES:

1. Improving the Quality of Health Care for Mental and Substance-Use Conditions. Washington, DC, National Academies Press, 2006 http://www.iom.edu/CMS/3809/19405/30836.aspx.
2. Grading the States,2006. Honberg, Duckworth, et al. NAMI national March 1, 2006.
3. Sowers,WS: Reducing Reductionism: Reclaiming Psychiatry Psychiatric Services, June, 2005.
4. Monograph-Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series, Washington, DC, National Academy Press, 2005.

No. 72C
LEADERSHIP AND COLLABORATION: TRANSFORMING COMMUNITY PSYCHIATRY

Wesley E. Sowers *206 Burry Ave, Bradfordwoods, PA, 15015–1240*

SUMMARY:

This section will discuss various activities on the American Association of Community Psychiatrists related to Quality Improvement in the delivery of mental health and substance use services in the public sector. The tools and guidelines developed by this organization will be briefly presented with special emphasis on the development of recovery oriented services and systems transformation initivitives. The transformation of the profession will also be discussed, with the presentation of the results of 34 focused, facilitated discussions involving consumers, psychiatrists and allied professionals. The results of these conversations and recommendations will be related to the findings and recommendations of other recent transformation document presented in this symposium, and the implications for the future of psychiatry will be considered.

No. 72D
GETTING THE WORD OUT: HOW TO SYNTHESIZE, DISSEMINATE, IMPLEMENT, AND SUPPORT THE IOM'S RECOMMENDATIONS

Neal H. Adams, M.D. *California Institute for Mental Health, 4129 Cherryvale Ave, Soquel, CA, 95073–9700*

SUMMARY:

Creating systems change is inherently difficult_but it is greatly facilitated by having a blueprint for change as well as a strategy for change. The IOM reported and related studies and documents provide a synergistic consensus about what needs to be done, and provide some initial detail about who should do what, but the necessary details for really creating change are not included. Change models and change management techniques become essential components of an overall change strategy. Three essential tasks scan be identified: synthesis, dissemination, and implementation. These have been successfully applied in several settings and have contributed significantly to realizing, at minimum, several components of the IOM vision of transformation. This paper will review successful dissemination initiatives, as well as implementation efforts based upon a synthesis of multiple reports and sets of recommendations. The important role roles of competency development, change management and project management as three essential tools will be presented. An evaluation of the recent California Learning Collaborative project at the California Institute for Mental Health is an excellent example of how this can be accomplished within a state and county mental healthy system. Challenges to sustaining change over time as well as specific examples of success will also be presented.

SYMPOSIUM 73—HIV UPDATE FOR PSYCHIATRIC CARE

EDUCATIONAL OBJECTIVES:

This Symposium will offer psychiatrists five short sessions on care, prevention, and treatment of HIV infection. An HIV Treatment Update will be followed by discussions of evidence-based psychiatric treatments, HIV as a lifelong illness, and international treatment efforts. The symposium combines the latest information on current clinical challenges, psychiatric management, and global responses. Clinical cases will be used as examples. A question and answer period will allow ample time for psychiatrists to share their clinical concerns.

No. 73A
HIV MEDICAL UPDATE: WHAT EVERY PSYCHIATRISTS NEEDS TO KNOW

Diane Pennessi *APA, 1000 Wilson Blvd, Arlington, VA, 22209*

SUMMARY:

HIV continues to spread at alarming rates throughout the world, having already claimed more than 20 million lives. While great strides have been made in understanding the natural history of the disease, much is still unknown, and treatments remain complex and available to less than 5% of those infected throughout the world. Rates of new infections continue to rise in the young, sexually active population, and in injecting drug users, while new infections are being documented in among seniors. And a co-existing epidemic of Hepatitis C has blossomed among those at risk for or infected with HIV.

As HIV both exacerbates and causes psychiatric disorders, psychiatrists continue to play an increasingly active role in the assessment and treatment of people infected with HIV, and in the care of those most at risk. HIV is a behavioral epidemic which requires the integration of medical, psychiatric, and social services in the health care delivery system. This session will provide an update on the basic medical knowledge all psychiatrists must have to work with people at risk for or infected with HIV, presenting information on epidemiology, new clinical challenges, current treatments, patient management, integrated care, and complications of drug-drug interactions.

No. 73B
EVIDENCE-BASED TREATMENTS IN HIV PSYCHIATRIC CARE

Stephen Ferrando *Payne Whitney Clinic, Payne Whitney Clinic, New York, NY, 10021–4870*

SUMMARY:

APA HIV Practice Guideline Workgroup has conducted a systematic, evidence-based review of research literature for HIV psychiatric care. Using an unbiased approach for extracting data, the workgroup

has identified an exhaustive set of eligible studies, analyzed data sets, and prepared structured reports on HIV care and treatment of psychiatric syndromes. This session updates participants on the preparation of the new HIV guidelines and provides recommendations to help psychiatrists make HIV treatment decisions that are supported by the best available evidence, current research and expert consensus. Included will be a discussion of anxiety and mood disorders, cognitive impairment, psychosis, and comorbidity.

No. 73C
HIV AS A LIFELONG ILLNESS

Karl Goodkin, M.D., Ph.D., *Department of Psychiatry and Behavioral Sciences, University of Miami, P.O. Box 016960, Miami, FL 33101–6960*

SUMMARY:

Treatment advances have improved survival for many patients with HIV infection and provided hope for a normal lifespan for the most fortunate among them. The impact of HIV infection, however, can have a significant impact on the central nervous system (CNS) of all age groups (some studies also suggest that the CNS effects of HIV may be related to antiretroviral treatment). Perinatally infected youth can experience substantive mental health problems that pose barriers to optimal health and well-being. Evidence cites a high incidence of loss, stress, anxiety and behavioral disorders. As they grow older, adolescent sexual and drug-using risk behaviors can affect both viral transmission and medication adherence. Moreover people living with HIV disease are growing older and cases of HIV in people over 50 are likely to expand.

In view of these lifelong trends, there is a need for a basic understanding of HIV, its associated CNS complications, and its mental health impact across every age group. During this session will review HIV-related mental health care and treatment for younger and older HIV-infected populations, discuss how age might impact the development of HIV neurocognitive dysfunction, identify the neurologic and psychiatric complications associated with HIV or its treatment at different ages, and highlight mental health interventions that should be incorporated into medical care throughout the lifespan.

REFERENCES:

1. Fernandez, F. Ten myths about HIV infection. FOCUS. The Journal of Lifelong Learning in Psychiatry. Spring 2005, Vol. III, No. 2.
2. American Psychiatric Association. Practice Guidelines for the Treatment of Psychiatric Disorders, Compendium 2006. American Psychiatric Publishing, Inc.
3. Treisman, GJ, Angelino AF: The Psychiatry of AIDS: A Guide to Diagnosis and Treatment. Baltimore, Johns Hopkins University Press, 2004.
4. Young AS, Sullivan G, Bogart LM, Koegel P, Kanouse DE: Needs for Services Reported by Adults With Severe Mental Illness and HI. Psychiatr Serv, Jan 2005; 56: 99–101.

SYMPOSIUM 74—DISSOCIATIVE DISORDERS: MEETING THE CHALLENGE OF THE *DSM-V*

EDUCATIONAL OBJECTIVES:

1. At the conclusion of this presentation, the participant should be able to have an overview of the history of the dissociation construct since the early 19th century.

2. At the conclusion of this presentation the participant will have a clear understanding of the range of data that support the linkage of dissociation and dissocative disorders with traumatic experiences.

3. At the conclusion of this presentation, the listener will be able to conceptualize the differential diagnosis between the phenomenology of dissociative pseudo-psychotic symptoms and the symptoms of psychotic patients.

No. 74A
DISSOCIATIVE DISORDERS: HISTORY, CONCEPTUAL ISSUES, DIAGNOSIS, AND RESEARCH

Richard J. Loewenstein, M.D. *Sheppard Pratt Health Systems, Trauma Disorders, 6501 North Charles Street, PJ 106, Baltimore, MD, 21204–6819*

SUMMARY:

Dissociative disorders have been described since the beginning of modern psychiatry. For part of the 19th century dual consciousness was the central explanatory model for hysteria. Around the turn of the 20th century, for a variety of reasons, dissociation was dissociated from the hysteria concept, except during 20th Century wars when dissociative conditions were frequently diagnosed. Since the 1970's, dissociation and dissociative disorders have again become subjects of serious scientific scrutiny. A new paradigm has emerged linking both dissociation and dissociative disorders to traumatic experiences. This paradigm shift also led to a re-conceptualization of the phenomenology of dissociative disorders, development of screening and diagnostic instruments, differentiation of dissociative disorders from other DSM-IVTR axis I and II disorders, studies of prevalence, and development of new treatment paradigms. Epidemiological studies have found that these disorders are far more prevalent than had been previously thought, with severe dissociative disorders possibly affecting about 3 percent of the general population. The understanding that dissociation may result from early life trauma has led to the study of traumatized and abused children with development of diagnostic and treatment paradigms for dissociative children. In addition, studies of memory, psychophysiology, personality structure, and neurobiology, among others, have led to a deeper understanding of dissociative disorders and their relationship to other trauma spectrum disorders. In addition, there is a literature on dissociation as a dimensional trait, one almost invariably linked to an antecedent history of traumatic and/or overwhelming experiences. Using standardized instruments, dissociative disorders have been diagnosed in Europe, Latin American, and Asia, frequently showing a phenomenology and history of traumatic experiences similar to those of patients in North America. The persistence of controversies about the existence of dissociative disorders, despite these data, also will be discussed.

No. 74B
DISSOCIATIVE IDENTITY DISORDER (DID) AND DID-LIKE CASES OF DISSOCIATIVE DISORDER NOT OTHERWISE SPECIFIED

Paul F. Dell, Ph.D. *Trauma Recovery Center, 330 West Brambleton Ave, Ste. 206, Norfolk, VA, 23510*

SUMMARY:

There are at least six reasons why the diagnostic criteria for DID should be revised: (1) they overemphasize an infrequent phenomenon of DID (i.e., visible switching from identity to another); (2) they sparsely reflect the disorder's most frequent dissociative phenomena (i.e., startling intrusions into executive functioning and sense of self);

(3) they sparsely reflect the dissociative phenomena of DID that constitute the core of the Structured Clinical Interview for the DSM-IV Dissociative Disorders (SCID-D) and the Dissociative Disorder Interview Schedule (DDIS); (4) they are unspecific, clinically abstract, and monothetic; (5) they do not meet the basic mandate of the modern DSM_to afford solid diagnostic reliability; and (6) they have inadequate clinical utility. The diagnostic criteria for DID seem to have inadvertently fostered misunderstandings about DID; they also may be directly responsible for the nosological strain that is evident in epidemiological studies. Epidemiological studies have repeatedly reported that 40% of dissociative cases are Not Otherwise Specified (NOS). In an adequate nosology, NOS cases should never be more frequent than the specific disorders. The empirical literature on DID contains many well-documented dissociative symptoms of DID that are specific, concrete, and easily assessed. These dissociative symptoms make it possible to construct polythetic diagnostic criteria for DID that are much more user-friendly than the current criteria. There is good reason to believe that new, research-based diagnostic criteria will allow the everyday clinician to reliably diagnose DID. It also seems likely that such criteria will eliminate the over-diagnosis of Dissociative Disorder NOS. These new diagnostic criteria are now being evaluated in a multi-site field trial.

No. 74C
DEPERSONALIZATION DISORDER AND DISSOCIATIVE AMNESIA

Daphne Simeon, M.D. *Mount Sinai School of Medicine, Psychiatry, Box 1230, One Gustave L. Levy Place, New York, NY, 10029–6574*

SUMMARY:

Despite the highly consistent nosology of depersonalization disorder (DPD) in two large cohorts, DPD remains one of the most commonly underdiagnosed and misdiagnosed psychiatric disorders. Part of the problem lies with the single and vague diagnostic criterion of the current DSM: "experiences of feeling detached from, and as if one is an outside observer of, one's mental processes or body." Empirical data now document the occurrence and frequency of various symptoms of DPD, which can be subsumed under several symptom domains and subjected to field trial investigation. Additionally, the classification of derealization in the absence of prominent depersonalization needs to be addressed; derealization alone is currently classified as a Dissociative Disorder NOS, but evidence demonstrates that depersonalization and derealization cannot be dissected into discrete disorders. The longitudinal course of DPD in relation to other comorbid Axis I disorders also needs to be sharpened in order to enhance diagnostic accuracy. In contrast to DPD, DSM-IV-TR Dissociative Amnesia (DA) remains a poorly studied dissociative disorder. In the absence of well-characterized large cohorts, not enough is known about its prevalence, duration, morbidity, prognosis, and occurrence independent of other syndromes such as Dissociative Identity Disorder or Acute Stress Disorder. The current diagnostic criterion for DA is single and vague: "the predominant disturbance is one or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness." Criteria for duration, severity, and extent of amnesia, along with clinical examples, are required for sharper definition. Guidelines are also needed for better differentiation from other trauma-related memory impairments such as those encountered in Acute Stress Disorder or PTSD. Dissociative Fugue might be conceptualized as a subtype of amnesia and may not require a distinct diagnostic status as in the current DSM.

No. 74D
CONVERSION DISORDER, DISSOCIATIVE PSYCHOSIS, AND CHILDHOOD DISSOCIATIVE DISORDER

Vedat Sar, M.D. *Istanbul University Istanbul Faculty of Medicine, Department of Psychiatry, Istanbul Tip Fakultesi Psikiyatri Klinigi Capa, Istanbul, 34390, Turkey*

SUMMARY:

Almost a half of patients with conversion disorder have an axis-I dissociative disorder. In accordance with the International Classification of Diseases (ICD-10) and in consideration of the common mechanism in both groups(somatoform dissociation), moving conversion disorder into dissociative disorders section in the DSM-V may be a realistic option. Dissociative psychosis (formerly hysterical psychosis) which is an acute polymorph psychosis distinct from schizophrenia in its quality,course, and outcome, is a living entity in many countries including Europe. The coverage of this condition as a specific diagnostic group in the dissociative disorders section or as one of the DDNOS types would prevent these patients from being considered a having schizotypal psychopathology. As dissociative disorders usually begin during childhood, the introduction of a childhood dissociative disorder may facilitate early intervention. Due to phenocopy, a large group of subjects with dissociative disorder are at risk of being diagnosed as having borderline personality disorder. A better definition of the 9th criterium should be provided. As the four conditions mentioned above have high prevalence in many countries, these considerations seem to be highly accurate from international and trans-cultural points of view as well.

REFERENCES:

1. Loewenstein RJ, Putnam FW: The Dissociative Disorders, in Comprehensive Textbook of Psychiatry VIII, Eighth Edition, vol 1. Edited by Sadock BJ, Sadock VA. Baltimore, Williams & Wilkins, 2004, pp 1844–1901.
2. Dell PF: Why the diagnostic criteria for dissociative identity disorder should be changed. J Trauma Dissociation 2001; 2:7–37.
3. Simeon D, Knutelska M, Nelson D, Guralnik O: Feeling unreal: a depersonalization disorder update of 117 cases. J Clin Psychiatry 2003;64:990–997.
4. Sar V: The scope of dissociative disorders: an international perspective. Psychiatr Clin North Am 2006; 29:227–244.

THURSDAY, MAY 24, 2:00 PM – 5:00 PM

SYMPOSIUM 75—CULTURE AS A RATIONALIZATION FOR VIOLENCE AGAINST WOMEN

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to distinguish between cultural sensitivity and discrimination against women; and demonstrate how to deal with discriminatory cultural practices.

No. 75A
CULTURE AS A RATIONALIZATION FOR VIOLENCE AGAINST WOMEN IN NORTH AMERICA

Gail E. Robinson, M.D. *university of toronto, psychiatry, 278 Bloor St E # 210, Toronto, ON, M4W 3M4, Canada*

SUMMARY:

When considering culturally santioned violence against women, ''westernized'' societies tend to look towards cultures and religions originating in other countries. We tend not to recognize the abuses that are home grown. As well, in attempting to be culturallly sensitive, we often accept behaviour from ethnic groups, native populations or religious groups that do not fit with our general belief as to how women should be treated. This presentation will give examples of individuals and groups whose behaviour has been excused on the grounds of religioun, culture or tradition and challenge whether these are reasons to excuse otherwise unacceptable actions. It will address questions as to how we can better deal with these issues, both as a society and individual therapists.

No. 75B
FINDING A FIRM BASE IN A SEA OF CULTURAL RELATIVISM

Sarah E. Romans *university of toronto, PSYCHIATRY, 278 Major St, Toronto, ON, M5S 2L6, Canada*

SUMMARY:

Physicians have a real clinical conundrum when it comes to considering culturally sanctioned practices which may affect health. Many (sub) cultures have views of women which curtail women's development and autonomy. This is seen clearly in the matter of violence against women. These restrictive practices are often justified by reference to the practices and values within that group.

Culturally competent clinicians respect others' cultural values and see them as not better or worse but different. So, it can be confusing to deal with a patient whose health problem seems directly related to an abusive practice, particularly if the patient herself appears to find nothing untoward about it. Philosophically, cultural relativism, the idea that beliefs and behaviors must be understood in their historico-cultural context, seems to provide support for the idea that physicians should not seek to change the culture of others.

Are there any over -arching principles to give guidance in these situations? We can turn to Codes of Ethics, religious texts, laws of the various countries and international documents such as the Declaration of Human Rights (whose authors struggled with these issues). These all have limitations, which will be outlined.

Health practitioners do have another conceptual base, which may be free of cultural complexities. This is the assessment of the practice's effect on health, measured with modern techniques. If the practice can be shown to damage (or promote health), we have a way forward. There is now substantial evidence that violence against women is injurious to the mental and physical health of its victims and to bystander family members. Good research data can transcend cultural boundaries and be often used effectively for change.

No. 75C
CULTURE AS A RATIONALIZATION FOR VIOLENCE AGAINST WOMEN-PAKISTANI PERSPECTIVE

Unaiza Niaz, M.D. *The Psychiatric Clinic & Stress Research Centre, Zamzama, Karachi, 5A/II West Avenue, Phase -1,DHA, 5A/11, Karachi 75500, 75500, Pakistan*

SUMMARY:

Culture & traditions in South Asia,have a significant effect on the mental health of women.In the name of family traditions & cultural expectations,women have suffered violence,from times immemorial-.Globalisation,awareness of human rights,UN Charter forWomens Rights,local women activists,changes in legal system for Right to Divorce,all have done very little service to majority of women in this part of the world.Violence against women continues in rural areas,unabated,the urban women,who are financially independent,still suffer years of torture in the name of family honour.And if they manage to get out of their violent relationships,they suffer isolation,loneliness & further marginalisation .In this presentation,some common issues,& cases will be discussed.Strategies to create awareness in masses to help & support women subjected to violence,in the name of traditions,& patriachal culture.will also be discussed,

REFERENCES:

1. Robinson GE. Violence Against Women in North America. Archives of Women's Mental Health. 6:185–191, 2003.
2. Garcia-Moreno, C. et al: Public health. Violence against women Science 2005; 310 (5752) 1282–3.
3. NIAZ,U,: Womens Mental Health in Pakistan, World Psychiatry,VOL3,#1,60–63.
4. Garcia-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts CH; WHO Multi-country Study on Women's Health and Domestic Violence against Women Study Team. Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. Lancet. 2006 Oct 7;368(9543):1260–9.

SYMPOSIUM 76—THE COMBINE TRIAL: TREATMENT OF ALCOHOL DEPENDENCE FROM BENCH TO BEDSIDE

EDUCATIONAL OBJECTIVES:

Participants will be able to articulate the principles involved in using a research finding and creating a tool to implement the finding in clinical practice, and will be able to use the medication management support tool in their own practices to provide behavioral support for patients receiving pharmacotherapy for alcohol dependence.

No. 76A
ADAPTING THE COMBINE TRIAL FINDINGS FOR CLINICAL PRACTICE: THE 2006 NIAAA CLINICIANS GUIDE

Mark L. Willenbring, M.D. *NIAAA-NIH, Division of Treatment and Recovery Research, 5635 Fishers Ln, Rm 2047, Bethesda, MD, 20892–9304*

SUMMARY:

Many important findings emerged from the COMBINE trial of medication and behavioral treatments for alcohol dependence, but perhaps the most important was that naltrexone combined with brief medical support was as effective as specialized alcohol counseling. This finding suggests that general psychiatrists can effectively treat alcohol dependence in outpatient office settings, reserving referral to specialized treatment programs for more severe or complicated cases. In 2005, NIAAA published a new edition of its Clinicans Guide: Helping Patients Who Drink Too Much. In that edition, general psychiatrists were urged to treat alcohol dependence with medications and support, but specific guidance for providing behavioral support was not available. For the 2006 Edition, the form of medical support used in the COMBINE trial, Medical Management, was adapted and shortened. In this presentation, I will review the steps involved in taking a complex study finding and developing tools for implementation in clinical settings. Medication management support will be described in detail, and clinicians should be able to begin to use it in their practices.

No. 76B
PRIMARY RESULTS FROM COMBINED PHARMACOTHERAPIES AND BEHAVIORAL INTERVENTIONS FOR ALCOHOL DEPENDENCE: THE COMBINE STUDY

Raymond F. Anton, M.D. *MUSC, Institute of Psychiatry, 67 President St, Box 250861, Charleston, SC, 29403–5712*

SUMMARY:

Objective: To evaluate the safety and efficacy of naltrexone and acamprosate alone and in combination with and without specialized counseling. Secondary objectives were to evaluate 1) the effect of pill taking on specialized counseling 2) the longer term effects of these treatments during the year after treatment.

Method: 1383 individuals with DSM IV alcohol dependence at 11 medical centers were randomized to one of 8 treatment cells, including naltrexone (100 mg/day) alone, acamprosate (3 grams/day) alone, naltrexone plus acamprosate or placebos. All received medical management (MM) with or without addiction-counselor administered Combined Behavioral Intervention (CBI). One final group received CBI without pills. Subjects were evaluated for drinking over a 16-week treatment period and up to a year afterward. The effects of naltrexone, acamprosate, and counseling as well as their interactions were analyzed.

Results: Naltrexone was superior to placebo but mainly in the group receiving MM only with effect sizes of 0.22 for percent days abstinent (PDA) and 0.28 for relapse to heavy drinking. In those receiving MM alone, 58% of placebo-treated versus 74% of naltrexone-treated had a good clinical outcome while of those who received MM with CBI, 71% of placebo-treated versus 74% of naltrexone-treated subjects had a good clinical outcome (interaction of naltrexone by counseling p=0.02). Those receiving CBI without pills compared to those receiving pills had less PDA (0.001), more relapse to heavy drinking (p=0.05) and worse clinical outcome (0.07). Acamprosate showed no significant effects either alone or combined with naltrexone, CBI, or both. Effects were still evident at the one-year follow-up but lost significance.

Conclusion: Results support the efficacy of both naltrexone and, to some extent, CBI therapy. Naltrexone when combined with a Medical Management procedure could be used successfully by various health care professionals, including psychiatrists. The lack of acamprosate effect needs further exploration.

No. 76C
RELATIONSHIP BETWEEN PATIENT ADHERENCE AND TREATMENTS OUTCOMES IN THE COMBINE STUDY

Allen Zweben, D.S.W. *Columbia University, School of Social Work, 1255 Amsterdam Avenue, Rm. 629, New York, NY, 10027*

SUMMARY:

The magnitude of the adherence problems in both pharmacological and behavioral treatment trials has been a source of concern for alcohol researchers. There is now strong evidence suggesting that the likelihood of treatment success can be improved by enabling patients to adhere to a medication and treatment regime. Significant positive relationships have been found between both treatment and medication adherence across a number of treatment outcomes dealing with symptomatic improvement, social functioning and well-being among individuals afflicted with alcohol problems. More specifically, pharmacotherapy can be effective for reducing acute cravings or protracted withdrawal, a necessary ingredient for changing drinking practices only when patients adhere to the prescribed dosage. Similarly, adequate exposure to the behavioral treatment is necessary for patients to improve coping skills, build a supportive environment and sustain a commitment to change, factors associated with good clinical outcomes.

The presentation will examine a number of issues related to medication and treatment adherence and drinking outcomes in the COMBINE Study. The latter was initiated to test combinations of two promising medications, naltrexone and acamprosate, and two behavioral interventions of differing levels of intensity, low intensive medical management and moderately intensive combined behavioral intervention. Patients were randomized to one of eight active or inactive medications and medical management with or without CBI. A ninth group received CBI only (no pills). Patients were evaluated for up to 1 year after treatment.

Predictors will be examined alone and together with the various treatment combinations to determine their impact on adherence. Estimates of effect sizes and hazard ratios will be used to examine the effects of medication and treatment adherence on outcomes across the various treatment combinations while stepwise regression analysis will be used to conduct the predictor analysis. Findings will be presented along with their implications for alcohol treatment and future research.

No. 76D
COST AND COST-EFFECTIVENESS OF THE COMBINE STUDY

Gary Zarkin, Ph.D. *RTI, Behavioral Health Research Division, 3040 Cornwallis Road, Post Office Box 12194, Research Triangle Park, NC, 27709–2194*

SUMMARY:

Context: The COMBINE clinical trial recently evaluated the efficacy of medications, behavioral therapies, and their combinations for the outpatient treatment of alcohol dependence. The costs and cost-effectiveness of these combinations are unknown and of interest to clinicians and policymakers.

Objective: To evaluate the costs and cost-effectiveness of the COMBINE interventions.

Design, Setting and Participants: A prospective cost and cost-effectiveness study of patients in COMBINE, a randomized controlled clinical trial (RCT) with 1383 patients across 11 US academic sites, with diagnoses of primary alcohol dependence. The costing algorithm followed the methodology described in Zarkin et al (2005, JSA); unit prices have been updated to current dollars.

Interventions: Nine treatment arms, with eight arms receiving medical management with naltrexone (100 mg/d) or acamprosate (3 g/d), or both, and/ or placebos, with or without combined behavioral intervention (CBI), and a ninth arm receiving CBI only.

Main Outcomes Measures: Incremental cost per day abstinent and incremental cost per avoided heavy drinking day.

Results: Based on the mean values of cost and effectiveness, 6 of the 9 interventions are dominated (less effective and more expensive) relative to other interventions in the study and not part of the optimal choice set. Incremental cost-effectiveness ratios (ICERs) are calculated for the 3 interventions that are not dominated.

Conclusions: Few RCT-designed cost-effectiveness studies have been performed for the treatment of alcohol dependence and none have evaluated 9 treatment options. The results suggest that pharmacological treatments for alcohol dependence are cost-effective.

No. 76E
PREDICTING DRINKING OUTCOMES IN THE COMBINE STUDY

Dennis M. Donovan, Ph.D. *Univ of Washington, Alcohol & Drug Abuse Institute, 1107 NE 45th Street, Suite 120, Seattle, WA, 98105–4631*

SUMMARY:

Purpose: The presentation examines the prediction of drinking-related outcomes, both over the course of 16-weeks of active treatment phase or over 1-year post-treatment follow-up of alcohol-dependent outpatients who received acamprosate and/or naltrexone, alone or in combination, with or without the addition of cognitive-behavioral therapy.

Methodology: A total of 1383 subjects meeting DSM-IV diagnosis of alcohol dependence were randomized into this double-blind, placebo-controlled clinical trial conducted in 11 academic sites. Participants were assessed at baseline with a battery of measures focusing on physical and medical status, alcohol consumption, severity of dependence, alcohol-related consequences, craving, psychological and psychosocial functioning, readiness to change and self-efficacy. Drinking-related measures were collected across the 16-weeks of treatment and at weeks 26, 52, and 68 post-randomization. Latent class growth curve modeling of longitudinal data will be used to categorize participants with respect to their trajectories on each of three outcome measures (percent of day abstinent, drinks per drinking days, and number of heavy drinking days) collected across the 16-week treatment phase and the 1-year post-treatment follow-up period.

Results: Measures based on the baseline assessment and treatment conditions will be entered into discriminant function analyses for multiple groups to identify those pretreatment characteristics and treatment types that differentiate between groups of participants having different trajectories on the drinking outcome measures (e.g., individuals with no heavy drinking days throughout the assessment period, those with initially multiple heavy drinking days but who demonstrate decrease over time, those with initially few heavy drinking days but who demonstrate an increase over time, and those who show continuous high rates of heavy drinking days across time).

Importance: Identifying personal characteristics and treatment type (s) that are predictive of positive and negative outcomes will inform clinicians of those combinations which, when matched, most likely to lead to positive treatment outcomes.

REFERENCES:

1. Helping Patients Who Drink Too Much: A Clinician's Guide; National Inst. on Alcohol Abuse and Alcoholism, Rockville, MD; 2005.
2. Anton, R. F., et al. (2006) Combined pharmacotherapies and behavioral interventions for alcohol.
3. F. Poldrugo, D-A Haeger, S. Comte, J. Walburg and A. J. Palmer. "A Critical Review of Pharmacoeconomic Studies of Acamprosate." Alcohol and Alcoholism 2005 40(5): 422–430.
4. Anton RF, O'Malley SS, Ciraulo DA, Cisler RA, Couper D, Donovan DM, et al. Combined pharmacotherapies and behavioral interventions for alcohol dependence: the COMBINE study: a randomized controlled trial. JAMA. 2006; 295(17):2003–2017.

SYMPOSIUM 77—DEPRESSION AS INDICATOR AND FOCUS OF TREATMENT IN PRIMARY CARE CLINICS

EDUCATIONAL OBJECTIVES:

At the end of the presentation, participants will be able to identify five required infrastructure elements that lead to successful mental health/primary care integration efforts.

No. 77A
FROM DREAMING TO DOING: ESSENTIAL INFRASTRUCTURE SUPPORTS FOR SUCCESSFUL MENTAL HEALTH/PRIMARY CARE INTEGRATION

Nancy Bryant Wallis (DrPH, LCSW) *Family Health Centers at San Diego, CA*

SUMMARY:

Most Americans seek care for their psychosocial needs from their primary care provider. But are primary care providers and primary care clinics ready, willing and able to meet those needs? Not generally. Similarly, simple co-location of mental health providers at the primary care clinic is not the answer. What is needed is a comprehensive, multi-disciplinary approach to the identification and treatment of mental health concerns. Primary care providers, psychiatrists, therapists and care coordinators are necessary players. Significant organizational and infrastructure support must also be in place to be successful in this integration effort.

No. 77B
ADDRESSING THE BEHAVIORAL HEALTH NEEDS OF THE MEDICALLY UNDERSERVED: INTEGRATING MENTAL HEALTH SERVICES INTO THE PRIMARY CARE SETTING

Nora Cole, M.Ed. *FAmily Health Centers of San Diego, Off-Site Operations, 823 Gateway Center Way, San Diego, CA, 92102*

SUMMARY:

The recent Presidential Commission on Mental Health underscored what has been known for years_mental health services in this country are fragmented; too many have unmet needs; and barriers impede care for those with mental illness. Twenty-eight percent of Americans have a diagnosable mental health and/or addictive disorder, yet less than one-third ever seek treatment.

Nonetheless, millions of primary care patients experience symptoms related to a mental health disorder; 70% of primary care visits have a psychosocial basis; and the majority of Americans receive treatment for mental health conditions from a primary care physician. We also know that the medically underserved are at a higher risk for poor health status and have more unmet mental health needs than the population at large.

Clearly, mental health is an essential component of primary care service delivery. A multidisciplinary approach is utilized at Family Health Centers of San Diego, with routine depression screening, intensive primary care provider health education, case management, monitoring of patient self-management goals, individual psychotherapy and medication management.

No. 77C
DEPRESSION TREATMENT FROM A PRIMARY CARE PHYSICIAN PERSPECTIVE

Paul E. Hubley MD

SUMMARY:

Primary care physicians play a major role in the provision of mental health treatment in this country. In fact, six or seven patients out of ten seeking care in a primary care setting share complaints and symptoms of a psychosocial nature. Experiences with an integrated mentall health/primary care service delivery will be shared focusing on the primary care provider's role, use of the PHQ-9 depression screening tool, examples of the PDSA (Plan/Do/Study/Act) model for care improvement, and patient testimonials.

No. 77D
A PSYCHIATRY PERSPECTIVE ON MENTAL HEALTH/PRIMARY CARE INTEGRATION

Claudio O. Cabrejos *4363 Donald Ave, San Diego, CA, 92117–3812*

SUMMARY:

Psychiatry plays an integral role in any mental health/primary care integration effort. Full potential is reached when the psychiatrist is

viewed and utilized in multiple ways—as teacher, as consultant, as team member and as clinician. Optimal patient health and outcome is much more likely when the patient's physical health needs are addressed in concert with their mental health concerns.

REFERENCES:

1. New Freedom Commission on Mental Health: Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS pub no SMA-03-3832. Rockville, Md, Department of Health and Human Resources, 2003.
2. Dobscha SK, Ganzini L. A program for teaching psychiatric residents to provide integrated psychiatric and primary medical care. Psychiatr Serv. 2001 Dec;52(12):1651–3.
3. Kirkcaldy RD, Tynes LL: Best Practices: Depression Screening in a VA Primary Care Clinic. Psychiatr Serv, Dec 2006; 57: 1694–1696.
4. Joo JH, Solano FX, Mulsant BH, Reynolds CF, Lenze EJ: Predictors of Adequacy of Depression Management in the Primary Care Setting Psychiatr Serv, Dec 2005; 56: 1524–1528.

SYMPOSIUM 78—THE PSYCHOPATHOLOGY OF PERSONALITY: PERSPECTIVES FROM THE COLLABORATIVE LONGITUDINAL PERSONALITY DISORDERS STUDY (CLPS)

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will understand how longitudinal data are changing our conceptualizations of personality disorders and highlighting their clinical significance.

No. 78A
LONGITUDINAL COURSE AND VALIDITY OF SCHIZOTYPAL PERSONALITY DISORDER.

Thomas H. Mc Glashan, M.D. *Yale University School of Medicine, Psychiatry, 301 Cedar St., New Haven, CT, 06519*

SUMMARY:

Purpose: Questions have arisen whether Schizotypal Personality Disorder (STPD) belongs on Axis 2 as a personality disorder or on Axis 1 as part of the schizophrenia spectrum of disorders1. Longitudinal follow-along of reliably identified STPD persons from the Collaborative Longitudinal Personality Study (CLPS2) can help to answer this question insofar as the long-term profile of STPD conforms more to an Axis 1 or to an Axis 2 trajectory.

Methods: The CLPS sample (N=668) of 4 PDs (Borderline, Avoidant, Obsessive Compulsive, and Schizotypal PD, N=96) and Axis 1 Major Depressive Disorder have been followed up to six years with blind biennial and non-blind monthly assessments.

Results: Using a stringent definition of remission (at least 12 months with no more than 2 criteria present) the cumulative probability of STPD remission was high at 69% at 6 years. This remission rate was comparable with the other PDs but significantly less than the remission rate for MDD over the same time. STPD was different from the other PDs in being more likely to remit in the younger (18–24) age range versus later, and remitted patients were much less likely to relapse by 6 years (2% of STPD vs 15% of BPD, 33% of AVPD, and 27% of OCPD). Also unlike the other PDs, STPD patients were more likely to develop Psychotic Disorder NOS, Schizophrenia, and Schizoaffective Disorder after baseline.

Conclusion: The long-term course of STPD suggests that it is both related to the schizophrenia spectrum but also demonstrates a longitudinal profile consistent with other Axis 2 PDs.

No. 78B
LIFE EVENTS AND RELAPSE IN PERSONALITY DISORDERS

M. Tracie Shea, R.Ph. *Brown University Medical School, Psychiatry and Human Behavior, 700 Butler Drive, Butler Hospital Box G-BH, Providence, RI, 02906*, John G. Gunderson, Shirley Yen, Psy.D., Robert L. Stout, Ph.D.

SUMMARY:

Background: Given the findings from multiple studies that the course of personality disorders is less stable than previously believed, understanding the factors that influence course changes becomes increasingly salient. Life events represent a logical factor to examine. Several studies have shown higher frequency of negative life events in personality disorders (PDs), and findings from the Collaborative Longitudinal Study of Personality Disorders (CLPS) have shown a negative impact of such events in terms of functioning and suicide attempts. This presentation will report on associations between life events and subsequent relapse in individuals who have remitted from a PD.

Method: An initial sample of 573 individuals with one or more of the 4 PDs (Schizotypal, Borderline, Avoidant, Obsessive-Compulsive) studies in the CLPS has been assessed at 6 month then yearly intervals. Follow-up data include monthly ratings of PD criteria and a range of positive and negative life events including dates of occurrence. Proportional hazards regression analyses are used to examine the relative risk of relapse in the month following the occurrence of specific categories of life events.

Results: Preliminary analyses show a highly significant association between negative life events involving love or relationships and subsequent relapse for remitted BPDs. Life events appear to have little or no impact on relapse for the other PDs studied.

Conclusions: Negative life events of an interpersonal nature may be an important signal for worsening course for BPD individuals previously doing well.

No. 78C
CLINICAL COURSE AND IMPACT OF AVOIDANT PERSONALITY DISORDER

Andrew E. Skodol, M.D. *New York State Psychiatric Institute, Personality Studies, 1051 Riverside Drive, Box 129, New York, NY, 10032*, Donna S. Bender, Ph.D., Maria E. Pagano, Ph.D.

SUMMARY:

Avoidant personality disorder (AVPD) has resided in the DSM for more than 25 years, but questions remain about the clinical significance of AVPD and its relationship to social phobia. In this presentation, findings on the course and impact of AVPD from the first six years of follow-up in the CLPS will be reviewed.

At intake, 158 patients with AVPD were recruited. The course of symptoms and psychosocial functioning, treatment received, and factors affecting clinical course have been evaluated in annual interviews.

At baseline and 2-year follow-up, functional impairment in patients with AVPD was less severe than that associated with borderline and schizotypal personality disorders, but was more pronounced than difficulties experienced by patients with obsessive-compulsive PD or MDD without PD. However, patients with AVPD were not more likely to report lifetime or prospectively assessed psychosocial or psychopharmacological treatment than patients with MDD.

By year 4, 55.1% of AVPD patients showed a clinically significant remission of symptoms. Improvement was associated with improvement in co-occurring anxiety disorders, especially social phobia, but the effects were bi-directional. In contrast, change in FFM personality traits, such as self-consciousness and shyness, predicted change in

AVPD; the reverse was not true. Despite reporting poorer athletic performance, less involvement in hobbies, and less popularity during childhood or adolescence than patients with MDD or other PDs, patients with AVPD who reported more achievements and more positive relationships with others were more likely to remit.

These findings suggest that AVPD is a clinically significant disorder related to anxious/inhibited personality traits and to Axis I anxiety disorders. The course of AVPD may be better than expected, consistent with a hybrid model of PDs comprised of more stable personality traits and less stable symptomatic behaviors. A subgroup of those diagnosed with AVPD, with fundamentally better interpersonal skills, may improve significantly over time.

No. 78D
A MULTIDIMENSIONAL MODEL OF OBSESSIVE-COMPULSIVE PERSONALITY DISORDER

Anthony Pinto, Ph.D. *Brown Medical School, Psychiatry and Human Behavior, 345 Blackstone Boulevard, Butler Hospital, Providence, RI, 02906*, Emily Ansell, Ph.D., Carlos M. Grilo, Ph.D., M. Tracie Shea, Ph.D.

SUMMARY:

Despite being relatively common, obsessive-compulsive personality disorder is vastly understudied and poorly understood. Research on the structure and validity of the OCPD construct is especially needed now, considering the substantial revisions to the disorder in DSM-IV and the impending DSM-V. The purpose of this study is to identify and initially validate core dimensions of OCPD. Treatment-seeking individuals (N=629; age 18–45) were evaluated as part of a multisite prospective study of the longitudinal course of personality disorders. To be included, participants had to meet full criteria for at least one of four representative personality disorders (schizotypal, borderline, avoidant, obsessive-compulsive) on the Diagnostic Interview for DSM-IV Personality Disorders (DIPD-IV). Intake DIPD-IV ratings for the eight OCPD criteria were randomly separated into two samples which were subjected to exploratory and confirmatory factor analyses. A principal components analysis on the first half (N=310) yielded a two-factor solution. Confirmatory factor analysis on the second half (N=319) compared the two-factor solution to a three-factor model previously identified by Grilo et al. (2004) in a binge eating sample. Fit indices (IFI=.984, TLI=.973, CFI=.984, RMSEA=.037) support the utilization of the three factors: rigidity, perfectionism, and miserliness. At intake, the factors demonstrated unique and clinically meaningful associations with established trait models (NEO, SNAP). Individuals with high scores on rigidity were more likely to be disagreeable, aggressive, and experience feelings of entitlement, while those high on perfectionism were less likely to be disinhibited. Follow-up data on participant functioning will be used to describe the adaptive and maladaptive effects of the identified dimensions. This study is the largest, and only the second, attempt to factor analyze DSM-IV OCPD criteria. Unlike the prior attempt, the current sample is diagnostically diverse and derived from four clinical sites. The proposed factors represent distinct interpersonal, intrapersonal (cognitive), and behavioral features of OCPD.

No. 78E
NEW EPISODES AND NEW ONSETS OF MAJOR DEPRESSION IN BORDERLINE AND OTHER PERSONALITY DISORDERS

John G. Gunderson, M.D. *McLean Hospital, Psychosocial Research, 115 Mill St, Belmont, MA, 02478–1041*

SUMMARY:

This paper uses longitudinal data to describe the frequency that patients with personality disorders (PD) have: a) new *onsets* of major depressive disorder (MDD) (for PD patients without lifetime MDD), or, b) new *episodes* (for PD patients with lifetime histories of MDD). We then examine whether having borderline personality disorder (BPD) confers added risk for new *onsets* or *episodes* compared to patients with other personality disorders (OPD).

To do this, six year follow up assessments with reliable repeated measures were conducted on PD criteria and on the presence and severity of MDD in a sample of 217 patients. The occurrence of new *onsets* or new *episodes* were calculated with life table analyses. The 56 patients with BPD were then compared to 161 patients with OPD. We also examined whether number or type of BPD criteria (controlling for GAF, age, or gender) are related to their new *onsets* or *episodes*.

We found that a remarkable 95% of the PD subjects had new *episodes* or new *onsets* of MDD in the six year period — contrasting with the normal lifetime prevalence of 15%. Surprisingly, the presence of lifetime MDD did not confer greater risk for new *episodes*. BPD subjects without MDD were not significantly more likely to have new *onsets* of MDD (88%) than were OPD subjects without MDD (97%).

These results suggest that having a personality disorder confers significant risk for episodes of MDD. BPD does not appear to increase this risk.

REFERENCES:

1. Yen S, Pagano ME, Shea MT et al. Recent life events preceding suicide attempts in a peersonality disorder sample: findings from the collaborative longitudinal personality disorders study. J of Consult and Clinical Psychol 2005; 73:99–105.
2. Shea MT, Stout RL, Yen S, Pagano ME, Skodol AE, Morey LC, et al: Associations in the course of personality disorders and axis I disorders over time. J Abnorm Psychol 2004; 113:499–508.
3. Grilo CM: Factor structure of DSM-IV criteria for obsessive compulsive personality disorder in patients with binge eating disorder. Acta Psychiatr Scand 2004;109:64–69.
4. Gunderson JG, Morey LC, Stout RL, et al: Major depressive disorder and borderline personality disorder revisited: longitudinal interactions. J Clin Psychiatry, 2004; 65(8): 1049–1056.

SYMPOSIUM 79—EXPANDING NEW YORK STATE PRISON PSYCHIATRY

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to describe a) the evolution of programs for violent prisoners posing very provocative challenges, such as multiple, almost lethal suicide gestures, unhygienic acts, assaultive behavior, etc., b) special program needs assessments, c) special programs developed and proposed, d) outcome so far for prisoners placed in programs instead of SHU.

No. 79A
PRISON PSYCHIATRIC CARE: ACCESS, PARITY AND HUMANE CARE

Zebulon C. Taintor, M.D., *NYU School of Medicine, Psychiatry, Orangeburg, NY, 10962*

SUMMARY:

This year's APA meeting themes, applied to prison mental health care, provide a mirror view that is a reverse image of society at large.

Access: Many US citizens are uninsured or underinsured. Often managed care companies delay, reduce, or deny care. Prisoners are assessed for care and treatment without regard to insurance coverage. The guiding force is simply medical necessity. Medical departments often provide treatment for HIV infections, Hepatitis C, various surgeries, blood testing for those allergic to PPD testing, etc., that recipients would not get otherwise. Psychiatric treatment also offers wide access in that the entire population is screened and referrals made. Corrections staff make referrals. Self referrals are allowed. Treatment is available from multidisciplinary treatment teams consisting of psychiatrists, psychologists, social workers and nurses. All medications are available, with no restrictions on more recently developed antipsychotic medications.

Parity: There is no provider discrimination against providing psychiatric services, which generally are welcomed. There are no restrictions on the number of visits; instead a minimum number is guaranteed as long as the patient is in active treatment. One measure of parity is provided by accrediting organizations. New York's system of prison care is JCAHO accredited, so far, the only such program in the nation. Barriers to treatment remain, however, based on denial, stigma, and variable motivation, especially for substance abuse.

Humane Care: While the punitive dimension of prisons may make the concept of humane care seem oxymoronic, other aspects of the correctional system promote it. There are many educational, occupational, and rehabilitation programs. Reduced census, improved training and professionalization have reduced staff abuse. Humane care for those in Special Housing Units, the subject of law suits and legislation, is the biggest area of recent change.

It is a sad irony that committing a crime may improve one's care.

No. 79B
FORENSIC MENTAL HEALTH TRIAGE & ADMISSION SERVICES: THE OPERATIONS OF THE NYS-OMH FORENSIC DIAGNOSTIC UNIT WITHIN A MAXIMUM SECURITY CORRECTIONAL ENVIRONMENT

Michael J. Hill, M.S. Ed., *Central New York Psychiatric Center, Forensic Diagnostic Unit, Downstate Correctional Facility, Red Schoolhouse Road, Fishkill, NY 12524*

SUMMARY:

With an inmate census of approximately 63,000, New York State (NYS) operates the third largest State Correctional System in the Country (behind California and Texas respectively). Each year, over 25,000 men and women enter the system as New Commitments or Parole Violators. As a part of the reception and classification process, inmates are screened regarding their potential need for mental health services during their incarceration.

Central New York Psychiatric Center (CNYPC) provides psychiatric services to sentenced inmates in both inpatient (hospital) and outpatient (prison based) settings. CNYPC consists of a 197-bed inpatient facility located in Marcy, NY and 24 Outpatient Units located at various correctional facilities throughout NYS. Downstate Correctional Facility, located in Fishkill, NY, is the primary maximum-security reception and classification facility operated by the NYS Department of Correctional Services. Each year Downstate CF will receive approximately 10,000 men for reception & classification purposes. Downstate CF is specifically designed to receive inmates who are initially classified as either maximum security &/or requiring comprehensive physical or mental health assessment.

In CY 2006, of the 11,059 inmates received at Downstate, over 7,000 were screened as being "at risk" for needing mental health services. Of the approximate 7,000 inmates identified "at risk," 4,397 participated in a face-to-face clinical interview with an Office of Mental Health clinician. As a result, 3,200 patients were admitted to service. While this number represents a relatively high percentage of mentally ill inmates entering our system, as compared to national data, the NYS Correctional system has established pre-screening procedures, in the County Jails, which intentionally direct "at risk" individuals to Downstate for reception and mental health assessment.

The OMH/CNYPC Forensic Diagnostic Unit at Downstate has 3 major functions:

1. To identify and evaluate those inmates potentially in need of mental health services,
2. To provide mental health services to identified inmates while residing at Downstate CF, and
3. To provide DOCS classification personnel with direction regarding the future placement of inmates requiring mental health services during their period of incarceration.

The presentation will reflect data relative to decision-making, diagnostics and the provision of treatment to this high acuity and challenging population.

No. 79C
THERAPY, ADVOCACY, AND STAFF BURNOUT

Al Shimkunas, Ph.D.

SUMMARY:

Treatment of psychiatric problems in prison comes with that challenge to clinicians to manage advocacy demands by inmate patients in order to permit therapeutic focus, and to prevent burnout among clinical staff.

Advocacy: A distinction between appropriate and inappropriate forms of advocacy informs clinicians of role boundaries that are necessary in providing therapy in correctional settings. Appropriate advocacy reflects both system and individual therapist efforts to enhance treatment options and improve patient compliance in accepting treatment. Inappropriate advocacy includes therapist responses to patient demands for case management of prison housing issues, opinions regarding patient guilt or innocence in institutional misbehavior, focusing on patient complaints about institutional policies and conditions.

Therapeutic Focus: Inmate patients bring numerous complaints concerning their personal circumstances to clinical staff under the guise of mental health problems. It is essential for therapists to monitor their therapeutic interventions to focus on behavioral and affective process, and avoid the impasse of responding to patients' unending requests for advocacy concerning personal circumstances. The key to therapist integrity in prison psychiatric services is to focus on process vs. content of the patients' complaints. Therapist neutrality is embodied in Johansen's distinction of the therapeutic vs. administrative role in treatment. The therapist's focus on the process of patient complaints is limited to the sources of psychopathology, realigning cognitive distortions, and providing strategies for overcoming self-defeating behavior. Content of patient complaints about institutional life are minimized and therapy can succeed.

Burnout: Therapist inability to distinguish between process and content of patient complaints increases the risk of inappropriate advocacy efforts, which facilitate the potential for therapist burnout. Limiting burnout potential relies on the ability to consistently maintain detached concern. Confusion of roles of therapist and administrator/case manager reduces therapist detachment and fosters burnout.

No. 79D
INMATES WITH SERIOUS MENTAL ILLNESS AND SIGNIFICANT DISCIPLINARY ISSUES

Bruce B. Way, Ph.D. *Central New York Psychiatric Center, Box 300, Marcy, NY, 13403*

SUMMARY:

Inmates with serious mental illness are more likely to violate prison rules, and therefore, to find themselves in disciplinary segregated housing. Although courts have become involving in monitoring, no state has prohibited the placement of the mentally ill in these disciplinary settings. The treatment of inmates with serious mental illness and significant disciplinary issues remains important.

Central NY Psychiatric Center (CNYPC) has several new initiatives to improve the treatment of these patients.

Special Treatment Programs (STP) for the seriously mentally ill were implemented at Attica and Five Points Correctional Facilities. The two programs provide two hours of out-of-cell treatment each weekday. Programs include symptom management, anger management, use and purposes of psychiatric medication, relaxation, and coping strategies.

Based on data from approximately the first 50 participants, both STP programs are serving patients with serious mental health and disciplinary histories. At STP program termination there were significant reductions in use of mental health crisis services, improvements in psychiatric functioning, and reductions in disciplinary infractions. At 6 months post program about 40% were maintaining improvements. Post-program follow-up data collection is underway. STP program will be expanded in 2007.

Behavioral Health Units for former SHU patients with antisocial personality disorder were implemented at Great Meadow and Sullivan Correctional Facilities. The BHU provides 2 or 4 hours of treatment per day. Preliminary outcomes will be presented.

Admististratively, CNYPC and Department of Corrections Services (DOCS) have committees at each maximum-security prison that meet bi-weekly to review the progress of STP/BHU participants, and other active mental health patients in SHU.

CNYPC is developing a new measuring scale of psychiatric functioning that may assist in determining which patients can and can not stay in segregated housing.

No. 79E
EVOLUTION OF NYS CIVIL COMMITMENT FOR SEX OFFENDERS

Bezalel Wurzberger, M.D. *New York State, Office of Mental Health, Central New York Psychiatric Center, 12 Rusfield Drive, Glenmont, NY, 12077*

SUMMARY:

Abstract: While other states were enacting laws to arrange for confinement and aftercare of sex offenders who had served their prison terms, New York State was unable to reach a consensus. The NYS Senate passed a bill annually for six years; the Assembly did not. Governor George Pataki forced the issue by asking the Office of Mental Health to apply the existing Mental Hygiene Law, which allows the involuntary hospitalization of people who are likely to be of harm to themselves or others.

Since 1994, New York appellate courts have handed down decisions which have clarified the concept of dangerousness for the purposes of mental health commitments. Beginning with Matter of Larry Hogue in 1993), the Appellate Division found that a patient's almost 30-year history of mental illness, noncompliance with treatment upon release and dangerous behavior could be factored into a decision to involuntarily retain that patient, despite improvement in a structured setting. Other cases affirmed that opinions concerning dangerousness should be based upon a variety of factors, including the person's history of dangerous conduct and the environment to which the person will move. Level 3 sex offenders about to be released were evaluated on three risk assessment measures (Static-99, MnSOST-R, and RRASOR) and interviewed by two board-certified psychiatrists. The commitment rate (17.6%) is consistent with those in other states and almost always is based on diagnoses (e.g., delusional disorder). other than one specifically related to sex offenses, Nonetheless, New York needs a statute for definitions and regulations, and a clear statement of the political will of its citizens. This paper will discuss the many controversial issues that remain unresolved: length of sentences, treatment prior to release from prison,treatment modalities, different approaches in proposed legislation, community care and follow up, etc.

REFERENCES:

1. Metzner, J.L. (1998). An introduction to correctional psychiatry: Part III. Journal of American Academy of Psychiatry and the Law, 26, 107–115.
2. Bruce J. Winick, JD, and John Q. La Fond, JD (eds) (2003): Protecting Society from Sexually Dangerous Offenders: Law, Justice, and Therapy, 372 pages, American Psychological Association, Washington, DC.
3. Wack, R. C. (1993). Treatment services at Kirby forensic psychiatric center. Internat. J. Law & Psychiatry 16: 83–104
4. Johansen, K.H. (1980) Separation of therapist and administrator in hospital treatment of borderline patients. Hospital and Community Psychiatry, 31, 259–262

SYMPOSIUM 80—NEURAL CORRELATES OF PSYCHODYNAMIC CONSTRUCTS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will be able to describe and understand constructs such as defense mechanisms, the formation of object-repesentations, and mentalization are associated with activity in particular neural networks.

No. 80A
NEURAL CORRELATES OF PSYCHODYNAMIC CONSTRUCTS

Georg Northoff *University of Magdeburg, Clinic for Psychiatry, Psychotherapy, Leipziger Strasse 44, Magdeburg, D-39120, Germany*

SUMMARY:

Current progress in the cognitive and affective neurosciences is constantly influencing the development of psychoanalytic theory and practice. However, despite the emerging dialogue between neuroscience and psychoanalysis, the neuronal processes underlying psychoanalytic constructs such as defense mechanisms remain unclear. One of the main problems in investigating the psychodynamic-neuronal relationship consists in systematically linking the individual contents of first-person subjective experience to third-person observation of neuronal states. We therefore introduced an appropriate methodological strategy, 'firstperson neuroscience', which aims at developing methods for systematically linking first- and third-person data. The utility of first-person neuroscience can be demonstrated by the example of the defense mechanism of sensorimotor regression as paradigmatically observed in catatonia. Combined psychodynamic and imaging studies suggest that sensorimotor regression might be associated with dysfunction in the neural network including the orbitofrontal, the medial prefrontal and the premotor cortexes. In general sensorimotor regression and other defense mechanisms are psychoanalytic constructs that are hypothesized to be complex emotional-cognitive constellations. In this paper we suggest that specific functional mechanisms which integrate neuronal activity across several brain regions (i.e. neuronal integration) are the physiological substrates of defense mechanisms. We conclude that first-person neuroscience could be an appropriate methodological strategy for opening the door to a better understanding of the neuronal processes of defense mechanisms and their modulation in psychoanalytic psychotherapy.

No. 80B
NEURAL CORRELATES OF COGNITIVE REAPPRAISAL IN BORDERLINE PERSONALITY DISORDER

Harold W. Koenigsberg, M.D. *Mount Sinai School of Medicine, Department of Psychiatry, Bronx VAMC, 130 West Kingsbridge Road, 116A, Bronx, NY, 10468*, Jin Fan, Ph.D., Kevin Ochsner, Ph.D., Scott Pizzarello, Antonia S. New, M.Div., Marianne S. Goodman, M.D., Larry J. Siever, M.Ed.

SUMMARY:

Affective instability is a hallmark feature of borderline personality disorder (BPD) that contributes to the extremes of depression and anger, tumultuous interpersonal relationships, identity disturbances and suicidality in borderline patients. One possible source of affective instability in BPD could be a decrease in the capacity to mobilize the emotion regulation networks employed by healthy individuals to control their emotional reactions. We compared regional brain activity in BPD patients and healthy volunteers (HC's) as they used a cognitive reappraisal strategy to attempt to reduce their emotional reactions to negative pictures selected from the International Affective Pictures System (IAPS). fMRI images were obtained at 3.0 T as BPD patients and age and sex matched HC's followed an instruction to either "maintain" or "suppress" their emotional reactions to negative IAPS pictures. Behavioral data demonstrated that both groups rated their emotional reactions as less negative to the pictures seen in the suppress condition than in the maintain condition, but that the difference was smaller for the BPD patients. We compared BOLD activation in the suppress vs. maintain condition. The BPD patients showed less of a difference (suppress – maintain) in activation compared to the HC's in the dorsal anterior cingulate cortex ($p<.01$), the pregenual anterior cingulate cortex ($p<.05$), and the intraparietal sulci ($p<.05$), and a trend for decreased activation in the tempero-parietal junction, and greater activation bilaterally in the striatum ($p<.01$). These findings suggest that BPD patients do not activate brain networks implicated in regulation of mood and control of attention as strongly as healthy volunteers when trying to suppress emotional reactions to negative pictures. In addition BPD patients activate striatal areas that may be involved in preparation for motor action more strongly than HC's. These findings will be discussed in terms of their relationship to characteristic defensive operations in borderline personality disorder.

No. 80C
BRAIN-BEHAVIOR RELATIONSHIP IN THE PROCESS OF ESTABLISHING A TRUSTING RELATIONSHIP IN INDIVIDUALS WITH A DIAGNOSIS OF BORDERLINE PERSONALITY DISORDER (BPD).

Peter Fonagy, Ph.D. *University College London, Clinical Health Psychology, Gower Street, London, WC1E 6BT, United Kingdom*, Brooks King-Casas, Ph.D., Carla Sharp, Ph.D., Laura Lomax, Ph.D., Read P. Montague, Jr., Ph.D.

SUMMARY:

The tools of neuroscience have only recently begun to probe the types of complex social interactions (e.g. cooperation, inequity, and social rejection) that are dysfunctional among individuals with borderline personality disorder (BPD). Our study focused on social exchanges of trust, as difficulties with trust and mistrust are frequently reported as triggers for aggressive reactions, feelings of impending abandonment, and disillusionment with others among individuals with BPD. In the 10 round Trust game, the investor (always healthy), invests money with the other player, the trustee, (BPD or healthy control). The money invested is multiplied by 3 and the trustee then decides how much to repay to the investor. We have comprehensively assessed and tested 30 female right handed and unmedicated patients aged 18–35 years.

On the basis of clinically observed predisposition to interpersonal hypersensitivity, we anticipated and found that small decreases in repayment ratios to an individual with BPD (getting less back from the trustee on round n than on the round n-1) resulted in larger decreases in future investments (or repayment) by an individual with BPD than a non-psychiatric control. Secondly, on the basis of experimental and clinical observations of a 'mentalization' deficit in BPD patients, we anticipated that patients will respond without adequately considering the impact of their reactions on their partner and thus will more frequently elicit catastrophic collapse of trust. We commonly found that, mutually increasing defections of the BPD dyads. We found evidence that these dysfunctional behaviors were associated with between group differences in the activation of a network of cortical structures previously associated with social cognition including medial PFC, OFC, anterior and middle cingulate, as well as limbic structures associated with negative affectivity. In general the study supported our assumptions of dysfunctional mentalization as part of the problem presented by patients with a BPD diagnosis.

No. 80D
NEUROIMAGING OF THE ROLE OF THE SELF AND IDENTIFICATION IN EMOTION REGULATION

Philippe Fossati, M.D. *Salpetriere Hospital, Department of Psychiatry, 47 Boulevard de l'Hopital, Paris, 75651 Paris Cedex, France*

SUMMARY:

Several neuroimaging studies have emphasized the role of the medial prefrontal cortex (mpfc) in self referential processing. Moreover the mpfc is also activated when subjects adopt the perspective of other people and process social stimuli.Ventral medial prefrontal cortex could be more involved in the processing of 'similar' other whereas the dorsomedial prefrontal cortex could be involved in the processing of 'dissimilar' other. We would suggest that the medial prefrontal cortex may subserve 'identification processes' and may represent one possible area for 'the shared representations between self and other' described in social psychology. During this talk we will present data supporting this hypothesis and discuss the limits of these data and the consequences for understanding the neural bases of psychotherapy.

REFERENCES:

1. Psychother psychosom 2006; 986: DOI: 10.1159.
2. Ochsner, K. N., R. D. Ray, J. C. Cooper, E. R. Robertson, S. Chopra, J. D. Gabrieli and J. J. Gross (2004).
3. Bateman, A. W., & Fonagy, P. (2006). Mentalization based treatment for borderline personality disorder: A practical guide. Oxford: Oxford University Press.
4. Fossati, P., Hevenor, S., Graham, S., Grady, C., Keightley, M., Craik, F.I.M., Mayberg, H. In search of the emotional self. A fMRI study with positive and negative emotional words. Am J Psychiatry,2003, 160, 1938–1945.

SYMPOSIUM 81—ADDRESSING PATIENT'S NEEDS: PATIENT CENTERED DIAGNOSIS

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to appreciate that the emergence of the phenomenon of "psychiatric comorbidity" has been to a large extent a by-product of some charac-

teristics of our current diagnostic systems, and that splitting artificially a complex clinical condition into several "pieces" may prevent a holistic approach to the individual patient, encouraging unwarranted polypharmacy.

No. 81A
RECORDING MULTIPLE PSYCHIATRIC DIAGNOSES IN AN INDIVIDUAL PATIENT: DOES IT LEAD TO A MORE COMPREHENSIVE AND TARGETED APPROACH TO TREATMENT?

Mario Maj, M.D. *University of Naples SUN, Department of Psychiatry, Largo Madonna delle Grazie, Naples, 80138, Italy*

SUMMARY:

The emergence of the phenomenon of "psychiatric comorbidity" has been to a large extent a by-product of some characteristics of our current diagnostic systems, such as "the rule laid down in the construction of DSM-III that the same symptoms could not appear in more than one disorder", the proliferation of diagnostic categories, the limited number of hierarchical rules, and the fact itself that the current systems are based on operational diagnostic criteria, which may be less able than traditional clinical descriptions to convey the "gestalt" of some diagnostic entities. Currently available research evidence suggests that psychiatrists tend not to record all the diagnoses that a given individual fulfils. Especially in very busy practices and in developing countries, only one diagnosis is usually made. The "piece" of the clinical picture which is actually recorded may not be the same when a given patient is seen by different psychiatrists, which represents a new powerful source of diagnostic unreliability. Available research does not document that the possibility to record multiple psychiatric diagnoses implies a more comprehensive and targeted approach to treatment. Splitting artificially a complex clinical condition into several "pieces" may prevent a holistic approach to the individual patient, encouraging unwarranted polypharmacy (one drug for each diagnosed disorder). If each of the concomitant "disorders" had its own specific pathophysiological correlates, it would be logical to use a different medication for each of them. But, are we sure that the "panic" of patients with agoraphobia, major depression and schizophrenia is exactly the same "entity", which simply "co-occurs" with the others, thus requiring an independent treatment that is the same in agoraphobic, depressed and psychotic patients? I am not aware of any empirical study dealing with this issue.

No. 81B
BIOPSYCHOSOCIAL THINKING: FRIEND OR FOE?

G. Scott Waterman, M.D. *University of Vermont College of Medicine, Department of Psychiatry, 89 Beaumont Avenue, Given E215, Office of Student Affairs, Burlington, VT, 05405*

SUMMARY:

It is axiomatic in medicine that optimal patient management is predicated on accurate diagnosis. 'Diagnosis' here refers not only to the conclusion that one or more named disease entities are present. It implies more broadly an understanding of the elements of and contributors to a patient's illness. Formulating valid and useful diagnoses is, however, frequently difficult. Inadequate data about patients' histories, heterogeneity of their clinical presentations, and indistinct boundaries among diagnostic entities are all common impediments. Equally important contributors or impediments to the diagnostic process, however, are the conceptual frameworks with which clinicians approach their work. In psychiatry – and, to a significant if less explicit extent in the rest of medicine – the biopsychosocial model (BPSM) continues to represent a near-consensus conceptual scheme that organizes the process of diagnosis. Does it aid or hinder our efforts at understanding our patients' illnesses?

I will approach this question from both within and outside the conventional boundaries of psychiatry. Within psychiatry I will subject to scrutiny the fundamental assertion of the BPSM that psychopathologies result from summations or interactions of biological, psychological and social influences and are best managed with combinations of biological, psychological and social therapies. In general medicine the mind-body dualism that I will argue is inherent in biopsychosocial thinking leads physicians to conceptualize health-relevant behaviors such as smoking, exercise, and eating as determinants rather than as manifestations of health and/or disease. The consequences of that distinction for patient care will be explored. Finally, an alternative conceptual model will be proposed and its implications for patient care will be compared with those of the BPSM.

No. 81C
THERAPEUTIC DIAGNOSING

Roger Peele *413 King Farm Blvd Apt 401, Rockville, MD, 20850–6680*

SUMMARY:

All five to the DSMs, beginning in 1952, have stressed the importance of a diagnostic system that has reliability, especially DSM-III, IIIR and IV. What would a diagnostic system look like that stress therapeutics?

There are two basic approaches to therapeutic diagnosing, those based on empirical results and those based the many concepts used in psychiatry.

An empirical approach is based on the efficaciousness of medications and psychotherapies. These efficaciousness are not tied to DSM-IV diagnostic entities in clinical practice. While the research world stays close to DSM-IV diagnostic criteria, in the clinical work, positive therapeutic results are not tied to the way DSM-IV has carved up psychopathology. Empirically, many therapeutics focus or signs or have a broad use that exceed specific DSM-IV categories.

All of the key conceptual frameworks used in American psychiatry have a framework that does not coincide with the way DSM-IV has carved up psychopathology. CBT, psychoanalysis, and interpersonal psychotherapy each have diagnostic system that are different from DSM-IV. While biological concepts in 2007 seem a step or two away from becoming a diagnostic system, there is no suggestion that a diagnostic system based on receptor sites, neurotransmitters, neuroimaging, or genetics will resemble DSM-IV.

No. 81D
PATIENT CENTERED PRACTICE GUIDELINES: THE CHALLENGE

John S. McIntyre *Unity Health Systems, 81 Lake Ave Fl 3, Rochester, NY, 14608–1410*

SUMMARY:

REFERENCES:

1. Maj M: "Psychiatric comorbidity:" an artefact of current diagnostic systems? (Editorial). Br J Psychiatry 2005; 186:182–184.
2. Goodman A: Organic unity theory: the mind-body problem revisited. Am J Psychiatry 1991; 148:553–563.
3. First MB, Pincus HA, Levine JB, Williams JB, Ustun B, Peele R. Clinical utility as a criterion for revising psychiatric diagnoses. Am J Psychiatry. 2004 Jun;161(6):946–54.
4. McIntyre JS. Usefulness and limitations of treatment guidelines in psychiatry. World Psychiatry. 2002 Oct;1(3):186–9.

SYMPOSIUM 82—OPTIMUM TREATMENT DURATION IN EARLY PSYCHOSIS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to know about current options for treating persons at risk of schizophrenia in the prodromal stage of the disorders and for treating first episode schizophrenia patients. Special regard is paid to the necessary duration of treatment.

No. 82A
EARLY INTERVENTION IN THE INITIAL PRODROMAL PHASE: RESULTS FROM THE GERMAN RESEARCH NETWORK ON SCHIZOPHRENIA

Joachim Klosterkötter *University of Cologne, Department of Psychiatry, Kerpener Str. 62, Cologne, D-50924, Germany*, Andreas Bechdolf, M.D., Andreas Bechdolf, M.D., Stephan Ruhrmann, M.D.

SUMMARY:

Objective: To determine whether a differential state specific intervention in the initial prodromal state is effective for preventing progression to psychosis

Method: 128 patients in the early initial prodromal state (EIPS) were randomized to receive either a comprehensive cognitive behavior therapy (CBT) intervention or supportive counseling (SC) for 12 months. 124 patients in a putatively late initial prodromal state (LIPS) were randomly assigned to a needs-focused intervention (NFI) or to NFI plus amisulpride.

Results: In the EIPS trial Kaplan-Meier estimates of the risks of transitions to LIPS (5.3 % vs. 18.5 %, p=0.032), psychosis (1.6 % vs. 13.8%, p=0.020) and schizophrenia (none vs. 13.8 %, p=0.005) at month 12 were statistically significant lower in the CBT group than in the SC group. In the LIPS trial Amisulpride+NFI produced superior effects to NFI alone on attenuated and full-blown psychotic symptoms, basic, depressive and negative symptoms and global functioning at week 12.

Conclusion: First results indicate that a differential intervention to the initial prodromal state is effective for preventing progression to psychosis.

No. 82B
INTERVENTION IN ULTRA-HIGH RISK PATIENTS – THE PACE EXPERIENCE

Patrick D. McGorry, M.D. *University of Melbourne, Department of Psychiatry, Locked Bag 10, 35 Poplar Road, Parkville, Victoria, 3052, Australia*

SUMMARY:

Psychotic disorders, particularly non-affective psychoses, are typically characterised by an often prolonged period of increasing distress and functional impairment prior to the emergence of full threshold clinical features which demand clinical care and allow a diagnosis of schizophrenia or other psychotic disorder. This period in retrospect clearly involves a need for care, yet to provide it prospectively necessarily involves drawing in patients, also with a current need for care, yet who turn out to be false positives for psychotic disorder (even though they nearly all have another diagnosis). This has created controversy not only about the content of treatment but even about whether it should be provided (and more particularly funded). In the past decade, substantial research has been carried out highlighting the many practical, ethical and financial issues that need to be addressed if this type of early diagnosis is to become feasible. Most but not all of the dilemmas have been tackled in developing early diagnosis in serious medical illnesses such as cancer, and these will be outlined. Evidence-based clinical guidelines will be featured and the broader issue of early intervention in youth mental health advance as a way forward.

No. 82C
ARE ANTIDEPRESSANTS AN ALTERNATIVE FOR THE EARLY TREATMENT OF THE SCHIZOPHRENIA PRODROME?

Barbara A. Cornblatt, Ph.D. *The Zucker Hillside Hospital, Department of Psychiatry Research, 75–59 263rd Street, RAP Program, Glen Oaks, NY, 11004*

SUMMARY:

Prevention research in schizophrenia has thus far focused on antipsychotics, with generally encouraging though not definitive results. The current study discusses the potential of antidepressants for early intervention. Forty-eight adolescents (mean age: 15.8 years) participated in a naturalistic medication study; all were treatment-seeking and in the prodromal phase of schizophrenia. Individuals were selected from a larger sample (n=152) if they: 1) displayed attenuated positive symptoms; 2) were treated for at least eight weeks; 3) had been followed-up for at least six months (mean=30.5 months) and 4) were rated for adherence to medication. Based on best practice standards, psychiatrists, blind to research hypotheses and ratings, primarily prescribed two types of medication: antidepressants (ADP, n=20) or second generation antipsychotics (SGAP, n=28), with polypharmacy common. There were no significant differences in presenting symptoms between subjects receiving SGAPs vs ADPs on either positive, negative, disorganized or general symptoms, except for disorganized thinking, which was more severe in SGAP-treated adolescents. Twelve of the 48 adolescents (25%) developed a psychotic disorder, with all converters having been prescribed SGAPs. There were no conversions among ADP-treated adolescents. Treatment outcome, however, was confounded, since 11 of the 12 converters were non-adherent. Adolescents, in general, were more likely to be non-adherent to SGAPs (61%) than to ADPs (20%; x^2=7.86; p= .005). Improvement in total positive symptoms was significant (F= 18.08, p<.0001) and similar for both medications. Disorganized thinking, however, did not improve regardless of treatment. The findings reported are primarily hypothesis generating, given nonrandom assignment and the possibility that some prodromal subjects responding to ADPs may be false positives. However, it can be concluded that a number of adolescents meeting criteria for prodromal schizophrenia were successfully treated with antidepressants, and.that in light of anti-psychotic nonadherence, it might be preferable to begin treatment with antidepressants, and progress to antipsychotics once symptoms intensify.

No. 82D
DURATION OF LONG-TERM TREATMENT IN FIRST EPISODE SCHIZO-PHRENIA: RESULTS FROM THE GERMAN RESEARCH NETWORK ON SCHIZOPHRENIA

Wolfgang Gaebel, M.D. *University of Duesseldorf, Department of Psychiatry, Bergische Landstrasse 2, Duesseldorf, D-40629, Germany*

SUMMARY:

Objective: To identify patients suited for drug withdrawal after one year of stable maintenance treatment with either atypical or a low-dose typical antipsychotic in an industry-independent long-term study on first episode schizophrenia, To evaluate the efficacy of

prodrome-based early intervention treatment with either a antipsychotic or a benzodiazepine.

Methods: A randomized double-blind 1 year maintenance treatment trial with risperidone vs haloperidole in first episode schizophrenia (ICD-10, N=176) preceeded a 1 year randomized open withdrawal plus early intervention with either antipsychotic or lorazepam (N=57) in 13 German psychiatric university departments.

Results: No relapse corresponding to predefined criteria was observable in the first treatment year under regular treatment conditions. Efficacy regarding secondary outcome criteria under low-dose haloperidol was comparable to risperidone. Drug side-effects were low, and although compliance on average was high, about 65% of the patients dropped out during the first study year. Regarding the second year about 20 % were not eligible for drug discontinuation and about 25 % chose the converse treatment as assigned.

Conclusion: Treatment in first episode schizophrenia is effective under both antipsychotics, however these patients are at high risk for treatment drop-out. This emphasizes the need for a special support program. Additionally, various long-term treatment strategies should be provided to take patients preferences into account.

*Funded by the German Ministry of Education and Research (BMBF).

No. 82E
PRESENTER TRETAMENT STRATEGIES IN REMITTED FIRST EPISODE PSYCHOSIS: TEH MESIFOS TRIAL

Durk Wiersma, Ph.D. *University Medical Center Groningen, Department of Psychiatry, PO Box 30.001, Groningen, NL-9700RB, Netherlands*, Lex Wunderink, M.D., Fokko Nienhuis, M.A.

SUMMARY:

Objective To compare the consequences of guided discontinuation strategy and maintenance treatment in remitted first episode psychosis in terms of relapse rates and functional outcome.

Method The study was conducted in seven mental health care organizations, covering a catchment area of 3.1 million inhabitants. A sample of 131 remitted first episode patients, aged 18 to 45 years, with a diagnosis of schizophrenia or related psychotic disorder was included. After six months of positive symptom remission they were randomly and openly assigned to discontinuation strategy or maintenance treatment. Maintenance treatment was carried out according to APA-guidelines, preferably using low dose atypical antipsychotics. Discontinuation strategy was carried out by gradual symptom-guided tapering of dosage and discontinuation if feasible. Follow-up was eighteen months. Main outcome measures were relapse rates, and social and vocational functioning.

Results Twice as many relapses occurred in discontinuation strategy (43% vs. 21%, $P = 0.007$). Of patients who received the strategy 20% were successfully discontinued. Recurrent symptoms caused another 30% to restart antipsychotic treatment, while in the remaining patients discontinuation was not feasible at all. There were no advantages of discontinuation strategy regarding functional outcome.

Conclusions Only a limited number of patients can be successfully discontinued. High relapse rates do not allow discontinuation strategy to be universal practice. However, if relapse risk can be carefully managed by close monitoring, in some remitted first episode patients guided discontinuation strategy may offer a feasible alternative to maintenance treatment. Further research is needed to find predictors of successful discontinuation.

REFERENCES:

1. Bechdolf et al.: Interventionsin the early initial prodromalstate of psychosis in Germany: Concept and recruitment. Br J Psychiatry suppl 2005; 48: 45–48.
2. McGorry PD, Yung AR, Phillips LJ: The 'close-in' or ultra-high risk model: a safe and effective strategy for research and clinical care in pre-psychotic mental disorder. Schiz Bull 2003; 29:771–790.
3. Cornblatt BA, Lencz T, Smith CW, Correll CU, Auther, AU, Nakayama, E: The Schizophrenia Prodrome Revisited: A Neurodevelopmental Perspective. Schiz Bull 2003; 29: 633–651.
4. Gaebel W et al. Pharmacological long-term treatment strategies in first episode schizophrenia. Eur Arch Psychiatr Clin Neurosci 2004; 254: 129–140.
5. Wunderink A, et al J Clin Psychiat 2006, in press.

SYMPOSIUM 83—MODEL PSYCHIATRY RESIDENCY PROGRAMS ON RELIGION AND SPIRITUALITY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to implement elements of model curricula on religion and spirituality in psychiatry residency training programs to meet ACGME core competency accreditation standards.

No. 83A
BAYLOR COLLEGE OF MEDICINE EDUCATIONAL PROGRAMS IN PSYCHIATRY AND SPIRITUALITY

Linda B. Andrews, M.D. *Baylor College of Medicine, Psychiatry, 1 Baylor Plz # 350, Houston, TX, 77030–3411*

SUMMARY:

The Baylor College of Medicine psychiatry residency program's current instruction on religion and spirituality has exised most formally within a few resident seminars. The proposed expansion of this curriciula will include the following: add videotaped interview demonstrations focusing on taking a religious and spiritual history during PGY I and II interviewing seminars; prodive scholarships for all residents who wish to attend the department-sponsored Annual Psychotherapy and Faith Conference; develop an Annual Spirituality Research Award within the resident research curriculum to encourage a resident(s) to choose a research project in which religious and spiritual dimensions of the human experience can be formally addressed and presented to colleagues; schedule an annual named Grand Rounds on spirituality; and develop a specific upper level resident clincal rotation with the chaplain staff within the Department of Spiritual Care and Education at one of our affiliated institutions. The proposed curricular expansions should improve every residents' education in the area of religion and spirituality and should allow some residents to recieve truly specialized and in depth clinical and reseach training experiences in religion and spirituality.

No. 83B
THE GEORGE WASHINGTON UNIVERSITY CURRICULUM IN PSYCHIATRY AND SPIRITUALITY

James L. Griffith, M.D. *George Washington University Medical Center, Psychiatry and Behavioral Sciences, 2150 Pennsylvania Ave NW, Washington, DC, 20037–3201*

SUMMARY:

The Curriculum on Psychiatry and Spirituality in our GWU residency teaches residents how to incorporate patients' spiritualities into psychiatric treatment in culturally diverse settings. Both syndromes of distress (such "normal suffering" as grief, demoralization, shock from trauma, or humiliation from stigma) and specific psychiatric disorders are covered. Particular emphasis is placed upon skills

for integrating spirituality into outpatient psychotherapies and bedside interviews with medically-ill or psychiatrically-ill inpatients. Lectures on psychiatry and spirituality are included in didactic seminars on the psychotherapies, cross-cultural psychiatry, consultation-liaison psychiatry, and political psychology. A ten-session PGY-III seminar, "Conducting Psychotherapy with Spiritually, Religiously, or Ideologically-Committed Patients," teaches residents how to work psychotherapeutically with spiritual metaphors, narratives, beliefs, prayers, practices, rituals, and communities. These skills are then supervised in brief psychotherapies and on the consultation-liaison service. This curriculum is a key element in an extensive cross-cultural psychiatry curriculum (seminars in PGY-I, II, and III years and 300 supervised hours in inner city and immigrant/refugee community clinics). It has been required for all residents for the past eight years. Clinical portfolios assess residents' competencies in working with spirituality in clinical work.

A program of clinical research on psychiatry and spirituality by PGY-III and PGY-IV residents is a new initiative. These projects fulfill the ACGME-mandated requirement that residents complete a scholarly work. Residents can elect to pursue investigations on the role of spirituality in countering demoralization from medical and psychiatric illnesses, in recovery from political torture and severe traumatic stress, and in moderating suicidal ideation and impulses.

No. 83C
THE UNIVERSITY OF CALIFORNIA, IRVINE, PSYCHIATRY AND SPIRITUALITY CURRICULUM FOR RESIDENT TRAINING

Aaron Kheriaty, M.D. *University of California, Irvine, Psychiatry, 33362-A Nottingham Way, Dana Point, CA, 92868*

SUMMARY:

This curriculum is dedicated to helping residents, students, and faculty members recognize, appreciate, understand, and explore the connections between patients' mental health and their spiritual, religious, philosophical, and moral convictions. The curriculum includes eighteen hours of required lectures, spread longitudinally over the first three years of residency (six lecture hours per year). In addition, there is an elective discussion group for fourth-year residents interested in pursuing special topics in psychiatry and spirituality.

During the PGY-1 year, core lectures focus on the doctor-patient relationship, and on understanding the patient's spirituality. PGY-2 lectures focus on the theme of religious traditions and culture, as these relate to mental health care. PGY-3 lectures focus on the theme of healing the whole person, with an emphasis on evaluating and integrating contributions from psychology, philosophy, religion, and spirituality.

Beyond the required lecture series, other venues for incorporating spirituality into psychiatric residents' training include grand rounds, journal club, case conferences, and individual supervision. This curriculum is strengthened by the Department's Psychiatry and Spirituality Forum, an interdisciplinary group of thirty members, including attending and resident physicians, medical students, nurses, psychologist, social workers, clergy, philosophers, and theologians. The Forum, which is supported by a grant from the Metanexus Institute, sponsors scholarly, educational, and community outreach activities in the area of Psychiatry and Spirituality. Forum activities this year include lectures for local clergy and religious leaders, educational meetings, reading groups, and Psychiatry Grand Rounds featuring highly prestigious speakers in the area of Psychiatry and Spirituality.

REFERENCES:

1. Brown AE, Whitney SN, Duffy JD. The physician's role in the assessment and treatment of spiritual distress at the end of life. Palliative and Supportive Care (2006) 4:81–86.
2. Griffith JL, Griffith ME: Encountering the Sacred in Psychotherapy: How to Talk with People about their Spiritual Lives. New York, Guilford Press, 2002.
3. Puchalski, Romer, "Taking a Spiritual History Allows Clinicians to Understand Patients More Fully," Journal of Palliative Medicine 2000; 3(1): 129–137.
4. Lukoff D, Lu F, Turner R. Toward a more culturally sensitive DSM-IV. Psychoreligious and psychospiritual problems. J Nerv Ment Dis. 1992 Nov;180(11):673–82.

SYMPOSIUM 84—SUICIDE: PRACTICAL PATIENT SAFETY FOR THE DOCTOR FROM RISK ASSESSMENT TO RISK REDUCTION

EDUCATIONAL OBJECTIVES:

Participants will learn and be able to discuss, pragmatic suicide risk assessment and risk reduction strategies. Review and application of the evidence-base and practice guidelines will be discussed. Participants will learn skills to operationalize improved patient safety in regard to the following: identifying patients at risk for suicide, identifying specific risk factors and risk reduction factors, addressing immediate safety management needs, providing treatment, and implementing crisis/relapse prevention plans.

No. 84A
SUICIDE: PRACTICAL PATIENT SAFETY FOR THE DOC FROM RISK ASSESSMENT TO RISK REDUCTION

Helena Chmura. Kraemer, Ph.D. *Stanford University School of Medicine, Psychiatry and Behavioral Sciences, 401 Quarry Road, MC 5717, Stanford, CA, 94305*

SUMMARY:

The discussion will center on current methodological limitations of risk research to provide clear and accurate guidance for monitoring and prevention of suicide attempts.

No. 84B
ASSESSING AND OVERCOMING THE FAILURE MODES TO IMPROVE SUICIDE RISK ASSESSMENT AND RISK REDUCTION

Yad M. Jabbarpour *Catawba Hospital, Office of Chief of Staff, PO Box 200, Catawba, VA, 24070–0200*

SUMMARY:

Suicide is a tragic event, which can result in clinicians questioning themselves and their practice. Mistakes do occur to good clinicians within good systems of care. Barriers exist for individual providers within themselves, their treatment teams, their organizations and mental health systems, creating potential failure modes impacting the ability to assess and manage suicide risk. Clinicians understanding and overcoming the failure modes can realize improved and potentially safer patient care. Failure modes express themselves across multiple dimensions of service from the individual clinician to the structure of the mental health system and include breakdown in training, orientation, communication, documentation, and implementation of best practices for suicide risk assessment and risk reduction. Failure modes can be extrapolated from the realm of common allegations of negligence, cited in claims in legal cases, ranging from failure to assess and diagnose to failure to hospitalize and treat. Failure Mode and Effect Analysis (FMEA) techniques

can help systems self-assess potential problems proactively before a sentinel event of a suicide occurs, allowing for development of improved systems for clinicians to provide psychiatric care. While anticipating all failure modes is not possible, solving the most common can possibly enhance reliability of services. Clinically focused solutions include suicide risk re-assessment at critical periods, family involvement, targeting dynamic suicide risk factors in treatment and relapse prevention, and implementing evidence-based practices. Overcoming the failure modes can result in a culture of exemplary patient safety focus and improved suicide risk assessment and risk reduction.

No. 84C
OPPORTUNITIES AND OBSTACLES TO IMPLEMENTING TREATMENT PRACTICE GUIDELINES

Rory P. Houghtalen, M.D. *Dept of Psychiatry and Behavioral Health, Unity Health System*

SUMMARY:

Despite the availability of APA practice guidelines that inform an evidence-based approach to the assessment and management of psychiatric conditions, it has been challenging for clinicians and systems to consistently implement the recommendations of guidelines in everyday practice. This session provides an overview and details of a systematic effort to implement the APA practice guideline for suicidal behavior in a large, community-based behavioral health system. Methods to enhance the diffusion, adoption and adherence of the guideline including cultivation of a supportive administrative structure, promotion of staff buy-in, development of curricula to improve knowledge and skills and implementation of processes and documentation tools to promote adherence to best practices will be described. Development of a trainers program and the harnessing of the quality assurance process to support the implementation will be reviewed. Data comparing pre and post-implementation adherence to guideline recommended practices will be used to demonstrate opportunities and obstacles to full implementation. This session will be relevant for clinicians and clinical administrators interested in enhancing guideline adherence in their practice settings.

No. 84D
SUICIDAL RISK ASSESSMENT IN THE EMERGENCY ROOM SETTING

Matthew F. Carroll, M.D, *UCSD School of Medicine, Department of Psychiatr*

SUMMARY:

In a psychiatric emergency room setting, the suicidal patient is the most common patients seen the the psychiatric emergency room setting. It is vital that the physician can recognize and treat the high risk suicidal patient. Malingering or exaggerating suicidal thought is also common in the emergency room setting. The physician must be vigilant in fully assessing the suicidal risk in all patients who present to the emergency room. This presentation will address specific emergency room interactions as well as risk prevention strategies in patients who have been admitted to the hospital.

REFERENCES:

1. Kraemer HC, Lowe KK, Kupfer DJ. To Your Health: How to Understand what research tells us about risk. Oxford University Press, 2005.
2. Clinical Correlates of Inpatient Suicide, Busch KA, Fawcett J, Jacobs DG.
3. Drake RE, Torrey WC, McHugo, GL: Strategies for implementing evidence-based practices in routine mental health settings. Evid Based Ment Health 2003; 6: 6–7.
4. Simon RI, Hales RE (eds.) The American Psychiatric Publishing Textbook of Suicide Assessment and Management. Washington, D.C., American Psychiatric Publishing, 2006.

SYMPOSIUM 85—COMBINED TREATMENT WITH PSYCHOTHERAPY AND MEDICATIONS: RESEARCH AND CLINICAL ISSUES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able

1. to recognize three challenges to designing clinical trials involving both medications and psychotherapy;
2. to recognize three challenges to a single clinician administering combined treatment with medications and psychotherapy; and
3. to discuss indications and contraindications for the clinical use of combined treatments.

No. 85A
MAKING THE CHOICE: MEDICATION OR PSYCHOTHERAPY

Ellen Frank, Ph.D. *University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA, 15213–2593*

SUMMARY:

Despite decades of clinical trial experience in major depression, our understanding of how best to achieve durable recovery is quite limited. Response rates rarely exceed 60%. Full remission is seen in only one in three subjects. Those who achieve remission remain at considerable risk of relapse. Even those who recover symptomatically fail to show a return to pre-morbid levels of functioning. Our knowledge about the determinants of response, remission, recovery, and relapse remains woefully inadequate and offers little guidance to the practicing clinician. When confronted with a moderately depressed outpatient, we have little more than our own predilections and the preference of the patient to guide us in determining whether to initiate treatment with pharmacotherapy or psychotherapy or to go directly to combination treatment.

Clinicians sorely need a set of indicators and corresponding assessment methods that show a strong, consistent and clinically significant association with treatment outcome. This presentation will focus on the design of and early results from a study a multisite study being conducted at the University of Pittsburgh and the University of Pisa, Italy and designed to address these questions. In this investigation, we are randomly assigning outpatients with major depression to initiation of treatment with pharmacotherapy alone or psychotherapy alone. Those patients whose initial treatment is not associated with remission of their depression, have the other treatment added to their regimen. Once remission is achieved patients enter a 6-month continuation treatment phase. To date, this sequential treatment strategy has been associated with a consistently excellent and virtually identical rates of complete remission (~75%) and relapse (~16%) at the two study sites. The implications of these findings for clinical practice will be discussed.

No. 85B
INTEGRATING PHARMACOTHERAPY WITH PSYCHODYNAMIC PSYCHOTHERAPY.

Steven P. Roose, M.D. *NY State Psychiatric Inst, 1051 Riverside Dr, New York, NY, 10032–1007*

SUMMARY:

The optimal therapeutic use of pharmacologic agents in psychodynamic psychotherapy remains difficult. Studies show patients entering such treatment have extremely high rates of affective and anxiety disorders and frequently are prescribed medication. The therapy literature primarily examines the possible effects of medication prescription on psychotherapy, but there is strikingly little information on whether psychodynamic psychotherapy affects the delivery of psychopharmacologic treatment. The few studies available underscore the challenges to delivering optimal psychopharmacologic treatment combined with psychotherapy, and recent developments in the pharmacology of depression point to increasing complexity. Specifically, psychodynamic psychotherapists may have difficulty diagnosing the presence of a depressive disorder, since the type of information necessary for a clinician to make the decision to prescribe medication and then evaluate its effectiveness requires a significant deviation from standard technique. Furthermore, the use of standardized rating scales to follow medication response strikes many psychotherapists as awkward or inappropriate, since they may fear the impact of direct questions about symptoms, including sexual functioning, on technical neutrality or the transference. However, the effective treatment of depression involves much more than prescribing an SSRI at a fixed dose. Rather, the optimal management of depressive disorders now involves a full and accurate diagnostic evaluation, treatment to remission as measured by regular measurement with standardized rating scales, and the sequential or combined use of multiple anti-depressant medications. Psychodynamic psychotherapists must develop facility with proper pharmacologic techniques and the ability to shift between psychodynamic and phenomenologic models of mind.

No. 85C
RESEARCH ON COMBINED TREATMENT OF MOOD DISORDERS

Michael E. Thase, M.D. *University of Pittsburgh Medical Center, Psychiatry, 3811 O'Hara Street, Pittsburgh, PA, 15213–2593*

SUMMARY:

The combination of psychotherapy and pharmacotherapy is widely considered by psychiatrists to be the best approach to treatment and is recommended by practice guidelines as the treatment of choice for more difficult-to-treat depressions, include episodes that are severe and recurrent, chronic, and complicated by relevant comorbidities. Although few studies have evaluated combined therapy for acute bipolar depressive episodes, accumulating evidence indicates that concomitant psychotherapy similarly improves longer-term outcomes of individuals with bipolar disorder. However, despite such popularity and evidence of additive benefit, the direct costs of treatment are increased by routinely combining psychotherapy and pharmacotherapy – at least in the short run – and in an era of limited resources for mental health care research is needed to confirm both the efficacy and cost-effectiveness of combined treatment for specific indications. This presentation will address issues of research design pertinent to the study of combined treatment, including selection of comparison groups, sample size considerations, questions of the specificity of additive effects, and calculation of cost-effectiveness.

No. 85D
SPECIFIC AND NONSPECIFIC TREATMENT FACTORS IN CLINICAL TRIALS FOR DEPRESSION

Bret R. Rutherford, M.D. *New York State Psychiatric Institute, Department of Biological Psychiatry, 10 Amsterdam Ave, Apt 702, New York, NY, 10023–7490*

SUMMARY:

Clinical trials of medications and psychotherapy for depression must differentiate treatment specific effects from nonspecific effects, since patients receiving the exact same treatment may respond differently under different experimental conditions. In particular, expectancy effects, which are condition-specific beliefs patients develop during research studies with respect to whether or not they will improve, are relatively unstudied and may greatly influence response to treatment. To investigate the possible influence of expectancy effects of clinical trials of medications and psychotherapy, meta analyses are being conducted to compare response and remission rates to anti depressant medications across: (1) placebo controlled and active comparator trials, (2) open and placebo controlled administration of anti depressants in combined psychotherapy and pharmacotherapy trials, (3) six, eight, and 12 week long placebo controlled anti depressant trials, and (4) six, eight, and 12 week long comparator anti depressant trials. Meta analyses of the outcome data from included studies were performed using the Comprehensive Meta-Analysis statistical software package. Most studies of medication and psychotherapy compare open administration of psychotherapy or combined treatment to placebo controlled medication, and differential patient expectations between these cells may bias these comparisons against medications. If response and remission rates to anti depressants are significantly different under double blind conditions and when patients know they are receiving active treatment, then the claims made in many combined trials that combined treatment is better than medication alone and psychotherapy alone is as effective as medication alone may be invalid. Furthermore, if no significant differences are found in response and remission rates between anti depressant trials of different durations, then current recommendations of medication trials up to 20 weeks long may expose patients to ineffective medications or troubling side effects longer than is justified.

REFERENCES:

1. Frank E, Grochocinski VJ, Spanier CA, Buysse DJ, Cherry CR, Houck PR, Stapf DM, Kupfer DJ: Interpersonal psychotherapy and antidepressant medication: Evaluation of a sequential treatment strategy in women with recurrent major depression 2000; J Cl.
2. Roose SP. Psychodynamic Therapy and Medication: Can Treatments in Conflict be Integrated? In Integrated Treatment of Psychiatric Disorders, ed. Kay J. Washington, DC: American Psychiatric Association Press, 2001.
3. Thase ME: The role of psychotherapy in the management of bipolar disorder. In: Handbook of Bipolar Disorder. Diagnosis and Therapeutic Approaches, edited by Kasper S, Hirschfeld RMA, New York, NY, Taylor & Francis Group, LLC, 2005, pp. 419–433.
4. Gaudiano BA and Herbert JD. Methodological Issues in Clinical Trials of Antidepressant Medications: Perspectives from Psychotherapy Outcome Research. Psychother Psychosom 2005; 74:17–25.

SYMPOSIUM 86—CHILDREN AND WAR: EMOTIONAL AND PSYCHIATRIC CONSEQUENCES OF WAR AND TERROR ON CHILDREN AND ADOLESCENTS
Council for Global Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant should be able to:

1. Identify the short and long term psychological and psychiatric consequences of exposure to war and terror in children and adolescents;
2. Identify several approaches to foster coping and resilience in children and adolescents exposed to wars and terror;
3. Describe treatment options geared toward minimizing psychiatric and psychological morbidity in children and adolescents exposed to wars and terror.

No. 86A
OVERVIEW: THE IMPACT OF WAR AND TERROR ON MIDDLE EASTERN CHILDREN AND ADOLESCENTS

Siham Muntasser, M.D. *West Virginia University, Department of Behavioral Medicine and Psychiatry, 930 Chestnut Ridge Rd, Morgantown, WV, 26505–2807*

SUMMARY:

Wars have characterized human history. However, since World War II, availability and access to ever more powerful military machinery has dramatically increased our lethal capacity. Poorly defined boundaries have led to a massive increase in civilian casualties. Children bear the blunt of these types of conflicts.

During armed conflicts rape, domestic violence, and sexual exploitation, all are known to increase. In some war striken countries, sexual violence has become a "normal" event and rape is considered a weapon of war. Rapes and sexual violence don't affect only females. Girls who get pregnant are frequently rejected from their families and become social pariahs. For boys, many born with strict taboos about male-to-male sex, rape has major consequences.

Millions of children are orphans because of wars. Thousands who lost their families live on the streets in perilous environments with vastly inadequate shelter, health care, education, and guidance. Hopelessness, low self-esteem and drug abuse are common. Unaccompanied girls are at high risk of sexual abuse. Unaccompanied boys are at high risk of forced or 'voluntary' participation in armed conflicts.

An overall increase in psychological problems and decrease in psychosocial functioning has been reported in children living in refugee camps.

With regard to mental health, acute signs and symptoms of distress remit quickly in most children, but some scars are long-lasting and often irreversible. Risk and severity correlate with duration and intensity of exposure to traumatic events, direct harm to self or close family members, quality of family support, and the amount of life disruption. Prolonged exposure to violence and chaotic living situations leads to the most severe forms of psychopathology.

This lecture provides an overview of the different realities affecting children in the Middle East, as result of exposure to war and terror. It provides some specific examples including Palestine, Sudan, and Somalia.

No. 86B
TREATMENT OF CHILDREN IN WAR

Elie G. Karam, M.D. *St George Hospital University Medical Center, Dept. of Psychiatry & Clinical Psychology, PO Box 166227, Ashrafieh, Beirut, 1100–2110, Lebanon*, John Fayyad, M.D., Aimee N. Karam, Ph.D., Caroline C. Tabet, M.A., Zeina Mneimneh, M.P.H., Hani Dimassi, Ph.D., Nadine Melhem, Ph.D.

SUMMARY:

The Institute for Development, Research, Advocacy and Applied Care (IDRAAC) has conducted several studies on war and mental health (1). This presentation will review the pertinent literature on interventions for children and adolescents exposed to war-trauma and highlights from a controlled group intervention study in Lebanon. While there are several descriptive accounts of psycho-social interventions for children following wars, methodological shortcomings of these studies make their results difficult to generalize. Well designed studies examining the efficacy and specificity of such interventions are needed. IDRAAC undertook such a study in the aftermath of war. All students (N=2500) of six severely affected villages received a classroom-based intervention delivered by teachers trained and supervised by IDRAAC. The manual-based intervention consisted of a combination of cognitive behavioural strategies and stress inoculation training. A random sample was evaluated before intervention one month post-war where mental disorders, psychosocial stressors and war exposure were measured, and reevaluated a year later. The prevalence of Major Depressive Disorder (MDD), Separation Anxiety Disorder (SAD) and Post-traumatic Stress Disorder (PTSD) was examined at 5 points : pre-war, 1 month post-war before intervention and 3, 6 and 12 months post-war. Session-by-session manuals filled by teachers were rated blindly after intervention for the specificity with which intervention techniques were applied resulting in a triple blind design. Treatment group (specific versus non-specific) did not predict disorders at the three post-intervention points. Disorders were predicted by younger age, pre-war disorders, family violence, physical illness, and war events. Impulse-control disorders are emerging as conditions needing special attention as evidenced by a parallel study of war orphans combining individual and group psychosocial interventions, as well as a recent national study. Debate will continue on whether to implement mass interventions or only target affected individuals or groups, and on the nature and timing of such interventions.

Reference: www.idraac.org

No. 86C
DEALING WITH CHILDREN'S ANXIETY AND FEARS DURING WARTIME

Alan Apter, M.D. *Feinberg Child Study Center, Schneider's Children's Medical Center of Israel., Dept. Of Child and Adolescent Psychiatry, Ziv Hospital, Safed, 90972, Israel*

SUMMARY:

This talk is based on experience with both Jewish and Arab children subjected to rocket bombardment in the Northern town of Safed in Israel and with children who live in Tel Aviv or were evacuated there in the recent Second Lebanese War. It is also based on experience with children who were victims of suicide bombings during the Intifada.

One major problem is to distinguish normal reactions to an abnormal situation from warning signs of developing psychopathology. "Normal" reactions include: fear, crying, irritability, temper tantrums, clinging to parents, fears of leaving the bomb shelter, clinging to parents and may other similar behaviors.

It is important to educate parents and primary physicians regarding the emotions, physical symptoms, thoughts and behaviors that are the components of normal fear and to encourage them to support the child without pathalogising these behaviors

We distinguish between three reactions to stress: Acute Stress Reaction; Acute Stress Disorder and Post Traumatic Disorder. Each of these reactions has a specific clinical picture and specific management considerations.

Each of these reactions will be discussed in the context of the Israeli situation including preventative and organizational measures. Some speculations about the influence of the media and the larger political situation will be made

No. 86D
WAR TRAUMA AND CHILD MENTAL HEALTH IN IRAQI KURDISTAN

Abdulbaghi Ahmad, Ph.D. *Uppsala University Hospital, Department of Neuroscience, Uppsala, S-751 85, Sweden*

SUMMARY:

Posttraumatic stress symptoms were identified among the children of Kurdistan during the mass-escape tragedy of 1991, and in a 6-months, 1-year, and 2-years follow-up studies. The relationship between the degree of traumatization and posttraumatic stress disorder (PTSD) was confirmed by a follow-up study of orphans, and a further study of the survived children after the Anfal military operations. The needs for child mental health services were further emphasized after an epidemiological study indicating high frequencies of child behavioural problems and PTSD among general population, orphans, primary medical care visitors, and hospital in-patients in the city of Duhok in Iraqi Kurdistan. As a result, the Department of Child Mental Health (CMH) was opened at the College of Medicine, University of Dohuk, in 20 September 2001, in collaboration with the Department of Neuroscience, Child and Adolescent Psychiatry, Uppsala University in Sweden. The main function of the CMH is postgraduate, undergraduate, and community-based education, producing local competence that provides clinical and training services in the region.

No. 86E
CONSIDERATIONS IN DEVELOPING THERAPEUTIC SERVICES FOR CHILDREN TRAUMATIZED BY WAR

Dennis J. Hunt, Ph.D. *Center for Multicultural Human Services, 701 West Broad Street,, Suite 305, Falls Church, VA, VA, 22046*

SUMMARY:

This presentation will describe a unique service delivery model aimed at helping refugee children heal from the traumas of war and displacement. Over the past 25 years the Center for Multicultural Human Services has developed a treatment approach that reflects an understanding that the complex psychological adjustment needs of traumatized refugee children require services that simultaneously addresses individual, family and community issues within the context of the child's culture. This session will discuss some of the key elements of the CMHS model and some of the core issues CMHS staff try to address in helping refugee children and their families rebuild their lives.

REFERENCES:

1. Pine DS, Costello J, Masten A. Trauma, proximity and developmental psychopathology: the effects of war and terrorism on children. Neuropsychopharmacology 2005; 30: 1781–1792.
2. Bisson, J.I., & Deahl, M.P. (1994).Psychological debriefing and prevention of post-traumatic stress. More research is needed . British Journal of Psychiatry, 165, 717–720.
3. Ahmad A: Childhood trauma and posttraumatic stress disorder: A developmental and cross-cultural approach: Doctoral Thesis, Uppsala, Uppsala University, 1999.
4. Dyregrov, A. et al. Children exposed to warfare: A longitudinal study. J. of Traumatic Stress, February 2002: Vol. 15, No. 1:.59–68.

SYMPOSIUM 87—THE PSYCHOCULTURAL FOUNDATIONS OF CONTEMPORARY TERRORISM

EDUCATIONAL OBJECTIVES:

To identify social cultural incentives for suicide terrorism, emphasizing "group identity" as well as economic rationality of self-interest.

No. 87A
KILLING FOR A CAUSE: AN INTEGRATED SOCIAL SCIENCE AND SOCIAL PSYCHOLOGICAL APPROACH

Dipak K. Gupta, Ph.D. *San Diego State University, Int'l Security & Conflict Resolution, 5500 Campanile Drive, Nasatir Hall 121, San Diego, CA, 92182–4427*

SUMMARY:

Those who participate in mass killings — terrorism to genocidal frenzy — are rarely diagnosed with psychiatric maladies. Neither do the extensive psychological studies based on personal interviews provide any stable profile. I argue that a profitable perspective can be gained by combining economic rationality of self-interest with "group identity." There are some who participate in violent collective actions primarily for their own enrichment, power, prestige, or even personal salvation, while others engage in these acts out of an "altruistic" concern for the in-group against the out-group. The latter is the basis of ethnic, religious or class-based political ideologies. When these perceptions are inculcated among a large number of people by the clever use of religious, historical, and mythological symbols, hatred for the odious "others" gets into the bones. Once the in-group has been defined and the enemies are properly identified, killings become the part of the process.

No. 87B
UNDERSTANDING THE GIRLS' MADRASAS IN PAKISTAN

Farhana Ali, M.A. *RAND Corporation, 1200 South Hayes Street, Arlington, VA, 22201*

SUMMARY:

Five years after the September 11th attacks, the word *madrasa* is invariably linked to militancy and has become a source of instability in Pakistan. While the majority of *madaris* (plural of *madrasa*) are centers of religious education, the media and intelligence agencies' have highlighted the links of the religious seminaries in Pakistan to possible sources of terrorism and hotbeds of religious extremism. Much attention has been given to boys' *madaris* and their ties to international terrorism, but an entire world of girls' *madaris* remains largely untapped and under explored by researchers, authorities, and governments of Pakistan and the United States. While the data on boys' *madaris* remains imperfect, a survey of girls' *madaris* in Pakistani cities and towns is missing entirely from the overall debate of *madrasa* curriculum, reform, and linkages, if any, with promoting militancy in Pakistan. In the absence of a holistic study of girls' seminaries, the U.S. policy community has no sophisticated understanding of girls' *madaris* and how the strict teachings of Islam behind closed doors can depress the development of democracy in Pakistan. A true democratic process is unlikely to succeed in Pakistan without sound educational development for the girls and women in the country. By including women in the *madrasa* reform process, the government of Pakistan and other regional actors can help find alternative approaches to sound educational development compatible with democratic ideals and processes.

No. 87C
WHY WE ARE LOSING THE WAR ON TERRORISM.

George Everly, Ph.D. *Johns Hopkins School of Medicine, Dept of Psychiatry, 615 N. Wolfe Street, WB030, Baltimore, MD, 21205*

SUMMARY:

This presentation will argue that the war against terrorism is in danger of being lost both on the ground in Iraq and here in the US. The current manner in which the ground war is being fought would appear to lack attendance to, or at least success in, the strategic aspects of psychological counterterrorism. Coalition formation in theater in the absence of a practical, sustaining, and achievable end point serves to jeopardize any sustained presence and the attainment of an "acceptable" outcome. In the US, similar to the war in Vietnam, the war against terrorism has accrued a polarizing quality that threatens to divide a country, politically and morally, thus creating increased vulnerabilities while adding inspiration to terrorists.

No. 87D
CRIMES OF OBEDIENCE

Jerrold M. Post, M.D. *The George Washington Univ., Elloitt School of International Affairs, 7106 Broxburn Drive, Bethesda, MD, 20817*

SUMMARY:

As one expert in Middle East politics ruefully observed, the Abu Ghraib prison abuse scandal has seriously damaged the US image in the Middle East, setting back the US position in the region 20 years. While the commissions and trials thus far have not found fault with senior officials, and the Secretary of Defense identified the fault as lying with "a few bad apple MPs," this paper suggests that the three conditions_authorization, routinization, and dehumanization_ identified by Kelman and Hamilton in their study of the My Lai massacre as being requisite for sanctioned massacres, were present. There is persuasive evidence that the actions by low level military personnel (MPs) were authorized and approved by higher authorities to produce positive interrogation results, even though not specifically ordered, that what they did was experienced by them as not out of the ordinary, and that there was a lack of empathy for their charges. Moreover, interrogation practices targeting the humiliation of Muslims demonstrated a cultural sophistication at senior levels. It is critical in conducting the war against terror that we not adapt the techniques of terror ourselves and in so doing weaken our democracy.

No. 87E
MIGRANT YOUTH AND THE RISK FOR TERRORISM

Stevan M. Weine, M.D. *University of Illinois at Chicago, Psychiatry, 2216 Lincolnwood Dr, Evanston, IL, 60201*

SUMMARY:

As Al Qaeda has morphed from a terrorist organization into a global movement, greater attention has turned to the risk for suicide terrorism amongst Muslim migrants in Western countries. How do we know if amongst them are potential suicide terrorists and if so how do we intervene? There is a growing body of journalistic reports and conceptual analysis on the topic of Muslim migrants and terrorism. The social, economic, cultural, and psychological conditions of some Muslim migrants in Western countries provide a fertile ground for neo-fundamentalism and entering the path towards terrorism. Some Muslim migrants would appear to be at some degree of risk for radicalization, but to intervene there is a need to better differentiate who is most at risk and what are the processes that account for risk and protection. This calls for empirical research of which there is very little. We can say with some certainty that to confront the risks of suicide terrorism amongst Muslims migrants is a long-term project that calls for multi-sectoral interventions, including psychosocial interventions, the likes of which have never been attempted amongst immigrant populations. Psychiatry can help to advance policy by promoting dialogue with Muslim professionals, by promoting public dialogue on risks, strengths, and prevention amongst Muslim migrants, and by conducting rigorous research on terrorism and migration.

REFERENCES:

1. Gupta DK: Path to Collective Madness: A Study in Social Order and Political Pathology. Portsmouth, NH, Greenwood Publishing, 2001.
2. Everly GS, Castellano C: Psychological Counterterrorism and World War IV. Ellicott City, MD, Chevron Publishing, 2005.
3. Post JM, Panis LK: Crimes of Obedience. Democracy and Security 2005, Vol. 1: 33–40.
4. Weine SM: Testimony after Catastrophe: Narrating the Traumas of Political Violence. Evanston, IL, Northwestern University Press, 2006.

SYMPOSIUM 88—WORK OUTCOME IN SCHIZOPHRENIA: ADVANCES IN PREDICTION AND INTERVENTION

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to:

1. Identify key predictors of successful work outcome in schizophrenia patients and discriminate these factors from predictors of social functioning and independent living;

2. Understand the principles of supported employment and supported education and appreciate the striking impact that this psychiatric rehabilitation approach can have in increasing the frequency of successful return to work or school in recent-onset and chronic schizophrenia; and

3. Understand recently developed neurocognitive remediation interventions and appreciate their efficacy for improving core cognitive deficits and work outcome in schizophrenia.

No. 88A
FUNCTIONAL CAPACITY AND WORK OUTCOMES: ARE THERE ANY SPECIFIC RELATIONSHIPS?

Philip D. Harvey, Ph.D. *Mt. Sinai School of Medicine, Psychiatry, 1425 Madison Avenue, New York, NY, 10029*

SUMMARY:

Background: Work performance, like other aspects of everyday functioning in schizophrenia, is likely to be influenced by a variety of factors. However, direct assessment of the ability to perform work-related skills (i.e., functional capacity) may be the best outcomes measure in any treatment studies. This presentation will provide information on the different types of capacity measures and show the results of a study that examined the relationship between neuropsychological (NP) performance, two different functional capacity measures (the social Skills Performance Assessment: SSPA and the UCSD performance-based skills assessment: UPSA) and everyday outcomes in the areas of social functioning, everyday living skills, and work.

Methods: Two hundred and eleven community-dwelling patients with schizophrenia were tested with an NP battery, performed the UPSA and the SSPA, and were rated by their case managers for their real-world (RW) outcomes.

Results: The single best correlate of RW social outcomes was performance on the SSPA, while the single best correlate of RW everyday living skills was UPSA performance. NP performance influenced both of these RW outcomes through correlations with the functional capacity measures. Neither the SSPA or the UPSA predicted work outcomes, which were, however, quite strongly related to performance on working and episodic memory tests.

Implications: These data suggest substantial specificity in the relationships between the different domains of functional abilities and RW outcomes. Prediction of RW work outcomes might be better predicted by different assessment of occupational abilities, and there are several measures that could be employed for this purpose. NP performance might also then have a mediated relationship with work outcomes, if occupational abilities were directly assessed.

No. 88B
IMPROVING WORK OUTCOME IN RECENT-ONSET SCHIZOPHRENIA: SUPPORTED EMPLOYMENT AND EDUCATION, WORKPLACE SKILLS TRAINING, AND NEUROCOGNITION

Keith H. Nuechterlein, Ph.D. *UCLA, Psychiatry and Biobehavioral Sciences, UCLA, 300 UCLA Medical Plaza, Rm. 2251, Los Angeles, CA, 90095–6968*, Kenneth L. Subotnik, Ph.D., Joseph Ventura, Ph.D., Michael J. Gitlin, Denise Gretchen-Doorly, Ph.D., Michael Green, Charles J. Wallace, Ph.D., Deborah R. Becker, M.A., Robert P. Liberman, M.D.

SUMMARY:

The initial period of schizophrenia may offer particularly strong opportunities to prevent chronic patterns of disability. This recently completed study examined the impact of combining two work rehabilitation approaches with recent-onset schizophrenia patients. The combination of Individual Placement and Support (IPS) and a Workplace Fundamental Module (WFM) was contrasted with traditional vocational rehabilitation. IPS, a form of supported employment/ education, involves integration of clinical and vocational services, rapid search for regular work or schooling, community outreach, and ongoing support. WFM consists of group training in workplace skill areas and uses videotaped demonstrations, role-played practice, problem-solving methods, and planned generalization to the community. In an 18-month randomized, controlled trial of 69 recent-onset schizophrenia patients, the IPS-WFM intervention was found to dramatically increase the percentage of patients who returned to paid work or regular school. The IPS-WFM intervention resulted in 83% of patients returning to regular paid work or school within 6 months, compared to 41% in the comparison group ($p < .001$). These recent-onset schizophrenia patients treated with IPS-WFM continued to be very likely to have paid work or to be in school during the following year of less intensive treatment (92%), as compared to 60% of the comparison group ($p < .01$). These rates are higher than in studies of supportive employment in chronic severe mental illness. In the context of such high rates of return to work or school, baseline neurocognitive performance did not predict who returned to work or school, but did strongly predict quality of work. In summary, an intervention that combines supported employment and education with workplace skills training is very clearly effective in helping recent-onset schizophrenia patients to return to regular school or work. Neurocognitive deficits continue to be major limiting factors in work quality and are important targets for additional intervention.

No. 88C
WORK OUTCOME IN SCHIZOPHRENIA: ADVANCES IN PREDICTION AND INTERVENTION

Jean-Pierre Lindenmayer *60 Remsen St, Brooklyn, NY, 11201–3453*

SUMMARY:

Cognitive impairments are a core feature of schizophrenia and are related to poor functional outcomes. Neurocognitive skills training show modest, but significant benefits on cognitive functioning, and on longer-term broader functional outcomes, including work.

Aims: To evaluate the feasibility and efficacy of a neurocognitive skills training program in improving cognitive functioning, clinical symptoms, adaptive life skills and work function in long stay psychiatric inpatients.

Methods: 84 inpatients with predominantly DSM IV schizophrenia were randomized to computerized neurocognitive training (COGPACK) providing practice on cognitive functions, or to a control condition. The program consisted of 24 one-hour laboratory sessions approximately 2 times per week for 12-weeks with a weekly discussion to facilitate transfer of cognitive skills to adaptive life functioning; control group received similar hours of staff and computer exposure without cognitive training.

Results: Mixed model ANCOVA with baseline assessments as covariates did not show significant effects indicating experimental and control group did not differ overtime in symptoms, adaptive functioning, and side effects. Time, but not group by time, effects were found on the SAFE ($F=6.34$, $df=1,188$; $p<0.01$), PANSS positive symptoms ($F=7.13$, $df=1,288$; $p<0.01$), and Barnes ($F=11.98$, $df=1, 288$, $p<0.001$), indicating improvement. Changes in cognitive measures with baseline measures as the covariate and 6 month post treatment assessment as the dependent variable showed significant group effects for Trail Making A ($F=7.9$, $df= 1,67$; $p<0.01$), Rey Auditory Learning (Total, Trials 1–5) ($F=4.3$,$df=1,71$; $p<0.05$), and cognitive composite score ($F=3.7$, $df=1,73$; $p<0.05$), indicating improvement in the experimental group. Patients in the experimental group worked more weeks ($t=2.1$, $df=66$; $p<0.05$) than the control group at 12-month follow-up.

Conclusions: Participation in the cognitive program was associated with improvements in learning, psychomotor speed, and higher participation in a work program.

No. 88D
NEUROCOGNITIVE ENHANCEMENT THERAPY AND WORK THERAPY: PRODUCTIVITY OUTCOMES AT 6- AND 12- MONTHS.

Joanna Fiszdon, Ph.D. *VA Connecticut Healthcare System & Yale University, Psychiatry, 950 Campbell Ave, Psychology Service (116B), West Haven, CT, 06516*, Morris D. Bell, Ph.D., Bruce E. Wexler, M.D.

SUMMARY:

Cognition has been identified as a strong determinant of vocational function in schizophrenia (1). There is also a growing body of literature indicating that cognition in schizophrenia can be improved (2). We examined whether adding cognitive remediation to a vocational rehabilitation program would positively impact work productivity outcomes, assessed at the end of the 6-month active treatment, and at a follow-up 12-months from intake. 145 veterans diagnosed with schizophrenia or schizoaffective disorder were randomly assigned to one of two 6-month conditions: Work Therapy only (WT) or Neurocognitive Enhancement Therapy (NET) plus WT (NET + WT). WT consisted of up to 20 hours a week of paid work with job placements at the medical center, along with additional work supports. NET + WT consisted of up to 15 hours of WT plus up to 5 hours of computerized cognitive training. Mixed random effects

analyses indicated a significant increase in hours worked and money earned over time for both conditions ($p < .0001$). Whereas both groups had similar productivity outcomes at the end of the 6-month active phase, differences emerged at the 12-month follow-up, at which time the NET + WT group worked more hours than the WT only group ($p < .03$). Additional analyses indicated that those individuals who responded to NET as evidenced by improved cognitive function worked the most and were more likely to be competitively employed.

These findings highlight the importance of providing work opportunities for individuals with schizophrenia as well as the benefits of incorporating cognitive remediation into vocational rehabilitation programs.

1. Green MF: What are the functional consequences of neurocognitive deficits in schizophrenia?[see comment]. American Journal of Psychiatry 1996; 153(3):321–30

2. Kurtz MM, Moberg PJ, Gur RC, Gur RE: Approaches to cognitive remediation of neuropsychological deficits in schizophrenia: a review and meta-analysis. Neuropsychology Review 2001; 11(4):197–210

REFERENCES:

1. Bowie CR, Reichenberg A, Patterson TL, Heaton RK, Harvey PD: Determinents of real-world functioning performance in Schizophrenia: Correlations with cognition, functional capacity, and symptoms. American Journal of Psychiatry 163:418–425, 2006.
2. Becker D, Drake R: A Working Life for People with Severe Mental Illness. New York, Oxford Press, 2003.
3. Wexler BE, Bell, MD: Cognitive remediation and vocational rehabilitation for schizophrenia.
4. Bell MD, Bryson G, Greig T, Corcoran C, Wexler B. Neurocognitive enhancement therapy with work therapy: effects on neuropsychological test performance. Archives of General Psychiatry, 2001; 58: 763–768.

SYMPOSIUM 89—PASSAGES: PERSPECTIVES OF WOMEN PSYCHIATRISTS NEGOTIATING CAREER TRANSITIONS

EDUCATIONAL OBJECTIVES:

Attendees will learn about healthy factors to consider for their retirement lives as well as personal and professional "Encore" experiences in the retirement life stage beyond 3 acts, of the presenter.

No. 89A
RETIREMENT AS A LIFE PASSAGE

Leah J. Dickstein, M.D. *3006 Dunraven Dr, Louisville, KY, 40222–6126*

SUMMARY:

Retirement, as the "ENCORE" to 3 Acts of Life, is definitely changing for many women and men today. As physicians we must consider retirement issues long before we enter this life stage such as its definition for us, our general and psychiatric health, our personal goals for our time ahead, whether in continuing involvement though in different directions in a professional life and new and old choices and opportunities and changes for and within personal lives.

Issues to be discussed include gender across all of them. Long-held visions and as yet unmet goals must be courageously faced and good risks taken with knowledge, insights, courage, commitment, compassion and creativity. Maintaining, seeking, and developing old and new personal and professional relationships should be considered in frequent time set aside, often never before taken.

Reading biographies and obituaries as well as personal insights gained from courageous reflection, can open days and years of heretofore unpredicted opportunities for personal and professional development as well as simultaneous contributions to others and to the worlds, both small and large within and beyond past expectations with conviction, good ethics, courage, compassion.

No. 89B
THE JUGGLING ACT: BALANCING THE SCALES AT MID-CAREER

Carol A. Bernstein, M.D. *NYU School of Medicine, Department of Psychiatry, 550 First Avenue, NBV 20 N11, New York, NY, 10016–6402*

SUMMARY:

Mid-career options are exciting and challenging. I will be discussing these transitions in my talk, along with helpful hints and opportunities.

No. 89C
CAREER TRANSITIONS FOR WOMEN IN PSYCHIATRY

Joan A. Lang, M.D., *Psychiatry, St Louis University, 2711 Lafayette Street, Soquel, CA 95073*

SUMMARY:

Transitions in the careers of women psychiatrists may be planned or surprising, desired and/or feared, smooth or disruptive. Considering the experiences of others, while not yielding experimental data nor formulae for success, may enable clearer thinking and wiser reflections on one's own current or future transitions.

No. 89D
PURSUING DIFFERENT PATHS IN ACADEMIC PSYCHIATRY

Laura W. Roberts *Medical College of Wisconsin, Dept of Psych & Behav Med, 8701 W Watertown Plank Rd, Milwaukee, WI, 53226–3548*

SUMMARY:

A fulfilling career in academic psychiatry may develop along many different lines, and a variety of different "choice points" will be encountered in the course of an academic psychiatrist's professional life. This presentation will explore typical and atypical paths taken by successful and effective academic psychiatrists.

No. 89E
TO THINE OWN SELF BE TRUE

Melva I. Green *109 Persimmon Cir, Reisterstown, MD, 21136–6462*

SUMMARY:

Concerns regarding marriage, children, finances, relocation, job choices and career paths are commonplace at various stages over anyone's professional development life cycle. Yet it's easily arguable that this balance is a more tenuous for women and more particularly women of color. In navigating this journey the words of William Shakespeare, *To thine own self be true*, reign true. The art of balancing personal desires and responsibilities requires along with a thoughtful strategy, a brutal honesty with oneself. In allowing some-

one else to define who one is or to not be truthful with oneself, the ability to discover and cultivate the best self is at a tremendous loss. This presentation seeks to promote some basis philosophies about openness with self: [1] it allows an acceptance of weaknesses and an appreciation of strengths [2] gives strength and [3] builds healthy boundaries. An embracement of these perspectives can help to shape a personal vision, a roadmap for positioning one self to get there, recruitment of mentors and role models and a comfort in working towards the goals set forth.

No. 89F
PASSAGES: NAVIGATING CAREER CHANGES WITHIN THE HEALTH CARE INDUSTRY

Kathy M. Vincent, M.D. *University of Louisville SOM, Dept of Psychiatry & Behavioral Sciences, 500 S Preston St # 210, University of Louisville SOM, Louisville, KY, 40202–1702*

SUMMARY:

This session will explore the transition between a nursing career and a career as a physician and woman psychiatrist.

No. 89G
PASSAGES: THE PERSPECTIVE OF A FEMALE MIT NAVIGATING THROUGH THE MEDICAL SCHOOL AND RESIDENCY YEARS

Navdeep K. Dhaliwal, M.D. *University of Louisville School of Medicine, Department of Psychiatry and Behavioral Sciences, 501 East Braodway, Suite 340, Louisville, KY, 40202*

SUMMARY:

According to the Graduate Medical Education National Consensus from 2003, the number of women graduating from all US residencies increased a total of 10.8% from 1999 to 2003. In 1999, the number of women graduating from accredited psychiatry programs was 43.5%. By 2003, this figure rose to exactly 50.0 % and this upward trend is projected to continue into the forseeable future. As such, issues pertaining to female psychiatrists in training are critical. These include topics such as balancing one's personal and professional goals, seeking mentorship early during medical school and residency, negotiating the life stages of relationships, marriage, pregnancy, and parenthood during medical training, and finally handling gender bias in the continuum of training. This portion of the symposium will address these and other issues relevant to women during the context of medical school and residency training, all from the perspective of a member in training.

REFERENCES:

1. Vailliant, George E., M.D. Aging Well: Surprising Guideposts to Happier Life from the Landmark Harvard Study of Adult Development, Little, Brown & Co. Mass. 2006.
2. Roberts LW, Hilty DM. Handbook of Career Development in Academic Psychiatry and Behavioral Sciences. Washington DC: APPI, 2006.
3. Chapter in a Book – Super, D. E.; Savickas, M. L.; and Super, C. M. "The Life-Span, Life-Space Approach to.
4. Austin, Linda: What's Holding You Back?, New York, Basic Books, 2000.
5. Foreman-El-Masri, Dickstein LJ: A resident's guide to surviving psychiatric training.

SYMPOSIUM 90—STUCK IN THE BLACK BOX: PRESCRIBING ANTIDEPRESSANTS: A PATIENT SAFETY APPROACH

EDUCATIONAL OBJECTIVES:

Participants will: 1) learn to assess suicide risk when prescribing antidepressants; 2) will consider the needs of special populations such as children, the elderly in prescribing; 3) will be informed about when and how genetic analysis must be done prior to prescribing; and 4) will integrate a resident's perspective in avoiding errors while managing patients.

No. 90A
ASSESSING SUICIDE RISK IN PRESCRIBING ANTIDEPRESSANT MEDICATIONS

Geetha Jayaram, M.D., *Johns Hopkins University, School of Medicine, Department of Psychiatry, Meyer 4–181, Johns Hopkins, Baltimore, MD, 21287*

SUMMARY:

Background: Good doctors and competent staff members make errors. In prescribing antidepressants, professional competence not only requires knowledge of the medications and their obvious benefits and risks, but also a thorough knowledge of the patient and his/her environment in which treatment occurs.

Antidepressant prescriptions for suicidal patients must include an assessment of 1) patient related, 2) systems related, 3) process related factors. Among those that are frequently overlooked in patient related assessments are educating the patient, simplifying safe dosage regimens, providing only necessary doses, and developing a therapeutic relationship with the patient.

System factors that need attention, particularly in inpatient settings involve the cohesiveness and communication among caregivers, regular and repeated pharmacological assessments of acutely ill patients, proper hand offs at transitions, to name a few.

Some process related factors that need increased attention are timely assessments for ongoing support and education, involvement of significant family members, gathering a history of non-response to medications, completing a risk/ benefit analysis.

This presentation will not repeat generally available textbook information on antidepressants, but will seek to provide a practical guide that enables clinicians to practice with keen judgement and attention to areas commonly overlooked. Case examples from actual clinical practice will be provided.

No. 90B
FROM OBSTETRICS TO PEDIATRICS TO GERIATRICS: SAFE ANTIDEPRESSANT PRESCRIBING ACROSS THE YEARS

Yad M. Jabbarpour, M.D., *Office of Chief of Staff, Catawba Hospital, PO Box 200, Catawba, VA 24070–0200*

SUMMARY:

Mood Disorders are serious and life-threatening illnesses. If untreated disability is high[1], including somber morbidity and mortality safety risks. 60% of the 30,000 annual suicides in the United States is associated with depression. Increases in prescriptions for SSRIs and other new-generation non-SSRIs are associated with lower suicide rates both between and within counties over time and may reflect antidepressant efficacy, compliance, a better quality of mental health care, and low toxicity in the event of a suicide attempt by overdose[2]. Bipolar disorder is the psychiatric disorder most associated with suicide[3]. Anxiety disorders can have significant impact on a person across the lifespan. Although mood disorders and anxiety

disorders were originally thought to be rare in pediatric and the geriatric populations, data support not only the existence of these illnesses but the impact of these illnesses upon the individual in their recovery and the family in their lives. Peripartum and postpartum mood and anxiety disorders impact the mother as well as her relationship with others, including the newborn. The risk of untreated psychiatric illnesses is high. However, clinicians are also needing to balance the evidence-based risk and perceived risk of antidepressants and alternatives. The FDA provides guidelines and warnings for antidepressants. A crucial step in safe antidepressant use is an ethical and evidence-based approach via informed consent. Antidepressants can be a vital and safe treatment modality for persons with mental illnesses.

No. 90C
MAKING IT TO MORNING: A RESIDENT'S PERSPECTIVE

Jason G. Roof, M.D., *Department of Psychiatry and Behavioral Sciences, U.T. Houston Medical School, 1300 Moursund St., Houston, TX 77030–3406*

SUMMARY:

In an academic training facility, a resident of psychiatry will often be the first physician to come into contact with a new patient. Residents in such situations evaluate and determine an initial framework of treatment for the patient's care. Many therapeutic options are available at this point and may include further care at the facility itself or referral to an outside source. Included with the various other difficulties to be overcome in this environment are information gathering problems such as incomplete histories from the presenting patient and their family as well as incomplete, inaccessible, or nonexistent medical records. Additionally, a recent study regarding resident error suggests excessive work hours, inadequate supervision and problems with communication between residents and staff may contribute to errors in care. Although this may be a less-than-optimal evaluation point to begin a treatment regimen, the initial treatment framework constructed by a resident can influence the direction of care of the patient for the duration of their inpatient stay and may well affect the direction of treatment for years to come. This presentation will explore characteristic and typical experiences of a resident physician as they assess patients and create treatment plans in the face of these multiple difficulties. Particular attention will be paid to starting, continuing or discontinuing medication regimens and how stabilization of the patient in an acute state of their illness can differ from later maintenance therapies. Additionally it will examine the role of serotonin selective reuptake inhibitors in this environment and explore practical current issues and information regarding the recent black box warning assigned to them regarding suicidality.

No. 90D
EDUCATING RESIDENTS IN PATIENT SAFETY

Carl B. Greiner, M.D., *Nebraska Medical Center, Department of Psychiatry, 12731 Burt St, Omaha, NE, 68154*

SUMMARY:

Psychiatric residents need to demonstrate competence in identifying medical errors. The practice of psychiatry includes specific areas that can generate medical errors: administration of medication with adverse reactions, assessment of suicide and violence, inadequate or missed diagnoses, inappropriate treatment, negligent discharge from the hospital, and inadequate communication with other caregivers.

Educational efforts will be discussed to increase the residents' "index of suspicion" about the development of medical errors, relevant systems issues, techniques to review errors, approaches to improved "handoff" of patients to fellow residents, and the ethics of providing an apology when an error has occurred. Comparisons between patient safety programs for residents in psychiatry and obstetrics/gynecology will be identified.

No. 90E
STUCK IN THE BLACK BOX: SAFE PRESCRIBING OF ANTIDEPRESSANTS USING A PATIENT-SAFETY APPROACH

Alfred Herzog, M.D., *Hartford Hospital, Psychiatry/Administration, 80 Seymour St, Hartford, CT, 06102–5037*

SUMMARY:

The field of genetic testing as applied to psychiatry is still rather inchoate 1. We remain far from predicting, based on genetic testing, which patient will respond to which antidepressant 2. However, the field of genetic testing has progressed sufficiently to be able to determine with good reliability, which patients, based on certain combinations of CYP structures, will be normal, fast or slow metabolizers of a particular antidepressant 2. Information is now likewise available to show which other medications a patient may be taking is similarly affected by a particular CYP structure 3.

This presentation will demonstrate a variety of outcomes from genetic testing and how, in turn, this information is and was useful in the antidepressant selection and treatment of patients in a primary outpatient-based psychiatric setting.

REFERENCES:

1. American Psychiatric Association. Practice guideline of patients with Major Depressive Disorder. Am J of Psychiatry 2000;157, Suppl 4: 1–45.
2. Rubin SB, Zoloth L. Margin of Error: The ethics of mistakes in the practice of medicine. Hagerstown: University Publishing Group, 2000.
3. Kirchheiner, J, Nickchen K, Bauer M, et al. Pharmacogenetics of antidepressants and antipsychotics: the contribution of allelic variations to the phenotype of drug response. Mol Psychiatry. 2004;9:442–473.
4. Mental Health: A Report of the Surgeon General, 1999, available at http://www.surgeongeneral.gov/library/mentalhealth/home.html, accessed June 2, 2006.
5. Gibbons RD, Hur K, Bhaumik DK, Mann JJ, The relationship between antidepressant use and rate of suicide. Arch Gen Psychiatry. 2005 Feb; 62(2): 165–72.
6. American Psychiatric Association: Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors, November 2003.

WORKSHOPS

MONDAY, MAY 21, 2007

MEDIA WORKSHOP 1

PERSONAL TRANSFORMATION THROUGH AN ENCOUNTER WITH DEATH: AKIRA KUROSAWA'S "IKIRU"

Chairperson: Francis G. Lu, M.D., *1001 Potrero Avenue, Suite 7M, San Francisco, CA 94110*

EDUCATIONAL OBJECTIVES:

1) To understand how an awareness of one's mortality can evoke four existential issues (death, meaninglessness, isolation and freedom)

2) To understand how the use of film can facilitate our appreciation of these existential issues for ourselves and in our work with patients

3) To understand how grappling with these four existential issues can lead to a transformation of consciousness

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 these existential issues, our hero Watanabe traces the path of the Hero's Journey as described by the mythologist Joseph Campbell among others. Simultaneous to this outward arc, Watanabe experiences an inward arc of transformation of consciousness taking him from the individual persona 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 of cinematic masterworks.

REFERENCES:

1. Lu F: Personal Transformation Through an Encounter With Death: A.
2. Richie D: The Films of Akira Kurosawa, Third Edition. Berkeley, CA:.

MEDIA WORKSHOP 2

"BROKEBACK MOUNTAIN": THE MYTH, THE REALITY, AND THE CONTROVERSY
APA New York County District Branch's Committee on Gay and Lesbian Issues

Chairperson: Kenneth Ashley, M.D.,*First Avenue at 16th, New York, NY 10003*
Presenters: Danni Michaeli, M.D., Daniel Garza, M.D., Steven J. Lee, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to appreciate issues of intimacy, disclosure, and anti-homosexual bias that gay men have faced historically, and continue to deal with, as well as the emotional reactions caused by this film.

SUMMARY:

This session will give participants the opportunity to watch and discuss on the most controversial films of recent years.It is the story of two young men who meet and fall in love in 1963 on a shepherding job on Brokeback Mountain in Wyoming. The film documents their complex relationship over the next twenty years. Through moderated discussion, participants will have an opportunity to explore impression of the national uproar fostered by the movie, thereby offering a broader discussion about conflicts engendered by images of homosexuality. A further emphasis will be placed on exploring transference issues and prevailing stereotypes regarding masculinity as it relates to communication, intimacy, vulnerability, and sexuality, Included in the presentation, reviews and blogs which appeared at the time of the film's releaase will serve as testimony about said conflicts, and as stimulus for exploration of individual and communal conflicts.

REFERENCES:

1. Holleran A: The Magic Mountain. The Gay & Lesbian Review Worldwide 2006; 13 (2).
2. Cabaj RP, Stein TS (eds): Textbook of Homosexuality and Mental Health. Washington, DC, American Psychiatric Press, 1996.

TUESDAY, MAY 22, 2007

MEDIA PRESENTATION WORKSHOP 3

"WHEN THE LEVEES BROKE: A REQUIEM IN FOUR ACTS BY SPIKE LEE" THE PSYCHIATRIC DIMENSIONS OF HURRICANE KATRINA
APA Council on Minority Mental Health and Health Disparities

Co-Chairpersons: Anthony T. Ng, M.D., *8777B Piney Orchard Parkway, Suite 204, Odenton, MD 21113*
Francis G. Lu, M.D., *1001 Potrero Avenue, Suite 7M, San Francisco, CA 94110*
Presenters: Annelle Primm, M.D., David E. Post, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the psychiatric dimensions of disasters such as those experienced by the victims and survivors of Hurricane Katrina.

SUMMARY:

WHEN the LEVEES BROKE: A REQUIEM in FOUR ACTS is a 2006 film by the noted African-American director Spike Lee. In four one-hour episodes, the entire film traces through heart-rending personal stories the destruction of New Orleans by Hurricane Katrina in August 2005, the despair and resilience of the people, and their struggles to rebuild their communities and lives. (Due to time constraints, only the first two episodes will be shown in this media workshop). "New Orleans is fighting for its life," says Lee. "These are not people who will disappear quietly - they're accustomed to hardship and slights, and they'll fight for New Orleans. This film will showcase the struggle for New Orleans by focusing on the profound loss, as well as the indomitable spirit of New Orleaneans." Three months after Katrina struck, Lee, cameraman Cliff Charles and a small crew made the first of eight trips to New Orleans. "Spike wanted to offer multiple points of view," says his longtime editor, Sam Pollard. "He needed to represent the voices from the community, the different levels of government, activists and the celebrity element to provide a balanced take on the issues facing New Orleans." Lee and his team selected close to 100 people from diverse backgrounds that represented a wide range of opinions to interview, including Governor Kathleen Blanco; Mayor Ray Nagin; activists Al Sharpton and Harry Belafonte; CNN's Soledad O'Brien; and musicians Wynton Marsalis, Terence Blanchard and Kanye West among others.

REFERENCES:

1. Dyson M: Come Hell or High Water: Hurricaine Katrina and the Color of Disaster. Cambridge, MA, Perseus Books, 2006.
2. Brinkley D: The Great Deluge: Hurricaine Katrina, New Orleans, and the Mississippi Gulf Coast. William Morrow, New York, 2006.

MEDIA WORKSHOP 4
"THIRTEEN": PARENTING AND TREATING THE ADDICTED TEENAGER
APA Corresponding Committee on Treatment Services for Patients With Addictive Disorders

Co-Chairpersons: Alvaro Camacho, M.D., *9500 Gilman Drive, San Diego, CA 92093*
Petros Levounis, M.D., *1000 Tenth Avenue, Suite 8C-02, New York, NY 10019*
Presenters: Marjorie E. Waldbaum, M.D., Milagros Demandante, M.D., Varinder Rathore, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1) Advise parents on how to help prevent addiction in teenagers, and 2) Recommend treatment options and interventions for substance abusing adolescents.

SUMMARY:

"Thirteen" (2003, 100 minutes) is a film about a thirteen-year old girl, Tracy, who wants to fit in with the popular school culture of her peers. Sexual experimentation, drug abuse, and conduct violations become powerful tools for Tracy in her efforts to "belong" and a nightmare for Tracy's mother in her ambivalence to intervene. "Thirteen" is a movie about adolescence, the loss of innocence, and growing up_fast. Substance use is intertwined in a world of expectations, peer pressures, family dynamics, and ultimately identity and responsibility. The film is rated R for drug use, self destructive violence, language, and sexuality_all involving young teens.

In this workshop, we will introduce the film in its psychiatric context and follow up the screening with commentary and discussion. Experts in Addiction Psychiatry and Child and Adolescent Psychiatry from the Committee on Addiction Treatment Services, along with psychiatrists-in-training will lead the conversation focusing on three questions: (a) What can a parent do to prevent their teenager from using drugs or alcohol? (b) What can a parent do to help their teenager who suffers from a substance use disorder? and (c) What is the role of the general psychiatrist in advising parents and adolescents who struggle with addiction?

The workshop is open to all psychiatrists who would like to learn more about parenting and addiction but is particularly targeted towards members in training and early career psychiatrists.

REFERENCES:

1. Kaminer Y, Tarter RE: Adolescent substance abuse. In Textbook of Substance Abuse Treatment, 3rd Edition, edited by Galanter M, Kleber HD, Washington, DC, American Psychiatric Publishing, 2004, pp 505-518.
2. McGovern G: Terry: my daughter's life-and-death struggle with alcoholism. New York, Plume, 1996.

WEDNESDAY, MAY 23, 2007

MEDIA WORKSHOP 5
"ROCK BOTTOM": UNDERSTANDING THE METHAMPHETAMINE EXPERIENCE AND THE STRUGGLE FOR SOBRIETY

Chairperson: Steven J. Lee, M.D., *130 West 15th Street, New York, NY 10011*
Presenters: Petros Levounis, M.D., Colin A. Weil, B.A., Jay Corcoran, M.D., Ubaldo Leli, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the positive and negative experiences of men-who-have-sex-with-men (MSM) methamphetamine users, recognize the sociocultural context in which meth is used in the MSM community, and describe various strategies for working with these patients.

SUMMARY:

Using a documentary film called Rock Bottom, this workshop explores the experiences of men who have sex with men (MSM) who have become addicted to methamphetamine and struggle with sobriety. This brief but powerful documentary follows four men through their experiences of using methamphetamine, from the euphoric high to the painful losses in life, as well as the difficulty of achieving recovery. The movie provides a glimpse of the insiders' emotional experiences of methamphetamine, as well as a clear portrayal of the sociocultural context in which meth is used and the internal conflicts of meth addicts contemplating quitting. After the film, discussion will focus on of how the experiences described in the film may guide clinicians to more effective ways of treating methamphetamine addiction.

This workshop is intended for clinicians of various disciplines who work with MSM who use methamphetamine. Participants are encouraged to discuss their own examples of treating people, including but not limited to MSM, who suffer from methamphetamine-related disorders.

REFERENCES:

1. Kosten TR, Singha AK. Stimulants. In Textbook of Substance Abuse Treatment, Second Edition, edited by Galanter M, Kleber HD. Washinton, DC, American Psychiatric Press, 1999, pp 183-194.
2. Halkitis, PN, Green, KA; Mourgues, P. Longitudinal Investigation of Methamphetamine Use among Gay and Bisexual Men in New York City: Findings from Project BUMPS. J Urban Health 2005; 82(1 Supl. 1): i18-25.

MEDIA WORKSHOP 6
"WE ARE DAD": HIV-POSITIVE CHILDREN AND LESBIAN, GAY, BISEXUAL, OR TRANSGENDER PARENTING

Chairperson: R. Kaan Ozbayrak, M.D., *1233 Main Street, Holyoke, MA 1040*
Presenters: Marshall Forstein, M.D., Warren Y.K. Ng, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should become more familiar with the psychosocial makeup and needs of HIV-positive children, and the psychosocial and legal factors that challenge lesbian, gay, bisexual or transgender (LGBT) couples as they plan on and live through LGBT parenting.

SUMMARY:

Lesbian, gay, bisexual or transgender (LGBT) couples have become increasingly more visible in the United States. Massachusetts is marrying same-sex couples, Vermont and Connecticut are offering civil unions, and several States offer partner-benefit programs. Given the long-standing shortage for skilled and dedicated foster and adoptive parents, LGBT couples fulfill an important gap as more and more research support the notion that children of lesbian mothers and gay fathers are not more likely to become homosexual and are not measurably different from children raised by heterosexual parents in terms of personality development, psychological development, and gender identity. However, in many States, State or local laws continue to work against successful foster parenting or adoption by LGBT adults.

We are presenting WE ARE DAD, a fascinating 68-minute 2005 documentary by Michael Horvat (http://www.WeAreDad.com) which tells the story of two gay men, raising five HIV-positive children as foster parents. As successful they have been as foster parents, they are not legally allowed in Florida to adopt one of the

children they have raised, when the child became HIV-negative. Florida would rather take the child away from the parents who have raised him, and make him available for adoption by a new set of parents who are heterosexual.

This Media Workshop will give us the opportunity to discuss the complex issue of LGBT parenting along with a perspective of HIV+ children and their psychosocial makeup. Following the viewing, each presenter will provide discussion points to the audience according to the area of their focus: Dr. Ng, HIV+ children; Dr. Ozbayrak, prospective LGBT parents; Dr. Forstein, raising kids as LGBT parents.

REFERENCES:

1. Downs AC, James SE: Gay, lesbian, and bisexual foster parents: strengths and challenges for the child welfare system. Child Welfare 2006; 85(2):281-98.
2. Tasker F: Lesbian mothers, gay fathers, and their children: a review. J Dev Behav Pediatr 2005; 26(3):224-40.

MEDIA WORKSHOP 7
PSYCHIATRIC RESIDENTS' PERSPECTIVE OF COUPLES AND FAMILY THERAPY TRAINING

Chairperson: Ian E. Alger, M.D., *500 East 77th Street, New York, NY 10162-0021*
Presenter: Anita Menfi, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be aware of those learning needs important to psychiatric residents, as they begin to engage in clinical work with couples and families

SUMMARY:

In this video documentary, PGY III psychiatric residents and faculty review their personal experiences of a yearlong course and supervision in couples' and family therapy. This presentation should be of special interest to those who are already, or may soon be developing or expanding residency training in couples' and family therapy

REFERENCES:

1. Berman, Ellen: Family Systems Training in Psychiatric Residencies, Family Process, Vol. 44 No. 3, 2005, pg. 321-335.
2. Faulker, Paul: Trainee Perceptions of Teaching of Different Psychotherapies, Australian Psychiatry, Vol. II (2), June 2003, 209-214.

MONDAY, MAY 21, 2007

COMPONENT WORKSHOP 1
A MODEL CURRICULUM FOR TEACHING THE WORKING ALLIANCE AS A CORE PROCESS ACROSS PSYCHOTHERAPIES
APA Committee on Psychotherapy by Psychiatrists

Chairperson: Eric M. Plakun, M.D., *25 Main Street, P.O. Box 962, Stockbridge, MA 1262*
Presenters: Donna M. Sudak, M.D., Bernard D. Beitman, M.D., David A. Goldberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be familiar with a curriculum that incorporates "common factors", cognitive behavioral and psychodynamic perspectives to the formation of a working alliance.

SUMMARY:

Recognizing the importance and the difficulty of teaching psychotherapy to residents, the APA Committee on Psychotherapy by Psychiatrists has developed a teaching model that unifies the three psychotherapy competencies into one integrated whole. The stem of the resulting "Y-shaped" structure includes the core processes of all psychotherapies, with attention to how these processes are conceptualized differently in cognitive behavioral and psychodynamic psychotherapy. The Y-model then diverges into cognitive behavioral therapy [CBT] and psychodynamic branches comprised of core features of CBT or psychodynamic therapy derived from the comparative psychotherapy process research literature. In the Y-model, CBT and psychodynamic therapy are conceptualized as two divergent therapies that build on basic skills, with differentiated approaches to managing therapist activity, the role of the unconscious, the therapeutic relationship, symptoms and affects. Supportive psychotherapy is conceptualized as principally based on skills learned in the stem of the Y, with components drawn from both cognitive behavioral and psychodynamic treatments.. This workshop offers a brief overview of the Y-model, and then focuses on its implementation as a teaching tool by illustrating a model curriculum to teach the working alliance that incorporates core processes of all psychotherapies and distinctive features of cognitive behavioral and psychodynamic approaches. Half the workshop will be reserved for audience discussion.

REFERENCES:

1. Blagys MD and Hilsenroth MJ. 2000. Distinctive features of short-term psychodynamic-interpersonal psychotherapy: A review of comparitive psychotherapy process literature. Clinical Psychology: Science and Practice; 7:167 - 188.
2. Blagys MD and Hilsenroth MJ. 2002. Distictive activities of cognitive-behavioral therapy: A review of comparative psychotherapy process literature. Clinical Psychology Review; 22: 671 - 706.

COMPONENT WORKSHOP 2
REENTRY AFTER PRISON: REJOINING THE COMMUNITY
APA Corresponding Committee on Jails and Prisons

Chairperson: Henry C. Weinstein, M.D., 1111 Park Avenue, New York, NY 10128
Presenters: William Arroyo, M.D., Erik Roskes, M.D., H. Richard Lamb, M.D., Cassandra F. Newkirk, M.D., Tom Hamilton, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to:

- describe the reentry process that must be navigated by inmates
- discuss systems and policy approaches to increasing the likelihood that inmates with mental illness will successfully return to their communities

SUMMARY:

In this workshop, participants will engage in a discussion of the vital role of the community reentry process at the end of a term of incarceration. Often overlooked, the reentry process can pose great difficulty to any inmate; transition back to the community is especially difficult for inmates with mental illness. While limited, research has demonstrated that inmates nearing release suffer increases in stress markers. Some individuals frankly decompensate in anticipation of an impending release, a process referred to as "gate fever" or "short time syndrome." The period of stress extends beyond the actual point of release into the early months of the individual's time in the community; if not dealt with appropriately, elevated stress

may result in behaviors that lead to reincarceration (either because of technical violations or the commission of new crimes).

The workshop presenters will discuss the reentry process from a variety of viewpoints. Attention will be paid to specific populations, including youth and women. A model program working with inmates reentering their communities will be presented. Audience participants will engage in an active discussion of reentry issues from their own perspectives, as the workshop attempts to develop a systematic approach to the issue. Specific policy approaches to reentry will be highlighted.

Target: Mental Health and Criminal Justice professionals working in institutional or community settings.

REFERENCES:

1. American Psychiatric Association, Psychiatric Services in Jails and Prisons, Second Edition, Washington DC, American Psychiatric Press, 2000.
2. Council of State Governments. Criminal Justice / Mental Health Consensus Project. New York: Council of State Governments. June 2002.

COMPONENT WORKSHOP 3
COMMITTING OCCUPATIONAL SUICIDE: A PSYCHIATRIC EMERGENCY
APA Corresponding Committee on Psychiatry in the Workplace

Chairperson: Andrea Stolar, M.D., 11100 Euclid Avenue, Cleveland, OH 44106
Presenters: Marcia Scott, M.D., Marie-Claude Rigaud, M.D., Marilyn Price, M.D., Aron S. Wolf, M.D., Steven E. Pflanz, M.D.

EDUCATIONAL OBJECTIVES:

The format of the workshop will be interactive. Following a 45-minute overview, the remainder of the workshop will be case presentations with active audience participation. Audience members will be presented with common scenarios and asked to consider the information provided in the session to develop management strategies. At the conclusion of this workshop, the participant should be able to recognize and manage acute and prodromal symptoms of occupational impairment and be familiar with alternatives to medical leave, the ADA, and the role of the psychiatrist in preventing disability and supporting work function.

SUMMARY:

A mid-fifties executive is experiencing difficulty keeping up with the demands of his job; his recurrent depressive disorder is becoming increasingly symptomatic. He is frustrated with the stress of work and wonders about taking early retirement. How does one advise? To meet DSM criteria most conditions require that symptoms cause clinically significant distress, or impairment in social, occupational or other important areas of function. When the impairment is social, psychiatrists do not usually encourage their patients to withdraw further, yet when the impairment is occupational, patients are often encouraged to take a medical leave. An illness-based decline in function can result in the loss of income, loss of health benefits, loss of day-to-day structure, and loss of work-related social support. For the highly skilled employee, workplace deterioration can amount to occupational suicide.

Once an employee has taken leave, his identity shifts within days, and new barriers to recovery are erected. This workshop will challenge us to consider our contribution to the pathologizing of distress in the workplace. We will address the impact of physician behavior on psychiatric impairment and how to monitor and be alert to signs of occupational impairment. Normalizing distress and supporting active coping strategies are a psychiatric equivalent to physical therapy. For patients who must leave work due to illness or who seek to return to employment when symptoms have abated, an awareness of how and what can be communicated to third parties may be crucial to a successful transition. There are ends to disability income, yet mental illnesses are chronic and recurrent. A working knowledge of the ADA, the role of accommodations, and alternatives to leave of absence can help us help our patients avoid occupational suicide.

REFERENCES:

1. Stewart WF, Ricci JA, Chee E, Hahn SR, Morganstein D: Cost of lost productive work time among US workers with depression. JAMA 2003; 289:3135-3144.
2. Wang PS, Beck AL, Berglund P, McKenas DK, Pronk NP, Simon GE, Kessler RC: Effects of Major Depression on moment-in-time work performance. Am J Psychiatry 2004; 161:1885-1891.

COMPONENT WORKSHOP 4
PROVIDING OPTIMUM CARE FOR PATIENTS WITH MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES IN THE PSYCHIATRIC EMERGENCY ROOM
APA Committee on Developmental Disabilities

Chairperson: Katharine A. Stratigos, M.D., *10 West 74th Street, New York, NY 10023*
Presenters: Joel Bregman, M.D., Carlos Almeida, M.D., Stephanie Hamarman, M.D., John de Figueiredo, M.D., Ramakrishnan Shenoy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to:

1. Identify and evaluate acute psychiatric symptoms and syndromes in patients with mental retardation/developmental disabilities (MR/DD) in the psychiatric emergency department (ED).
2. Understand the unique challenges of symptom interpretation, diagnosis, treatment, and referral for these patients, including the difficulties of admission to inpatient units.
3. Conceptualize strategies to meet the special needs of MR/DD patients and optimize treatment in the psychiatric ED.
4. Develop proactive post-discharge treatment plans for MR/DD patients.

SUMMARY:

Epidemiological studies conducted over the past several decades have documented a high prevalence of treatable psychopathology and neuropsychiatric disorders among persons with mental retardation and developmental disabilities (MR/DD), several fold in comparison with those in the general population (1-2). Although the range of psychopathology manifested by persons with mild to moderate mental retardation is similar to that within the general population, symptom characteristics and presentation can differ. This is particularly true for mood disorders and psychosis, necessitating alternate assessment procedures. Persons with severe to profound mental retardation are more likely to exhibit externalizing than internalizing forms of psychopathology; nonetheless, symptom clusters mirror general psychopathology and often can be identified and successfully treated.

Since deinstitutionalization over the last few decades, an increasing number of persons with disabilities are living with their families or in community-based residential settings. As a result, psychiatric services (differential diagnosis and treatment) are being sought within local community and hospital settings. Despite this, few psychiatrists have expertise in evaluating and treating MR/DD patients. Not uncommonly these patients will require acute services in psychiatric emergency departments, and oftentimes, this setting is not specifically equipped to address their unique needs. There are also many

difficulties admitting these persons to inpatient units both clinically (e.g., individual placed in a new environment and change in the routine and staff) and for hospital systems (e.g., financial and staffing concerns). Thus, ideally the psychiatric emergency room would take the important lead in the systematic evaluation, treatment, and disposition of MR/DD patients, as well as liaison with the family or residential home in hopes of formulating a constructive and optimistic disposition.

REFERENCES:

1. Bregman JD: Current developments in the understanding of mental retardation: II. Psychopathology. Journal of the American Academy of Child & Adolescent Psychiatry 1991; 30(6):861-872.
2. Rush K, Bowman L, Eidman S, Toole L, Mortenson B: Assessing psychopathology in individuals with developmental disabilities. Behavior Modification 2004; 28 (5): 621-637.

COMPONENT WORKSHOP 5
OBESITY IN OUR YOUTH: THE WEIGHT OF MENTAL ILLNESS
APA/SAMHSA Minority Fellowship Selection and Program Corresponding Committee

Co-Chairpersons: Daniel I. Bober, D.O., *66 Dinsmore Avenue, Framingham MA 1702*
Jodi E. Star, M.D., *11924 West Forest Hill Boulevard, Wellington, FL 33414*
Presenters: Ana E. Campo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to:

1) Define childhood obesity and the epidemiological consequences in children

2) Recognize the importance of the relationship between co morbid psychiatric conditions and childhood obesity

3) Demonstrate the adverse effects of psychotropic medications and their role in contributing to the obesity epidemic

4) Define the disproportionate burden of childhood obesity in underserved populations

5) Understand the role of the child psychiatrist in treating childhood obesity

SUMMARY:

Although the rate of obesity in children and adolescents has nearly doubled in the last thirty years, child psychiatrists often fail to correctly identify and address this ever increasing problem. It is well established that early intervention will ensure the greatest chance for success, especially in patients with comorbid psychiatric disorders. In the past, emphasis has been placed on screening and intervention in the primary care setting, but the child psychiatrist can play a critical role in addressing this issue as well. The purpose of this workshop is to provide clinicians with tools for the diagnosis and management of children who are overweight or obese. More detailed presentations will discuss psychotropic induced weight gain, as well present the psychiatric disorders that are often comorbid in overweight children. A final session will focus on the disparities found in underserved populations and the impact of the community and media in promoting weight gain in our child population. Additionally, advice will be given on disease management strategies using interactive techniques and clinical cases to encourage audience participation.

REFERENCES:

1. Corell CE, Carlson, HE:Endocrine and metabolic adverse effects of psychotropic medications in children and adolescents.J Am Acad Child Adolesc Psychiatry. 2006 Jul;45(7):771-91.
2. Vila E, Zipper E, Dabbas M et al:Mental Disorders in Obese Children and Adolescents.Psychosom Med. 2004 May-Jun;66(3):387-94.

COMPONENT WORKSHOP 6
HOW TO BECOME A MORE CREATIVE TEACHER: WINNING STRATEGIES FOR RESIDENTS AND FACULTY
APA Council on Medical Education and Lifelong Learning

Co-Chairpersons: Joan M. Anzia, M.D., *1115 Forest Avenue, River Forest, IL 60305-1355*
Lowell D. Tong, M.D., *401 Parnassus Avenue, San Francisco CA 94143-0984*
Presenters: Margo Lauterbach, M.D., Jerald Kay, M.D., Theodore Feldmann, M.D., Rachel C. Molander, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop participants will:

1) Be able to incorporate at least two innovative teaching methods into lectures, seminars, case conferences or rounds.

2) Be able to give and receive feedback about teaching performance

SUMMARY:

At a time when the quality of teaching in psychiatry is more important than ever, but resources are limited, how do you get more "bang for your buck"? How to you inject fun, excitement and spontanaeity in teaching?

Presenters will describe and demonstrate innovative techniques that can be used in a variety of different formats (lectures, small groups, seminars, rounds) with a range of teachers - from residents to senior faculty. Then workshop participants will have the opportunity to practice novel techniques in a specific teaching task. Participants will also be able to provide feedback to each other and to the presenters.

REFERENCES:

1. Whitcomb, M: More on medical education reform. Academic Medicine 2004; 79:1-2.
2. National Research Council: How People Learn. Washington D.C; National Academy Press, 2000.

COMPONENT WORKSHOP 7
BEYOND POWERPOINT: HOW TECHNOLOGY CAN IMPROVE MENTAL HEALTH TRAINING
APA Ad Hoc Work Group on Information Systems

Co-Chairpersons: Seth Powsner, M.D., *20 York Street, 2039 CB, New Haven, CT 06510-3202*
Sharon Packer, M.D., *145 4th Avenue, Apt 7K, New York, NY 10003-4920*
Presenters: Thomas J. Kim, M.D., , Willadene Walker-Schmucker, M.Ed.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the benefits and limitations of online educational technology and telepsychiatry. He or she should be able to describe how online technology could improve their teaching or clinical environment, or explain why such technology would not be helpful.

SUMMARY:

Mental health training must convey nuance, not just fact. Clinician-patient interaction (to say nothing of "transference") can be harder to teach than hard sciences like pharmacology. The electronic distor-

tions of online interaction seem to make them unusable for teaching any subtlety. However, some literature suggests that these very distortions are advantageous-- online instruction can create a more neutral environment, one in which trainees can directly experience the benefits of suspended judgment and less prejudiced human interaction.

The literature indicates that some students learn better in online environments than traditional settings. Cultural barriers are reduced (gender and ethnic prejudice): online, soprano voices sound just as "loud" as basso profundo voices. Asian Americans raised to be soft-spoken and to avoid interrupting, may communicate more freely online. Minorities generally, can make a more equal call on class attention through the medium of email or text messages.

Common wisdom holds that young trainees, "Gen Y," prefer a digital environment. They have been raised in a world of information on-demand: Internet, iPods, and satellite TV. How can teachers espouse the importance of making patients comfortable and understood, if they themselves insist on old style seminars and ward rounds.

This workshop will start by polling attendees about their experiences with online instruction (programmed modules, PowerPoint webcasts, podcasts, chat-room seminars, etc). Their answers form the basis for a "learning contract:" What technology do they already understand? What new information do they need? With that in mind, our panel will give a series of short presentations describing their experience incorporating current technology (internet, video, etc) into their teaching and clinical work. Presentations will emphasize actual classes and cases. Our audience will be encouraged to ask questions and add their own personal observations. At the end, there will be a short wrap-up to emphasize take-home points.

REFERENCES:

1. Packer S: Racial revelation in the color blind cyber-class. In Race in the College Classroom: Pedagogy and Politics, edited by TuSmith B, Reddy MT. New Brunswick NJ, Rutgers University Press, 2002.
2. Fenichel M, Suler J, Barak A, Zelvin E, Jones G, Munro K, Meunier V, Walker-Schmucker W.

COMPONENT WORKSHOP 8
MENTAL HEALTH TRANSFORMATION: IS IT FOR REAL?
APA Committee on Psychiatric Administration and Management

Chairperson: L. Mark Russakoff, *701 North Broadway, Sleepy Hollow, NY 10591*
Presenters: Sy A. Saeed, M.D., Brian M. Hepburn, M.D., Lydia E. Weisser, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to articulate the concepts underlying recovery in mental health and how the transformation of the mental health care system oriented towards recovery affects administration of psychiatric programs. Participants will learn about the distinctions between older models of treatment, including medical and rehabilitative, and recovery. Participants will learn about the empowerment of patients concomitent with the movement towards evidenced-based practices. The evolving roles of psychiatrists in the provision of treatment will be discussed. The challenges for administrators of how to help mental health professionals adapt to the evolving models of healthcare will be discussed. The challenges confronted by the director of a state hospital will be reviewed as a stimulus for discussion.

SUMMARY:

The President's New Freedom Commission on Mental Health challenged the industry to adopt a new paradigm for psychiatric care. Most practitioners have not been either trained or educated about the differences between older models of care and a recovery orientation. They are calling for a transformation of mental health care, and administrators will need to lead the change. The workshop will discuss the principles and the challenges of such change.

REFERENCES:

1. Achieving the Promise: Transforming Mental Health Care in America. Pub no SMA-03-3832. Rockville, Md., Department of Health and Human Services, President's New Freedom Commission on Mental Health, 2003.
2. Aarons, GA: Transformational and Transactional Leadership: Association with attitudes toward evidence-based practices. Psychiatric Services, 57:1162-1169, 2006.

COMPONENT WORKSHOP 9
MENTAL HEALTH AND MEN WHO HAVE SEX WITH MEN IN THE AFRICAN-AMERICAN COMMUNITY: CONTROVERSIES ABOUT THE DOWN LOW
APA Committee on Gay, Lesbian, and Bisexual Issues

Co-Chairpersons: Lourdes M. Dominguez, M.D., *165 West 66th Street, Suite 4, New York, NY 10023*
Napoleon B. Higgins, Jr., M.D., *1560 West Bay Area Boulevard, Suite 110, Dickinson, TX 77539*
Presenters: Kelvin Exum, M.D., Sandra C. Walker, M.D., Saundra A. Maass-Robinson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to:

1.) describe psychodynamic issues in identity formation and sexual behavior in this population,

2.) recognize the impact of the "coming out process" both individually and socially,

3.) understand the social influences on this phenomenon

4.) recognize the impact on HIV transmission and mental health in this community, and discuss possible interventions

SUMMARY:

Men who have sex with men without a sexual identification of gay or bisexual have been a longstanding phenomenon in many ethnic and racial groups. Recently, the term "on the down low" has become more widely known for those men who have sex with men in the African American community. An understanding of this behavior has been particularly salient as the impact of nondisclosure of risky sexual behavior has been identified as a contributing to higher rates of HIV transmission. This workshop will explore the phenomenon of the "down low," including issues impacting on sexual identity formation, psychodynamic, and socio-cultural influences on this way of life. Special issues in the African American population such as higher rates of incarceration, negotiating safer sex, disclosure of sexual orientation/sexual behavior, and sexual practices will be discussed. The impact of racism, racial stereotypes and stigma will be delineated as will the contribution of religion and spirituality. These themes will be highlighted by a case presentation, as will the impact on African American communities. As this is a workshop, audience participation will be strongly encouraged to further characterize themes relevant to this topic. We will end with a discussion of possible social and interpersonal interventions. This workshop is being co-sponsored by the Committee of Black Psychiatrists and the Committe on Gay Lesbian and Bisexual Issues.

REFERENCES:

1. King JL: On the down low: a journey into the lives of "straight" black men who sleep with men. New York, Broadway Books, 2004.
2. Boykin K: Beyond the down low:sex lies and denial in black america. New York, Avalon Publishing Group, 2006.

COMPONENT WORKSHOP 10
GENDER AND CULTURE IN ACADEMIC LEADERSHIP: IMPROVING THE CURRENT STATE FOR WOMEN
APA Women Psychiatrists

Chairperson: Roslyn Seligman, M.D., *231 Albert Sabin Way, Cincinnati, OH 45267-0559*
Presenters: Vivian Reznik, M.D., Robert Freedman, M.D., Ming T. Tsuang, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to recognize and know the steps needed for them (women) to advance in academic psychiatry and to be chosen for leadership positions. They should be able to recognize institutional roadblocks that have previously limited such advancement. The participants should be able to have a roadmap for improving institutional roadblocks.

SUMMARY:

This workshop explores gender and culture issues; personal, societal, cultural, and institutional; that have limited equity and opportunity and impeded the advancement of women in academic medicine/psychiatry and in academic medical/psychiatric leadership and provides solutions.

Medical school entry classes are now composed of about 50% women. Despite this near-equal representation a 2004 report in the Annals of Internal Medicine notes that equal compensation remains evasive. The article notes that, "The medical profession should be mortified that no other profession in the United States exhibits greater salary disparities." More recently, an article in the NEJM and an accompanying editorial focuses on a 35 year perspective on the "Gender Gap" in authorship in academic medical literature. As of 2005, only 15 percent of full professors and 11 percent of department chairs in medicine were women. Who will mentor the next academic medical/psychiatric leaders and what remedies will alter this disgraceful history?

A diverse group of influential leaders will present briefly various perspectives. The views of distinguished leaders are important in understanding these matters and in providing remedies for effective change. Dr. Freedman is editor of the American Journal of Psychiatry, Chair of the Department of Psychiatry at Colorado, and a distinguished researcher. Dr. Reznik has directed a formal mentoring program to advance junior women faculty. She is a member of the UCSD National Center of Leadership in Academic Medicine. Dr. Tsuang is a distinguished researcher, academician, journal editor, and director of a Center at the UCSD and an Institute at Harvard.

This workshop will be interactive. Come with your views and your questions. The health of academic medicine and women is directly linked to these issues. To date the health score card is dismal. The workshop will be successful if we leave with a roadmap for addressing these travesties with definitive cures.

REFERENCES:

1. Wingard DL, Garman KA, Reznik V: Facilitating Faculty Success: Outcomes and cost benefit of the UCSD National Center of Leadership in Academic Medicine. Acad Med 2004;S79(10):.
2. Bickel J, Wara D, Atkinson BF, et al. Increasing women's ;eadership in academic medicine: report of the AAMC Project Implementation Committee. Acad Med. 2002;77:1043-61.

COMPONENT WORKSHOP 11
OPTIMIZING DEPRESSION TREATMENT: CLINICAL APPLICATIONS OF MEASUREMENT-BASED CARE
APA American Psychiatric Institute For Research And Education (Apire)

Co-Chairpersons: Jack S. McIntyre, M.D., *2000 Winton Road, South, Rochester, NY 14618*
Farifteh F. Duffy, Ph.D., *1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209*
Presenters: Henry Chung, M.D., Madhukar H. Trivedi, M.D., Darrel A. Regier, M.D., David J. Katzelnick, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will gain hands-on experience with incorporating measurement-based care in routine psychiatric practice. Participants will become familiar with the use of quantitative instruments such as the nine-item Patient Health Questionnaire (PHQ-9) and the sixteen-item Quick Inventory of Depressive Symptoms ($QIDS_{16}$) for monitoring depression severity in routine clinical care.

SUMMARY:

Depression is a common medical condition, responsible for an estimated economic cost of over $40 billion annually, a large impact on quality of life and productivity, and indirect effects on other health states including cardiovascular disease (1). Prior research highlights the importance of a systematic approach to ensure adequate diagnosis and management of depression in clinical practices (2). Routine follow-up and monitoring are considered essential components for the management of depression. However, the majority of clinicians do not employ a systematic approach in monitoring patient outcomes when treating depression. Much like blood pressure monitoring for hypertension, a simple quantitative instrument to measure severity of depression holds significant promise in improving treatment for depression in primary care and psychiatry alike.

This session will: 1) discuss depression care based on proactive measurement of depression severity in the practice through application of the chronic care model, 2) discuss incorporating STAR-D findings to facilitate measurement-based care in routine clinical care, 3) introduce the nine-item Patient Health Questionnaire (PHQ-9) and the sixteen-item Quick Inventory of Depressive Symptoms ($QIDS_{16}$) and other evidence-based tools for monitoring depression severity and managing depression, highlighting their value to treatment decision-making, 4) review findings of the APA National Depression Management Leadership Initiative (a collaborative venture of the APA, the American Academy of Family Physicians, and the American College of Physicians) to improve care for patients with depression, and 5) explore ways of overcoming potential barriers in the implementation of measurement-based care in routine clinical practice.

REFERENCES:

1. 1. Von Korff M, Ormel J, Katon W, Lin EH: Disability and depression among high utilizers of health care. A longitudinal analysis. Arch Gen Psychiatry 1992; 49:91-100.
2. 2. Gilbody S, Whitty P, Grimshaw J, Thomas R: Educational and organizational interventions to improve the management of depression in primary care: a systematic review. JAMA 2003; 289:3145-3151.

COMPONENT WORKSHOP 12
REACHING OUT: APPROACHES TO SUICIDE AMONGST THE PHYSICIAN POPULATION
APA Corresponding Committee on Physician Health, Illness, and Impairment

Chairperson: Malkah T. Notman, *54 Clark Road, Brookline, MA 2445*
Presenters: Derek Puddester, M.D., Penelope P. Ziegler, M.D., Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop, participants will be able to:

1. Identify the determinants of physician suicide, the current controversies in the physician-suicide literature, and the current efforts in physician-suicide research.
2. Develop and individual and institutional plan for reaching out and supporting a suicidal colleague.
3. Demonstrate a reasonable understanding of the components of response to a completed physician-suicide.

SUMMARY:

Physician suicide is an ongoing concern. Data have varied and there have been methodological problems in the past studies. This workshop summarizes the literature on physician suicide with particular emphasis on the literature of the past ten years, including methodological challenges and reasonable interpretations of the data. Dr. Puddester will present a recent review of international literature by the Canadian Medical Association's Centre for Physician Health and Well Being and the University of Ottowa's Faculty Wellness Program. It suggests that suicide and suicidal ideation amongst physicians and medical students in not uncommon. There is limited experience and skills with dealing with this. This has a significant impact on the physician's family and colleagues. He will also describe a number of methodological issues that limit our quantitative understanding of the problem. Dr. Ziegler will briefly discuss these findings. Dr. Notman will describe the effects on physicians' families particularly in the context of the changing demographic of medicine. Losing a patient has been called one of the most stressful events in a psychiatrist's career. Dr. Myers will discuss how this loss of a patient affects the psychiatrist. He will describe common symptoms and outline ways in which psychiatrists can protect their personal health. Participants will then spend the balance of the workshop engaged in individual and interactive discussion.

REFERENCES:

1. Givens JL, Tjia J: Depressed medical students' use of mental health services and barriers to use. Acad. Med 2002; 77(9):918-921.
2. Frank E, Dingle AD: Self-reported depression and suicide attempts among U.S. women physicians. Am J Psychiatry 1999;156(12):1887-1894.

MONDAY, MAY 21, 2007

COMPONENT WORKSHOP 13
ADVOCACY TRAINING FOR EARLY CAREER PSYCHIATRISTS WITH A FOCUS ON PARITY LEGISLATION
APA Assembly Committee of Early Career Psychiatrists

Chairperson: Carol L. Trippitelli, M.D., *1133 Connecticut Avenue NW, Washington, DC 20036*
Presenters: Bob Kearley, M.D., Jason Young, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to: 1. Understand the current status of parity legislation on the federal and state levels. 2. Understand various strategies for grass roots advocacy and media communications.

SUMMARY:

This workshop will provide information on the current status of parity legislation on both the state and federal levels, and provide advocacy and media communications training for early career psychiatrists and members in training. Early Career psychiatrists have expressed an interest in having more advocacy training available to them and the APA office of government relations has agreed to provide mentorship in this area by sending representatives from their office to participate in this workshop. Early Career psychiatrists will be provided by the office of government relations with up to date reading material on the status of parity legislation throughout the country prior to the workshop. Bob Kearley, the APA State Legislative Field Representative will give a presentation on grassroots advocacy. Jason Young, Deputy Director of the Office of Communications will do a presentation on how to deal with the media. Computer terminals will be set up for letter-writing to Congressmen after the workshop.

REFERENCES:

1. Ruiz, P: Psychiatry, Advocacy, and the Federal Budget, Psychiatric News, Aug 2006; 41:3.
2. Rosenthal, A: The Third House; Lobbyists and Lobbying in the States, CQ Press, 1993.

COMPONENT WORKSHOP 14
UNCOVERING THE SECRET: INTIMATE PARTNER VIOLENCE AMONG ASIAN-AMERICANS
APA Asian-American Psychiatrists

Chairperson: Surinder S. Nand, M.D., *900 South Wood Street, Chicago, IL 60612*
Presenters: Mina Bak, M.D., Jacquelyn Chang, M.D., Yujuan Choy, M.D., Mona H. Gill, M.D., Eugene Lee, M.D.

EDUCATIONAL OBJECTIVES:

Objective:

At the conclusion of this presentation, the participants should be able to

-recognize intimate partner violence among Asian-Americans
-identify cultural factors that contribute to domestic violence
-manage psychiatric consequences and develop strategies for intervention and prevention

SUMMARY:

This workshop will explore the myth of Asian-Americans as the "model minority" by uncovering the hidden secret of intimate partner violence. Some surveys indicate that as much as 47% of Asian-Americans have experienced intimate partner violence. Many sociocultural factors contribute to the cycle of violence, for example, stress of immigration and frustrated expectations, family dynamics, socialized gender roles and role reversal. Barriers to seeking help include stigma, shame, language, financial dependency and isolation. Consequences of domestic violence are often overlooked. In addition to medical problems, there are resulting psychiatric conditions such as depression, anxiety, panic attacks, suicide and substance abuse that are often under-recognized. This workshop will illustrate the challenges of identifying intimate partner violence. Presenters will explore the above issues and help attendees develop strategies for intervention and prevention of domestic violence in this population. This workshop aims to enhance the cultural competence of all clinicians in caring for Asian-Americans.

REFERENCES:

1. Yoshioka, M.R. and Dang, Q. (2000). Asian family violence report: A study of Cambodian, Chinese, Korean, South Asian and Vietnamese communities in Massachusetts, Boston: Asian Task Force Against Domestic Violence, Inc.
2. Weil JM, Hwayun HL, 2004. Cultural considerations in understanding family violence among Asian-American pacific islander families. Journal of Community Health Nursing. 217-227.

COMPONENT WORKSHOP 15
CONTROVERSIES IN THE MANAGEMENT OF BEHAVIORAL DISTURBANCE IN DEMENTIA
APA Committee on Access and Effectiveness of Psychiatric Services for the Elderly

Chairperson: David A. Casey, M.D., *500 South Preston Street, Louisville, KY 40202*
Presenters: Mercedes M. Rodriguez, M.D., Keith R. Stowell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe the types of treatments available for behavioral disturbance in dementia, including both pharmacologic and non-pharmacologic alternatives. The participant should be able to discuss the controversies concerning the use of atypical antipsychotics in dementia, and design an appropriate treatment plan for such a patient with this information in mind.

SUMMARY:

Most dementia patients suffer from behavioral symptoms which often comprise the most difficult aspect of care. Frequently, both environmental and interpersonal issues contribute. A variety of management approaches have evolved, but none have proven ideal. Cholinesterase inhibitors and memantine may play a role but have not proven to be panaceas. A combination of environmental management, caregiver support, and pharmacotherapy are often required. No particular medication has proven ideal. Case reports and small studies which seemed to support a varety of pharmacologic approaches have generally not been confirmed by controlled studies. The small number of such trials have tended to show efficacy for atypical antipsychotics which have become the predominant treatment. Critics have emerged focusing on their safety. The FDA examined the literature and issued several advisories describing an increased risk of cerebrovasular adverse events in some agents, as well as a higher risk of mortality for all atypicals in dementia. These observations have proven controversial and have caused doubt about the best way for clinicians to proceed. No psychotropic agent is actually FDA indicated in dementia. Clinicians must choose among imperfect alternatives. In this workshop we will discuss these issues and report on the rapidly evolving literature. We will also discuss non-pharmacologic management. We will present a case which highlights these issues and invite the audience to participate in discussion. The lack of a consensus should contribute to the expression of a variety of opinions. We will present a logical approach to medication management and the attendant medicolegal issues. Our discussion will include the authors, the audience, and members of the sponsoring component, the APA Committee on Access and Effectiveness of Psychiatric Services for the Elderly. Local experts from the San Diego area will be asked to join the discussion.

REFERENCES:

1. Schneider LS, Dagerman K, Insel P: Efficacy and Adverse Effects of Atypical Antipsychotics for Dementia: Meta-analysis of randomized, placebo-controlled trials. Am J Geriatr Psychiatry 2006;14:191-210.
2. Carson S, McDonagh MS, Peterson K: A systematic review of the efficacy and safety of atypical antipsychotics in patients with psychological and behavioral symptoms of dementia. J Am Geriatr Soc 2006;54:354-361.

COMPONENT WORKSHOP 16
MULTI-NATIONAL PERSPECTIVES OF PSYCHIATRIC ETHICS
APA Ethics Appeal Board

Co-Chairpersons: Donna M. Norris, *54 Cartwright Road, Wellesley, MA 2482*
Driss Moussaoui, M.D., *Rue Tarik Ibn Ziad, Casablanca, Morocco 20010*
Presenters: Wade C. Myers, M.D., William Arroyo, M.D.,

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should be able to recognize, compare and contrast the different codes of psychiatric ethics in force throughout the world.

SUMMARY:

The APA Ethics Committee and the World Psychiatric Association Standing Committee on Ethics will jointly conduct a workshop that will address similarities and differences applicable to the practice of psychiatry. Therapeutic boundary violations, confidentiality, informed consent, industry support, involuntary treatment, psychiatric involvement in torture, and the influence of religious and cultural factors on professional conduct. The audience will have ample opportunities to interact with the presenters who are members of the either the APA Ethics Committee or the Standing Committee on Ethics of the World Psychiatric Association.

REFERENCES:

1. American Psychiatric Association: The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry. United States of America, American Psychiatric Association, 2006.
2. American Medical Association: Code of Medical Ethics of the American Medical Association. United States of America, American Medical Association, 2006.

COMPONENT WORKSHOP 17
HOW TO TEACH CULTURAL COMPETENCE IN GERIATRIC PSYCHIATRY: ADDRESSING UNMET PATIENT NEEDS
APA Committee on Ethnic Minority Elderly

Co-Chairpersons: Maria D. Llorente, M.D., *5470 SW 17 Street, Plantation, FL 33317*
Warachal E. Faison, M.D., *5900 Core Road, North Charleston, SC 29406*
Presenters: Moises Martinez, M.D., Shunda McGahee, M.D., Vernon I. Nathaniel, M.D., Cynthia I. Resendez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to:

1. recognize key cultural aspects of assessment and treatment of older psychiatric patients
2. identify at least 2 teaching methods that are useful in learning cultural competence
3. select the teaching method that is most suitable for the cultural concept to be taught

SUMMARY:

During the next 30 years, the number of older adults with major psychiatric illness is expected to double from 7 to 15 million persons.

During this same time period, the United States will undergo a dramatic transformation into a multi-ethnic/racial society, with minorities comprising 40% of the US population by 2035. By 2020, 21% of the US elderly population will belong to a minority group. Mental disorders occur commonly in ethnic minority elderly, are less likely to be detected, or treated, and are associated with higher utilization and costs of general medical services. Additionally, ethnic minority elderly encounter unique barriers in communicating their healthcare needs, resulting in consistent reports of healthcare disparities, even after controlling for severity of disease and socioeconomic factors. Among the interpersonal aspects of healthcare delivery that have been studied as explanatory factors for these disparities, has been the issue of lack of cultural competence of physicians. Three years ago, the APA Committee on Ethnic Minority Elderly undertook the development of a model curriculum for Cultural Competence in Geriatric Psychiatry, in part, to address this critical unmet patient need.

This Workshop will review the Core Competency Residency Requirements for Cultural competence, with particular application in ethnic minority elderly. A variety of teaching and evaluation methods will be reviewed, and demonstrated, in order to provide workshop participants an opportunity to view the teaching models in action and then be able to interact actively with the instructors. Cultural competence is an invaluable skill for psychiatric clinicians practicing today and in the coming decades.

REFERENCES:

1. 4. Report Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. (2003) Unequal Treatment: Confronting racial and ethnic disparities in health care. Smedley BD, Stith AY, Nelson AR eds. The Na.
2. 3. Ormel J, VonKorff M, Ustun TB, Pini S, Korten A, Oldehinkel T. Common mental disorders and disability across cultures. Results from the WHO Collaborative Study on Psychological Problems in General Health Care. JAMA. 1994 Dec 14;272(22):1741-8.

COMPONENT WORKSHOP 18
PROVIDING SERVICES TO MENTALLY ILL INMATES RETURNING TO THE COMMUNITY
APA Task Force on Forensic Outpatient Services

Chairperson: Steven K. Hoge, M.D., *103 Roloing Hill Road, Manhasset, NY 11030*
Presenters: Alec Buchanan, M.D., Beatrice Kovasznay, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the clinical, legal, social, and administrative obstacles that limit released mentally ill inmates' access to community services. The participant will understand how limited access to services contribute to inadequate treatment, continued homelessness, and recidivism. In addition, the participant will understand the key features of specialized programs designed to address the needs of mentally ill inmates returning to the community, research findings that services result in improved functioning and reduced recidivism.

SUMMARY:

Criminalization of the mentally ill is recognized to be a major social problem confronting post-deinstitutionalization psychiatry. In this workshop, data regarding the scope of criminalizaton, co-morbidities of the incarcerated mentally ill, and legal, social, and administrative barriers limiting post-release access to services. These findings challenge the general assumption that the solution to criminalization is a general increase in funding of the community mental health system. The presenters will describe existing model programs that have shown promising results with respect to treatment goals, functional capabilities, and reduction in recidivism. The lessons from the experience of these programs suggest that specialized services are needed to break the cycle of re-arrest and re-incarceration.

REFERENCES:

1. James DJ, Glaze LE: Mental health problems of prison and jail inmates. US DOJ Special Report, Sept. 2006.
2. Metzner JL, Fryer GE, Usery D: Prison mental health services: results of a national survey of standards, resources, adminstrative structure, and litigation. Journal of Forensic Sciences 1990; 35:433-438.

COMPONENT WORKSHOP 19
BOOT CAMP FOR BURNOUT
APA Representatives of Minority/Underrepresented Groups

Co-Chairpersons: Altha J. Stewart, M.D., *111 South Highland #180, Memphis, TN 38111*
Gail E. Robinson, M.D., *200 Elizabeth Street, Toronto, ON M5G 2C4*
Presenters: Nada L. Stotland, M.D., Tana A. Grady-Weliky, M.D., Melva I. Green, M.D., Eva M. Szigethy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to:

1.Recognize the importance of identifying stress and burnout in women's personal and professional lives

2.Demonstrate practical strategies useful in preventing and handling burnout and stress

SUMMARY:

Over the past 20 years we have witnessed some changes in the status of women, yet there are still conflicting expectations for women seeking balance between their personal and professional lives. The different experiences of women and men in the workplace clearly reflect continued gender differences and discrimination. Available opportunities for success (and the risk of failure), obvious for men aspiring to leadership in their profession, remain blocked to women by the 'lexan' ceiling described by Leah Dickstein. For most women professionals, having to deal with gender stereotypes create tremendous stress and burnout which further complicates efforts to achieve both personal and professional goals.

This presentation will describe the most frequently cited stressors for psychiatrists, manifestations of burnout in women professionals, including psychiatrists, and discuss mechanisms for coping with stress and burnout. The discussion will include an understanding of these issues across the life cycle, especially for those experiencing them in multiple roles and for special populations, as they choose different paths than those assigned by tradition. In addition, tips for managing the stress these women face will be provided. Strategies for managing stress and relaxation techniques will be available on site with live demonstrations.

REFERENCES:

1. Shrier DK: Career and Workplace Issues. In Women's Mental Health: A Comprehensive Textbook, edited by Kornstein SG, Clayton, AH, New York, Guilford Press, 2002, pp 527-54.
2. Fothergill A, Edwards D, Burnard P: Stress, burnout, coping and stress management in psychiatrists: findings from a systematic review. Int J Soc Psychiatry 2004; 50:54-65.

COMPONENT WORKSHOP 20
THE IMPACT OF VIOLENCE IN LATINO COMMUNITIES
APA Committee of Hispanic Psychiatrists

Co-Chairpersons: Andres J. Pumariega, M.D., *6th Avenue and Spruce Street, Reading, PA 19611*
Daniel Castellanos, M.D., *2121 Ponce DeLeon Boulevard, Coral Gables, FL 6924*
Presenters: Esperanza Diaz, M.D., Tatiana Falcone, M.D., Natalie Weder, M.D., Rene J. Valles, M.D.

EDUCATIONAL OBJECTIVES:

1. At the conclusion of this presentation the participant should be able to recognize the impact of violence in Latino communities
2. The main objective of this presentation will be to motivate the participants to learn about how cultural variables can impact in the development of violence in Latino communities as well as to identify some helpful interventions to recognize and prevent domestic violence, child abuse and gang violence in Latino individuals, families, and communities.

SUMMARY:

Latino communities are exposed to different forms of violence that can affect individuals, their families, and the community as a whole. Latino populations are highly vulnerable to traumatic life events. When compared to US-born non Latino whites, Hispanics were 76% more likely to report traumatic experiences in the past, the most common form of trauma were interpersonal violence occurring outside of the family 21%, acute losses or accidents 17%, witnessing death 13%, and domestic violence 12%. The chronic effect of low intensity community violence is greatly overlooked; some specific intrinsic social characteristics of the Hispanic community may predispose Latino families to be chronically exposed to child abuse and domestic violence. These could be also factors contributing to Latino youths participating as gang members, with their comprising as high as 40% of the gang population. The latter impact of these traumatic life events might be associated with poor physical functioning and higher rates of primary care utilization. One of the most effective protective factors in Latino communities is "familismo", which refers to how attitudes and behaviors are governed and sustained within an extended family system. However, many Latino immigrants don't have access to this important cultural strength due to stressful circumstances (i.e. low household income, immigration issues, no medical insurance, and poor living conditions). The lack of such protective values can also predispose vulnerable members of Latino communities to become perpetrators or victims of violence. The purpose of this presentation will be to explore the impact of child abuse, domestic violence and gang violence in Latino communities as well as to evaluate different principles and models of intervention to decrease and prevent violence within the Latino cultural context.

REFERENCES:

1. Hollman E, Silver R, Waitzkin H. Traumatic life events in primary care population a study in an ethnically diverse sample. Archives of Family Medicine 2000 (9) 802-810.
2. Kataoka S, Fuentes S, O'donoghue, Castillo-Campos et al. A community participatory research partnership, the development of a faith based intervention for children exposed to violence. Ethnicity and Disease 2006 16 (supl 1) S89-97.

COMPONENT WORKSHOP 21
CONCEPTUALIZING ACCESS TO PSYCHIATRIC CARE
APA Access to Care Work Group

Co-Chairpersons: Eliot Sorel, M.D., *2031 East Street, N.W., Washington, DC 20037*
Roger Peele, M.D., *401 Hungerford Drive, Rockville, MD 20850*

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop the participants will be able to explicate substantial historical and current themes as to the meaning of "access" to care and treatment of people with psychiatric illnesses and apply them to advocacy initiatives for our patients.

SUMMARY:

Conceptualizing access to care and treatment of people with psychiatric illnesses in the United States has undergone a number of changes through the decades from 1) the state asylums approach to access, 2) the federal entitlement programs initiatives in the 1960's that substantially changed the sense of access, 3) through the managed care impact on access in the 1980's and 1990's, 4) to this century's emphasis on achieving cultural and linguistic access as well as enhanced services integration. Furthermore, access to care and treatment needs to be conceptualized and contextualized globally.

REFERENCES:

1. Office of the Surgeon General: Surgeon General's Report on Mental Health: Race, Culture, and Ethnicity. US Department of Health and Human Services, August 2001.
2. Kessler, R., et al, Prevalence, Severity, and Comorbidity of 12-Month DSM IV Disorders in the National Comorbidity Survey Replication, Arch Gen Psychiatry2005, 62:617-627.

COMPONENT WORKSHOP 22
PEARLS AND PITFALLS IN NEGOTIATING YOUR FIRST JOB
APA Committee of Residents and Fellows

Co-Chairpersons: Justin B. Hunt, M.D., *310 Charles Street, Little Rock, AR 72205*
Lea E. DeFrancisci Lis, M.D., *30 East 21st Street, Apt. 30S, New York, NY 10010*
Presenter: William H. Campbell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to understand key concepts necessary for sound decision-making in negotiating professional employment including:

I. Exploring Job Opportunities
II. Interviewing
III. Negotiating Agreements
IV. Contracting
V. Professional Liability Insurance
VI. Psychiatric Practice Management
VII. Legal and Risk Management Considerations

SUMMARY:

Experience has shown that residency programs in psychiatry do not adequately prepare residents for the job market. Psychiatry residents must acquire a working knowledge of both the common and competing interests of employers and employees to adequately protect their interests. This workshop provides a systematic review of key concepts that will empower the participants to make sound decisions when negotiating their first job. The faculty, the director of a large mental health care system and former health maintenance organization senior executive, will cover the key concepts in a PowerPoint presentation. Following the presentation, ample time will be devoted to a Q&A session to promote faculty-participant interaction.

REFERENCES:

1. Fisher R, Ury W, Patton B: Getting to Yes: Negotiating Agreement Without Giving In. 2nd Edition. New York, NY, Penguin Books, 1991.
2. Lazarus JA (ed): Entering Private Practice: A Handbook for Psychiatrists. Washington, DC, American Psychiatric Publishing, 2005.

TUESDAY, MAY 22, 2007

COMPONENT WORKSHOP 23
EVALUATING COMPETENCY IN PSYCHOSOMATIC MEDICINE
APA Council on Psychosomatic Medicine

Co-Chairpersons: Mary J. Massie, M.D., *1275 York Avenue, New York, NY 10021-6007*
Thomas N. Wise, M.D., *3300 Gallows Road, Falls Church, VA 22042*
Presenters: Lawson R. Wulsin, M.D., David F. Gitlin, M.D., Angel A. Caraballo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants will know: 1) the ACGME core competency requirements for the training of residents and fellows in psychosomatic medicine (PM); 2) the knowledge (i.e., specific syndromes and disorders, psychiatric aspects and complications of nonpsychiatric illness and treatment, etc.), skill (i.e., evaluating and discussing consultation findings) and attitude requirements for the competent PM practitioner; 3) how competency of trainees can be effectively and practically evaluated in PM through case presentation; and 4) how training program directors (TPDs) can utilize information learned from resident assessment to modify their program objectives and strengthen teaching in PM.

SUMMARY:

As a first step in a long term effort designed to emphasize educational outcome assessment in residency programs and in the accreditation process, the ACGME defined 6 areas (patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice) in which residents must achieve competency for a training program to achieve and retain ACGME accreditation. Currently specialists in PM are defining the knowledge, skills, and attitudes required for training in PM; designing learning objectives and curricula to provide educational experiences as needed in order for trainees to demonstrate achievement in the competencies; developing tools to measure achievement of objectives; and are determining how to use the information gleaned to improve the educational experience. **Purpose:** Attendees will learn how TPDs can efficiently and effectively evaluate the success of their trainees in achieving learning in the competency areas in PM. **Methodology:** In this case based, interactive workshop two challenging psychosomatic medicine cases will be described. The participants, all leaders in the field of PM education and members of organizations committed to developing standards (APM) and assuring competency (ABPN), will show what a resident or a fellow needs to know or to demonstrate in order to be considered competent in PM. During these lively demonstrations (one on the resident level and one on the fellow level), the audience will observe how resident/fellow performance is assessed. The presenters will invite debate with the workshop participants about the useful application of ACGME standards of competence to assess trainee performance and the use of assessment data to provide feedback to trainees and to modify program curricula. **Results and Importance:** This workshop will help TPDs receive continued program accreditation from the ACGME in the area of PM and will facilitate trainees' understanding of how they are evaluated.

REFERENCES:

1. Andrews LB, Burrus JW: Core Competencies for Psychiatric Education: defining, teaching, and assessing resident competence. Washington, DC, American Psychiatric Publishing, Inc 2004.
2. Scheiber SC, Kramer TAM, Adamowski SE: Core Competencies for Psychiatric Practice: What Clinicians Need to Know (A Report of the American Board of Psychiatry and Neurology, Inc.). Washington, DC, American Psychitric Publishing Publishing, 2003.

COMPONENT WORKSHOP 24
CULTURE MATTERS: A MULTICULTURAL PERSPECTIVE ON THE IMMIGRANT EXPERIENCE
APA/AstraZeneca Minority Fellows

Co-Chairpersons: Alejandra Postlethwaite, M.D., *3180 Sawtelle Boulevard, Suite 102, Los Angelos, CA 90066*
Natalie D. Weder, M.D., *42 Mechanic Street, New Haven, CT 6511*
Presenters: Liwei L. Hua, M.D., Jacqueline Henschke, M.D., Navdeep K. Dhaliwal, Rascha Dughly, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be better able to understand the mental health consequences of immigration on different immigrant groups. They will be able to identify mental health needs of different immigrant populations. Most importantly, participants will enhance their cultural competence through a sharpened recognition of the relevance of immigration in a biopsychosocial formulation.

SUMMARY:

The mental health consequences of migration have been debated in American psychiatry since the end of the nineteenth century. Studies during the first half of the twentieth century emphasized the social, economic, political, and health-related challenges of recent immigrants. These works touted assimilation into American society, also known as acculturation or "Americanization," as the key to dispelling most of the immigrants' disadvantages. An extensive body of literature has since emerged questioning the assumption that acculturation is equally beneficial to all immigrant groups.

This workshop will explore the impact of immigration amongst a variety of ethnic minority groups representative of the population of United States of America. Initially we will examine general patterns of immigration and the statistical evidence behind recent immigration trends. We will explore how perspectives on mental illness from the country of origin impact the immigrant's ability and willingness to seek treatment in the U.S. We will also discuss the impact of torture and complex trauma in various immigrant populations. In addition, we will review the data behind mental health manifestations in a multigenerational perspective.

REFERENCES:

1. Thielman SB: Psychiatry and social values: the American Psychiatric Association and immigration restriction, 1880-1930. Psychiatry.1985 Nov; 48(4):299-310.
2. Odegaard O: A statistical investigation of the incidence of mental disorder in Norway. Psychiatry Q 1946; 20: 382-3.

COMPONENT WORKSHOP 25
SWEET CHILD OF MINE: PREGNANCY AND PARENTAL LEAVE DURING RESIDENCY
APA/GlaxoSmithKline Fellows

Co-Chairpersons: Keith R. Stowell, M.D., *3811 O'Hara Street, Pittsburgh PA 15213*
Vishal Madaan, M.D., *6922 Spring Street, Omaha, NE 68109*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to:

1. Recognize the impact of pregnancy and new parenthood on residency training for the new parents, other residents, and administrators;
2. Understand unique issues of psychiatry residents as new parents;
3. Develop a dialogue amongst administrators and trainees on this issue.

SUMMARY:

Issues involved in starting a family have become more relevant in psychiatry residency training. Pregnancy presents special challenges for trainees, including the potential maternal-fetal health risks of undergoing pregnancy and rigorous clinical training simultaneously. Additionally, the demands of residency often conflict with the realities of childbearing for both female and male new parents. Such trainees also deal with a multitude of other issues, including leave, interruptions in training, and possible loss of income. These matters impact not only the new parent resident, but have wider ramifications - impacting patients, fellow residents, and administrators.

This workshop, led by the APA/GlaxoSmithKline Fellows, will focus on these important topics. Through an interactive case presentation format, the impact of new parenthood on residency training will be explored and critically appraised. Existing models for managing pregnancy and parental leave during residency will be discussed and critiqued. Audience participation will allow for collaboration among residents, program directors, and others with the goal of developing other potential methods of improving the experience for new parent residents and the many other involved parties.

REFERENCES:

1. Finch SJ: Pregnancy during residency: a literature review. Acad Med 2003;78:418-428.
2. Walsh A, Gold M, Jensen P, Jedrzkiewicz M: Motherhood during residency training: challenges and strategies. Can Fam Physician 2005;51:990-991.

COMPONENT WORKSHOP 26
THE APA WEB SITE: POTENTIAL FUTURE DIRECTIONS AND OPPORTUNITY FOR DIALOGUE
APA Ad Hoc Work Group on Information Systems

Chairperson: Robert C. Hsiung, M.D., *5737 South University Avenue, Chicago, IL 60637*
Presenter: William Bruce

EDUCATIONAL OBJECTIVES:

Educational Objectives

At the conclusion of this workshop, the participant should be able:

1. To describe the main features of the current Members Corner area of the APA web site.

2. To feel his or her suggestions for that area have been heard and taken seriously by APA.

SUMMARY:

The APA web site <http://www.psych.org> is used by its components, district branches, and allied organizations, advocacy coalitions, governmental organizations, the public -- and APA members. APA has recently redesigned the Members Corner area of the site, and in this workshop, the chair of the APA Ad Hoc Work Group on Information Systems and the Chief Information Officer of the APA present a status report and potential future directions and seek feedback from APA members. APA may or may not wish to follow the lead of other organizations. We will have Internet access, participants will be encouraged to suggest changes that might be made and other web sites that might be emulated, and together we will explore those possibilities. If the Members Corner is to be most effective, dialogue is needed.

REFERENCES:

1. Winker MA, Flanagin A, Chi-Lum B, White J, Andrews K, Kennett RL, DeAngelis CD, Musacchio RA. Guidelines for medical and health information sites on the Internet: Principles governing AMA web sites. JAMA 2000 Mar 22-29. 283 (12): 1600-6.
2. Calvert PC, FitzGibbon EJ: The North American Neuro-Ophthalmology Society on the Internet. Journal of Neuro-Ophthalmology 2004 Mar. 24 (1): 88-91.

COMPONENT WORKSHOP 27
UPDATE ON PSYCHIATRY AND LAW
APA Council on Psychiatry and Law

Chairperson: Paul S. Appelbaum, M.D., *1051 Riverside Drive, New York NY 10032*
Presenters: Steven K. Hoge, M.D., Howard V. Zonana, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the major legal issues related to psychiatric advance directives, the insanity defense, and statutes for the civil commitment of sexually violent predators; and to understand the policy questions facing APA on these major issues.

SUMMARY:

The APA Council on Psychiatry and Law addresses major legal issues facing psychiatry on behalf of APA. In this workshop, we will share with the audience several of the "hot topics" that the Council is addressing, including late-breaking matters. Brief presentations will outline the major issues associated with use of psychiatric advance directives, especially by committed patients; revision of the APA's 1982 position statement on the insanity defense; and the evolving nature of statutes for commitment of sexually violent predators, including the role of psychiatrists in implementing those statutes. After reviewing the options facing APA as it makes policy on these issues, feedback will be sought from the audience regarding their views and suggestions for the formulation of APA's positions.

REFERENCES:

1. Appelbaum PS: Psychiatric advance directives and the treatment of committed patients. Psychiatric Services 2004; 55:751-2.
2. APA Position Statement on the Insanity Defense, 1982.

COMPONENT WORKSHOP 28
LEARNING DISORDERS UPDATE FOR MENTAL HEALTH PROFESSIONALS
APA Corresponding Committee on Mental Health and Schools

Chairperson: Marcia J. Slattery, M.D., *6001 Research Park Boulevard, Madison, WI 53719*
Presenters: Jodi E. Star, M.D., Hong Shen, M.D., Lina M. Lopez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to

1. Identify and understand the major types of DSM-IV learning disorders in children and adolescents
2. Identify comorbid psychiatric disorders commonly associated with specific types of learning disorders
3. Demonstrate an understanding of educational rights and programs available for children with learning disabilities

SUMMARY:

Learning disorders (LD) are highly prevalent in youth, affecting up to 5-10% of children and adolescents. The diagnosis of LD is often missed, contributing to both academic and psychosocial sequelae. This presentation will review major DSM-IV Learning Disorders including Reading and Math Disorders, Disorder of Written Expression, and Learning Disorder, Not Otherwise Specified, including Nonverbal Learning Disorders. Discussion will include empirically-based reviews of diagnostic criteria and assessment measures, including office-based screening tools; phenomenology; psychosocial and neurobiological risk factors; and application of major treatment approaches at school and in the home.

Learning disorders (LD) affect up to 5% to 10% of children and adolescents. Mental health professionals are commonly central to the identification of LD in children and the subsequent coordination of essential assessment and treatment interventions. This workshop will focus on the role of the mental health professional in the diagnosis and clinical management of youth with LD. Presentations will include 1) review of major types of LD including phenomenologic, etiologic, assessment, and treatment approaches, 2) discussion of specific types of psychiatric comorbidity commonly associated with different types of LD, including more detailed review of the assessment and treatment of comorbid depression in youth, and 3) examination of types and content of school-based intervention venues including review of recent legal changes in guidelines affecting Individual Educational Programs (IEPs) and related educational plans. Presentations will emphasize the role of the mental health professional in the clinical assessment and treatment of youth with LD within the clinic, home, and school settings. Participants will be encouraged to share their experiences related to challenges and successes associated with the assessment and treatment of youth with LD.

REFERENCES:

1. Kohli A, Malhotra S, Mohanty M, Khehra N, Kaur M: Specific learning disabilities in children: deficits and neuropsychological profile. Int J Rehabil Res. 2005; 28:165-9.
2. Saunders CD, Hall EJ, Casey JE, Strang JD: Subtypes of psychopathology in children referred for neuropsychological assessment. Child Neuropsychol 2000; 6:129-143.

COMPONENT WORKSHOP 29
THE NATIONAL HEALTH INFORMATION NETWORK AND PSYCHIATRY: HOW WILL ELECTRONIC HEALTH RECORDS IMPACT OUR PATIENTS AND OUR PRACTICE?
APA Corresponding Committee on Electronic Health Records

Chairperson: Farrell H. Braziel, M.D., *PO Box 1509, Roswell GA 30077-1509*
Presenters: Peter F. Fore, M.D., Zebulon Taintor, M.D., Robert M. Plovnick, M.D.

EDUCATIONAL OBJECTIVES:

Educational Objectives

At the conclusion of this workshop, the participant should be able to:

1. Describe the current status and major initiatives of the national EHR movement
2. Describe the current activities of the APA involving EHR and identify resources for learning more about and staying abreast of further developments
3. Describe potential advantages of Electronic Health Records

SUMMARY:

In response to the growing political and consumer demand for electronic health records (EHR), the Secretary of the Department of Health and Human Services released in July 2004 the first outline of a 10-year plan to build a national health information infrastructure in the U.S. This effort has been consolidated under the Office of the National Coordinator for Health Information Technology (ONC), which is funding several large-scale efforts to accomplish this goal. It is important that psychiatrists have an understanding of and contribute to this rapidly accelerating movement, ensuring that concerns such as privacy are addressed while optimizing advantages such as reduction in medical errors, enhanced continuity of care and improved efficiency. This workshop will review the status of the Electronic Health Record movement, privacy and confidentiality issues, and the processes that are being utilized to develop standards and requirements for a nationally interoperable EHR. The workshop will include a demonstration of the VA's VistA system to illustrate some of the features and benefits of EHRs. Participants will be asked to review and/or develop psychiatric "use cases," real-world scenarios that are an effective tool for communicating to clinicians, standardization partners, and vendors the complexities and requirements that are needed for a psychiatry-compatible EHR.

REFERENCES:

1. Connecting for Health: Achieving Electronic Connectivity in Healthcare. New York, NY, Markle Foundation, 2004.
2. Institute of Medicine: Key Capabilities of an Electronic Health Record System. Washington, D.C, The National Academies Press, 2003.

TUESDAY, MAY 22, 2007

COMPONENT WORKSHOP 30
PASSAGEWAYS: PSYCHOLOGICAL ROUTES TO DELINQUENCY AND THERAPEUTIC OPTIONS OUT OF THE JUVENILE JUSTICE SYSTEM
APA Corresponding Committee on Juvenile Justice Issues

Co-Chairpersons: Camilla Lyons, M.D., *330 Brookline Avenue, Boston, MA 2215*
Stephen B. Billick, M.D., *11 East 68th Street, #1-B, New York, NY 10021*
Presenters: Eraka Bath, M.D., Louis J. Kraus, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to:

1. Describe the relationship between childhood and adolescent maltreatment to juvenile delinquency.
2. Identify psychosocial and developmental factors that can limit a child's capacity to participate in his/her trial.
3. Identify the goals of residential treatment as a therapeutic option in juvenile delinquency.

SUMMARY:

The children in the juvenile justice system have high rates of psychiatric illness and navigating the system in search of mental health treatment is complex. This workshop aims to more clearly delineate the paths into and out of the system for the mentally ill juvenile delinquent.

Dr. Lyons will introduce the workshop content and goals; Dr. Billick will moderate discussion among the audience and panelists. Audience participation will be encouraged throughout each presentation using question and answer formats, and surveys of the clinical and administrative experience of audience members. Audience participation will also be solicited during a dedicated 20-minute question and answer session at the conclusion of the workshop.

Dr. Bath will describe the fluidity between the child protective custody system and the juvenile justice system. She will explore the nature of the relationship between childhood maltreatment and the development of juvenile delinquency. She will review how maltreatment interacts with other risk factors, such as poverty, to promote violent behavior.

Dr. Kraus will discuss issues that arise in competency evaluations, including developmental immaturity and cognitive and educational deficits.

Dr. Billick will present an overview of residential treatment, including its historical roots and goals of this treatment option. He will review with the audience a number of case examples to illustrate prevention and treatment of juvenile delinquency.

Dr. Lyons will review case reports of mentally ill children in the juvenile justice system; these cases will highlight the dilemma faced when therapeutic options are lacking for the treatment of acute psychiatric illness in this population.

The workshop will conclude with questions from the audience and discussion by audience and panel members.

REFERENCES:

1. Kraus L, Arroyo W: Recommendations for Juvenile Justice Reform, Second Edition. Washington, D.C., American Academy of Child and Adolescent Psychiatry, 2005.
2. Steuwig J, McCloskey LA: The relation of child maltreatment to shame and guilt among adolescents: psychological routes to depression and delinquency. Child Maltreat 2005; 10(4):324-36.

COMPONENT WORKSHOP 31
DEMENTIA IN DOWN SYNDROME: RISK FACTORS, BIOMARKERS, DIAGNOSIS, AND TREATMENT
APA Council on Aging

Chairperson: John M. De Figueiredo, M.D., *PO Box 573, Chesire CT 06410-0573*
Presenters: Ramakrishnan Shenoy, M.D., Leo O. Noragbon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the reasoning that led to the discovery of the links between Down syndrome and Alzheimer disease; identify the symptoms, signs and behaviors that herald the occurrence of dementia in Down syndrome patients; recognize the overlap of dementia in patients with cognitive limitations associated with mental retardation; and formulate the interventions that are likely to be helpful to Down syndrome patients who become demented.

SUMMARY:

Virtually every person with Down syndrome develops dementia if he or she lives long enough. Neuropathological lesions of Alzheimer disease begin to occur around the age of 40. There are large individual variations in the age of onset of clinical manifestations of dementia. In the past two decades we have achieved remarkable success in the rehabilitation of individuals with Down syndrome and other types of mental retardation. The worsening of cognition in Down syndrome after a successful adjustment to community living comes as a catastrophe to both patients and their caretakers, constituting what we call the "Lazarus syndrome in reverse". This workshop will review and discuss the history of the discovery of the link between Down syndrome and Alzheimer disease; the signaling clinical events that herald the occurrence of dementia; the risk factors and biomarkers of dementia; the clinical presentations of dementia overlapping with the pre-existing intellectual subnormality; and the pharmacological, behavioral, and socioenvironmental interventions that are likely to improve the quality of life and possibly delay the onset of dementia. This interactive workshop will present some useful approaches to educate and comfort the families and caretakers of individuals with Down syndrome who are developing dementia.

REFERENCES:

1. Epstein CJ, Nadel L: Down syndrome and Alzheimer Disease New York, NY, Wiley-Liss 1992.
2. Zigman W, Schupf N, Haveman M, Silverman W: Epidemiology of Alzheimer Disease in Mental Retardation: Results and Recommendations from an International Conference American Association on Mental Retardation 1995 W.

COMPONENT WORKSHOP 32
SPIRITUS CONTRA SPIRITUM: THE STRANGE CASE OF SPIRITUALITY AND ADDICTION: DISCUSSION OF THE 2007 OSKAR PFISTER AWARD LECTURE
APA Corresponding Committee on Religion, Spirituality, and Psychiatry

Chairperson: George Vaillant, M.D., *75 Francis Avenue, Boston, MA 2115*
Presenter: William R. Miller, Ph.D.,

EDUCATIONAL OBJECTIVES:

At the conclusion of this worshop the participant should be able to (1) identify spiritual factors that play a key role in the etiology, course of and recovery from addictions; (2) appreciate the scientific basis for this relationship; (3) distinguish religion from spirituality; and (4) understand the role of spiritual considerations in the integrated treatment of addiction.

SUMMARY:

It is widely believed that spiritual factors play a key role in the etiology, course of, and recovery from addictions. What is the scientific basis for this relationship? How is spirituality different from religion, and how can these constructs be measured in health research? What is known about the outcome of "faith-based" treatment and recovery programs? Should spiritual considerations be integrated with other therapeutic approaches, and if so, how?

REFERENCES:

1. Miller, W. R. (1998). Researching the spiritual dimensions of alcohol and.
2. Miller, W. R., & Thoresen, C. E. (2003). Spirituality, religion, and health:.

COMPONENT WORKSHOP 33
SHOULD THE COMMUNITY REPLACE THE ASYLUM IN THE 21ST CENTURY?
APA Lifers

Co-Chairpersons: Edward Hanin, M.D., *211 East 70th Street, H30G New York, NY 10021-5209*
Sheila Hafter Gray, M.D., *40612 Palisades Station, Washington, DC 20016*
Presenters: Alan Q. Radke, M.D., Roger Peele, M.D., David L. Huang, M.D., Helen MacLeod Thomson

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop participants should be able to

1. Understand the factors to be considered in designing a mental health system that allocates and coordinates care from referral through long term followup
2. Compare community-based and asylum treatment for individuals who have severe and persistent mental disorders.
3. Understand the special challenge of providing care to military service members in deployed situations, and how it may be met.
4. Develop reasoned individualized plans for the psychiatric management of acute and continuous mental disorders.

SUMMARY:

When the community is the preferred setting for psychiatric management of mental disorders, access to care is a critical factor in treatment success. Essential resources may be widely scattered or unavailable; or individuals may be unable to connect with existing programs. Presenters and participants will explore and evaluate some approaches to address these systemic failures. What are the characteristics of a public program that offers comprehensive care from referral through long term followup? Is involuntary outpatient commitment an option in light of recent evidence that it is generally ineffective in reducing rehospitalization? When is it appropriate for a patient to move from the community to an asylum? Does residence in an asylum facilitate access to treatment for individuals who suffer from severe and persistent mental disorders? How can psychiatrists optimize care when resources are constrained and the environment is austere and perilous, as it is during military deployments?

REFERENCES:

1. Lamb HR, Peele R: The need for continuing asylum and sanctuary. Hosp Community Psychiatry. 1984 Aug;35(8):798-802.
2. Swartz MS, Swanson JW, Wagner HR, et al. Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severely mentally ill individuals. Am J Psychiatry 1999 Dec;156:1968'75.

COMPONENT WORKSHOP 34
NOVEL CAREERS IN PSYCHIATRY: WOMEN WHO HAVE MADE THEIR OWN WAY
APA Committee on Women

Co-Chairpersons: Kimberley Bogan, M.D., *10835 Grantwood Avenue, Cleveland, OH 44108*
Melva I. Green, M.D., *109 Persimmon Circle, Reistersown, MD 21136*
Presenters: Gail H. Manos, M.D., Barbara S. Schneidman, M.D., Gabriela Cora-Locatelli, M.D., Janet Taylor, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify and appreciate creative solutions to professional challenges from the perspectives of pioneering women who have built unque careers in psychiatry.

SUMMARY:

In training, psychiatrists are exposed to a limited number of career options. Mentors typically represent traditional choices in academia, private practice or public sector psychiatry. And, yet those who have established non-tradtional paths may have knowledge that could help colleagues through diverse career challenges. In this interactive roundtable discussion, innovative psychiatrists who have had unusual careers will be interviewed regarding challenges they faced as well as successful strategies developed. The personal exploration of their experiences including triumphs and mistakes may offer insighrs to psychiatrists on all levels.

REFERENCES:

1. Book - Heim,P and Golant,S: Hardball for Women: Winning at The Game of Business, 1992.
2. Book - Foreman-El Masri, Dickstein, L: A Resident's Guide to Surviving Psychiatric Training, 2003.

COMPONENT WORKSHOP 35
FOCUSING ON ASIA: A REVIEW OF DISASTERS, INTERVENTION AND PREVENTION PROGRAMS
APA Council on Global Psychiatry

Co-Chairpersons: Bruce S. Singh, M.D., *Level 1 North, Main Block, Victoria, Australia 3050*
Pedro Ruiz, M.D., *1300 Moursund Street, Houston, TX 77030*
Presenters: Pichet Udomratn, M.D., M. Parameshavara Deva, M.D., Tsuyoshi Akiyama, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop, the participants will be able to: 1) understand the extend of the psychiatric impact of these naturally made disasters in Asia, 2) design appropriate methods of psychiatric intervention in this region, and 3) develop preventive strategies vis-a-vis future disasters.

SUMMARY:

The Asian region is one of the most populated areas of the world; yet it is a region that has received little attention from a mental health point of view. This despite the fact that the United States has several thousands of psychiatrists from Asian countries. Additionally, there are about 11 million Asian Americans residing in the United States.

Recently, several naturally made disasters have stricken this region. Among them, the Tsunami that recently affected several countries in this region, including Sri Lanka, Indonesia, etc. Additionally, the recent earthquake that affected Bangladesh and Pakistan. The outcomes of these regional disasters have clearly demonstrated that this region of the world requires attention and assistance from a mental health point of view.

It is therefore very important that we design models of psychiatric care that can effectively be used in addressing the mental health treatment needs of the persons living in this region of the world.

In this workshop, we will address these psychiatric and mental health needs and hope to delineate effective methods of psychiatric intervention geared to this region.

REFERENCES:

1. Shalev AY: Acute Stress Reactions in Adults. Biological Psychiatry, 51:532-543, 2002.
2. Ursano RJ, Fullerton CS, Norwood AE (eds.): Terrorism and Disaster: Individual and Community Mental Health Interventions. Cambridge, United Kingdom, Cambridge University Press, 2003.

COMPONENT WORKSHOP 36
HIV AND METABOLIC SYNDROME
APA Committee on AIDS

Chairperson: Marshall Forstein, M.D., *10835 Grantwood Avenue, Cleveland, OH 44108*

EDUCATIONAL OBJECTIVES:

1. Recognize the metabolic abnormalities sometimes present in patients with HIV/AIDS
2. Understand the psychical and psychological effects of these metabolic changes
3. Gain a working knowledge of the management strategies and available treatment

SUMMARY:

The remarkable progress of medical science in the treatment of HIV and AIDS has been found to have a price tag attached. Physicians are encountering a litany of heretofore-unrecognized metabolic abnormalities and body-composition changes in patients receiving the antiretroviral therapy that has so greatly improved their lives. One of the most distressing observations includes visible changes in body shape and appearance as a result of lipodystrophy. HIV lipodystrophy syndrome, which includes metabolic complications and altered fat distribution, is of major importance in HIV therapy. Lipodsytrophy has significant physical and psychological effects on the individual including, but not limited to, metabolic issues, cardiovascular disease, bodily discomfort, low self esteem, depression, sexual dysfunction, social isolation, and reduced treatment adherence. During this session participants will review metabolic syndrome, discuss the impact of lipodystrophy on HIV management, diagnosis and treatment, steroid use, mental health, and quality of life.

REFERENCES:

1. Carr A, Law M. An objective lipodystrophy severity grading scale derived from the Lipodystrophy Case Definition Score. J Acquir Immune Defic Syndr 2003;33:571-576.
2. Grinspoon S, Carr A. Cardiovascular risk and body-fat abnormalities in HIV-infected adults. N Engl J Med 2005; 352:48-62.

WEDNESDAY, MAY 23, 2007

COMPONENT WORKSHOP 37
CAREER ADVANCEMENT IN ADMINISTRATIVE PSYCHIATRY FOR EARLY CAREER PSYCHIATRISTS
APA Assembly Committee of Early Career Psychiatrists

Chairperson: Dimitri D. Markov, M.D., *1020 Sansom Street, Philadelphia, PA 19107-5004*
Presenters: Arthur L. Lazarus, M.D., Thomas S. Newmark, M.D., Shivkumar Hatti, M.D., Joanette A. Sorkin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to demonstrate familiarity with business theories, leadership skills and issues of career development in administrative psychiatry.

SUMMARY:

Most early career psychiatrists (ECPs) encounter administrative responsibilities in their every day work. The field of psychiatry also presents numerous business and executive opportunities. Yet, like most physicians, ECPs do not have the business training or experience needed for advancement in administrative positions. Because the practice of medicine is often combined with the business of medicine, this workshop, conducted by senior administrative psychiatrists, will help ECPs learn how to better manage their current administrative duties and prioritize goals to develop their careers. The workshop will be highly interactive with emphasis on eliciting the needs of early career psychiatrists and providing guidance from senior faculty.

REFERENCES:

1. Lazarus A: What Threatens Psychiatric Administrator's Job Security? Psychiatric Services 220; 53:1018-1022.
2. Lazarus A: Soften Up: The Importance of Soft Skills for Psychiatrist Executives. Psychiatrist Administrator 2004, 4(1) 19-23.

COMPONENT WORKSHOP 38
THE SACRED HERB AND ADDICTION SCIENCE: A STUDY OF NICOTINE DEPENDENCE AND AXIS I COMORBIDITIES AMONG AMERICAN INDIANS
APA Committee of American Indian, Alaska Native, and Native Hawaiian Psychiatrists

Chairperson: Daniel L. Dickerson, D.O., *1730 State Street, Hamden CT 6517*
Presenters: Joseph J. Westermeyer IV, M.D., David A. Gilder, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to:

1.) Recognize the cultural relevance of traditional tobacco use among American Indians and the importance of implementing culturally-relevant treatments in nicotine cessation programs serving American Indians.

2.) Understand the relationships of nicotine dependence with psychiatric and substance use disorders among American Indians.

3.) Understand the potential influences of culture and genetics with regards to nicotine dependence among American Indians.

SUMMARY:

To examine the co-occurrence of current DSM-IV nicotine dependence with psychiatric and substance use disorders in American Indians. To date, studies analyzing these associations among American Indians have been limited. One recent study found no significant association between smoking and alcohol use in a plains American Indian tribe.

The primary focus of this presentation will be based on findings from our study of nicotine-dependent American Indian veterans. Further commentary with regards to potential genetic and cultural influences of nicotine dependence among American Indians will be discussed. The primary study was based on a community-based survey consisting of 558 American Indian Veterans from the Minneapolis V.A. Hospital. Participants completed a demographic questionnaire, and the Quick Diagnostic Interview Schedule (Q-DIS), which provides Axis I psychiatric diagnoses. Cross tabulations were used to calculate prevalences of disorders. Odds ratios with 95% C.I. derived from chi-square analysis were used to study associations between nicotine dependence with psychiatric and substance use disorders.

In our primary study, nicotine dependence rates were higher among American Indian veterans compared to the general U.S. population (17.6% vs. 12.8%). Nicotine dependence was significantly associated with comorbid anxiety disorders, affective disorders, post traumatic stress disorder, and gambling disorders. Nicotine dependence and alcohol and drug use disorders were not significantly associated. Nicotine-dependent American Indian veterans had noticeably lower rates of alcohol and drug disorders compared to nicotine dependent individuals in a larger U.S. sample (20.4% vs. 34.5% and 24.4% vs. 52.4%, respectively).

The lack of an association between nicotine dependence with both alcohol and drug use disorders in this American Indian veteran

sample was surprising. The traditional and ceremonial use of tobacco may need to be taken into consideration regarding the lack of association between nicotine dependence and other substances use disorders among American Indians.

REFERENCES:

1. Grant B: Nicotine dependence and psychiatric disorders in the United States. Arch Gen Psychiatry 2004; 61: 1107-1115.
2. Enoch MA, Waheed JF, Harris CR, Albaugh B, Goldman D: Sex differences in the influence of COMT Val158Met on alcoholism and smoking in plains American Indians. Alcohol Clin Exp Res 2006; 30: 399-406.

COMPONENT WORKSHOP 39
TRANSCULTURAL ARAB PSYCHIATRY WITH A FOCUS ONWOMEN'S MENTAL HEALTH
APA Arab American Psychiatric Association

Co-Chairpersons: Mahmoud S. Taman, M.D., *411 East Wisconsin Street, Chippewa Falls WI 54729*
Ossama T. Osman, M.D., *P.O. Box 17666 Al-Ain*
Presenters: Mona H. Al-Sawaf, M.D., Naser F. Loza, M.D.,

EDUCATIONAL OBJECTIVES:

OBJECTIVES

At the conclusion of this workshop, the participant should be able to:

1. Demonstrate familiarity with the most prominent characteristics of the Arab culture and its component subcultures.

2.Recognize the importance of cultural variations in the presentation of common psychiatric disorders.

3. demonstrate familiarity with special Arab women mental health challenges.

SUMMARY:

The Arab culture is heterogenous and very much value oriented. The extended family structure still survives the rapid technological, social and economic developments. The speed with which the Arab culture is developing is very striking. Improved educational systems and public awareness is transforming the attitudes toward mental illness. Among special Arab groups, women's special status in such rapidly developing culture is accompanied by unique responsibilities and stresses. Stigama attached to psychiatric problems still exist but is gradually improving. Arab women's Mental health issues including substance abuse and domestic violence are being recognized and confronted. Women mental health issues are increasingly becoming a priority for comrehensive mental health national programs. These special issues will be addressed in details with examples from four different Arab subcultures; in the United Arab Emirates, Saudi Arabia, Egypt and the United States.

REFERENCES:

1. Fakhr El-Islam M: Clinical Applications of Cultural psychiatry in Arabian Gulf Communities. In linical Methods In Transcultural Psychiatry, edited by Okpaku SO, Washington D.C., American Psychiatric Press, 1998, pp155-170.
2. Frances A: Nosologic Perspectives. In Culture and Psychiatric Diagnosis-A DSM-IV Perspective, edited by Mezzich JE, Kleinman A, Fabrego H, Parron DL, Washington D.C., American Psychiatric Press, 1996, pp43-48.

COMPONENT WORKSHOP 40
SUICIDE ICON: THE GOLDEN GATE BRIDGE
APA Northern California Psychiatric Society

Chairperson: Mel Blaustein, M.D., *1199 Bush Street #420, San Francisco CA 94109*
Presenter: Anne Fleming, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop the participant will be able to 1) explain myths and misconceptions about suicide; 2) discuss studies of suicide and impulsivity; and 3) understand the most effective deterrents to suicide.

SUMMARY:

May 2007 marks the 70th anniversary of the Golden Gate Bridge, the most photographed manmade structure in the world and the most lethal. The bridge is the number 1 suicide site in the world with over 1,200 bodies found (not counting those washed out to sea). The death toll continues at two per month.

This year, after eight prior failed efforts to build a suicide barrier, the Bridge Board of Directors has agreed to undertake an engineering and environmental feasibility study.

A coalition of psychiatrists (the Psychiatric Foundation of Northern California), family members of victims and the general public has been instrumental in achieving this major step. This campaign is a significant one. Suicide is the 10th leading cause of mortality nationally, and number three among 15-24 year olds. We know that most suicides are impulsive crisis events of individuals in overwhelming psychic pain. Numerous studies link impulsivity to suicide (see ref.).

We also know that the most effective suicide deterrent is physician education and recognition of depression and restriction of access to lethal means (see ref.).

This workshop will explore the mystique and allure of the Golden Gate Bridge, look at myths and misconceptions about suicide and address the issues of aesthetics and funding.

My co-presenter, who survived a jump from the bridge in December 2000, will tell his story.

REFERENCES:

1. Mann J: Suicide Prevention Strategies. JAMA 2005, 294(16): 2004-2074.
2. Seiden R: Where Are They Now? A Follow-up Study of Suicide Attempters From The Golden Gate Bridge. Suicide and Life Threateing Behavior 1978, 8(4): 203-216.

COMPONENT WORKSHOP 41
LESSONS LEARNED FROM BUSINESS PRACTICES: HOW CAN PSYCHIATRISTS INCREASE THEIR PRACTICE OPPORTUNITIES BY IMPLEMENTING SUCCESSFUL BUSINESS STRATEGIES
APA Committee on APA/Business Relations

Chairperson: Gabriela Cora-Locatelli, M.D., *680 Grand Concourse, Miami Shores, FL 33138-2474*
Presenters: Dauda A. Griffin, M.D., Alan Langlieb, M.D., Kenneth C. Nash, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to:

- Identify the diverse practice opportunities that may be available for entrepreneurial psychiatrists at different stages of their careers
- Implement specific strategies to pursue novel opportunities

- Identify ways of networking with larger groups to align potential services
- Learn about opportunities for cross collaboration with other colleagues
- Learn the similarities and differences between a psychiatry practice and a coaching practice
- Identify the opportunities of offering consulting services in a wide range of settings
- Learn the importance of marketing psychiatry services

SUMMARY:

As psychiatrists, we are prepared to tend to the needs of those who experience disease states ranging from those who function at a high level to those who suffer of severe chronic mental illness. Clinically prepared, we are able to develop our practices in diverse settings, including solo practice models, to providing services in a community setting, or venturing into the academic world incorporating clinical research into practice.

Traditional models of practice may suit many of our colleagues as they master the art of medicine and psychiatry. However, many of us struggle with the challenges of integrating a deeply felt sense of responsibility to serve those with mental illness as well as to fully develop entrepreneurial and financially rewarding opportunities. There has always been an underlying stigma associated with combining the practice of medicine with business. We are faced with the need to reconcile these two models as we try to maximize our practice opportunities.

Psychiatry practice models include consulting practices at business and government levels as they relate to corporate needs around absenteeism, presenteeism, and disability. Additionally, other corporate consulting opportunities closely participating in the creation of health and wellness programs both at the corporate, government, and health insurance levels are also available. Executive coaching has been a growing practice where non-medical professionals, some with little counseling or psychological background, have spread through small, medium, and large sized businesses. Novel opportunities to provide direct patient care are also available. Third party groups "facilitating" the relationship between large employee groups and their treating mental health specialists are on the rise. Psychiatry residency programs lack the entrepreneurial training as a part of their core programs across the United States, thus, leaving new residents unprepared to face the current and future world of practicing psychiatrists.

REFERENCES:

1. Harvard Business Essentials: Coaching and Mentoring. Boston, Mass.: Harvard Business School Press, c2004.
2. Mental Health and Productivity in the Workplace: a handbook for organizations and clinicians. Editors: Kahn, J; Langlieb, A. San Francisco: Jossey-Bass, c2003.

COMPONENT WORKSHOP 42
SOCIAL DIMENSIONS OF DISASTERS AND COMMUNITY RECOVERY
APA Committee on Psychiatric Dimensions of Disasters

Co-Chairpersons: Jacqueline Henschke, M.D., *14306 Bauer Drive, Rockville, MD 20853*
Sonali Sharma, M.D., MSc., *210 Lafayette Street, New York, NY 10012*

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation the participant should be able to:

1. Identify the most salient social factors affecting disaster outcomes.
2. Understand your role as a Pyschiatrist/mental health provider in a disaster.
3. Integrate the knowledge of social disparities during a disaster in the delivery of Psychiatric care.
4. Be able to locate local and national resources during a disater to guide practice.

SUMMARY:

Our workshop entitled Social Dimensions of Disasters and Community Recovery will examine the various social factors that affect health-seeking behavior, shape provider roles, and dictate outcomes before, during, and after a disaster. In the last five years we have experienced major disasters in the United States. 9/11 and Hurricane Katrina remind us that disasters are varied. While there are similarities among major disasters social disparities within a society lead to different outcomes regarding response and recovery. We feel this discussion is timely and necessary given recent disasters. We propose two speakers. The first speaker will address social factors; such as, but not limited to, race, poverty, health disparity, and unemployment. Our second speaker will be a Psychiatrist that has been on the frontlines of most recent disasters and can comment on the practical implications of the outlined social factors. For example, that speaker will highlight his/her experience during the disaster. They will also comment on their role as a Psychiatrist and how that role had to change during the disaster. In conclusion, it is essential for the Psychiatrist/mental health professional to understand the social forces that drive peoples behavior during any disaster and integrate this into their clinical practice.

REFERENCES:

1. Ursanp, RJ: The Impact of Disasters and Their Aftermath on Mental Health. Journal of Clinical Psychiatry 2006; 8(1):4-11.
2. Ahern J, Galea, S: Social context and depression after a disaster: the role of income inequality 2006. Journal of epidemiology and Community Health 2006 Sep;60(9):766-70.

COMPONENT WORKSHOP 43
THE ISMS: HOW RACISM, SEXISM, CLASSISM, AND HETEROSEXISM AFFECT MENTAL HEALTH CARE
APA/SAMHSA Minority Fellows

Co-Chairpersons: K. Ron-Li Liaw, M.D., *66 Dana Street, Cambridge, MA 2138*
Nisba F. Husain, M.D., *101 West 15th Street #3LN, New York, NY 10011*
Presenters: Alphonso E. Nichols III, M.D., Tracee Burroughs, M.D., Eugene Lee, M.D., Jennifer D. Pender, M.D.

EDUCATIONAL OBJECTIVES:

Educational Objectives:

1) At the conclusion of the presentation, participants will be able to define the four major *-isms* or types of discrimination.

2) Participants will develop a broader understanding of how the *-isms* impact mental health care.

3) Participants will learn how to reduce discrimination within the context of therapeutic relationships, the local community, and society at large.

SUMMARY:

In 2001, the U.S. Department of Health and Human Services published *Mental Health: Culture, Race, and Ethnicity - A Supplement to Mental Health: A Report of the Surgeon General* documenting the existence of striking disparities in the understanding and treatment of mental illness in minority populations. In addition to the barriers of costs and societal stigma that contribute to disparities in mental health services, the report states that "disparities also stem

from minorities' historical and present day struggles with racism and discrimination'' (1). In a nationally representative telephone survey, Kessler et al. found ''day-to-day perceived discrimination'' to be related to the development of psychological distress in general and specifically related to the development of generalized anxiety and depression (2). Five years later, mental health disparities for minorities continue to persist and much work still needs to be done to understand the impact of discrimination on mental health.

Through the presentation of case studies, personal experiences, and a review of the current literature, this workshop examines the ways in which discrimination impacts mental health and patient care. Beginning with an overview of the topic, each presenter will describe individual case studies highlighting each of the four major *isms* -- racism, sexism, classism, and heterosexism. The cases will illustrate the influence of discrimination from the perspective of the patient and the clinician as well as the impact of discrimination on the profession of psychiatry and the health care system as a whole.

REFERENCES:

1. U.S. Department of Health and Human Services. (2001). Mental Health: Culture, Race, and Ethnicity -- A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: US DHHS, SAMHSA, CMHS: Author.
2. Kessler, RC, Mickelson, KD, Williams, DR. The prevalence, distribution, and mental health correlates of perceived discrimination in the United States. Journal of Health and Social Behavior 1999; 40: 208-230.

COMPONENT WORKSHOP 44
MANAGED CARE, PSYCHIATRISTS, AND EMPLOYERS: COLLABORATING EFFECTIVELY TO ENSURE PATIENT CARE
APA Committee on Managed Care

Chairperson: Paul H. Wick, M.D., *3300 South Broadway Avenue, Tyler, TX 75701*
Presenters: David K. Nace, M.D., Alan Axelson, M.D., George D. Santos, M.D., Joel P. Johnson, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participants should be able to understand significant aspects of professional, ethical and business dynamics.

SUMMARY:

Working effectively with managed care organizations and employers can be complicated. The following workshop presented by the APA committee on managed care will address ways to build quality healthcare from several different viewpoints. First, Dr. David Nace will give an overview on business and professional relationships. Second, Dr. Alan Axelson will discuss how building relationships with businesses and employers can provide positive outcomes for child and adolescent psychiatrists. Also, Dr. George Santos will discuss public funding and public policy implications of future trends in managed behavioral healthcare. These include the current and future tends in the implementation of managed care principles in the delivery of healthcare in the public and private arenas addressed from a public policy perspective with a focus on its impact in delivery of psychiatric healthcare to the aged, the poor, and the under-insured populations. Last Dr. Joel Johnson will discuss the effects of managed care on residency training and practice with a specific focus on recruitment, psychotherapy training, pscyhopharmaceutical choice, autonomy, administrative burden, accountability, standardization, and technology. Dr. Johnson will also discuss how training programs can incorporate information on working collaboratively with managed care programs.

REFERENCES:

1. Finch, R.A. & Phillips, K. An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing and Implementing Beahviral Healht Services Washington DC: National Business Group on Health; 2005.
2. Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry2006 spring; 34 (1); 127-33.

COMPONENT WORKSHOP 45
RACISM, RACIAL DISCRIMINATION, AND XENOPHOBIA: HOW PSYCHIATRY CAN REDUCE THEIR ADVERSE EFFECTS ON MENTAL HEALTH
APA Council on Minority Mental Health and Health Disparities

Chairperson: Francis G. Lu, M.D., *1001 Potrero Avenue, Suite 7M, San Francisco CA 94110*
Presenters: Sandra C. Walker, M.D., Michele Reid, M.D., Andres J. Pumariega, M.D., Rahn K. Bailey, M.D., Napoleon B. Higgins, Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to:

1) Understand how both individual and institutional racism and racial discrimination have adverse effects on mental health including disparities in mental health care

2) Understand how the field of psychiatry can work toward eliminating racism and racial discrimination through member and public education, advocacy for equitable services, and research

3) Understand the adverse mental effects of xenophobia and how psychiatry may address these effects

SUMMARY:

This workshop will provide a discussion forum for the implementation of recommendations from the 2006 APA Position Statement of Racism, Racial Discrimination, and its Adverse Effects on Mental Health as well as a proposed APA Position Statement on Xenophobia and its Adverse Effects on Mental Health. The 2006 position statement, prepared by the APA Committee of Black Psychiatrists, provided the field of psychiatry a summary of the adverse effects of individual and institutional racism and racial discrimination on mental health including mental health care disparities. It recommended enhanced member and public education about impacts of racism and racial discrimination, advocacy for equitable mental health services for all patients, and further research into the impacts of racism and racial discrimination as an important public mental health issue. Discussion will focus on how APA can implement these recommendations.

REFERENCES:

1. American Psychiatric Association, Position Statement on Racism, Racial Discrimination, and Their Adverse Impact on Mental Health, 2006.
2. American Psyciatric Association, Reducing Mental Health Disparities for Racial and Ethnic Minorities: A Plan of Action, 2004.

WEDNESDAY, MAY 23, 2007

COMPONENT WORKSHOP 46
LEADERSHIP CHALLENGES: BREAKING BARRIERS TO SUCCESS
APA Committee on International Medical Graduates

Co-Chairpersons: Annelle B. Primm, M.D., *1000 Wilson Boulevard, Arlington VA 22209*
Antony Fernandez, M.D., *1201 Groadrock Boulevard, Richmong, VA 23249*
Presenters: Francis M. Sanchez, M.D., Emilio F. Romero, Marie-Claude Rigaud, M.D., Alejandra Postlethwaite, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to identify challenges in the various stages of their careers. Through interactive discussions with those who have achieved success, IMG and minority participants will learn strategies to overcome barriers and become leaders in their fields.

SUMMARY:

IMG and minority psychiatrists remain underrepresented in academia and the APA. Contrary to popular belief, people are not always *born* leaders but can be molded into leaders through self-awareness and by developing leadership skills. Leadership is a continuous process that involves ongoing learning and mentorship. The IMG committee has been charged to examine this issue and develop methods to promote leadership among its members. This workshop seeks to identify hurdles in the path towards leadership and explore strategies to overcome them. These include amongst others identifying internal and external barriers, transforming weaknesses into strengths and seizing opportunities as they present. The effective use of mentorship, available resources and developing alliances will be emphasized. The distinguished panel will share their experiences and engage the audience in finding solutions to these challenges.

To make the workshop more interactive, relevant scenarios will be presented and discussed.

REFERENCES:

1. Kay J, Siberman E, Pessar L. Handbook of Psychiatric Education and Faculty Development. Washington, DC, American Psychiatric Press, 1999.
2. Lim R: Clinical Manual of Cultural Psychiatry. Washington, DC, Americn Psychiatric Press, 2006.

COMPONENT WORKSHOP 47
PUBLIC POLICY, HIV AND MENTAL HEALTH: POLITICS, IDEOLOGY OR SCIENCE
APA New York County District Branch's AIDS Committee

Chairperson: Mary Ann Cohen, M.D., *220 West 93rd Street, New York, NY 10025*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to demonstrate an understanding of conflicts and controversies involved in: global HIV prevention, opioid agonist therapy in US correctional facilities, in changing paradigms for HIV testing and funding in the US.

SUMMARY:

In this workshop, we will explore the impact of mental health issues on four evolving areas of public health policy related to HIV prevention and treatment.

1) Although US foreign policy has adopted the "ABC" (Abstinence, Be faithful and Condoms) approach to HIV prevention, there is debate about whether abstinence and being faithful should be emphasized relative to condom use. We will discuss the implications of this policy for women, who experience more discrimination and stigmatization than men. Women also face the potential anguish of perinatal infection and of providing care for their families despite limited access to HIV medications, and financial and social support.

2) HIV testing has generated debate between activists and policy makers since the test became available in 1985. Since HIV has become a treatable illness, the CDC recommends routine testing in all medical settings with an "opt out" approach. Additionally, new guidelines eliminate signed consent and pre-test counseling, and promote rapid testing. We will discuss the implications of this policy shift in terms of mental health considerations at point of testing and effect on access to care.

3) Opioid replacement therapy is an effective strategy for reducing HIV transmission. Yet, correctional facilities routinely withdraw prisoners currently on methadone and withhold opioid replacement as a treatment option. We will discuss the ideological underpinnings of this policy and suggest a more evidence-based approach.

4) The Ryan White Care Act is the largest HIV federal program providing funds for medical and support services. The Federal government plans to alter geographic distribution and types of fundable HIV services. These changes will diminish the provision of HIV mental health services that are crucial for access to medical care.

REFERENCES:

1. Bayer R, Fairchild AL: Changing the Paradigm for HIV Testing ' The End of Exceptionalism. New England Journal of Medicine 2006; 355: 647-49.
2. Golembeski C, Fullilove R: Criminal (In)Justice in the City and Its Associated Health Consequences. American Journal of Public Health 2005; 95:1701-06.

COMPONENT WORKSHOP 48
CPT CODING AND DOCUMENTATION UPDATE
APA Committee on RBRVS, Codes, and Reimbursements

Co-Chairpersons: David Nace, M.D., *716 Hamilton Rd., Bryn Mawr, PA 19010*
Ronald M. Burd, M.D., *1702 S. University Drive, Fargo, ND 58122*
Presenters: Chester W. Schmidt, Jr., M.D., Tracy R. Gordy, M.D., Allan A. Anderson, M.D., Edward Gordon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop the participants will be 1) knowledgeable about current Medicare and CPT coding changes, 2) are updated about Medicare reimbursement concerns, 3) have their individual questions about coding, documentation and reimbursement answered.

SUMMARY:

The goals of the workshop are to inform practitioners about changes in the RBRVS Medicare physician reimbursement system, modifications in CPT coding and current issues associated with documentation guidelines. This year's workshop will focus on 1) updating participants as to current issues related to CPT coding, 2) a review of current Medicare reimbursement issues and concerns, and 3) discussion of documentation guidelines for psychiatric services as well as the evaluation and management service codes. Time will be reserved for questions and comments by the participants about the above topics as well as issues and problems faced by the participants in their own practices.

REFERENCES:

1. American Medical Association: CPT 2006, Chicago, IL, American Medical Association, 2005.
2. Schmidt C, Yowell R, Jaffe E: CPT Handbook for Psychiatrists, Third Edition, Arlington, VA, American Psychiatric Press, 2004.

COMPONENT WORKSHOP 49
ETHICS AND ETIQUETTE: KEEPING OUT OF TROUBLE
APA Ethics Committee

Chairperson: Wade C. Myers, M.D., *P.O. Box 100234/ JHMHC, Gainesville, FL 32603*
Presenters: William Arroyo, M.D., Richard D. Milone, M.D., Burton V. Reifler, M.D., Harriet C. Stern, M.D., Lawrence Hartmann, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize common situations which may signal professional risk.

SUMMARY:

An interactive workshop designed to engage psychiatrists in discussion of common situations which may signal professional risk. Areas include: Confidentiality, coverage, collaborative treatment, pharmaceutical industry relationships, speaking to the media, and boundary violations. The workshop panel will be composed of members of the APA Ethics Committee.

REFERENCES:

1. American Psychiatric Association: The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry. United States of America, American Psychiatric Association, 2006.
2. American Medical Association: Code of Medical Ethics of the American Medical Association. United States of America, American Medical Association, 2006.

COMPONENT WORKSHOP 50
MANAGING OPIATE DETOXIFICATION WITH BUPRENORPHINE/NALOXONE
APA Council on Addiction Psychiatry

Chairperson: John A. Renner, Jr., M.D., *2511 Causeway Street, Room 314, Boston, MA 2114*
Presenters: Eric C. Strain, M.D., Herbert D. Kleber, M.D., Ray C. Hsiao, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify those patients appropriate for either BUP/NX detoxification or long-term treatment, and to manage detoxification treatment more effectively, based on research findings and currently accepted treatment practices. The participant will be better able to handle long-term BUP/NX treatment, including decisions on dose adjustments, the appropriate duration of treatment, the intensity of supportive services, and criteria for detoxification and the termination of treatment.

SUMMARY:

Federally mandated physician training and the majority of the peer-reviewed literature on the use of buprenorphine/naloxone (BUP/NX) have focused on the long-term treatment of opiate dependent patients. However, SAMHSA/CSAT data indicates that 21% of the physicians utilizing BUP/NX in 2005 provided detoxification services exclusively and that 32% of the patients treated nationally received only detoxification treatment. While the use of BUP/NX for detoxification is included in the APA Practice Guidelines for the Treatment of Patients with Substance Use Disorders [1], there are no generally accepted criteria for selecting patients appropriate for detoxification, standards for detoxification protocols, including guidelines for maximum doses, recommendations for the optimal duration of detoxification treatment or the appropriate rate for medication taper. Similarly, there are no generally accepted criteria or protocols for the detoxification of individual who have been maintained on BUP/NX long-term. This workshop will briefly review the literature on the use of BUP/NX for detoxification and will then present a series of case vignettes designed to stimulate discussion on appropriate criteria for both detoxification and long-term treatment, and protocols for both brief and long-term BUP/NX detoxification. Workshop participants will be divided into three groups, each led by a nationally recognized expert in BUP/NX treatment. Each group will be asked to review the cases and make recommendations for appropriate clinical management. The workshop will conclude with reports from each group and a general discussion aimed at establishing a consensus on criteria and protocols for BUP/NX detoxification treatment. This workshop is designed for clinicians with experience in the use of BUP/NX, either for detoxification or long-term treatment.

REFERENCES:

1. American Psychiatric Association: Practice Guidelines for the Treatment of Patients with Substance Use Disorders. Am J Psychiatry 2006; 163:8, Supplement.
2. Center for Substance Abuse Treatment. Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 45. DHHS Publication No. (SMA) 06-4131. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

COMPONENT WORKSHOP 51
NEW APA PRACTICE GUIDELINES ON DEMENTIA, PANIC DISORDER, AND OCD
APA Steering Committee on Practice Guidelines

Chairperson: Jack S. McIntyre, M.D., *2000 Winton Road South, Rochester, NY 14618*
Presenters: Lon S. Schneider, M.D., Murray B. Stein, M.D., M.P.H., Lorrin M. Koran, M.D., Laura J. Fochtmann, M.D.

EDUCATIONAL OBJECTIVES:

- Understand objectives and development process of the APA practice guidelines project
- Know the key recommendations of new APA practice guidelines on Alzheimer's disease and other dementias of late life, panic disorder, and obsessive-compulsive disorder

SUMMARY:

Since 1991, APA has published 14 practice guidelines using an evidence-based process that results in recommendations that are both scientifically sound and clinically useful to practicing psychiatrists. New practice guidelines are expected to be published on Alzheimer's disease and other dementias of late life (2007), panic disorder (2008), and obsessive-compulsive disorder (2007). Workshop panelists will discuss the development process for APA practice guidelines and the specific recommendations of these new guidelines. Attendees are invited to comment on the recommendations, implications for the field, and dissemination and treatment strategies.

REFERENCES:

1. American Psychiatric Association. Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006. Washington, DC: APPI, 2006.
2. American Psychiatric Association. Practice guideline for the treatment of patients with obsessive-compulsive disorder. Am J Psychiatry, in press.

COMPONENT WORKSHOP 52
MISSION POSSIBLE: RECLAIMING AMERICA'S STATE HOSPITAL BEDS
APA Council on Social Issues and Public Psychiatry

Co-Chairpersons: Jagannathan Srinivasaraghavan, M.D., *1000 North Main Street, Anna IL 62906-1652*
Jeffrey L. Geller, M.D., *55 Lake Avenue North, Worcester, MA 01655-0002*
Presenters: Tracee Burroughs, M.D., Terri L. Randall, M.D., Ruth S. Shim, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participants will be able to appreciate the major challenges facing the public mental health system, the plight of severe and persistently mentally ill patients and the criminalization of mental illness.

SUMMARY:

In the 43 years since the Community Mental Health Centers Act, psychiatric care has shifted from institutions to community settings, resulting in a decline in the number of state hospital beds. While community mental health care remains an important facet of treatment, the fragmentation of the health care system and insufficient resources often leaves people with severe mental illnesses without adequate care. This workshop will examine deinstitutionalization and the impact of the decline in state hospital beds on the current mental health system. The presentation will focus on the historical context of deinstitutionalization, the resulting consequences of limitations of state hospital beds, and the overall impact on those with severe and persistent mental illness. In addition, the discussion will address issues related to access to care and the resulting burden on social service agencies and the criminal justice system.

REFERENCES:

1. Geller JL, Shore H, Grudzinskas AJ, Appelbaum PS: Against the grain? A reasoned argument for not closing a state hospital. Psychiatric Quarterly 2005; 76:177-194.
2. Accordino MP, Porter DF, and Morse T: Deinstitutionalization of Persons with Severe Mental Illness: Context and Consequences. Journal of Rehabilitation 2001; 67:16-21.

COMPONENT WORKSHOP 53
EARLY COGNITIVE DEVELOPMENT AND PSYCHIATRIC PRESENTATION: IMPLICATIONS FOR ETIOLOGIC UNDERSTANDING AND INTERVENTION
APA Corresponding Committee on Infancy and Early Childhood

Co-Chairpersons: Irene Chatoor, M.D., *111 Michigan Avenue, NW, Washington, DC 20010-2916*
Jean M. Thomas, M.D., *5301 Reno Road, NW, Washington, DC 20015*
Presenter: Penny Glass, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1) Appreciate the long-term impact of neurodevelopmental risk and the benefit of early intervention; 2) Appreciate that the identification of comorbidities inform etiologic understanding and guide specific intervention strategies for toddlers with disruptive behavior disorders; 3) Appreciate that parent-child conflict interventon can provide key support for toddler cognitive development.

SUMMARY:

Perinatal Brain Injury: Implications for Neurodevelopmental Outcome and Early Intervention

Objective: Critically ill full-term newborns in cardio-respiratory failure provide a model for understanding neurodevelopmental outcome in high-risk newborns. Results: CT scan findings (N=150) demonstrate that brain injury severity and side of unilateral brain injury in the neonatal period correlate with neurodevelopmental outcome at age 5 years. Summary/Conclusion: This study suggests the long-term impact of neurodevelopmental risk and the importance of early identification of neurodevelopmental difficulties. The benefit of early intervention will be discussed.

Comorbidities Inform Etiologic Understanding of Early Disruptive Behavior Disorders and Guide Specific Intervention Strategies

Objective: Attention to comorbid diagnoses informs etiologic understanding of toddler disruptive behavior disorders and specific intervention strategies. Results: Using the Preschool Age Psychiatric Assessment (modified) and observation of parent-toddler interactions, comorbid neurodevelopmental difficulties were identified in two-thirds of toddlers aged 2 to 3 Ã‘Â½ years (N=140) presenting with disruptive behavior disorders. In the other third, significant anxiety/mood symptoms, often associated with parent-toddler relational difficulties, were demonstrated. Summary/Conclusion: Identification of comorbidities in toddlers with disruptive behavior disorders guides specific intervention strategies.

The Impact of Mother-Toddler Conflict During Feeding and Play on Cognitive Development

Objective: Mother-toddler conflict during feeding and play demonstrates that parent-child conflict can significantly impact toddler cognitive development. Results: A study of toddlers with Infantile Anorexia, growth failure, and a healthy control group (N=102) revealed that mother-toddler conflict during feeding and play, not nutritional status, is correlated with the cognitive development of toddlers, as measured by the Bayley Scales of Development-II. Summary/Conclusion: Parent-child conflict intervention can provide key support for cognitive development.

This workshop highlights the need for early identification of neurodevelopmental risk and comorbid diagnoses in toddlers, and calls for effective early neurodevelopmental and parent-child interventions.

REFERENCES:

1. Thomas JM, Guskin KA: Early disruptive disorder: What does it mean? JAACAP 2001; 40:44-51.
2. Chatoor I, Surles J, Ganiban J, Beker L, McWade-Paez L, Kerzner B: Failure to thrive and cognitive development in toddlers with infantile anorexia. Pediatrics 2001; 113:e440-e447.

COMPONENT WORKSHOP 54
MENTORING OF WOMEN IN ACADEMIC PSYCHIATRY
APA Central California Psychiatric Society

Chairperson: Linda L.M. Worley, M.D., *4301 West Markham #789, Little Rock, AR 72205*
Presenters: Tracy H. McCarthy, M.D., Andreea L. Seritan, M.D., Donald M. Hilty, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, participants should be able to:

1. Demonstrate enhanced understanding of mentoring as a developmental process in one's academic career and how to begin assessing one's needs.

2. Develop creative ways to meet individual and group mentoring needs.

3. Understand gender differences in mentoring: design programs geared towards women's needs.

The goal for this workshop is the exchange of ideas and experiences related to mentoring of academic women. The format will be highly interactive, with questions welcome throughout the presentations. Each panelist will present for 15 minutes, with the remaining 30 minutes reserved for discussion.

SUMMARY:

In 2004-05, women constituted 47.1% of medical school graduates and 42% of residents and fellows. Nevertheless a gender gap exists among faculty who achieve high academic rank: 31% of male faculty are full professors compared with only 11% of female faculty. Over 70% of medical school graduates rated mentoring as having a strong or moderate influence on their specialty choice, over lifestyle, family expectations, and potential salary. Mentoring is linked to greater productivity and career satisfaction. Female role models, mentors, and changes in administration are needed to close the gender gap, but there are competing demands for time and money. So what is the answer to this catch 22?

This workshop will explore approaches to women's mentoring, with emphasis on less traditional models (peer mentoring, mentoring across gender and specialty barriers, long-distance mentorship, and technical vs. developmental mentoring). A resident, a junior faculty member and two senior faculty members in national leadership positions will review novel solutions. A showcase of valuable mentorship opportunities ranging from the University of Arkansas for Medical Sciences women's faculty development caucus, to AAMC opportunities, to professional organizations such as the Association for Academic Psychiatry will be presented. Panelists will also speak from their experiences in mentoring, being mentored, and developing a culture of mentoring in departments.

REFERENCES:

1. Worley LM, Borus JF, Hilty DM: Being a Good Mentor and Colleague. In Handbook of Career Development in Academic Psychiatry and Behavioral Sciences, edited by Roberts LW, Hilty DM, Arlington, American Psychiatric Publishing, Inc., 2006, pp. 293-298.
2. Pato MS: Taking Some Unnatural Steps: *f*Improvements to Complex Systems Do Not Occur Naturally§. Academic Psychiatry 2004; 28:4: 351-353.

MONDAY, MAY 21, 9:00 AM - 10:30 AM

ISSUE WORKSHOP 1
HEADSPACE THEATRE: AN INNOVATIVE METHOD FOR EXPERIENTIAL LEARNING OF PSYCHIATRIC SYMPTOMOTOLOGY USING MODIFIED ROLE-PLAYING AND IMPROVISATIONAL THEATRE TECHNIQUES ASSOCIATION FOR ACADEMIC PSYCHIATRY

Chairperson: Bruce Ballon, M.D., *33 Russell Street, Toronto, ON M5S 2S1*
Presenters: Ivan Silver, M.D., Donald C. Fidler, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop participants will be able to:

1) Discuss how experiential role-playing techniques facilitate teaching and learning

2) Describe how they would adapt this technique to their teaching

3) Use "Headspace Theatre" concepts in their teaching / setting

SUMMARY:

Although techniques have been developed in the past in an attempt to simulate psychiatric symptoms for learners, most have been limited in that the learners always have the knowledge that it is a simulation or the method does not capture the true experience of living with the conditions. HEADSPACE THEATRE has been developed to allow small group learning of psychiatric conditions by creating role-play situations in which participants are placed in a scenario that simulates the experience of the condition.

The goals of using this technique include: 1) Increasing the learners' empathy and professional attitudes towards patients with the conditions being simulated by understanding the patient's experience; 2) Desensitizing students to role-playing techniques by teaching them specific skills for role-playing as well by allowing group members different levels of intensity of the action; 3) Using the processing of the experience to link to specific teaching points or mini-didactic lectures to reinforce the knowledge to promote retention and synthesis of the teaching material; 4) One can do teaching that is fun and serious at the same time that respects patients suffering from the condition under review; 5) An addition effect of teaching learners drama and acting skills, and helps them begin to think innovatively

Workshop learners will be able to participate in an example scenario and have an opportunity to reflect on how method can be applied to their teaching with students of empathy with and understanding of patients with psychiatric illness.

THIS WORKSHOP IS SPONSORED BY THE ASSOCIATION OF ACADEMIC PSYCHIATRY

REFERENCES:

1. Boud. D. and Miller, N. (eds.) Working with Experience: animating learning, London: Routledge. 1997.
2. Gross Davis, B. *f*Role Playing and Case Studies§ in Tools for Teaching. Jossey-Bass Publishers: San Francisco. 1993.; 159-165.

ISSUE WORKSHOP 2
RISK MANAGEMENT ISSUES IN PSYCHIATRIC PRACTICE

Co-Chairpersons: Jacqueline M. Melonas, J.D., *1515 Wilson Boulevard, Suite 800, Arlington, VA 22209*
Martin G. Tracy, J.D., *1515 Wilson Boulevard, Arlington, VA 22209*
Presenters: Marynell Hinton, M.A., Donna Vanderpool, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to

1) identify the major high-risk psychiatric professional liability risks that lead to malpractice lawsuits;

2) discuss at least 3 risk management strategies that can be incorporated into their practices to decrease or prevent exposure to high-risk psychiatric professional liability risks; and

3) understand that effective risk management strategies support patient safety initiatives.

SUMMARY:

This workshop will be the APA-endorsed Psychiatrists' Professional Liability Insurance Program's annual opportunity to present its psychiatric malpractice claims data. Based on the Program's 20 years of managing claims and lawsuits against psychiatrists, we are able to identify common sources of malpractice actions against psychiatrists and the outcomes of such lawsuits. Malpractice lawsuits post a significant problem for psychiatrists in all practice settings. At least 8% of practicing psychiatrists are sued each year. It is important for psychiatrists to understand the sources of malpractice lawsuits and the malpractice risks they face as clinicians, teachers and administrators.

Participants will have an opportunity to participate in the workshop by reviewing and discussing malpractice case studies with the panel of risk managers (specialists with clinical, legal, insurance and risk management experience/expertise). Special emphasis will be placed on what can be learned from analyzing high-risk exposure liability cases. In particular, the case studies will focus on 1) patient suicide and 2) adverse events related to prescribing psychotropic medica-

tions; two frequent sources of malpractice lawsuits against psychiatrists. Other issues that have the potential to influence malpractice risk will be illustrated in the case studies (e.g., collaborative and/or supervisory relationships with non-medical therapists, off-label use of psychotropic medication, termination of the patient-psychiatrist relationship, etc.). Additionally, the cases will illustrate how including risk management strategies and actions, such as effective communication and documentation, into a psychiatrist's practice can reduce malpractice risk as well as support patient safety and quality patient care.

The workshop will conclude with the panel providing a review of risk management strategies that have the most potential to protect against high-risk psychiatric malpractice actions and with a question and answer period with the audience.

REFERENCES:

1. Studdert DM, Mello MM, Gawande AA, Gandhi TK, Kachalia A, Yoon C, Puopolo L, Brennan TA. Claims, errors, and compensation payments in medical malpractice litigation. New Eng Journal of Medicine. 2006. 354:2024-2033.
2. Melonas, JM. Professional liability risk related to psychopharmacology. Psych Times 2005. Vol. XXIII, Issue 14.

ISSUE WORKSHOP 3
CHILDREN OF PSYCHIATRISTS

Co-Chairpersons: Leah J. Dickstein, M.D., *3006 Dunraven Drive, Louisville, KY 40202*
Michelle B. Riba, M.D., *1500 East Medical Center Drive, Ann Arbor, MI 48109-0295*
Presenters: Jessica Goin, Stephanie A. Zisook, M.D., Jessica L. Worley, M.D.

EDUCATIONAL OBJECTIVES:

Recognize and understand how as psychiatrist-parents, their children think and feel about their psychiatrist-parents.

SUMMARY:

This 10th annual workshop, which enables children of psychiatrists to share personal anecdotes and advance with the audience of psychiatrist-parents and parents-to-be, has been offered to standing room audiences annually. While stigma toward psychiatry in general has diminished, psychiatrists, because of training and professional work, in addition to their professional life, bear emotional fears and concerns of how they will and do function as parents. The four presenters will speak for 15 minutes each about their personal experiences and also offer advice to attendees. There will be a brief introduction by the co-chairs to set the tone for the audience, and the co-chairs will lead a 30-minute discussion following the individual presentations.

REFERENCES:

1. Dickstein, LJ: an interview with Stella Chess, M.D., in Women Physicians in Leadership Roles, edited by Leah J. Dickstein, M.D. and Carol C. Nadelson, M.D., American Psychiatric Press, Inc., pp. 149-158.
2. Mueller-Kueppers, Manfred: The Child Psychiatrist as Father, The Father as Child Psychiatrist (German), Praxis der KInderpsychologie und Kinderpsychiatrie, Vol. 34j(8), Nov. ' Dec., 1985, pp. 309-315.

ISSUE WORKSHOP 4
PSYCHIATRY AND THE MEDICAL HUMANITIES

Co-Chairpersons: Bret R. Rutherford, M.D., *1051 Riverside Drive, Box 95, New York, NY 10032*
David J. Hellerstein, M.D., *180 Ft. Washington Avenue, Suite HP256, New York, NY 10032*
Presenter: Kay R. Jamison, M.D.

EDUCATIONAL OBJECTIVES:

1. At the conclusion of this workshop, the participant should be able to recognize three areas in which study of the medical humanities may affect medical care.
2. At the conclusion of this workshop, the participant should be able to discuss three reasons the practice of psychiatry and experience of being a psychiatric patient might be improved by the medical humanities.
3. At the conclusion of this workshop, the participant should be able to discuss differences in the emphasis on medical humanities in internal medicine and psychiatry education and publishing.

SUMMARY:

Study of the humanities has been advocated in the internal medicine literature over the last 20 years as a means of facilitating empathic engagement with patients, adding humanism to a scientifically advanced medicine, and restoring medical idealism. The same time period has witnessed an explosion of biological research in psychiatry, resulting in an emphasis on genetics, brain imaging, and other technology based models of inquiry over subjective experience and the narrative method. In this workshop, data from a quantitative study of the humanities in internal medicine and psychiatry spanning the past five decades will be presented, and possible reasons for the declining influence of the humanities in psychiatry will be discussed. It will be suggested that a renewed study of the humanities may complement the biological advances taking place in psychiatry by improving psychiatric education, facilitating dialogue between clinicians and researchers in disparate disciplines, and integrating subjective experience with the dramatic advances being made. Examples of such an integration will be provided by discussing how writing and engagement with the humanities has influenced the clinical and research work of two of our presenters.

REFERENCES:

1. Charon R. Narrative and Medicine. N Engl J Med 2004; 350(9):862-864.
2. Jamison KR. An Unquiet Mind. New York: A. A. Knopf, 1995.

ISSUE WORKSHOP 5
LESSONS FROM TEACHING INTERVIEWING TO INTERNATIONAL RESIDENTS: INTEGRATING CULTURAL COMPETENCY FROM THE START OF TRAINING

Chairperson: Jacob Sperber, M.D., *139 Amity Street, Brooklyn, NY 11202*
Presenters: Nyapati Rao, M.D., Milton Kramer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should be able to:

1) explain how the self is learned from the infant's social environment, including its culture.

2) illustrate three examples of non-US cultural beliefs which define the self as part of the larger social group, and also offer the contrasting US view.

3) employ the distributed assessment tool for culturally competent interviewing to evaluate a trainee interview.

4) demonstrate key techniques in a method for improving IMG interviewing competency

SUMMARY:

Purpose of workshop: to demonstrate a training method and assessment tool which integrate sociologic/anthropologic concepts of cultural differences in the self into culturally-competent psychiatric interviewing. To use the IMG trainees' own cross-cultural issues to illustrate interviewing techniques which are universally applicable.

IMGs, who comprise 36.4% of US Psychiatric Residents, come from vastly different cultural, linguistic, and educational backgrounds. They play a key role in health care, especially for underserved populations. As US patients increasingly represent multiple cultures as well, all trainees are frequently faced with delivering care cross-culturally. The culture-based way of understanding self, personality, and symptoms emphasized in this course have universal applicability to the psychiatric interview.

The workshop's *method* consists of three ten-minute presentations, each followed by twenty-minute discussions of *content*:

1) demonstrating teaching tools which integrate basic sociological/anthropological ideas about cultural sources of self, personality, and symptoms into interview training. Interview video excerpts will be used to demonstrate the impact of this training on effectiveness of communication between therapist and patient, on the trainee's ability to analyze cultural issues in her/his own countertransference, and on the patient's understanding of cultural variables which impact negatively on self-esteem.

2) applying a new, culturally-focused evaluation tool for psychiatric interview training to a video excerpt of a cross-cultural interview.

3) sharing a practical method for improving Board-interview outcomes of IMG trainees by taking into account cultural differences in self.

Results: The participant will have learned a modified way of teaching interviewing which makes the intercultural situation between IMG psychiatrist and US-born patient an example of interpersonal differences which must be appreciated and explored in every interview. The *importance* of these results is making available a way for *integrating important concepts of cultural variations in the self into the teaching and evaluating of psychiatric interviewing.*

REFERENCES:

1. 1) St. Clair M, Wigren J, Object Relations and Self Psychology: An Introduction (4th edition), Monterey, Calif., Brooks/Cole Pub. Co., 2004.
2. 2) Markus, HR, Shinobu K, Culture and the Self: Implications for Cognition, Emotion, and Motivation. Psychological Review 1991: Vol. 98. No.2: 234 ' 253.

ISSUE WORKSHOP 6
GRANTWRITING WORKSHOP: RESEARCH FUNDING OPPORTUNITIES FROM THE NATIONAL INSTITUTE ON DRUG ABUSE
National Institute on Drug Abuse

Chairperson: Lucinda L. Miner, Ph.D., *6001 Executive Boulevard, Suite 5230, Rockville, MD 20852*
Presenters: Joseph Frascella, Ph.D., Teresa Levitin, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be more familiar with the research funding process at the National Institutes of Health and know how to be proactive in the grant funding process to increase the likelihood of funding.

SUMMARY:

The National Institute on Drug Abuse (NIDA) will sponsor this workshop on successful grantwriting strategies for obtaining research funding from the National Institutes of Health (NIH). Participants will learn about the various different funding mechanisms available to support research projects, how the NIH evaluates grant applications and how funding decisions are made. In addition, participants will learn some of the keys to writing a successful grant applicaton.

ISSUE WORKSHOP 7
GENE-ENVIRONMENT-DEVELOPMENT INTERACTIONS: IMPLICATIONS FOR PSYCHIATRIC AND SUBSTANCE ABUSE DISORDERS
National Institute on Drug Abuse

Chairperson: Jonathan D. Pollock, Ph.D., *6001 Executive Boulevard, Bethesda, MD 20850*
Presenters: Julia Kim-Cohen, Ph.D., Stephen J. Suomi, Ph.D., Cornelius T. Gross, Ph.D., Frances A. Champagne, Ph.D., Kathleen R. Merikangas, Ph.D.

EDUCATIONAL OBJECTIVES:

Attendees of the workshop will learn how highly inherited characteristics can be modified by early experience interact to produce different behavioral outcomes and alters psychopathology in humans, non-human primates, and rodents. The workshop attendees will acquire knowledge of the epigenetic mechanisms by which the environment alters inherited characteristics. Workshop attendees will also learn that epigenetics refers to heritable and long-term changes in gene function, occurring without a change in the DNA sequence through modification of chromatin structure. Upon completing attendance of the workshop, attendees will gain knowledge of what chromatin is, how it is modified, and the significance of modification of chromatin structure for producing gene-environment interactions. At the end of the workshop attendees also will acquire an understanding of some of the methods used discover the interactions between the gene and environment as well as some of the controversies in the field.

SUMMARY:

Genes, environment, and critical periods during development play an important role in the manifestation of psychiatric and substance abuse disorders. Genetic, environmental, and developmental factors are frequently analyzed independently in psychiatry and neuroscience without regard for effects of these variables on each other, mainly because of the complexity of the statistical methodologies. This symposium reviews some of the recent epidemiological and animal findings, as well as some methodological issues of studies that analyze gene-environment-and developmental interactions. Results from epidemiological studies will be presented showing that maltreated children with low MAO levels develop conduct disorder, antisocial personality disorder, and adult crime while maltreated children with high levels of MAO do not. Other epidemiological results will show that a functional polymorphism in the serotonin transporter alters the likelihood of developing depression following stressful life events. Similar results have been observed in monkeys showing that a polymorphism in the serotonin transporter in monkeys who experience poor maternal attachment, but not those with secure maternal attachment is associated with increased aggression, abnormalities in serotonin metabolisms, and increase alcohol consumption. A novel gene-

environment screening paradigm in the mouse has also shown that mutations in the serotonin transporter moderate the effects of poor maternal care on adult anxiety and depression-like behavior. Data will be presented that suggests maternal behavior modifies stress reactivity through an epigenetic mechanism in which DNA is methylated.

REFERENCES:

1. Caspi A, Moffitt TE: Gene-environment interactions in psychiatry: joining forces with neuroscience. Nat Rev Neurosci. 2006 7(7):583-90.
2. Suomi SJ: Ann N Y Acad Sci. 2003 1008;132-9.

ISSUE WORKSHOP 8
ASSESSMENT OF CAPACITY: A MULTIMEDIA APPROACH TO ENHANCING CLINICAL SKILLS IN DIFFERENT CULTURAL AND LEGAL SETTINGS

Co-Chairpersons: Julian Beezhold, M.B.Ch.B., *Drayton High Road Hospital, Norwich NR6 5BE*
M.E. Jan Wise, M.B.Ch.B., *13-15 Brondesbury Road, London NW6 6HX*

EDUCATIONAL OBJECTIVES:

To be aware of the issues involved in assessing capacity, including relevant legal tests. To improve the assessment skills of participants. To learn about resources for assessing capacity and consent.

At the conclusion of this session, the participant will be able to recognise the principles of capacity and informed consent, their differences, and how cultural issues may challenge evaluation. They will be aware of different resources used in the assessment of capacity, and new ideas for recording the information in more defendable formats.

The aim of the workshop is to help participants improve their ability to assess capacity and be aware of relevant tools for aiding decisions regarding capacity and consent.

The workshop is aimed at psychiatrists of all levels. Research has shown that there is room for improving the knowledge of the principles of capacity at all levels of experience from trainee to board registered practitioner.

Teaching will be a mix of interactive exercises, demonstrations, presentation, videotaped material, and discussions. Initially participants will view a clinical dilemma and discuss whether capacity is present. A presentation will then inform participants of legal principles.

A second dilemma will allow participants to determine their understanding of the principles. The second case will be used to demonstrate an algorithm, which has been used in multiple jurisdictions for the assessment of capacity. A third dilemma will illustrate the boundaries of tools and involve a group decision. Prior versions of this workshop have improved assessment accuracy from 40% to 80%.

SUMMARY:

This session will involve participants in a multimedia approach to developing their clinical skills in the assessment of capacity in a range of cultural and legal settings.

REFERENCES:

1. 1. Restoration of Competency to Stand Trial. Journal of the American Academy of Psychiatry & Law. 31(2): 189-201, 2003.
2. 2. Informed Consent: Information or Knowledge? Medicine & Law. 22(4): 743-50, 2003.

ISSUE WORKSHOP 9
PREVENTION OF BURDEN AND BURNOUT IN CAREGIVERS AT HOME AND HEALTHCARE WORKERS IN LONG-TERM CARE SETTINGS

Chairperson: Sanjay M. Vaswani, M.D., *PO Box 11581, Bakersfield, CA 93389-1581*
Presenters: Amita R. Patel, M.D., Chuck Wall, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop the participants should be able to:

1. Learn to identify and differentiate between burden and burnout in caregivers of elderly patients at home and in long term care settings.
2. Appreciate the significant potential risk factors of the burden and burnout.
3. Understand the implications of burden and burnout on quality of life of caregivers and the elderly patients.
4. Learn viable strategies to cope and prevent the burden and burnout and achieve balance in professional life.

SUMMARY:

Caring for the cognitively and physically compromised elderly patient is challenging and can lead to devastating consequences at all levels of the caregiving spectrum. The stress of caregiving can result in physical, emotional, mental and spiritual exhaustion. Decreased personal satisfaction, substance abuse, depression and errors of judgment are common. This constellation of symptoms is often referred to as *Caregiver Burden and Burnout.*

In-home caregivers and staffs of skilled nursing and assisted living facilities are subject to Burden and Burnout. Psychiatrists, despite having a unique understanding of caregiver's biological, psychological, social and spiritual factors are particularly at risk for experiencing Caregiver Burden and Burnout.

The circular effect of caregiver burden and burnout along the caregiver continuum needs to be recognized early to prevent further compromise of quality of care and life for the elderly patient.

Part I will include three short presentations

1. Caregiver Burden and Burnout in primary in-home caregivers. Emphasis will be placed on evidence-based tips on surviving the burden of caregiving.

2. Caregiver Burden and Burnout in health care staff of long term care facilities. Emphasis will be placed on application of psychiatrist facilitated group therapies as intervention techniques

3. Caregiver Burden and Burnout in Psychiatrists.

Part II of this Workshop will involve real-time demonstrations focused on identification of dangers and effective strategies to deal with the caregiver burden and burnout of medical professionals. Active audience participation and group enactment will be the cornerstone learning experience.

Chuck Wall, Ph.D., who has been lecturing and conducting workshops in the dangers of stress and burnout for over two decades, will give a social scientist perspective on what ails the medical professional today. A question and answer session will follow with the goal of furthering the participant's understanding of the complexities of caregiving to elderly patients.

REFERENCES:

1. Journal Article - Schulz R., Matrire, L.M.m Klinger, J: Evidence-based caregiver interventions in geriatric psychiatry. Psychiatry Clin North Am 2005; 28:1007-1038.
2. Book - Jacobs, Barry, J: The Emotional Survival Guide for Caregivers; Guilford Press, 2006.

ISSUE WORKSHOP 10
GOING TO THE HEART OF THE MATTER IN PATIENT INTERVIEWS: A FURTHER EXPLORATION

Chairperson: Harold J. Bursztajn, M.D., *96 Larchwood Drive, Cambridge, MA 02138-4639*
Presenters: Max Day, M.D., Thomas G. Gutheil, M.D., Robindra K. Paul, M.D., Beata A. Zolovska, M.D., David Mobley, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the relevance of the work of historically well-recognized clinician psychotherapists such as Elvin Semrad to:

1. training programs for medical students and residents in psychiatry
2. education programs for psychiatrists
3. psychiatrists practicing in managed health care settings
4. psychiatrists practicing psychopharmacology
5. clinicians working with patients suffering from the spectrum of psychiatric disorders ranging from psychosomatic to schizophrenic

SUMMARY:

Subsequent to our overflowing 2005 Toronto APA presentation there has been an increased demand for us continue to explore the relevance of the work of Elvin Semrad, a master psychotherapist to contemporary psychiatric practice. We will use the first 20 minutes to review an interview by Dr. Semrad with a deeply anxious patient which illustrates his remarkable ability to, even in a limited amount of time, go to the heart of the matter. The next 30 minutes will allow our panel members representing four generations of psychiatrists and a distinguished social worker to highlight the relevance of going to the heart of the matter even in today's time limited and pharmaceutically orientated treatment environment. The remainder of the time will allow for interaction between panelists and audience participants who will be bringing their own patient treatment concerns for review and analysis.

REFERENCES:

1. Treatments for Later-Life Depressive Conditions: A Meta-Analytic Comparison of Pharmacotherapy and Psychotherapy. Am J Psychiatry 2006 163: 1493-1501.
2. Rako, Susan, Semrad: The Heart of a Therapist, Backinprint.-com, 2003.

ISSUE WORKSHOP 11
PRACTICAL PHARMACOTHERAPY FOR THE TREATMENT OF ALCOHOL DEPENDENCE
National Institute on Alcohol Abuse and Alcoholism

Chairperson: Robert M. Swift, M.D., *Box G-BH, Providence, RI 2912*
Presenters: Roger D. Weiss, M.D., Allen Zweben, D.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant will demonstrate improved knowledge about medications used to treat alcohol dependence through an interactive discussion of the practical aspects of using pharmacotherapies for the treatment of alcohol dependence. The audience is encouraged to contribute clinical examples and cases for discussion.

1. Know the available pharmacotherapies available for the treatment of patients with alcohol dependence, their indications, side effects and how to choose the optimal medication.

2. Understand the benefits of combining pharmacotherapy with psychosocial support in enhancing abstinence and preventing relapse.

3. Understand the diagnostic and therapeutic issues (both medication and psychotherapy) with dually diagnosed patients.

4. Enhance knowledge and skills related to improving adherence in combined medication and behavioral treatment for alcohol problems.

SUMMARY:

There has been increasing interest in the use of pharmacotherapies for the treatment of alcohol dependence. A compelling rationale for using medications to treat alcohol dependence is that a component of alcohol

dependence, like many other psychiatric disorders, has a biological basis that can be addressed pharmacologically. Four medications are now FDA approved for the treatment of alcohol dependence: Disulfiram, naltrexone (oral and injectable) and acamprosate. While each of these medications shows some evidence for efficacy, medications have not achieved widespread use by clinicians. Surveys indicate that both physicians and non-physician clinicians have limited knowledge about medications used to treat alcohol dependence.

This workshop will address this knowledge gap through an expert discussion of the practical aspects of using pharmacotherapies for the treatment of alcohol dependence. Evidence will be presented for the effectiveness of pharmacotherapies, including results from the recently published COMBINE Study. Strategies for choosing the optimal medication for particular patients and common side effects will be discussed. Both epidemiologic and clinical studies have shown a high rate of co-occurrence between alcohol use disorders and psychiatric illness. Patients with this ''dual diagnosis'' typically have an increased rate of hospitalization, poor adherence to medication, a higher rate of suicidality, and poor outcomes in both substance use and psychiatric functioning. Therapeutic issues (both pharmacologic and psychotherapeutic) in treating the challenging patient with alcoholism and comorbid psychiatric disorders will be addressed.

There is now strong evidence suggesting that the likelihood of treatment success can be improved by enabling patients to adhere to a medication and treatment regime. The problem of medication adherence will be addressed and methods for optimizing adherence introduced.

This workshop will be highly interactive and will encourage audience participation.

REFERENCES:

1. Swift RM: Medications in the Treatment of Alcohol Dependence. In R. Hester and W Miller (eds), *f*Handbook of Alcoholism Treatment Approaches: Effective Alternatives, 3rd Ed§,: Allyn & Bacon, 2002.
2. Anton et al and the Combine Study Research Group: Combined Pharmacotherapies and Behavioral Interventions for Alcohol Dependence: The COMBINE Study: A Randomized Controlled Trial. JAMA 295: 2003-2017, 2006.

ISSUE WORKSHOP 12
THE TRAUMA OF WAR: UNDERSTANDING INTERVENTIONS IN A DEVELOPMENTAL CONTEXT.

Chairperson: Alisa J. Land, M.D., *760 Westwood Plaza, Los Angelos, CA 90024-1759*
Presenters: Stevan M. Weine, M.D., Lynne M. Jones, M.D., Christopher M. Layne, Ph.D., Patricia Lester, M.D.,

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to:

1) Understand a conceptual framework of the effects of war on child and adolescent development.

2) Describe different international and national models of family and community-based interventions to support positive psychosocial adjustment after war trauma.

SUMMARY:

War presents a complex developmental trauma for children and adolescents worldwide. As a result of war, over four million children and adolescents have been permanently disabled, over a million orphaned, and more than twelve million displaced. Nearly half of the world's twenty-five million refugees are children. Experiences of witnessed violence, loss of family and home, survival in refugee camps, forced military conscription, gender-based violence, malnutrition, disease, and the loss of normal educational opportunities are only a few of the sequelae of war. In light of current events, this vulnerable population of children exposed to war is growing and presents urgent challenges for integrating our understanding of the effects of war on child development with the ability to organize appropriate services to support affected populations. This workshop will explore the developmental effects of war and consider several psychosocial frameworks for recovery. The literature on children's responses to war shows evidence of both trauma-induced distress and stress-resistant or resilient outcomes across various sub-groups. Workshop speakers drawn from several different global contexts will consider the ongoing interplay between sources of resilience and vulnerability, suggesting that significant strengths can be supported through family and community as important environmental modulators of child development, as discussed in the Institute of Medicine's book, *From Neurons to Neighborhoods* (Shonkoff, 2003). The goal will be to identify informed approaches to services for affected children to achieve more sustainable psychosocial adjustment after war.

REFERENCES:

1. Shonkoff JP: From neurons to neighborhoods: old and new challenges for developmental and behavioral pediatrics. Journal of Developmental and Behavioral Pediatrics 2003; 24: 70-76.
2. Lustig SL, Kia-Keating M, Knight WG, Geltman P, Ellis H, Kinzie JD, Keane T, Saxe GN: Review of child and adolescent refugee mental health. Journal of American Academy of Child and Adolescent Psychiatry 2004; 43 (1): 24-36.

ISSUE WORKSHOP 13
METABOLIC SCREENING OF PATIENTS ON ANTIPSYCHOTIC MEDICATIONS: IMPLEMENTATION OF A QUALITY IMPROVEMENT PROGRAM IN AN URBAN TRAINING CLINIC

Co-Chairpersons: Aurelia N. Bizamcer, M.D., *Episcopal Hospital, 100 East Lehigh Avenue, Philadelphia, PA 19125*
Diane B. Gottlieb, M.D., *Episcopal Hospital, 100 East Lehigh Avenue, Philadelphia, PA 19125*
Presenters: Jieun Kim, M.D., Chioma Iheagwara, D.O., April S. Ladavac, M.D., Shaneek Johnson, M.D., Kathleen Diller, M.D.

EDUCATIONAL OBJECTIVES:

At the completion of this workshop participants will be able to recognize the risks of obesity, glucose intolerance, and lipid abnormalities in patients on Antipsychotics and utilize a mechanism to monitor these clinical parameters and make approriate interventions and referrals.

SUMMARY:

Increased awareness of the Metabolic Syndrome, characterized by obesity, the lipodystrophies, and glucose intolerance, has raised concern about the risks of treatment with antipsychotics. These changes may increase mortality in this population. Despite the need for interventions, programs to identify, prevent and treat these disorders have been limited or minimally effective.

We have instituted a quality initiative (QI) in our inner city University training clinic to identify patients on antipsychotic medication. Our goals are to teach residents to identify these health concerns, and train them to monitor these clinical parameters, and institute appropriate interventions. We will demonstrate how this will maximize the quality of health care by providing appropriate diagnoses and referrals for our patients.

Our program monitors clinical outcomes for these patients, communication with primary care physicians, and adherence to psychiatric treatment. We will present a literature review, and demonstrate our flow sheet, and our monitor of compliance with the use of the flow sheet. Ongoing chart reviews determine whether patients are being adequately monitored for potential health problems, and detail the clinical decision making which occurs as a result of abnormal findings. We will discuss changes in our QI process instituted as a result of this monitoring, and the feedback from our workshop at the APA in Toronto.

No funding was obtained for this project.

Mental health professionals who treat patients taking antispsychotic medication.

REFERENCES:

1. Marder, SR, Essock, SM, Miller, AL, Buchanan, RW, Casey, DE, Davis, JM, Kane, JM, Lieberman, JA, Schooler, NR, Covell, N, Stroup, S, Weissman, EM, Wirshing, DA, Hall, CS, Pogach, L, Pi-Sunyer, X, Thomas Bigger, J, Frriedman, A, Kleinberg, D, Yevich,.
2. American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, and North American Association for the Study of Obesity (2004). Consensus Development Conference on Antipsychotic Drugs and Obesity an.

ISSUE WORKSHOP 14
INTERNET CHILD PORNOGRAPHY AND MENTAL ILLNESS: THE PSYCHIATRIST'S ROLE

Chairperson: Humberto Temporini, M.D., *2230 Stockton Boulevard, Sacremento, CA 95814*
Presenters: Charles L. Scott, M.D., Vladimir Coric, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this symposium workshop, the participant should be able to recognize the role of the psychiatrist in the evaluation of individuals engaged in internet child pornography offenses.

SUMMARY:

While child pornography possession is not a new phenomenon, its frequency appears to have burgeoned with the widespread use of the Internet. Ubiquitous broadband connections provide fast access and the ability to download or receive copious amounts of information, such as photographs or videos. As a result most of the cases involving possession of child pornography are linked to the trade of digital images. From a legal standpoint, the possession of child pornography constitutes both a state and federal offense. Individuals found with child pornography images on their property can receive sentences of up to 20 years of incarceration depending on the number of images available.

Psychiatrists are commonly asked to evaluate these individuals for the purposes of risk assessment (is this individual dangerous?) or to provide consultation to the legal system regarding whether psychiatric disorders played a role in the commission of the offense. During this workshop we will provide background information on the issue of internet pornography and child pornography, and their link to psychopathology. We will also present a framework for the

successful psychiatric evaluation of these individuals using case vignettes and examples of forensic reports.

REFERENCES:

1. Seto MC, Cantor JM, Blanchard R.:Child pornography offenses are a valid diagnostic indicator of pedophilia.J Abnorm Psychol. 2006 Aug;115(3):610-5.
2. Seto MC, Eke AW.The criminal histories and later offending of child pornography offenders.Sex Abuse. 2005 Apr;17(2):201-10.

ISSUE WORKSHOP 15
CHALLENGING THE STATUS QUO: CENTRALIZED ASSESSMENTS IN PSYCHIATRIC CLINICAL TRIALS

Chairperson: John M. Kane, M.D., *7559 263rd Street, Glen Oaks, NY 11004-1150*
Presenters: Janet B.W. Williams, D.S.W., Maurizio Fava, M.D., William Z. Potter, Ph.D., Jack A. Grebb, M.D., Andrew C. Leon, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will understand the challenges associated with obtaining reliable and precise outcome ratings in psychiatric clinical research. Participants will understand the scientific rationale for centralizing assessments using a new application of telepsychiatry in evaluating treatment outcome in psychiatric clinical drug trials. Participants will be able to evaluate the data to emerge from application of this methodology and appreciate the unique challenges from the pharmaceutical industry and research site perspectives associated with challenging the status quo in obtaining outcome ratings in psychiatric clinical drug trials.

SUMMARY:

The challenges associated with testing the effectiveness of new treatments in psychiatry have prompted evaluation of innovative approaches and methodologies that may positively impact the ability to discriminate drug and placebo treatments. Expert centralized rating is a novel approach to improve signal detection and study power in CNS clinical trials. Using telepsychiatry, in the form of high-resolution videoconferencing, to connect research sites to a centralized team of highly trained, routinely calibrated assessors, standardized, reliable and unbiased assessments can be obtained remotely at fewer sites and with fewer raters. The implications include smaller, higher-powered studies enabling faster, more accurate decision-making.

This workshop will review existing and new data that illustrate the challenges associated with obtaining accurate outcomes in large-scale psychiatric clinical trials using site-based raters. Obstacles to obtaining precise assessments, including bias in the form of baseline visit score inflation and expectation or "demand" characteristics, as well as poor reliability and interview quality, will be illustrated with examples from recent research. Data supporting the use of expert centralized raters in clinical drug trials will be presented, with comments from both the industry sponsor and research site perspectives. Data evaluating the use of centralized assessments to recruit and evaluate primary care patients for psychiatric research will also be presented.

REFERENCES:

1. Kobak K: A comparison of face to face and videoconference administration of the HAMD. J of Telemedicine and Telecare 2004; 10:231-235.
2. Kobak K, DeBrota DJ, Engelhardt N, Williams JBW: Site vs. centralized raters in a clinical depression trial. Poster presented at the 46th Annual NCDEU Meeting, June 12-15, 2006, Boca Raton, FL.

ISSUE WORKSHOP 16
ACHIEVING MEDICATION ADHERANCE BY UNDERSTANDING RECOVERY

Chairperson: Stephen N. Wilson, M.D., *5369 Vista Grande Drive, Santa Rosa, CA 95403*

EDUCATIONAL OBJECTIVES:

1. Understand the dynamics of recovery relevant to the prescription of medications.
2. Know several specific strategies that will enhance the effectiveness of prescribing

SUMMARY:

This workshop will provide an understanding of the dynamics of the Recovery Journey that will allow psychiatrists the ability to more effectively prescribe medications to individuals with serious and persistent mental illnesses. The expertise developed in psychopharmacology is diminished when less than half medications are taken as prescribed.

There is much reference to Recovery in these times, but little understanding of the dynamics of process of the Recovery Journey. Some specific recovery elements useful in working with someone in the development of an effective medication plan include:

- Awakening hope as a strategy to enhancing the perceived value of medications and the motivation to take them.
- Understanding the role of power in the process of effectively prescribing medications.
- The role of an individual's identity in defining their perception about medications, and how that can be changed.
- Teaching the skill of effective choice-making in the context of taking medications.

The workshop will present an approach used in twelve programs, including a mixture of community and intermediate-term inpatient settings. Those recovery elements used by psychiatrists in prescribing medications will be presented using case presentations. Approximately half of the time will be devoted to discussion and expanding the understanding based on the experiences of psychiatrists in attendance.

Through this workshop psychiatrists will develop specific, practical understandings and approaches that will enhance the effectiveness of their prescription of medications for individuals with serious and persistent mental illnesses.

REFERENCES:

1. Frese FJ, Stanley J, Kress K, Vogel-Scibilia S: Integrating Evidence-Based Practices and the Recovery Model. Psychiatric Serv 2001 52: 1462-1468.
2. Fenton WS, Blyler CR, Heinssen RK: Determinants of Medication Compliance in Schizophrenia: Emperical and Clinical Findings. Schzophrenia Bulletin 1997 23(4): 637-651.

MONDAY, MAY 21, 11:00 AM - 12:30 PM

ISSUE WORKSHOP 17
THE DILEMMA OF WOMEN'S PROFESSIONAL GARMENTS AND PROFESSIONALISM

Co-Chairpersons: Katharine A. Stratigos, M.D., *10 West 74th Street, New York, NY 10023*
Leah J. Dickstein, M.D., *1000 Wilson Boulevard, Louisville, KY*
Presenters: Stephanie Le Melle, M.D., Christina Mangurian, M.D., Lisa Mellman, M.D., Asher Simon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to

1. Understand the ways in which physicians' clothing and appearance choices influence patients' perceptions of their professionalism and competence, especially concerning women psychiatrists.
2. Understand the difficulties and paradoxes related to women's professional attire, including tensions among appearing competent, authoritative, and feminine, and to acknowledge and understand the influence of ongoing societal-level sexism on these processes.
3. Understand and consider multiple perspectives on these issues from women residents and attendings, male psychiatrists, and audience members.

SUMMARY:

The face of psychiatry has changed tremendously in the last generation, as more and more women enter the field. Many times women make up the majority in classes of medical students and residents; however, women continue to encounter gender-specific challenges. One interesting and academically unexplored area is the issue of how women psychiatrists' professional attires and appearances influence patients' (and colleagues') perceptions of their professionalism and competence. We will review research pertaining to doctors' attire and patients' perceptions of professionalism and competence. However, most of this research was not specific to gender, and little is focused on psychiatry. Other important topics to be discussed include the following: comparing assumptions about and perceptions of women versus men professionals; assumptions about women professionals' place in the work hierarchy; sexualization of women's appearance and femininity; and the natural variety of women's body types (i.e., women's professional clothing does not lend itself to the "one size fits all" approach of men's clothing). Given that open discussions about these issues are rare, both resident and attending psychiatrists' experiences will be shared in this workshop, and audience participation will be encouraged. Finally, suggestions will be provided (and elicited from the audience) collaboratively to explore how women psychiatrists should go forth most effectively.

REFERENCES:

1. Lill MM, Wilkinson T: Judging a book by its cover: Descriptive survey of patients' preferences for doctors' appearance and mode of address. British Medical Journal 2005; 331: 1524-1531.
2. Rehman SU, Nietert P, Cope D, and Kilpatrick AO: What to wear today? Effect of doctor's attire on the trust and confidence of patients. The Am J of Medicine 2005; 118: 1279-1286.

ISSUE WORKSHOP 18
DYNAMIC THERAPY WITH SELF-DESTRUCTIVE BORDERLINES

Co-Chairpersons: Edward R. Shapiro, M.D., *25 Main Street, P.O. Box 962, Stockbridge, MA 01262-0962*
Eric M. Plakun, M.D., *25 Main Street, P.O. Box 962, Stockbridge, MA 01262-0962*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to enumerate principles in the dynamic psychotherapy of self-destructive borderline patients, implement newly acquired skills in establishing and maintaining a therapeutic alliance with such patients, and be familiar with the countertransference problems inherent in work with these patients.

SUMMARY:

Psychotherapy with self-destructive borderline patients is recognized as a formidable clinical challenge. Although much has been written about metapsychological issues in psychodynamic psychotherapy, little is available to help clinicians establish a viable therapeutic relationship with these patients. This workshop includes review of 8 principles helpful in establishing and maintaining a therapeutic alliance in the psychodynamic psychotherapy of self-destructive borderline patients. The principles are: (1) differentiation of lethal from non-lethal self-destructive behavior; (2) inclusion of lethal self-destructive behavior in the initial therapeutic contract; (3) metabolism of the countertransference; (4) engagement of affect; (5) non-punitive interpretation of the patient's aggression; (6) assignment of responsibility for the preservation of the treatment to the patient; (7) a search for the perceived injury from the therapist that may have precipitated the self-destructive behavior; and (8) provision of an opportunity for reparation. These principles are compared to Linehan's DBT and Kernberg's Transference Focused Psychotherapy. After the presentation, the remaining time will be used for an interactive discussion of case material. Although the workshop organizers will offer cases to initiate discussion, workshop participants will be encouraged to offer case examples from their own practices. The result should be a highly interactive opportunity to discuss this challenging and important clinical problem.

REFERENCES:

1. Plakun EM: Principles in the psychotherapy of self-destructive borderline patients. Journal of Psychotherapy Practice and Research 1994; 3:138-148.
2. Plakun EM: Making the alliance and taking the transference in work with suicidal borderline patients, Journal of Psychotherapy Practice and Research 2001; 10: 269-276.

ISSUE WORKSHOP 19
FIRST EPISODE MOOD DISORDERS: WHAT HAVE WE LEARNED AND WHERE DO WE GO FROM HERE?

Chairperson: Kathryn J. Macdonald, M.D., *243 Sanatorium Road, Hamilton, ON L9C 1Z4*
Presenters: Kaan Yucel, M.D., Ph.D., Valerie Taylor, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to: 1) demonstrate an understanding of the current clinical and research issues in first episode mood disorders; 2) recognize the importance of rapid response and early intervention in new onset depression and bipolar disorder; 3) recognize signs and symptoms of comorbid medical issues such as metabolic syndrome and have a clear strategy for monitoring patients at risk; 4)recognize the potential impact of mood disorders on anatomical structures in the brain.

SUMMARY:

Mood disorders are common psychiatric illnesses with high variability in outcome and response to treatment. There has been a relatively recent surge in interest in the development and progression of mood disorders from the time of first episode of symptoms and initial treatment. Most of the information available to this point has been based on studies of individuals with varied illness profiles. Methods: The First Episode Project is a longitudinal, naturalistic study monitoring the course of illness and treatment in individuals presenting with untreated first episodes or never treated episodes of hypomania, mania and depression. Subjects are aged 16 to 50 and have primary DSM-IV diagnoses of Major Depressive Disorder or Bipolar Disorder, confirmed by SCID-IV. Extensive data on cognitive, social and physical variables have been collected on over 120 subjects since 1999. Results: This workshop reviews the information from the current literature on management of first episode mood disorders and presents the current data from the First Episode Project with respect to demographics, family history, time to remission/ recovery/ relapse/recurrence, analysis of MRI data, and metabolic issues at baseline and related to treatment. Conclusions: Individual treatment outcomes are highly variable in mood disorders but there is suggestion from current research that early intervention and treatment

may have a major impact on physical as well as mental health. Close monitoring for changes in physical status is important, and an awareness of the potential complications of treatment is vital for patient health. Mood disorders themselves as well as treatment factors can have an impact on anatomic structures in the brain and further research is needed into the clinical implications of these findings.

REFERENCES:

1. Tohen M, Zarate CA, Hennen J, Khalsa HM, Strakowski SM, Gebre-Medhin P, Salvatore P, Baldessarini RJ. The McLean-Harvard First-Episode Mania Study: prediction of recovery and first recurrence. Am J Psychiatry 2003; 160(12):2099-107.
2. MacQueen GM, Campbell S, McEwan BS, Macdonald K, Amano S, Joffe RJ, Nahmias C, Young LT: Course of illness, hippocampal function and volume in major depression. Proc Natl Acad Sci USA 2003; 100:1387-92.

ISSUE WORKSHOP 20
TEACHING COGNITIVE BEHAVIOR THERAPY TO CHILD AND ADULT RESIDENTS

Chairperson: Judith S. Beck, Ph.D., *1 Belmont Avenue, Suite 700, Bala Cynwyd, PA 19004-1610*
Presenters: Donna M. Sudak, M.D., Jesse H. Wright III, M.D., Robert D. Friedberg, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to:

1. Describe various methods of training and supervising child and adult residents in CBT
2. Access and use CBT evaluation tools
3. Identify educational resources in teaching CBT to residents
4. Teach residents to integrate CBT with psychopharmacology
5. Teach residents basic CBT skills

SUMMARY:

Many residency training programs need to improve their cognitive behavior therapy component. CBT is not just a collection of techniques. In order to demonstrate competency, residents must learn sophisticated methods of conceptualization and how to use a cognitive formulation (which varies from one disorder to another) to plan treatment effectively--in addition to learning basic cognitive and behavioral strategies. A host of resources are available for faculty to help them design or improve their programs. This workshop will help participants identify these resources to enable them to establish standards of competency, devise curricula, learn various methods for training and supervising residents, obtain training materials, identify potential instructors and supervisors, and evaluate residents' competency. Participants will be encouraged to bring up specific problems in training both child and adult residents in CBT, such as helping residents treat challenging cases and work with families, integrating psychopharmacology with CBT, and creating space in the overall curriculum to teach CBT.

REFERENCES:

1. Beck JS: Cognitive Therapy: Basics and Beyond. New York, Guilford Press, 1995.
2. Wright J, Basco M, Thase M: Learning Cognitive-Behavior Therapy. Washington, APPI, 2006.

ISSUE WORKSHOP 21
AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY UPDATE: CERTIFICATION AND MAINTENANCE OF CERTIFICATION IN PSYCHIATRY AND ITS SUBSPECIALTIES

Chairperson: Larry R. Faulkner, M.D., *200 Lake Cook Road, Deerfield, IL 60015*
Presenters: Daniel K. Winstead, M.D., Naleen N. Andrade, M.D., Beth Ann Brooks, M.D., David A. Mrazek, M.D., Burton V. Reifler, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the American Board of Psychiatry and Neurology's policies and procedures for certification and maintenance of certification in psychiatry and its subspecialties.

SUMMARY:

The purpose of this workshop is to present information on the requirements for certification by the ABPN in psychiatry and the subspecialties of addiction psychiatry, child and adolescent psychiatry, forensic psychiatry, geriatric psychiatry, and psychosomatic medicine, as well as clinical neurophysiology and pain medicine. Proposed new subspecialty certificates in sleep medicine and hospice and palliative medicine will be discussed. Application procedures, including training and licensure requirements, will be outlined. The content of the Part I (multiple choice), Part II (oral), and subspecialty (multiple choice) examinations will be reviewed. New test administration procedures related to the administration of the multiple-choice examinations in a nationwide network of computer test centers will be delineated. Information on maintenance of certification (recertification) will also be provided, and a substantial amount of time will be available for the panelists to respond to queries from the audience.

REFERENCES:

1. Shore JH, Scheiber SC (eds): Certification, Recertification, and Lifetime Learning in Psychiatry. Washington, DC, American Psychiatric Press, 1994.
2. Scheiber SC, Kramer TAM, Adamowski S (eds): Core Competencies for Psychiatric Practice: What Clinicians Need to Know. Washington, DC, American Psychiatric Press, 2003.

ISSUE WORKSHOP 22
ASSESSING CAPACITY TO DRIVE: A PRACTICAL APPROACH TO THE PSYCHIATRIST'S ROLE AND RESPONSIBILITIES

Co-Chairpersons: Dimitri D. Markov, M.D., *1020 Sansom Road, Philadelphia, PA 19107-5004*
Presenters: Clarence Watson Jr, M.D., Marc Rothman, M.D., Elisabeth J.S. Kunkel, M.D.

EDUCATIONAL OBJECTIVES:

1. At the conclusion of this workshop, the participant should be able to understand the components of driving capacity evaluation of drowsy drivers and patients with dementia.
2. At the conclusion of this workshop, the participant should understand the legal and regulatory aspects of treating drivers with dementia or excessive sleepiness.

SUMMARY:

Sleep deprivation, shift work, primary sleep disorders, sleep disturbance associated with medical and psychiatric illness, and/or psycho-

pharmacologic interventions cause excessive daytime sleepiness. Dementia affects memory, judgment, visual, spatial and motor skills. Psychiatrists are increasingly faced with patients whose driving ability may be impaired either by dementia or excessive daytime sleepiness. Drowsy driving is associated with fatality rates and injury severity that is similar to that of alcohol-related crashes. Patients with dementia are 3 to 5 times more likely to be involved in a motor vehicle accident than age-matched controls.

This symposium will offer a practical framework to approach questions related to a patient's capacity to drive in the setting of dementia and excessive daytime sleepiness. Attention will be given to both the legal foundations and how to assess capacity to operate a motor vehicle. We will offer a practical clinical approach to managing questions of driving capacity.

REFERENCES:

1. Kane, KM: Driving into the Sunset: A Proposal for Mandatory Reporting to DMVby Physicians Treating Unsafe Elderly Drivers, 25 Hawaii L. Rev. 59, 2002.
2. Stutts J, Wilkins J: Driver Risk Factors for sleep-related crashes. Accid Annal Prev 2003; 35: 321-331.

ISSUE WORKSHOP 23
IMPLEMENTING A TELEPSYCHIATRY PROGRAM IN THE KERN COUNTY MENTAL HEALTH SYSTEM IN RURAL CALIFORNIA

Chairperson: Tai P. Yoo, M.D., *15120 Vista Grande Drive, Bakersfield CA 93306*
Presenter: Salvador R. del Rosario, Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will understand the six stages of developing a telepsychiatry program, from identifying needs to solidifying the program. The participant will appreciate the elements necessary for developing a successful telepsychiatry program based on a literature review and our experience. Lastly, the participant will recognize that implementing a telepsychiatry program is a formidable endeavor that should improve delivery of mental health care to rural areas, where access to qualified, clinical providers is limited.

SUMMARY:

Objective: Kern County spans over 8,000 square miles of rural California with a population of 785,000, which is projected to surpass 1,070,000 by 2020. Currently, there are only 26 psychiatrists in the county system, mostly located in the city of Bakersfield. Insufficient public transportation coupled with a vast mountain and desert terrain severely limit access to care. The Kern County Mental Health System and the UCLA-Kern Psychiatry Department are implementing a telepsychiatry program with clinical, educational, and administrative functions, in a mission to improve mental health care for the underserved rural areas.

Method: We conducted a MEDLINE literature search from 1965 to August, 2006, using the terms telepsychiatry, development, and implementation. A team consisting of an administrative coordinator, a technology advisor, and a clinical champion, was formed to lead the implementation. The team attended a 3-day training session at the UC Davis Telemedicine Training Center, for mentorship. This team continued to meet on a weekly basis during the early stages of development. At the pilot site, we measured the access to care, the quality of care, and clinical outcomes, before and after the implementation.

Results: There is a growing body of research on developing a telepsychiatry program in a rural setting, and on the efficacy of telepsychiatry. Elements necessary for developing a successful telepsychiatry program include: a clinical champion, site coordinators, technical support, grant funding, a team approach, a conservative timeline, sufficient training, goals that are consistent with the organization, and positive initial encounters. We share our experience at each stage of developing our telepsychiatry program, and the impact on clinical care at the pilot site.

Conclusion: Implementing a telepsychiatry program is a formidable endeavor that should improve delivery of mental health care to rural areas, where access to qualified, clinical providers is limited.

REFERENCES:

1. Hilty DM, Marks SL, Urness D, Yellowlees PM, Nesbitt TS: Clinical and educational telepsychiatry applications: a review. Can J Psychiatry. 2004 Jan;49(1):1-3.
2. Shore JH, Manson SM: A developmental model for rural telepsychiatry. Psychiatr Serv. 2005 Aug;56(8):976-80.

ISSUE WORKSHOP 24
WOMEN RESIDENTS' NEEDS DURING PSYCHIATRIC TRAINING

Chairperson: Anu A. Matorin, M.D., *1300 Moursund, Houston, TX 77030*
Presenters: Lina M. Lopez, M.D., Toi B. Harris, M.D., Deborah Spitz, M.D., Sandra B. Sexson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants would have increased awareness of the unique challenges and opportunities facing women residents during psychiatric training. This workshop will also provide a forum for exchange of ideas to identify and implement creative and innovative strategies to foster career growth and advancement for women in psychiatry.

SUMMARY:

The "Glass Ceiling" effect as described in corporate America is seen in the medical field as well, with women physicians underrepresented in positions of leadership and authority, in spite of significant numerical gains in medical school admissions and in the workforce. As of 2005, only fifteen percent of full professors and eleven percent of department chairs are women. This trend further holds true for women, especially as first or senior authors in prominent medical journals. Unfortunately, at present, in the field of psychiatry, women's under-representation in academia in this regard is even more dramatic. However, psychiatry should lead the way in ending this disparity. A key opportunity to reverse this trend is during residency training. Women psychiatry residents may lack the tools, background, and experience necessary to navigate challenges during residency and beyond in order to successfully advance in their career path. Women who are international medical graduates or minorities face further unique barriers in their quest for advancement. This workshop will critically assess and identify key challenges facing women residents and focus on current issues impacting career advancements for women psychiatrists, including lack of mentors and role models, inadequate mentoring, professional prejudices and stereotypes, uncertainty regarding how to seek out leadership positions, lack of awareness regarding criteria for promotion and advancement, sociocultural and psychological factors, and special issues related to family needs. Utilizing personal and professional experiences, this workshop will promote a dialogue for exchange of ideas focusing on practical and creative solutions to ameliorate barriers facing women psychiatric residents.

REFERENCES:

1. 1. Hamel MB, Ingelfinger JR, Phimister E, Solomon CG: Women in Academic Medicine-Progress and Challenges. N Engl J Med 2006; 355(3):310-312.
2. 2. Jain S, Ballamundi B: Women in U.S. Psychiatric Training. Acad Psychiatry 2004; 28(4):299-304.

ISSUE WORKSHOP 25
THE EARLIEST ENVIRONMENT: PRENATAL STRESS, ANXIETY, AND DEPRESSION AND CHILD OUTCOME

Chairperson: Hanna E. Stevens, M.D., *230 South Frontage Road, New Haven, DT 6520*
Presenters: Catherine Monk, Ph.D., Thomas O'Connor, Ph.D., Zachary N. Stowe, M.D., Pathik D. Wadhwa, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will:

1. understand many components of stress, anxiety and depression during pregnancy

2. appreciate the scientific data demonstrating persistent effects in the physiological, behavioral and emotional development of children exposed to these prenatal phenomena

3. gain a better understanding of the hypothalamic-pituitary-adrenal axis in pregnant women and in children exposed to stress *in utero.*

4. be able to use these findings to inform their thinking about prenatal psychiatric care and the care of children with significant exposure to gestational stress.

SUMMARY:

Pregnancy is a time of significant change in both physiology and life circumstances. It is well known that prenatal medical care can make a positive impact on the health of the mother, development of the fetus, and outcome of the child after birth. Appropriate mental health care during this time can also prevent negative outcomes. Mental illness and behavioral processes experienced by pregnant women play a significant role in the health of the fetus and child after birth. A growing body of evidence suggests that maternal prenatal stress, anxiety and depression create changes in fetal physiology which may be linked to later child outcome. In this workshop, participants will hear from investigators studying physiological and behavioral correlates, both transient and persistent, of prenatal stress and depression observed in offspring. This workshop will explore the mechanisms by which stress may effect child development, such as alterations of maternal hypothalamic and placental hormones. The hypothalamic-pituitary-adrenal (HPA) axis is influenced by acute stressors but also by mood disorders and perceptions of anxiety and stressors. The fetal HPA axis may be particularly vulnerable to changes in maternal HPA biochemistry, permitting prenatal stress to have both transient and persistent effects in offspring. Presenters will discuss findings linking fetal cardiovascular physiology and behavior with prenatal stress and maternal corticotropin releasing hormone. Participants will be involved in discussions about recent data showing correlations of infants' and children's cortisol levels with maternal depression and anxiety during pregnancy. Behavioral and emotional problems in children have also been linked to their *in utero* exposure to anxiety. These links are relevant to adult psychiatrists who provide treatment to women that can ameliorate stress, anxiety and depression during pregnancy but also to child psychiatrists who seek to understand and treat behavioral and emotional problems from infancy to adolescence.

REFERENCES:

1. Wadhwa PD: Psychoneuroendocrine processes in human pregnancy influence fetal development and health. Psychoneuroendocrinology 2005; 30: 724-743.
2. O'Connor TG, Ben-Shlomo Y, Heron J, Golding J, Adams D, Glover V: Prenatal anxiety predicts individual differences in cortisol in pre-adolescent children. Biol Psychiatry. 2005; 58 :211-7.

ISSUE WORKSHOP 26
DETECTION OF MALINGERING

Chairperson: Alan R. Hirsch, M.D., *845 North Michigan Avenus, Suite 990W, Chicago, IL 60611-2201*
Presenters: Carl M. Wahlstrom, Jr., M.D., David E. Hartman, Ph.D.

EDUCATIONAL OBJECTIVES:

To utilize techniques to help delineate malingering.

SUMMARY:

In forensic psychiatry, mental health professionals routinely need to assess the truth or falsity of histories and to weigh candor or disingenuousness during the physical examination. Yet psychiatrists are only 57% accurate in recognizing deception. This session is designed to teach different methods for detecting both verbal and nonverbal cues of deception in the clinical setting. Through use of live audience participation and videotapes of actual lying episodes, methods of determining lying will be demonstrated.

REFERENCES:

1. Hirsch, A.R., Wolf, C.J. Practical methods for detecting mendacity: A case study. J Am Acad Psychiat Law, 2001;29:438-444.
2. Ekman, P., O'Sullivan, M., Friesen, W.V., Scherer, K.R. Face, voice and body in detecting deceit. J Nonverbal Behav, 1991; 15:125-135.

ISSUE WORKSHOP 27
MUSIC AS A MEANS OF SURVIVAL: THE SIGNIFICANCE OF MUSIC IN SURVIVING THE HOLOCAUST

Chairperson: Andrei Novac, M.D., *400 Newport Center Drive, Newport Beach, CA 92660-7604*
Presenter: Bonita Nahoum-Jaros VIII, Ph.D.

EDUCATIONAL OBJECTIVES:

At the end of the presentation, participants should: 1. Understand the relationship between acquired rtesiliency and survival of severe traumatic stress; 2. Recognize the resiliency-building effect of music during the Holocaust; 3. Familiarize with some of mthe compositions developed by survivors in their process of resiliency building.

SUMMARY:

During the first decade of the 21st century, many hopes about a less belligerent world have not materialized. Instead, wars, genocides, terrorist acts continue to be on the front page of daily newspapers. Therefore, the authors find it necessary to reexamine some of the lessons from past historical traumas. Dr. Nahoum-Jaros, a professor of linguistics, who is also a trained opera singer, and Dr. Novac, a psychiatrist specializing in trauma, are exploring how music has served as a modality of survival during the Holocaust and WW II era. First Dr. Nahoum-Jaros will be giving a live performance of songs that she has collected as part of her research from Holocaust survivors. The story behind each song will be explained. In addition to the live presentation, excerepts from a recently produced CD entitled *Kaddish: Voices from the Holocaust,* will be presented. Dr. Novac will be discussing some of the known and hypothesized mechanisms of psychological resiliency building employed by trauma victims. An open discussion with the audience will follow.

REFERENCES:

1. Jaros, BN. Sounds of survival and regeneration: A microstoria of the Holocaust, 1940-1945. PQIL, Ann Arbor, MI: 2005..

2. Novac, A. "Trauma--Global and social considerations." Special report--The Psychiatric Times, 2003;20(4):33.

TUESDAY, MAY 22, 9:00 AM - 10:30 AM

ISSUE WORKSHOP 28
PSYCHIATRY IN THE PRIMARY CARE SETTING: MAKING IT WORK FOR PATIENTS AND DOCTORS

Chairperson: John C. Urbaitis, M.D., *2401 West Belvedere Avenue, Baltimore, MD 21215-5216*
Presenters: Jonathan S. Davine, M.D., David A. Pollack, M.D., Shauna P. Reinblatt, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to describe and illustrate ways to strengthen commmunication with primary care practitioners and non-psychiatric specialists, and improve patient care in a variety of primary care settings.

SUMMARY:

Many patients in primary care settings have significant psychiatric problems: depression, anxiety including PTSD, as well as somatization and substance abuse, which can exacerbate their medical problems. Primary care patients often are reluctant to make special arrangements to see a psychiatrist, yet active medical conditions can complicate their psychiatric problems. For example, poorly controlled diabetes can aggravate depression. When psychiatrists see patients in primary care (ambulatory) settings, they can do much to treat the patients and can reach those who otherwise might not receive effective psychiatric care. Patients with cardiac disease may not realize that treatment of their depression can help medically; women with post partum depression often want coordination with their pediatrician before agreeing to medication. In this workshop, psychiatrists and other clinicians interested in psychiatry in primary care settings can learn more about working with patients in these settings. Psychiatrists who have successfully worked in a variety of primary care settings, including public, private, and academic settings, share their clinical and administrative experiences. One speaker has extensive experience in health planning and administration at the state level. Two of the panelists have extensive experience in Canada, including working in the shared care model; one speaker offers the added perspective of a former family practice physician. Topics include engaging patients in treatment, arranging and managing practice sites, arranging or advocating for coordinated funding and management, communicating with primary care physicians, coordinating treatment, and developing referrals.

REFERENCES:

1. Unutzer J, Schoenbaum M, Druss B, Katon W: Transforming Mental Health.
2. . Whooley MA: Depression and Cardiovascular Disease. JAMA 2006;295:.

ISSUE WORKSHOP 29
THE UTILITY OF COMPUTER-ASSISTED PSYCHOEDUCATION FOR RESIDENTIAL TREATMENT OF VETERANS WITH PTSD

Co-Chairpersons: Daniella David, M.D., *1201 N.W. 16th Street, Unit 116A-12, Miami, FL 33125*
Gary S. Kutcher, Ph.D., *1201 NW 16th Street, Miami, FL 33125*
Presenter: Maria D. Llorente, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to:

1. Become familiar with the design, development and implementation of a computer-assisted psychoeducation program.
2. Develop a better understanding of the role and use of computer-assisted psychoeducation as part of a comprehensive rehabilitation treatment program for patients with PTSD.
3. Learn how to design and collect individual patient progress as well as group outcome data for computer-psychoeducation activities in psychiatric patients.

SUMMARY:

A newly designed Computer Assisted Psychoeducation Program has been implemented at the Miami VA Healthcare System as part of Rehabilitation Treatment for veterans with chronic military related PTSD. WWII through recently returned Operation Iraqi Freedom veterans attend bi-weekly psychoeducation sessions during their residential rehabilitation admission. Each patient is provided with a PC to access educational modules covering various program-related topics. Educational material is delivered using a popular point-and-click interactive software program. After an initial instructional module, patients select module topics and work at their own pace. A 16-question multiple-choice quiz is embedded in each module to ensure understanding and mastery of the information presented. Immediate feedback is provided after each question and scoring is performed automatically. A score of 80% is necessary before advancing to the next module.

As part of program outcome monitoring, veterans who participated in computer assisted psychoeducation were assessed with respect to their ability to successfully interact and learn using the computer delivery system. Various dimensions and aspects of the program were also evaluated. To date, twenty subjects with a primary diagnosis of military related PTSD completed a pre- and post-assessment for 10 psychoeducational modules. Data revealed that subjects successfully learned and mastered new information using the computer assisted psychoeducation program. Subjects reported a preference for this delivery method over traditional staff facilitated didactic classes. Furthermore, patients positively rated factors such as the standardization of material, the ability to repeat modules and work at an individualized pace, user-friendliness, and the dynamic graphic design. Patients reported a desire to have the program made available to them and to family members for home use, to be distributed on a CD (which is currently available) or available via internet.

The computer-assisted psychoeducation modules will be presented in an interactive mode, with three laptop computers set up for hands-on experience.

REFERENCES:

1. Burda PC, Starkey TW, Dominguez F, Tremont MR: Computer-assisted psychoeducation of psychiatric inpatients. Computers in Education 1995; 25:133-137.
2. Hirai M, Clum GA: An internet-based self-change program for traumatic event related fear, distress, and maladaptive coping. Journal of Traumatic Stress 2005; 18:631-636.

ISSUE WORKSHOP 30
HOW DOES CULTURE MAKE A DIFFERENCE IN AMERICAN MENTAL HEALTH CARE? CULTURALLY-SPECIFIC CARE IN CHANGING CONTEXTS

Co-Chairpersons: Lawrence T. Park, M.D., *55 Fruit Street, WRN-605, Boston, MA 2114*
Mary Jo Good, Ph.D., *631 Huntington Avenue, Boston, MA 2115*
Presenters: Roberto Lewis-Fernandez, M.D., Sadeq Rahimi, Ph.D., Lisa Stevenson, Ph.D., Ken Vickery, Ph.D.

EDUCATIONAL OBJECTIVES:

Following the presentation, participants should be able to 1) recognize how segments of the American health care system are responding

to new forms of immigration and the increasing demands of ethnic diversity, 2) compare and contrast cultural competencies in culturally-specific clinics with those in general hospitals, 3) recognize the often unseen and unspoken challenges that culturally and linguistically diverse patients bring to the clinical encounter, 4) learn about successful strategies to accommodate culturally-diverse populations, and 5) recognize the barriers that continue to plague even the most successful efforts to bridge cultural divides in the delivery of health care.

SUMMARY:

Given the significant increase in immigration and cultural diversification in the United States at the beginning of the 21st century, managing such diversities have taken new and significant dimensions. Such issues as ethnicity, race, religion, poverty, refugee status, language, and culturally particular understandings and practices have posed new challenges to the American mental health care system, as reflected in the Surgeon General's (2001) assertion that "culture counts." But exactly 'how' culture counts remains nebulous. Despite the impressive proliferation of services and interventions aimed at improving access to and quality of health care for minorities, relatively little seems to be concretely known or scientifically understood in terms of the efficiency or validity of much of those services and interventions. The proposed workshop will examine the results of a qualitative, interdisciplinary, six-site study examining the modalities through which cultural diversity impacts the delivery of mental health care. Data for the study consisted of interviews with 200 clinicians and staff in culturally-specific and culture-generic clinican venues, and repeated interviews over a 6 month period with 50 clinician-patient dyads. The results indicate clearly that numerous efforts to accommodate diversity - namely, translation services, cultural competencies training, diversity in staffing, and the development of culturally-specific clinics - are becoming part of mainstream treatment. Despite these efforts, detailed analyses of the accounts of the subjective experiences of clinicians, staff, and patients reveal a need for addressing a number of elemental obstacles which remain capable of undermining the efficiency of culturally specific interventions. Such basic issues as trust, translation/communication, insurance coverage, social support, and immigration status continue to impede full effectiveness of these efforts. This workshop will explore both the successes of current efforts, as well as the challenges that remain, even in those institutions with significant expertise in accommodating culturally and linguistically diverse populations.

REFERENCES:

1. Betancourt JR et al: Cultural Competence and Health Care Disparities: Key Perspectives and Trends. Health Affairs 2005;24(2):499-505.
2. Anderson LM et al: Culturally Competent Healthcare systems: A Systematic Review. Am J Prev Med 2003;24(3S):68-79.

ISSUE WORKSHOP 31
THE PROVIDER'S PURSUIT OF CULTURAL COMPETENCE: A BIOPSYCHOSOCIAL QUEST

Chairperson: Richard K. Harding, M.D., *15 Medical Park, Suite 104A, Columbia, SC 29203*
Presenters: Nioaka N. Campbell, M.D., Meera Narasimhan, M.D., Eric R. Williams, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to:

1. Evaluate the impact that media may have on psychiatrists in their perception, assessment, and treatment of minority patients.
2. Assess the trends in practice for minority physicians and residents in training, and discuss how these trends may affect patient care and cultural competency in psychiatric practice.
3. Review the characteristics and vision of a psychiatric training program with 36% minority residents, excluding international medical graduates.
4. Identify the provider's role in recognizing physiological differences in various ethnic populations and potential pharmacological treatment strategies.
5. Discuss implementation strategies for enhancing the face of psychiatry and integrating the influence of culture into everyday practice.

SUMMARY:

The limitations in our knowledge, skills, and competency in the area of psychiatric care for minority patients are daunting. Our personal practice as psychiatrists is the first step in changing the face of psychiatry for these patients. In this workshop we will consider issues at the provider level which may influence our own cultural awareness and the competency with which we treat our patients.

How psychiatrists self-identify and are recruited into our chosen field may be a reflection of how our specialty addresses cultural diversity. Women residents in psychiatry are approaching 53% as of 2004, yet minority residents are extremely lacking with less than 2.5% of psychiatrists in the United States being African-American. We will review the trends in minority physicians and psychiatrists while identifying how they relate to our goal of cultural competence.

The influence that the media has on the psychiatric provider is more evident than most would admit. Providers, like the lay public, are bombarded with images, stories, and statistics packaged to generate maximum interest, sometimes at the expense of accuracy and truth, and often at the expense of minorities. These images can lead to biases that affect patient care. Recognizing the tactics of the media, as well as our vulnerability to them, is another step toward ensuring the deliverance of the most culturally competent care possible.

The vast diversity across ethnic groups occurs within drug metabolism, receptors and transporter genes. These areas show great promise by utilizing genetic information to individualize drug therapy, and have been estimated to become standard of practice for prescribing many medications by 2020. The promise of the genomic age is fast approaching and is key to creating personalized treatments with greater efficacy and safety that would eventually translate to improved quality of life for all of our patients.

REFERENCES:

1. Weissman J et al: Resident Physicians' Preparedness to Provide Cross-Cultural Care. JAMA 2005;294:1058-1067.
2. Stassen HH et al. Genetic predisposition of antidepressant drug response. Am. J. Med. Genetics; Neuropsychiatric Genetics 2003;122: 123-124.

ISSUE WORKSHOP 32
1: 1 OBSERVATION IN A GENERAL HOSPITAL SETTING: ISSUES AND RECOMMENDATIONS.

Co-Chairpersons: Kamil Jaghab, M.D., *2201 Hempstead Turnpike, East Meadow, NY 11554*
Nyapati Rao, M.D., *2201 Hempstead Turnpike, East Meadow, NY 11554*
Presenters: Tanveer Padder, M.D., Jacob Elliott Sperber, M.D.

EDUCATIONAL OBJECTIVES:

At the end of the workshops the participant should be able to

1. To identify various predictors/ variables of 1:1 observations.
2. To find the ways to effectively reduce 1:1 observations.

3. Increase effectiveness of treatment of underlying conditions, which give rise to 1:1 observation.

4. Recommendations for ordering, reviewing, and discontinuing 1:1 observations in order to reduce cost without increasing risk.

5. Understand the economics of healthcare delivery in a hospital setting

SUMMARY:

I: 1 observation (1:1) also known as constant observation is a commonly used clinical intervention to manage patients in general hospital setting with various acute psychiatric symptoms. It is defined as an increased level of observation and supervision in which continuous, one-to-one monitoring techniques are utilized to assure the safety and well-being of an individual patient or others in the patient-care environment. While this practice makes abundant clinical sense, it is, however, seen as a very expensive intervention by hospital administrators. The mean length of time for 1:1 cited in various studies ranges between 3.7 and 9.2 days. 1 Moore, et al studied the cost of constant observations in three general hospitals, which he estimated to range between $2, 33,000 and $5, 81,000per year. 2 In this workshop we propose to elucidate the factors that necessitate 1: 1, and our experience in managing this issue cost effectively.

In response to our hospital administrators request to examine the rapidly rising 1:1 costs, we conducted a retrospective chart review of all patients who were placed on 1:1 from May 1st 2006- July 31st 2006.We reviewed 225 charts to examine the demographic information, medical/psychiatric history, indications for 1:1 and expenses incurred.

We found that mean duration was 3.4 days with range from 1-22 days. Most of the patients were located on medical/surgical floors, followed by psychiatry inpatient, ICU and ER. . The most common reason was suicide risk followed by agitation, overdose, prior psychiatry diagnosis and others. Based on this study we came up with certain alternative methods of caring for these patients and we discus the merits of each. We discuss 5 major areas, which can significantly reduce the number of in 1: 1. We also discuss our experience in dealing with the economics of 1:1 observation status.

REFERENCES:

1. Blumenfield M, Milazzo J, and Orlowski B. Constant Observation in the General Hospital. Psychosomatics, Aug 2000; 41: 289 - 293.
2. Moore P, Berman K, Knight M, et al: Constant observation: implications for nursing practice. Journal of Psychosocial Nursing 1995; 33:46'50.

ISSUE WORKSHOP 33
RECOGNITION AND MANAGEMENT OF NEUROLEPTIC MALIGNANT SYNDROME

Co-Chairpersons: Andrew J. Francis, M.D., *Health Sciences Center T-10, Stony Brook, NY 11794*
Stephan C. Mann, M.D., *800 Zorn Avenue, Louisville, KY 40206*
Presenters: Stanley N. Caroff, M.D., Sanjay Gupta, M.D., Dora D. Kohen, M.D., Perminder Sachdev, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should (1) know how to contact the NMSIS Hotline, (2) be aware of the typical clinical features of neuroleptic malignant syndrome [NMS], and (3) identify basic differential diagnosis and management strategies for NMS.

SUMMARY:

Neuroleptic malignant syndrome (NMS) is an uncommon but potentially fatal complication of treatment with antipsychotics and related agents. Defining features include hyperthermia, muscle rigidity, mental status changes and autonomic dysfunction. Because NMS is rare, individual practitioners may have limited experience with its often complex evaluation and management and are frequently baffled by the array of hyperthermic conditions that overlap with NMS and complicate the differential diagnosis. NMS persists in the present era of predominance of atypical over conventional antipsychotic drugs. The Neuroleptic Malignant Syndrome Information Service (NMSIS) provides web-based clinical information and a 24-hr hotline with expert consultant guidance for the management of NMS and related hyperthermic syndromes including serotonin syndrome, malignant catatonia and antipsychotic drug-related heatstroke. All members of the international panel assembled for this workshop are affiliated with NMSIS. The goals of this workshop are to describe NMSIS and its hotline service, briefly review recent relevant experience and research on NMS and related conditions, and use clinical examples from the NMSIS hotline, the panel's practice and the audience's experience to illustrate expert strategies for identification and management of NMS. Brief presentations will describe the NMSIS hotline (Dr. Caroff), an NMS registry in the United Kingdom (Dr. Kohen) and the advent of NMS rating scales (Drs. Francis and Sachdev). The panel will distribute and present 2-4 cases whose evaluation and management they and the audience will then discuss. The audience will be encouraged to bring their own cases for consideration. This format is interactive with panel members briefly presenting their segments (45 minutes total) followed by the panel and audience discussion of clinical vignettes. There will be ample opportunity for dialogue among the panelists and audience concerning the recognition, diagnosis and management of NMS and related conditions.

REFERENCES:

1. Mann SC, Caroff SN, Keck PE, Lazarus A. Neuroleptic malignant syndrome and related conditions (Second Edition), Arlington, VA, American Psychiatric Press, 2003.
2. Caroff SN, Mann SC, Campbell EC: Atypical Antipsychotics and Neuroleptic Malignant Syndrome. Psychiatric Annals 2000; 30: 314-324.

ISSUE WORKSHOP 34
INVOLUNTARY HOSPITALIZATION OF MEDICAL PATIENTS WHO LACK DECISIONAL CAPACITY: AN UNRESOLVED ISSUE

Chairperson: Nancy Byatt, D.O., *55 Lake Avenue North, Worcester, MA 1655*
Presenters: Debra A. Pinals, M.D., Patrick Smallwood, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop participants should be able to:

(1) Understand and identify the differences between decisional capacity and commitment criteria.

(2) Recognize issues encountered when patients who lack decisional capacity secondary to a medical illness request to leave the hospital against medical advice.

(3) Discuss potential approaches to hospitalization of medical patients who lack decisional capacity and are requesting to leave the hospital against medical advice.

SUMMARY:

Psychosomatic Medicine psychiatrists often struggle with problems presented by patients who lack decisional capacity secondary to a medical illness, want to leave the hospital against medical advice (AMA) and are considered dangerous to themselves secondary to lack of decision making capacity. In such cases, patients may become combative in their attempt to leave AMA and require restraints. Currently, there is a dearth of information available about involuntarily holding such patients. This workshop will begin with a case presentation that provides an objective lesson in both the difficulty

of managing patients who lack decisional capacity, and the conundrums and legal issues involved in the issue of continuing to hospitalize patients involuntarily when such patients seek to leave AMA. Participants will be able to use the case example and their own experience to discuss potential approaches to effectively manage such complex cases. Presenters will include an overview of the appropriate and inappropriate use of restraint, legal holds related to psychiatric patients, and engagement in multidisciplinary collaboration and planning. In conclusion, this workshop will review proposed approaches in light of clinical, ethical, and legal considerations on psychosomatic medicine services, while providing guidance for medical and psychiatric staff in such complex situations.

REFERENCES:

1. Byatt N, Pinals D, Arikan R: Involuntary hospitalization of medical patients who lack decisional capacity: an unresolved issue. Psychosomatics 2006; 47: (In Press).
2. Wise T, Berlin R: Involuntary hospitalization: an issue for the consultation-liaison psychiatrist. Gen Hosp Psychiatry 1987; 9:40-44.

ISSUE WORKSHOP 35
HOW TO INVOLVE YOUR PATIENTS WITH BIPOLAR DISORDER IN THEIR TREATMENT PLAN: A GUIDELINE FOR CLINICIANS

Chairperson: Heinz Grunze, M.D., *Nussbaumstrasse 7, Munich 80336*
Presenters: Francesc Colom, Ph.D., Eduard Vieta, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to understand 1) the importance of treatment adherence in bipolar disorder, 2) the need to educate patients on the implications of their illness, 3) the concept of "therapeutic alliances" that promote patient participation in treatment decisions, and 4) the ways physicians can involve their patients with bipolar disorder in the development of their own treatment plans.

SUMMARY:

To provide guidance to practicing physicians in the development of a successful therapeutic alliance with their patients with bipolar disorder with subsequent improvement in adherence and other beneficial outcomes.

Discussions based on the literature and derived from real-world experiences of the challenges of treatment adherence, the impact of psychoeducation, the types of therapeutic alliance, and the opportunities for involving patients in formulating an individualized and optimized treatment plan.

Involving patients in management of their illness has been shown to improve treatment adherence in a number of chronic psychiatric conditions. For patients with bipolar disorder in particular, a lack of insight into the nature of their disease can hinder full participation in the treatment plan. Psychoeducation can provide patients with information on the symptoms and consequences of bipolar disorder and help explain the need for regular, long-term pharmacologic therapy. For many clinicians, psychoeducation is a fundamental component of the "therapeutic alliance," an approach that actively involves the patient in treatment decisions and has been shown in trials to improve adherence to pharmacologic therapies and positively affect long-term outcome. Presenters at this workshop will discuss opportunities for enhancing the therapeutic alliance through psychoeducation and other methods, citing supportive evidence from recent clinical trials and personal experience. Based on these presentations, workshop participants will have the opportunity to discuss the development of an optimized treatment plan within the context of the therapeutic alliance.

By providing psychoeducation and developing the therapeutic alliance, physicians can encourage patients to participate in the development of an individualized and optimized treatment plan, which may improve treatment adherence and maximize outcomes.

Supported by funding from AstraZeneca Pharmaceuticals LP.

REFERENCES:

1. Berk M, Berk L, Castle D: A collaborative approach to the treatment alliance in bipolar disorder. Bipolar Disord 2004; 6(6):504-18.
2. Colom F, Vieta E, Reinares M, Martinez-Aran A, Torrent C, Goikolea JM, Gasto C: Psychoeducation efficacy in bipolar disorders: beyond compliance enhancement. J Clin Psychiatry 2003; 64(9):1101-5.

ISSUE WORKSHOP 36
MAINTENANCE OF CERTIFICATION FOR DIPLOMATES OF THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

Chairperson: Larry R. Faulkner, M.D., *500 Lake Cook Road, Deerfield, IL 60015*
Presenters: Victor I. Reus, M.D., Naleen N. Andrade, M.D., Christopher C. Colenda, M.D., Burton V. Reifler, M.D., Daniel K. Winstead, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe the four components of the maintenance of certification (MOC) program of the American Board of Psychiatry and Neurology as it applies to general psychiatry and to the subspecialties.

SUMMARY:

The purpose of this workshop is to review the components and requirements of the ABPN's maintenance of certification (MOC) program. The four components are professional standing (licensure), self-assessment and lifelong learning, cognitive expertise (recertification examination), and assessment of performance-in-practice. The participant will learn what options are available to complete the MOC requirements as well as what new requirements to expect in the future. A substantial amount of time will be available for the panelists to respond to queries from the audience.

REFERENCES:

1. Shore JH, Scheiber SC (eds): Certification, Recertification, and Lifetime Learning in Psychiatry. Washington, DC, American Psychiatric Press, 1994.
2. Scheiber SC, Kramer TAM, Adamowski S (eds): Core Competencies for Psychiatric Practice: What Clinicians Need to Know. Washington, DC, American Psychiatric Press, 2003.

ISSUE WORKSHOP 37
HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE: PART 1

Co-Chairpersons: Keith W. Young, M.D., *10780 Santa Monica Boulevard, Suite 250, Los Angelos, CA 90025-4749*

William E. Callahan, Jr., M.D., *120 Vantis, Aliso Viejo, CA 92656*
Presenters: Marynell Hinton, M.A., Martin G. Tracy, J.D.

EDUCATIONAL OBJECTIVES:

1. know 10 key tips to avoiding lawsuits and malpractice;
2. know the 3 most frequent reasons why psychiatrists are successfully sued;

3. understand different types of malpractice insurance and which one is best for you.

SUMMARY:

This is part 1 in a 3-part comprehensive course that provides you all the info yo need to launch a successful private practice. It is composed of 2 workshops and 1 symposium all on 1 day. Offered for the last 9 years and directed by faculty who have succeeded using this info. Even if you are not in private practice this course will offer lots of useful info that will assist you in launching your career. Our material is constantly updated with up-to-the-minute solutions from our faculty with thriving practices. In part 1 we focus on risk management, avoidance of malpractice suits, ways to maximize quality, and high risk issues that you must address in your practice. Other sessions cover coding for maximum billing, marketing, ofice location and design, streamlining your practice, and business/financial principles.

REFERENCES:

1. Molloy, Patrick: Entering the Practice of Psychiatry: A New Physician's Planning Guide, Roering and Residents, 1996.
2. Practice Management for Early Career Psychiatrists, APA Office of Healthcare Systems and Financing, 1998.

ISSUE WORKSHOP 38
INTERPRETING AND DISSEMINATING FINDINGS FROM AN EVIDENCE-BASED DRUG REVIEW: ANTIEPILEPTIC DRUGS FOR MOOD DISORDERS

Chairperson: John M. Oldham, M.D., *2801 Gessner Drive, Houston, TX 77080*
Presenters: Cathy Melvin, Ph.D., William D. Evans, Ph.D., John Byrd, M.B.A.

EDUCATIONAL OBJECTIVES:

1) At the conclusion of this symposium workshop, the participant should be able to understand the purpose and methods of drug class reviews.

2) At the conclusion of this symposium workshop, the participant should be able to understand the choice of the key questions, explicit eligibility criteria, systematic searches of the literature, article abstraction, and pooling of data using meta-analysis techniques with direct or indirect comparison of study findings.

3) At the conclusion of this symposium workshop, the participant should be able to be aware of the key scientific concepts identified in the AED Drug Effectiveness Review Project.

4) At the conclusion of this symposium workshop, the participant should be able to recognize how evidence-based dissemination is designed to facilitate incorporation of evidence into practice.

SUMMARY:

There have been major advances in the number and types of medications for psychiatric illness. However, as the number of medications within a class increases, so does the complexity of decision-making for the provider. While a systematic review of a medication class can inform the prescription of appropriate and effective treatments, reports generated by these reviews are often not used by physicians to inform prescribing.

To help physicians utilize drug effectiveness reviews to improve patient care and reduce drug expenditures.

Participants will gain an understanding of how drug effectiveness reviews are conducted and their results are interpreted for clinical practice. They will also explore how evidence-based dissemination strategies are designed to accelerate incorporation of available evidence into practice.

A case study approach will be used based on the April 2006 Drug Effectiveness Review Project of the use of antiepileptic drugs (AEDs) for treating mood disorder. The process of moving from a more than 700 page report on AEDs to 8 key concepts relevant to AED prescribing will be described. We will describe proven marketing strategies to increase the likelihood that this and other drug class reviews are understood and used by physicians. Social marketing strategies have been shown to increase physician acquisition and maintenance of knowledge and to lead to change, if necessary, in current prescribing.

Attendees will gain skills in reading and interpreting drug class reviews and in evaluating marketing strategies designed to influence AED prescribing.

With an increasing number of agents available within a therapeutic class for many conditions, there is an expectation that clinicians be able to utilize drug reviews to improve patient care. This workshop addresses the dual challenge of interpreting available evidence from drug reviews and disseminating and incorporating this evidence into practice.

REFERENCES:

1. Goodman F, Glassman P, Maglione M, Suttorp M: Drug class review on antiepileptic drugs in bipolar mood disorder, neuropathic pain and fibromyalgia, Santa Monica CA, Southern California Evidence-based Practice Center, 2006.
2. Figueiras A, Sastre I, Gestal-Otero JJ: Effectiveness of educational interventions on the improvement of drug prescription in primary care: a critical literature review. J Eval Clin Pract, 2001; 7(2):223-241.

ISSUE WORKSHOP 39
PLANNED CARE FOR DEPRESSION: A PROGRAM FOR THE MANAGEMENT OF DEPRESSION IN PRIMARY CARE

Chairperson: Robert C. Joseph, M.D., *1493 Cambridge Street, Cambridge, MA 2139*
Presenters: Laureen Gray, M.S.N., Carleen A. Riselli, M.S.N., Laura Nevill, M.S.N., Claire Pierre, M.D.

EDUCATIONAL OBJECTIVES:

I. Understand the components of the Planned (Chronic) Care Model and identify the key elements necessary to overcome the common barriers to implementation of a depression care management program in the primary care setting.

II. Understanding key steps in developing collaborative partnerships between primary care and mental health

III. Understand the critical role of collaboration with information systems in the development of a depression care management program in the primary care setting..

SUMMARY:

Research indicates that the detection and treatment of depression in the primary care setting remains largely inadequate. Less than 50% of depressed patients are detected and depressed patients are rarely offered evidence based care.

In response to these data, efforts have focused on ways to improve health care delivery to these patients. Many successful strategies for improving delivery of care have been based on the Planned (Chronic) Care Model. Elements of the model include the community, the health system, self-management support, delivery system design, care management decision support and clinical information systems.

As part of the Robert Wood Johnson *Pursuing Perfection* initiative, Cambridge Health Alliance (CHA) adopted the Planned Care Model in 2001 as a framework for delivering care to patients with diabetes, depression, and childhood asthma. Simultaneously, CHA began to develop and implement a sophisticated electronic medical record (EMR) and web-based disease registry to support the planned care work.

CHA has met many challenges associated with the implementation of a chronic disease management program. With persistence and creative solutions, the CHA planned care depression program has begun to flourish. This workshop will review the rationale for planned care programs, our process of implementation, specifically identifying challenges and highlighting key solutions. We will address how our EMR, innovative interactive PHQ-9 depression screening tool and co-located psychiatric clinicians support the primary care clinician and contribute to the program's success. We will also share outcome data related to the impact of planned care depression on HEDIS antidepressant management measures.

Sharing our experience in developing an effective primary care depression care management program will enable others to more rapidly and effectively implement such programs, contributing to improved outcomes for individuals with depression.

REFERENCES:

1. Cabana MD, Rushton JL, Rush AJ: Implementing practice guidelines for depression: applying a new framework to an old problem. Gen Hosp Psychiatry 2002; 24: 35-42.
2. Gilbody S, Whitty P, Grimshaw J, Thomas R: Educational and organizational interventions to improve the management of depression in primary care: a systematic review. J Am Med Assn 2003; 289:3145-3151.

TUESDAY, MAY 22, 11:00 AM - 12:30 PM

ISSUE WORKSHOP 40
SECOND OPINION CONSULTATION ON ONGOING PSYCHOTHERAPY TREATMENTS

Co-Chairpersons: Marc Jacobs, M.D., *401 Parnassus, San Francisco, CA 94143*
Mardi Horowitz, M.D., *401 Parnassus, San Francisco, CA 94143*
Presenters: Martina Smit, M.D., Jennifer Cummings, M.D., Jason Bermak, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to recognize when he or she has reached an impasse in psychotherapy, and how consultation might lead to a reformulation that can alter technique and improve the outcome of the revised process.

To allow for abundant discussion, each presenter will provide an overview and case illustration from the operation of our UCSF clinic offering second opinions on ongoing, and likely to continue, psychotherapies. This will occupy 50 minutes leaving 30 minutes for audience participation at the end, with eight minutes of presenter talk and two minutes of questions after each of five presentations.

An integrative perspective to case formulation will be the core of the case examples.

SUMMARY:

A great deal of contemporary psychotherapy discussion concerns evidence based therapies and divides therapies into seperable competencies for psychodynamic, cognitive-behavioral, and interpersonal therapies, plus others such as schema based, dialectical, and existential schools of thought. Empirical evidence shows that most practicioners combine techniques in an eclectic fashion. The field is moving towards integration. Clinicians often need help in actual practice, not only in considering the vital question of '' what, in this phase of this patient's treatment with me can be expected to change?", but also in considering how to reformulate the case now that much is known. We have operated a clinic for this purpose, returning cases after we interview and review them with a written report for therapists to consider. This operation raises questions by integrative formulation and technique itself, as well as a possible future function of psychiatrists for consulting with the many non physicians who conduct treatments and may not be trained in how to put together different techniques for complex, difficult cases who may approach after an intial symptomatic improvement a stalemate in therapy. We find we can loosen the snags that constitute such stalemates or impasses, at least in some cases. We think we will promote a vigorous discussion of these issues with those who choose to participate !

REFERENCES:

1. Book - Horowitz MJ Formulation as a basis for planning psychotherapy technique. Wash DC: APPI, 1997.
2. Book- Understanding Psychotherapy Change Wash DC: Amer Psychol Assoc, 2005.

ISSUE WORKSHOP 41
PRIVACY AND CONFIDENTIALITY CONCERNS IN SHARED ELECTRONIC HEALTH RECORDS

Chairperson: Benjamin Liptzin, M.D., *759 Chestnut Street, Springfield, MA 1199*
Presenters: Ruth A. Barron, M.D., Mary A. Sullivan, M.D., Rohn S. Friedman, M.D., Edward Zuzarte, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to:

1. Understand what electronic health records are being implemented in hospital-based practices.
2. Discuss concerns regarding confidentiality of psychiatric information in electronic records.
3. Discussion.

SUMMARY:

As the country moves towards the implementation of electronic health records, psychiatrists and other mental health professionals have raised concerns about what information should be included in such records and how to protect the privacy of psychiatric patients and the conidentiality of their personal information. Speakers from 5 different hospital systems in Massachusetts will describe the current status of their implementation of an electronic health record in inpatient and/or outpatient settings. Each presenter will discuss how the privacy/confidentiality concerns related to psychiatric information have been addressed. A member of the APA Committee on Electronic Health Records will be a discussant.

REFERENCES:

1. Improving the Quality of Health Care for Mental and Substance Use Conditions. Institute of Medicine. National Academies Press, Washington, D.C., 2006.
2. Mental Health: A Report of the Surgeon General. DHHS. Government Printing Office, Rockville, MD, 1999.

ISSUE WORKSHOP 42
METHAMPHETAMINE ABUSE AND ADDICTION: PREVALENCE AND TREATMENT.
National Institute on Drug Abuse

Co-Chairpersons: Ahmed M. Elkashef, M.D., *6001 Executive Boulevard, Bethesda, MD 20892*
Frank Vocci, Jr., Ph.D., *6001 Executive Boulevard, Bethesda, MD 20892*
Presenters: William F. Haning III, M.D., Trevor Robbins, Ph.D., Wilson M. Compton, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to appreciate the extent of the problem of methaphetamine

addicition worldwide and in the US. they should recognize the impact of methamphetamine use on cognitive functions and how these deficits could impact treatment and retention. They should also be familiar with medications that have been tried so far to treat methamphetamine addiction and what seems to work and what did not.

SUMMARY:

Methamphetamine addiction is a major public health problem with an estimated 12 million Americans and 30 million worlwide ages 12 and older reported trying methamphetamine at least once in their lifetime. This workshop will focus on pharmacological targets to treat methamphetamine addiction. An updated review of the epidemiological data to convey the extent of the problem will be presented first followed by data on the cognitive sequelae of methamphetamine addiction focusing on decision making, impulsivity and other exceutive function impaiments. An overview of medications targets and trials supported by NIDA that are underway or completed will be reviewed with the focus on the recently completed trial of bupropion to treat methamphetamine addiction.

Bupropion was tested in a double-blind placebo-controlled study for the treatment of methamphetamine addiction. 151 participants were consented and enrolled, 72 randomized to placebo and 79 to Bupropion SR 150mg BID. The primary outcome was the proportion of participants having a methamphetamine-free week. Secondary outcomes included Addiction Severity Index, craving, and quantitative urine methamphetamine.

Analysis of the primary outcome showed a trend toward significance for the total sample (p=0.09) favoring bupropion. Baseline use in the 30 days prior to screening, using time- line follow back, differentiated the total sample into low/moderate users (<18 days, n= 71) and high users (>18 days, n=80). Bupropion showed a statistically significant effect in the low/moderate use subgroup compared to placebo (p=0.03), for a greater increase in the number of non-use weeks over the treatment period. This subgroup also had significantly reduced mean quantitative methamphetamine in urine. High users did not have similar effects.

Gender analysis for the total sample showed that males (n=101) had a significant effect favoring bupropion treatment (p=0.03), while females (n=50) did not. Co-morbid conditions, including depression and attention deficit disorder, did not change the findings.

REFERENCES:

1. Volkow ND, Chang L, Wang GJ, Fowler JS, Franceschi D, Sedler M, Gatley SJ, Miller E, Hitzemann R, Ding YS, Logan J: Loss of dopamine transporters in methamphetamine abusers recovers with protracted abstinence. J Neurosci 2001; 21:9414'9418.
2. Vocci, F.J., Acri, J., Elkashef, A.E. Medications development for addictive disorders: State of the science. Am J. Psychiatry 162:1432-1440, 2005.

ISSUE WORKSHOP 43
HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE: PART 2

Co-Chairpersons: Keith W. Young, M.D., *10780 Santa Monica Boulevard, Suite 250, Los Angelos, CA 90025-4749*
William E. Callahan, Jr., M.D., *120 Vantis, Aliso Viejo, CA 92656*
Presenters: Tracy R. Gordy, M.D., Chester W. Schmidt, Jr., Jr., M.D.

EDUCATIONAL OBJECTIVES:

1. understand the use of codes for insurance to accurately reflect your work with patients;

2. understand documentation requirements consistent with the codes you use;

3. know where to go to get updated information on coding throughout your career.

SUMMARY:

This is part 2 in a 3-part comprehensive course that provides you all the information you need to launch a successful private practice. It is composed of two workshops and one symposium all on one day. Offered for the last 9 years and directed by faculty who have succeeded using this information. Even if you are not in private practice, this course will offer lots of useful information that will assist you in launching your career. Our material is constantly updated with up-to-the-minute solutions from our faculty with thriving practices. In part 2, we focus on the complexities of using the insurance industry's procedure codes to accurately reflect your work with patients. Even if you intend to have a fee-for-service cash-based practice, many patients will require "superbills" for insurance so they can get reimbursed. There are documentation requirements for each code, and not understanding them and following them can leave you prosecuted for fraud.

REFERENCES:

1. Practice Management for Early Career Psychiatrists, APA Office of Healthcare Systems & Financing, 1998.
2. Logsdon, L: Establishing a Psychiatric Private Practice, Washington, D.C., American Psychiatric Press, Inc., 1985.

ISSUE WORKSHOP 44
PSYCHIATRY IN THE AMERICAS: UPDATE FROM THE WORLD PSYCHIATRIC ASSOCIATION

Co-Chairpersons: Michelle B. Riba, M.D., *1500 East Medical Center Drive, Ann Arbor, MI 48109-0295*
Rodrigo A. Munoz, M.D., *3130 Fifth Avenue, San Diego, CA 92103*
Presenters: Roger M. Montenegro, M.D., Julio E. Arboleda-Florez, M.D., Enrique R. Camarena, M.D., Edgard Belfort, M.D.

EDUCATIONAL OBJECTIVES:

1. Have a better appreciation for the issues of providing psychopharmacology and psychotherapy in the Americas, including some of the differences, obstacles, problems

2. The relationship between WPA member countries in the Americas and how we can foster better communication, clinical care and research

3. Opportunities for collaborative psychiatric work between the Americas

SUMMARY:

The American Psychiatric Association is a member organization of the World Psychiatric Association (WPA). Within the WPA, there have been increased linkages between the member countries in the "Americas" related to topics of access to psychiatric care, ways to improve psychiatric training, approaches to emergency efforts in disasters, diagnostic issues as they relate to culture and ethnicity, primary care psychiatry, and immigration/migration of physicians. One particular issue that has been increasingly important is access and the role of primary care providers and physician extenders in the provision of psychotherapy and pharmacotherapy. This issue will be the focus of this workshop. We expect that members of the workshop audience will be able to participate and provide a means to begin to facilitate discussion and communication between WPA member organizations. In addition, we will provide audience members a better understanding of the WPA and how its work impacts on APA and other member organizations and individual members.

REFERENCES:

1. Mezzich JE: Institutional consolidation and global impact: towards a psychiatry for the person. World Psychiatry 5:2, June 2006, 65-66.
2. Hongoro C, MCPake B: How to bridge the gap in human resources for health. Lancet 2004;364:1451-6.

ISSUE WORKSHOP 45
ASSESSING VIOLENCE RISK AMONG PERSONS WITH MENTAL ILLNESSES

Co-Chairpersons: Paul S. Appelbaum, M.D., *1051 Riverside Dr., New York, NY 10032*
Steven K. Hoge, M.D., *462 First Avenue, Room #19N45, New York, NY 10016*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the major risk factors violence demonstrated in recent research on persons with mental illnesses; and to appreciate the advantages and disadvantages of several of the major approaches to violence risk assessment.

SUMMARY:

Violence risk prediction is a perennial challenge for psychiatrists and other mental health professionals. Recent large-scale research projects have confirmed an elevated risk of violence in many categories of mental disorder, although persons with mental illness still account for only a small percentage of the violence in our society. These studies have also identified a more precise set of violence risk factors, including psychopathy, substance abuse, psychosis, and neighborhood of residence. As a consequence of these studies, violence risk assessment approaches have been developed that provide structured evaluation tools for clinicians, and in some cases yield quantitative estimates of future violence risk. This workshop will review and summarize the results of recent studies of violence risk, and will highlight several of the major assessment tools, focusing on the advantages and disadvantages of each. Ample time will be reserved for audience questions and discussion.

REFERENCES:

1. Monahan J, Steadman HJ, Appelbaum PS, Robbins PC, Mulvey EP, Silver E, Roth LH, Grisso T: Developing a clinically useful actuarial tool for assessing violence risk: results from the MacArthur Violence Risk Assessment Study. British Journal of Psyc.
2. Appelbaum PS: Violence and mental disorders: data and public policy (editorial). American Journal of Psychiatry 2006 163: 1319-1321.

ISSUE WORKSHOP 46
PSYCHIATRIC EXPERT TESTIMONY: INCREASED SCRUTINY, INCREASED LIABILITY

Chairperson: Philip Merideth, M.D., *P.O. Box 14251, Jackson, MS 39236-4251*
Presenters: Renee L. Binder, M.D., Donna Vanderpool, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to:

1) recognize the liability exposure created by the increased scrutiny of medical expert activity by state medical boards, the courts, and professional societies;

2) understand the basis for this liability related to medical expert services; and

3) incorporate risk management strategies into their forensic practices to decrease liability risks related to medical expert activities.

SUMMARY:

Over the past few years, psychiatrists seem to be pursuing forensic work in increasing numbers. Concurrently, or perhaps in response, courts, regulators, and professional associations have demonstrated an increasing interest in evaluating and holding physicians accountable for forensic activities, and it is expected that further scrutiny of experts will continue in the future. Accordingly, psychiatric experts face liability exposure from a variety of sources, including discipline by the state licensing board, and peer review and discipline by professional organizations such as specialty societies and state medical associations. It is important for psychiatrists to understand the sources of liability and the risks they face in their forensic practice to enable them to successfully manage these risks. This workshop will review the current liability concerns created by the courts, the state medical boards, and professional associations, as well as the basis for this liability, to include a review of various guidelines and standards. As an officer of a state medical licensure board that has expanded its regulatory and disciplinary reach to cover medical expert activity, the Chair of this workshop will share with participants one state's views and actions related to regulating physicians who serve as experts. There will also be a discussion of specific risk management strategies for reducing liability. Participants will have an opportunity to participate in the workshop by discussing case studies and through an ample question and answer period. Understanding the current scrutiny of medical expert activities, and the rationale behind this scrutiny, will enable participants to utilize risk management strategies to decrease their liability risk.

REFERENCES:

1. Binder RL: Liability for the psychiatrist expert witness. Am J Psychiatry 2002; 159:1819-1825.
2. Appelbaum PS: Law & psychiatry: policing expert testimony: the role of professional organizations. Psychiatr Serv 2002; 53(4):389-90, 399.

ISSUE WORKSHOP 47
QUALITY OF LIFE OF PATIENTS WITH MAJOR DEPRESSION IN A NATURAL CLINICAL SETTING

Co-Chairpersons: Mark H. Rapaport, M.D., *8730 Alden Drive, Los Angelos, CA 90048*
Waguih W. IsHak, M.D., *8730 Alden Drive, W101, Los Angelos, CA 90048*

EDUCATIONAL OBJECTIVES:

1. Recognize the importance of quality of life as an important dimension in the treatment of depressive disorders.

2. Demonstrate skills of utilizing quality of life measures in addition to other assessment methods to guide treatment strategies

SUMMARY:

The World Health Organization defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease". Successful treatment must go beyond ameliorating signs and symptoms to address the broader issue of restoration of health. Patients' subjective views of social relationships, physical health, functioning in daily activities, work and economic status, and overall sense of well being need to be factored in the assessment of the impact of psychiatric illness or interventions. The above perceptions are quantified in quality of life measures. Patients with major depressive disorder are assumed to have a decline in quality of life. Most studies had small samples of individuals and did not focus on a natural clinical setting but rather on a highly selective population of recruited subjects. Studies had shown that symptom severity measures explained only a small proportion of the variance in quality of life. Clinical trials also showed that quality of life changes with treatment tend to occur during robust and sustained

response to interventions and are least likely to respond to placebo interventions, when compared with symptom severity measures. The individual's perception of his or her quality of life is an essential factor that should be part of a complete patient assessment. The presenters will show clinical data supporting the importance of incorporating quality of life as a dimension in detecting clinical improvement or deterioration. This workshop will engage participants in a lively debate about the importance and the implementation of quality of life measurement in addition to other methods of assessment in natural clinical settings.

REFERENCES:

1. Rapaport MH, Clary C, Fayyad R, Endicott J. Quality-of-Life Impairment in Depressive and Anxiety Disorders. Am J Psychiatry 162(6):1171-8, 2005.
2. Trivedi MH, Rush AJ, Wisniewski SR, et al: Factors Associated with Health-Related Quality of Life Among Outpatients with Major Depressive Disorder: A STARD Report. Journal of Clinical Psychiatry 67:185-195, 2006.

ISSUE WORKSHOP 48
ARE SEX OFFENDERS CRIMINALLY RESPONSIBLE?

Chairperson: Renee M. Sorrentino, M.D., *2 Shaker Road, Shirley, MA 1464*
Presenters: Susan H. Friedman, M.D., Joy E. Stankowski, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will better understand the relationship between paraphilias and sex offenses. Participants will learn the criteria for criminal responsibility and its application to sex offenders.

SUMMARY:

Although scientific evidence does not clearly indicate whether deviant sexual interest is a mental disease or defect, evidence supports the notion that sexual urges, fantasies, and behaviors affect the capacity to conform one's own conduct to the requirements of the law (1). Lawyers and policymakers have brought these academic explanations for deviant sexual behavior into the legal arena. As a result, the courts have been confronted with the question of criminal responsibility in sex offenders. Several states have answered this question by passing laws that subject sex offenders to civil commitment.

Civil commitment to mental institutions requires that an individual be both seriously mentally ill and dangerous. This principle is erroneously being applied to incarcerated sex offenders nearing release from prison under the theory that they have antisocial personalities or paraphilia disorders, which are called mental illnesses (2). However, the mental health and legal communities are at odds regarding the use of a diagnosis of personality disorder or paraphilia to justify civil commitment. The American Psychiatric Association (APA) sponsored a symposium (2003) in which participants discussed the removal of paraphilias from the Diagnostic and Statistical Manual of Mental Disorders (DSM).

The legal concept of criminal responsibility will be discussed. The hypothesis of a paraphilia, or sexually deviant behavior, as a mental illness or defect will be presented. The clinical characteristics of sexual offenders will be described through the use of case studies. In conclusion the panel will review the legal, ethical, and scientific challenges in the determination of criminal responsibility in sex offenders.

REFERENCES:

1. Falk A: Sex offenders, mental illness and criminal responsibility: The Constitutional Boundaries of Civil Commitment after Kansas v. Hendricks. American J Law and Medicine, 1999; 25.
2. Winick BJ, LaFond JQ: Protecting Society from Sexually Dangerous Offenders: Law, Justice, and Therapy. Washington, DC, American Psychiatric Press, 2003.

ISSUE WORKSHOP 49
IMPACT OF PATIENT SUICIDE ON PSYCHIATRY RESIDENTS: A WORKSHOP DISCUSSION

Chairperson: Christina Mangurian, M.D., *1051 Riverside Drive, New York, NY 10032*
Presenters: Francine Cournos II, M.D., Carolyn J. Douglas, M.D., Elizabeth Harre, M.D., Edmund Griffin, M.D., Aaron Reliford, M.D., Andrew Booty, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to identify the myriad of feelings resident psychiatrists may have after a patient commits suicide. Participants should be able to better understand their feelings about the experience of patient suicide. The participant should be able to recognize the common colleague and residency training program responses that residents typically receive after a patient commits suicide. At the conclusion of the presentation, the participant should also be able to make recommendations for their home institution to help better support residents during this difficult time.

SUMMARY:

According to the Centers for Disease Control and Prevention (CDC), almost 31,000 people committed suicide in the US in 2001. Studies estimate that anywhere from 20-68% of psychiatrists will lose a patient to suicide at some point in their career.

A significant number of residents will experience the suicide of a patient during residency training. Unfortunately, open discussions about the feelings and issues raised in response to suicide are rare in training programs and in the literature. This silence may be due to the shame, guilt, fear, confusion, sadness, and other emotions that exist in residents and their colleagues and supervisors after a patient commits suicide. It is the belief of this panel that this lack of discussion interferes with the use of positive coping strategies by residents during this incredibly difficult training experience.

The workshop will begin with the four psychiatry resident panelists sharing their feelings and experiences after their own patients committed suicide. The senior attending panelists will then reflect on their early experiences with patient suicide. The panelists will then open the discussion for audience members to share their own experiences as residents, supervisors, and training directors. The final portion of the session will be devoted to developing helpful strategies that could be proposed to residency training programs to provide better support to residents who have a patient that commits suicide. These strategies may include (but are not limited to) discussions about how to maximize mentorship/supervision, encouraging senior staff members to share their experience in an open forum, general education, peer discussions, and case conferences.

In general, this workshop will be dedicated to providing a safe place for residents to share the personal experience of having a patient who commits suicide, and attempt to develop better ways to support them through this experience in the future.

REFERENCES:

1. Gitlin MJ: A psychiatrist's reaction to a patient's suicide. Am J Psychiatry 1999; 156(10):1630-1634.
2. Plankun EM, Tillman JT: Responding to the impact of suicide on clinicians. Dir In Psychiatry 2005; 25:301-309.

ISSUE WORKSHOP 50
PHYSICAL TRAUMA AS A RESULT OF WAR OR NATURAL DISASTER: PSYCHIATRIC INTERVENTIONS

Co-Chairpersons: Geoffrey M. Gabriel, M.D., *7201 Countrywood Lane, New York, NY 53719*
Harold J. Wain, Ph.D., *6900 Georgia Avenue, NW, Washington, DC 20307*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to 1) recognize effective interventions and techniques to decrease and/or prevent disabling psychiatric co-morbidity associated with the impact of a traumatic event; 2) understand the development of a comprehensive program designed to assist the entire medical institution in the response to a traumatic event; and 3) understand the role of iatrogenic stressors, hospitalization, and the meaning of injury for medical and surgical patients following traumatic injuries.

SUMMARY:

The psychological issues facing medical and surgical patients suffering from traumatic injuries are numerous and varied. These injuries may occur in the settings of armed conflict, terrorist attack, natural disaster, or accident. Recent events have demonstrated the need for Psychiatric Consultation Liaison Service (PCLS) to be available as early responders and to be part of the trauma team. The prevention of significant and disabling psychiatric co-morbidity can often be the objective and assignment of a PCLS. A comprehensive trauma consultation service must be designed to assist the entire medical complex in its response to various events. The needs of the patient, the patient's primary support group, and the medical staff must be considered in the development of treatment strategies in the setting of traumatic events. The following workshop will explore varous trauma specific topics including 1) the impact of trauma and iatrogenic stressors; 2) the use of preventive medical psychiatry in working with trauma patients to destigmatize psychiatry; 3) therapeutic interventions and prevention of psychological stress disorders; 4) treatment of the trauma patient's primary support group; 5) support of the medical treatment team; 6) the evolution of the PCLS at Walter Reed Army Medical Center as a model for psychiatry as part of the trauma team; and 7) the use of a biopsychosocial approach to trauma.

REFERENCES:

1. Wain HJ, Grammer G, Stasinos J: Psychiatric intervention for medical and surgical patients following traumatic injuries. In Mental Health Interventions in Terrorism and Natural Disasters, edited by Ritchie EC, Guilford Press, 2006, pp278-298.
2. Watson PJ, Friedman MJ, Ruzek JI, Norris F: Managing acute stress response to trauma. Current Psychiatry Reports 2002;4:247-253.

WEDNESDAY, MAY 23, 9:00 AM - 10:30 AM

ISSUE WORKSHOP 51
BIOPSYCHOSOCIAL AND SPIRITUAL ASPECTS OF TREATING OUR PHYSICIAN COLLEAGUES

Co-Chairpersons: Monisha R. Vasa, M.D., *8730 Alden Drive, Los Angelos, CA 90048*
Syed S. A. Naqvi, M.D., *8730 Alden Drive, Los Angelos, CA 90048*
Presenters: Michael F. Myers, M.D., Amir Ettekal, M.D., Tara Klein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to understand burnout, depression and anxiety in physicians, and ways that psychiatrists can use their biopsychosocial and spiritual training to identify and treat such syndromes in our colleagues.

SUMMARY:

Maslach eloquently described burnout as "erosion of the soul." Burnout is a syndrome characterized by emotional exhaustion, decreased personal satisfaction, and a sense of depersonalization in physicians exposed to chronic stress. Personal consequences of burnout include marital difficulties, substance abuse, and the development of depression and anxiety. Physician burnout has also been associated with poor prescribing habits, and increased likelihood of physician error. Depression is just as prevalent in physicians as in the general population; however, physicians have an increased suicide rate compared to the general population, as well as compared to other professionals. As psychiatrists, we are poised in the unique position of understanding the biological, psychological, social, and spiritual factors that affect a physician throughout training and practice. We should assume a leading role in decreasing stigma associated with mental health care in physicians, and encouraging physicians to receive treatment for burnout and its debilitating consequences. This workshop is intended for all mental health professionals who are involved in the care of physicians. Forty-five minutes will be lecture-based; the remaining forty-five minutes will be reserved for lively interaction with the audience. This section will include case discussions, audiovisual clips, and experiential exercises for the participants.

REFERENCES:

1. Center, C et al: Confronting Depression and Suicide in Physicians: A Consensus Statement. JAMA 2003; 289: 3161-3171.
2. Goldman, LS, Myers, M, Dickstein, LJ: The Handbook of Physician Health: The Essential Guide to Understanding the Healthcare Needs of Physicians. Chicago, American Medical Association, 2000.

ISSUE WORKSHOP 52
RESPONDING TO THE IMPACT OF SUICIDE ON CLINICIANS

Chairperson: Eric M. Plakun, M.D., *25 Main Street, P.O. Box 962, Stockbridge, MA 1262*
Presenters: Edward R. Shapiro, M.D., Jane G. Tillman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to [1] enumerate clinician responses to patient suicide and [2] list practical recommendations for responding to patient suicide from the personal, collegial, clinical, educational, administrative and medico-legal perspectives.

SUMMARY:

It has been said that there are two kinds of psychiatrists--those who have had a patient commit suicide and those who will. Mental health clinicians often have less contact with death than clinicians from other environments. Nevertheless, each death by suicide of a psychiatric patient may have a more profound effect on psychiatric personnel than other deaths do on non-psychiatric colleagues because of powerful emotional responses to the act of suicide, and the empathic attunement and emotional availability that is part of mental health clinical work. This workshop offers results from a study revealing 8 thematic clinician responses to suicide: Initial shock; grief and sadness; changed relationships with colleagues; dissociation; grandiosity, shame and humiliation; crises of faith in treatment; fear of litigation, and an effect on work with other patients. Recommendations derived from this and other studies are offered to guide individually impacted clinicians, colleagues, trainees, training directors and administrators in responding to patient suicide in a way that antici-

pates and avoids professional isolation and disillusionment, maximizes learning, addresses the needs of bereaved family, and may reduce the risk of litigation. The workshop will include ample time for interactive discussion with participants about their own experiences with patient suicides.

REFERENCES:

1. Plakun, EM, Tillman, JT. Responding to the impact of suicide on clinicians. Directions In Psychiatry, 2005; 25:301-309.
2. Powell J, Geddes J, Deeks J, et al.: Suicide in psychiatric hospital inpatients. British Journal of Psychiatry 2000; 176:266-272.

ISSUE WORKSHOP 53
DEVELOPING RESEARCH TRAINING OPPORTUNITIES WITHIN A PSYCHIATRIC RESIDENCY TRAINING PROGRAM: GOALS, MOTIVATIONS, BARRIERS, AND SOLUTIONS

Chairperson: Robert J. Love, D.O., *7703 Floyd Curl Drive, San Antonio, TX 78229-3900*
Presenters: Vanessa Wong, M.D., Julianne Flynn, M.D., Thomas L. Matthews, M.D., Pedro L. Delgado, M.D.

EDUCATIONAL OBJECTIVES:

1) Participants will increase their knowledge of the available literature which describes the need for increased research training during psychiatric residency as well as the issues faced by residents and program directors who seek to develop research opportunities during residency training.

2) Participants will be exposed to both resident and faculty perspectives regarding the motivations which produce this interest and the identified barriers to satisfying this need

3) Participants will become informed of current efforts to accommodate resident requests for expanded research opportunities at the University of Texas Health Science Center at San Antonio, which will include initial experiences and potential pitfalls we have identified.

SUMMARY:

Several national organizations including the National Institute of Mental Health (NIMH), the Institute of Medicine (IOM), and the Accreditation Council for Medical Education (ACGME) have voiced concern regarding the diminishing pool of psychiatrists choosing to pursue research careers. These organizations have stressed the need to make concerted efforts to increase the exposure to research that is provided to physicians currently training in psychiatry.

We will review the available literature related to the topic of declining patient oriented physician researchers in psychiatry to highlight the benefit of research experiences in psychiatry training as an important, if not necessary element for the development of a new generation of physician-scientists, as well as a integral factor in providing adequate education of residents in the areas of research literacy and competence with evidence based medicine. We will discuss resident perceptions of those factors which motivate interest in this area, as well as those factors which may interfere with the pursuit of research while in training. The discussion will include a review of the practical issues faced by residency training directors and other faculty mentors, when efforts to improve residents' opportunities to participate in research are undertaken. We will close with an overview of our experiences with the ongoing development of a flexible research track option in psychiatry at UTHSCSA. We hope to use this workshop as an opportunity to actively engage participants, in discussing our current efforts to develop additional research training opportunities within the context of general psychiatric residency training.

REFERENCES:

1. Fenton, W, James, R, & Insel, T: Psychiatry Residency Training, the Physician-Scientist, and the Future of Psychiatry. Academic Psychiatry, 2004; 28: 263-266.
2. Gilbert, A, Tew, J., JD, Reynolds, I, CF, Pincus, H., Ryan, N, Nash, K, et al.: A Developmental Model for Enhancing Research Training During Psychiatry Residency. Academic Psychiatry, 2006; 30: 55-62.

ISSUE WORKSHOP 54
THE ADHD/PEDIATRIC BIPOLAR INTERFACE: SAILING THROUGH TROUBLED WATERS?

Co-Chairpersons: Kiki D. Chang, M.D., *401 Quarry Road, Palo Alto, CA 94305*
Vishal Madaan, M.D., *3528 Dodge Sstreet, Omaha, NE 68106*
Presenters: Christopher J. Kratochvil, M.D., Janet Wozniak, M.D.

EDUCATIONAL OBJECTIVES:

At the end of the workshop, the participants will:

1) Recognize the controversies and diagnostic dilemmas associated with comorbid Pediatric Bipolar and ADHD.

2) Demonstrate an understanding of the various treatment strategies available for the ADHD/Pediatric bipolar interface.

SUMMARY:

Objective: This workshop examines the debatable diagnostic and clinical dimensions of two frequently comorbid disorders in the pediatric population--Pediatric Bipolar Disorder (PBD) and ADHD. It also addresses the challenges involved in diagnosing PBD given the overlap of symptoms with ADHD and a developmentally distinct presentation from the adults.

Summary: The ADHD/Pediatric Bipolar interface involves a significant and yet, contentious overlap of core ADHD symptoms including hyperactivity, distractibility, inattention and pressured speech. This overlap has been previously overlooked due to skepticism regarding the diagnosis of PBD and continuity of ADHD into adulthood. This interface results in considerable confusion concerning an accurate diagnosis of PBD that is compounded by a developmentally distinct presentation in children characterized by irritability and mixed episodes. Further, there is a relative lack of evidence-based consensus regarding the available treatment strategies when dealing with this complex but clinically frequent conundrum. This workshop will provide an overview of cutting edge research and highlight current diagnostic issues involved in accurately distinguishing the phenotypic overlap of symptoms. Introductory remarks on the ADHD/PBD interface will be followed by the first presentation focused on the phenomenological aspects and diagnostic dilemmas associated with ADHD. The next presenter will address the evolving diagnostic paradigm for PBD, the neuroimaging studies and will illustrate the challenging clinical presentations of PBD that result from chronicity of symptoms, presence of comorbidities and age dependent presentation of symptoms. The third talk will probe the existence of this interface as a separate subtype and update on the distinguishing criteria and treatment strategies for this intriguing scenario. The workshop will provide for a lively, interactive discussion while raising this fundamental controversial issue in everyday child psychiatry practice.

Conclusions: Given the high comorbidity of the two disorders, accurate diagnosis and treatment of ADHD/Pediatric bipolar interface is of paramount importance in clinical practice.

REFERENCES:

1. Wozniak J. Recognizing and Managing Bipolar Disorder in Children. J Clin Psychiatry 2005; 66 (suppl 1): 18-23.

2. Carlson GA: Mania and ADHD: comorbidity or confusion. J Affect Disord 1998; 51:177'187.

ISSUE WORKSHOP 55
ORAL BOARDS BOOT CAMP: 2007

Co-Chairpersons: Elyse D. Weiner, M.D., *113 University Place, New York, NY 10003*
Eric D. Peselow, M.D., *550 First Avenue, New York, NY 10016*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to begin creating a personalized, comprehensive strategy for studying and taking the oral board exam in psychiatry. Participants will learn techniques to improve their diagnostic interview skills, essential to succeeding as an oral boards candidate.

SUMMARY:

Now in its fourth year, Oral Boards Boot Camp is a comprehensive, interactive approach to becoming an effective oral boards candidate. This in-depth strategy for oral boards preparation is continuously being updated and improved by the chairpersons. The format incorporates a long-term study method, actual advice from candidates gained from past workshops, and time for audience questions. Consistent with the Oral Boards Boot Camp long-term approach, we invite all future candidates, no matter how early in their training, to begin working on refining their diagnostic interview and familiarizing themselves with the requirements for passing the oral boards. An overview of the entire oral boards preparation process is presented, from the day a candidate passes the written section until the day of the oral exam. A detailed study timeline, how to practice, study aids, the interview, fielding examiners' questions, how to relate to patients and examiners, travel arrangements, boards courses, how to dress, what to bring, day of the exam, and reasons for failure are among some of the topics covered in this comprehensive workshop. As the format of the oral boards has recently changed, updated information on the vignettes which have replaced the video portion of the exam is included. The goal of Oral Boards Boot Camp is to help candidates begin developing an individual long-term training framework that they will further expand in the months and years to come. We also invite APBN diplomates to come and share their advice with our candidates. Through lively discussion, future examinees will be on the road to increased confidence and decreased anxiety as they begin to define their own oral boards study experience and refine their diagnostic interview technique.

REFERENCES:

1. Morrison J, Munoz RA: Boarding Time: A Psychiatry Candidate's New Guide to Part II of the APBN Examination, Third Edition. Washington DC, American Psychiatric Press, 2003.
2. Strahl NR: Clinical Study Guide for the Oral Boards in Psychiatry, Second Edition. Washington DC, American Psychiatric Press, 2005.

ISSUE WORKSHOP 56
NEUROIMAGING RESEARCH: IMPLICATIONS FOR THE TREATMENT OF SUBSTANCE ABUSE
National Institute on Drug Abuse

Chairperson: Steven J. Grant, Ph.D., *6001 Executive Boulevard, Bethesda, MD 20857*
Presenters: Anna R. Childress, Ph.D., Martin P. Paulus, M.D., Clinton D. Kilts, Ph.D., Christopher deCharms, Ph.D., Cameron Carter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to demonstrate an understanding of 1) the advantages and limitations of real-time fMRI methods, 2) anatomical organization and functional role of the anterior cingulate cortex, 4) specific aspects of substance abuse that have been associated with dysfunction of the anterior cingulate and other brain regions, 3) specific aspects of substance abuse which could be amenable to treatment using real-time fMRI methods.

SUMMARY:

This session will explore the prospects of how Functional Magnetic Resonance Imaging (fMRI) can be expanded beyond its usual role in a research to a clinical tool that can inform and facillitate treatment of substance abuse. These first speakers will address how fMRI studies have shown how dysfunction of specific set of brain regions, in particular the Anterior Cingulate and other frontal lobe regions, contribute to continued substance abuse, such as drug craving, impaired decision-making and error monitoring, and loss of inhibitory control. They will also address how such dysfunction of these brain regions may serve as a predictor risk of relapse, as well as how changes in the activity of these regions change in the course substance abuse treatment. Finally, the prospect of using fMRI as a treatment modality will be addressed. Real time fMRI permits patients to learn to directly control brain regions that exhibit abnormal activity. In real-time fMRI, individuals are shown the level of activation in a specific brain region or set of regions of interest as they occur. Patients then use this information to develop strategies to bring the activity of brain regions exhibiting abnormal activity under voluntary control and thus regulate specific symptoms mediated through that brain region. For example, this approach has been used to train individuals to modulate activity in the Anterior Cingulate to control pain. Since the Anterior Cingulate also exhibits abnormal activation in substance abuser, there is now the prospect for using real-time fMRI training technology for the treatment of substance abuse. The discussant will close by proposing how a unifying framework for understanding the function of these brain regions can be applied as framework to inform the treatment of substance abuse.

REFERENCES:

1. deCharms RC, Maeda F, Glover GH, Ludlow D, Pauly JM, Soneji D, Gabrieli JD, Mackey SC: Control over brain activation and pain learned by using real-time functional MRI. Proc Natl Acad Sci USA 2005; 102:18626-18631.
2. Paulus MP, Tapert SF, Schuckit MA: Neural activation patterns of methamphetamine-dependent subjects during decision making predict relapse. Arch Gen Psychiatry 2005; 62:761-8.

ISSUE WORKSHOP 57
PROJECT MATCH: A RESIDENT CURRICULUM OF MENTORSHIP, ADVOCACY, TEACHING, CAREER ISSUES, AND HEATH

Co-Chairpersons: Heather L. Flett, M.D., *22 Roxton Road, Toronto, ON M6J 2Y2*
Jillian Sussman, M.D., *555 University Avenue, Elm Wing, ON M5G 1X8*
Presenter: Bruce Ballon, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop participants will be able to:

1. Understand the wellness issues common to postgraduate trainees.

2. Describe the MATCH model as an example of a curriculum that targets residents' professional and personal wellbeing.

3. Attain skills to design their own wellness curriculum at their training site.

SUMMARY:

To be an effective physician it is important to maintain balance between professional and personal priorities. There is no current

postgraduate curriculum to better inform and instruct residents on upholding this balance described in the current literature. Project MATCH was created as a wellness curriculum and mentoring program that addresses the issues of mentorship, advocacy, teaching, career issues, and health of residents.

The three integral components of this project included (1) assessment of the wellness needs of residents (2) a series of ten seminars focusing on personal and professional wellbeing issues was piloted and evaluated (3) a directory of faculty physicians accessible for mentorship. Together, these three components helped us create a wellness curriculum in the Department of Psychiatry at the University of Toronto (U of T).

Through repeated evaluations, Project MATCH was identified as successful in supporting resident wellness. Specifically, residents reported feeling less anxious regarding career planning and specialty training and more competent in balancing their personal and professional lives. There has been overwhelming support at the postgraduate level within the department of psychiatry and the faculty of medicine at U of T. Elements of Project MATCH may be adapted at other training sites to further support residents on a large scale. This workshop will function as a springboard for furthering these efforts at other training sites.

By developing physician wellness programs, not only will physicians benefit, but so too will the patients for whom they provide care.

REFERENCES:

1. Journal Article: Cohen, J. & Patten, S: Well-being in residency training: a survey examining resident and physician satisfaction both within and outside of residency training and mental heath in Alberta. BMC Medical Education 2005; 5:21.
2. Journal Article: Levy, BD et al.: An initiative in mentoring to promote residents' and faculty members' careers. Academic Medicine 2004; 79:9, 845-850.

ISSUE WORKSHOP 58
THE RESIDENT EXPERIENCES A PATIENT SUICIDE: STRATEGIES THAT CAN HELP

Co-Chairpersons: Joan M. Anzia, M.D., *1115 Forest Avenue, River Forest, IL 60305-1355*
Surinder S. Nand, M.D., *900 South Wood Street, Chicago, IL 60612*
Presenters: Janet L. Kemp, Arshdeep S. Jawandha, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to recognize the full range of possible resident responses to a patient's suicide, to create a curriculum to prepare residents for the possibility of patient suicide, and to devise and implement supportive interventions for the resident who experiences this event.

SUMMARY:

Although psychiatrists are generally well-educated in assessment of suicide risk, very little has been studied and written about the impact of suicide on psychiatry residents, who often care for the most severely ill patients. It is quite common for residents to experience a patient suicide during training; two studies found that at least half of residency graduates report a patient suicide during the training years.There are several studies which describe significant psychological and professional impact of this event on the trainee, including anxiety, feelings of helplessness and guilt, insomnia, and preoccupation with clinical decision-making.

Currently, most training programs do not offer curricula that could help residents prepare for a patient suicide, nor do most programs have protocols in place for what should happen after a suicide - including information on preparation for critical incident reviews or working with the families of suicide victims. The RRC currently does not require any education in suicide care.

A curriculum for suicide care, including seminars, skill-building workshops and supervision, should be included in all residency training programs in psychiatry. There is a need for larger-scale surveys of patient suicide during training years, and for assessment of interventions.

REFERENCES:

1. Pilkinton P, Etkin M: Encountering suicide: the experience of psychiatric residents. Acad Psychiatry 2003; 27(2): 93-99.
2. Ruskin R, Sakinofsky I, Bagby RM, Dickens S, Sousa G: Impact of patient suicide on psychiatrists and psychiatric trainees. Acad psychiatry 2004;28(2): 104-110.

ISSUE WORKSHOP 59
TELEPSYCHIATRY IN ACTION: IMPLEMENTING AND SUSTAINING A SUCCESSFUL TELEPSYCHIATRY PROGRAM

Chairperson: Susan Stabinsky, M.D., *15 Boulder Trail, Armonk, NY 10504*
Presenters: Richard A. Silverman, M.D., Maria L.A. Tiamson-Kassab, M.D., James Varrell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participants will be able to:

1. Describe the evolution of telepsychiatry including current status and future directions.

2. Understand clinical, administrative, legal and ethical issues involved in implementation of a successful telepsychiatry program.

SUMMARY:

This workshop is intended for clinicians who are interested in learning about telepsychiatry. It is organized into 3 parts. Part 1 will focus on the introduction to telepsychiatry with emphasis on historical perspective and current trends. It is important to have basic understanding of the evolution of telepsychiatry in order to grasp the issues involved in the implementations of a successful program. Part 2 will be dedicated to the clinical issues involved in such encounters including diagnostic issues and medication management. It will also include a discussion of the evidence-based telepsychiatry and videotaped examples of real-life sessions as presenters (Drs. Khan, Silverman and Varrell) provide routine psychiatric care using videoconferencing. Part 3 will be devoted to programmatic issues. The presenters will discuss their experiences in the implementation and administration of these services to a variety of patient population including children, adolescents, adult and geriatric patients. The focus will be on technical issues, billing, credentialing, legal and ethical concerns.

This workshop will be interactive and have significant time allocated for discussion from the participants. In addition, participants will be provided with handouts, research papers, and additional resources to launch their own, successful telepsychiatry program.

REFERENCES:

1. Hyler SE, Gangure DP, Batchelder ST: Can telepsychiatry replace in-person psychiatric assessments? A review and meta-analysis of comparison studies.CNS Spectr. 2005;10:5:403-413.
2. Ruskin PE, Silver-Aylaian M, Kling MA, Reed SA, Bradham DD, Hebel JR, Barrett D. et al: Treatment outcomes in depression: comparison of remote treatment through telepsychiatry to in-person treatment. Am J Psychiatry. 2004;161:8:1471-1476.

ISSUE WORKSHOP 60
RESEARCH TRAINING FOR ALL PSYCHIATRIC RESIDENTS: A PROBLEMATIC ENDEAVOR

Chairperson: Milton Kramer, M.D., *914 48th Street, Brooklyn NY 11219*
Presenters: Jerald Kay, M.D., Mantosh J. Dewan, M.D., Michele T. Pato, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation the participant should be able to have several techniques to implement a research and scholarly experience for residents using case report publication, retrospective reviews and poster presentations. Dealing with resident reluctance/ resistance will be a focus. The value and method of teaching design and statistics and the link to evidence base psychiatry will become clear. The value of such an endeavor will be the topic for group discussion

SUMMARY:

The desire that psychiatric residents become knowledgeable about research and scholarship and develop critical evaluative skills to be able to understand the research and scholarly literature is an admirable goal. The Psychiatric Residency Review Committee (R.R.C.) has espoused the view that training programs should embark on a series of educational undertakings to ensure that such learning takes place. The report by Balon and Singh(2001) points to the dismal state of research training, while Kupfer et.al.(2002) addresess their attention to the training of research psychiatrist.

Difficulties immediately appear when residency programs attempt to meet such goals. However, the time taken from the research psychiatrist to educate residents whose interests are clinical does not seem to the researcher a productive use of his time. The usual techniques of splitting off part of the researcher's project for the clinically committed resident often leads to duplication of effort and inadequate output.

The problems in programs with more limited research teaching resources face a different series of problems, but share the motivational problem of trying to interest clinically committed residents in scholarly and research endeavors. These programs have to find a professional in their group who has the skills, time and interest to undertake developing an educational program.

The efforts in three psychiatric programs will be reviewed to develop a program in critical skills related to research and scholarly assessment. Dr. Dewan will report on his efforts to voluntarily involve residents to do research or scholarly activity utilizing writing and publishing a case report as a focus. Dr. Kramer will describe his experience in utilizing retrospective chart reviews and poster presentations at National Meetings. Dr. Kay will discuss the intent of the R.R.C. and share his approach. It will become clear that specific techniques and approaches focused on completion "payoffs" are essential motivators for success.

REFERENCES:

1. Balon, R. and Singh, S.(2001) Status of research training in psychiatry. Academic Psychiatry, 25:34-41.
2. Kufer, D.J., Hyman, S.E., Schatzberg, M.D., Pincus, H.A., Reynolds, C.F. (2002) Recruiting and retaining future generations of physician scientists in mental health. Arch Gen Psychiatry, 59:657-660.

ISSUE WORKSHOP 61
DETECTING BIPOLAR DISORDER

Co-Chairpersons: Gary E. Miller,, M.D., *530 Wells Fargo Drive, Houston, TX 77090-4026*
Richard L. Noel, M.D., *530 Wells Fargo Drive, Houston, TX 77090-4026*

EDUCATIONAL OBJECTIVES:

1. At the conclusion of this workshop, the participant will have acquired an understanding of the prevalence of bipolar spectrum disorders, the varying manner in which these disorders present clinically, and the frequency with which patients with bipolar spectrum disorders are misdiagnosed.
2. At the conclusion of this workshop, the participant will have become familiar with clues for detecting the presence of bipolar spectrum disorders in patients presenting with depression, psychosis, aggressive behaviors and impulsivity.

SUMMARY:

This workshop will focus on clues for detecting bipolar disorder in children, adolescents and adults presenting with depression, psychosis, aggressive behavior and other conditions in which diagnosis is less-than-obvious. Since bipolar disorder is frequently misdiagnosed and since inaccurate diagnosis can lead to inappropriate pharmacological management and possible worsening of the course of illness, it is important that patients be carefully evaluated for subtle indications of mood instability. The moderators are clinical psychopharmacologists who have treated over 10,000 patients of all ages over the last thirteen years. They will present vignettes of actual patients, each illustrating a presentation of bipolar disorder in which the classic features of the disorder are not apparent but in which detailed history-taking revealed clues to the correct diagnosis. Cases include adults with "recurrent major depression," an adolescent with an acute psychotic episode, a woman with postpartum depression and children diagnosed with ADHD. Participants will be encouraged to discuss the cases presented and to convey their own clinical experience and views. We estimate that about 60 of the 90 minutes of the workshop will be given over to questions, answers and general discussion.

REFERENCES:

1. Akiskal, H.S. et al: Re-evaluating the Prevalence and Diagnostic Composition within the Broad Clinical Spectrum of Bipolar Disorders. Journal of Affective Disorders 2000; 59 (supplement 1): S5-S30.
2. Blanco, C. et al: Trends in the Treatment of Bipolar Disorder by Outpatient Psychiatrists. Am J Psychiatry 2002: 159: 2005-2010.

ISSUE WORKSHOP 62
CAN WE DO BETTER AT PREVENTING THE CHRONIC COURSE OF MOOD DISORDERS?

Co-Chairpersons: Alina Marin, M.D., *100 West 5th Street, Hamilton, ON L8N 3K7*
Irene Patelis-Siotis, M.D., *100 West 5th Street, Hamilton, ON L8N 3K7*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1) understand the factors contributing to the unfavorable course in Mood Disorders and identify interventions aiming to improve outcome; 2) become familiar with the concepts underlying neurobiological mechanisms implicated in the regulation of emotions and self; 3) learn about specific psychosocial treatments addressing the patient's autonomy, competence and ability to relate to others and targeting improvement of quality of life and functioning, in patients newly diagnosed with mood disorders.

SUMMARY:

Despite appropriate treatment regimens, more than fifty percent of patients diagnosed with Mood Disorders will develop a chronic course of illness. Pharmacological approaches alone are often insufficient for maintaining remission. It appears imperative to develop psychosocial protocols that would enhance patient's self-management skills.

The MDP at McMaster University has created a Rehabilitation program, START designed to improve functioning and quality of life in patients diagnosed with Chronic Mood Disorders. The START experience with chronic or "treatment resistant" patients identified both patients and psychiatrists factors contributing to resistance. It also suggests that a balanced therapeutic alliance instilling hope, acceptance and shared responsibility would optimize individual's quality of life.

Based on our clinical experience with START, we have designed a new strategic psychosocial intervention. This intervention would hopefully prevent the evolution towards a chronic course for newly diagnosed patients. We base the rationale for our approach on the neuronal potential for neuroplasticity and on the critical role empathy is playing in promoting these processes. Neurobiological studies increasingly support that the development of neuronal circuits is lifelong and considerably influenced by environmental factors. Furthermore, the continuous development of the brain's integrative capacities is likely to be fostered by good attachment relationships. We know that exposure to an empathic environment promotes the acquisition of emotional, cognitive and interpersonal skills required to improve emotion regulation. This new intervention will enhance the patient's capacity for self-determination and amend functionality. Additionally, modern technology would also enable us to measure the neurobiological changes expected to follow such interventions.

In summary, this highly interactive workshop will allow discussion about ways to improve psychosocial approaches to Mood Disorders. The emerging evidence of lifelong neuronal networks changes supports combining new psychological interventions with well established pharmacological treatment. That would prevent the chronic course of Mood Disorders.

REFERENCES:

1. Bauer M, McBride L: Structured Group Psychotherapy for Bipolar Disorder. The Life Goals Program. New York, NY, Springer Publishing Company, Inc, 1996.
2. Grosjean B: From Synapse To Psychotherapy: The Fascinating Evolution of Neuroscience. Am J Psychotherapy 2005, 59,3: 181-197.

ISSUE WORKSHOP 63
SAFETY TRAINING FOR MEDICAL STUDENTS DURING THEIR PSYCHIATRY CLERKSHIP

Chairperson: Erica Z. Shoemaker, M.D., *1720 East 120th Street, Los Angelos, CA 90059*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to:

1) Recognize training settings in which students may be at risk of assualt

2) Recognize characteristics of patients who are more likely to assault staff, including students

3) Recognize actions by staff and trainees that put them at highest risk for being assaulted.

4) Design a training program to give medical students the knowledge and skills to reduce their risk of assault during their psychiatry clerkship and throughout their medical training.

SUMMARY:

Recent research estimates that 20-40% of internal medicine residents and 40-65% of psychiatry residents are physically assaulted by a patient during their residency training. Considerably less research has investigated the risk medical students face during their clinical training, but a recent study at the University of Toronto found that 6 of 173 students in a single medical school class had been physically assaulted by patients. Assaults to students had occurred in both psychiatric and medical services. These findings underscore the need to educate and train medical students about how to recognize potentially dangerous situations and patients and to reduce their risk of being harmed. Such training would be analagous to training students in universal precautions, which protect all healthcare workers from infectious agents.

This workshop will review the existing literature on risk of assault by patients on staff and trainees in medical and psychiatric settings. We will discuss characteristics of patients who are more likely to assault staff and trainees. We will review characteristics of and actions by staff which increase the risk of assault. We will review components of a training program for 3rd year medical students intended to increase their awareness of potentially dangerous situations during their medical training and to reduce their risk of being harmed.

REFERENCES:

1. 1) Coverdale JH, Louie AK, Roberts LW: Protecting the Safety of Medical Students and Residents. Academic Psychiatry 2005; 29:4 329-331.
2. 6) Waddell AE, Katz MR, Lofchy J, Bradley J: A Pilot Survey of Patient-Initiated Assaults on Medical Students During Clinical Clerkship. Academic Psychiatry 2005; 29: 350-353.

ISSUE WORKSHOP 64
THE ROLE OF DSM-IV RATING SCALES IN PSYCHIATRY

Chairperson: Joyce Sprafkin, Ph.D., *Putnam Hall, South Campus, Stony Brook, NY 11794*
Presenters: Kenneth D. Gadow, Ph.D., Margaret D. Weiss, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to discuss the role of DSM-IV rating scales in differential and dual diagnosis, monitoring response to treatment, chart documentation, and quality assurance requirements.

SUMMARY:

The use of behavior rating scales is now a common component of a clinical evaluation of children and adolescents and is becoming more widely accepted in adult psychiatry. There are several DSM-IV-oriented rating scales, but most focus on a single disorder such as ADHD or depression. The Symptom Inventories are unique in that they are comprehensive rating scales that contain the symptoms of a broad range of disorders; there are parallel versions for children, adolescents, and adults; and they are a useful, cost-effective method to acquire information about patients from multiple sources. An extensive program of research has shown that the Symptom Inventories are reliable and valid measures. Norms make it possible to compare a patient's score with a community sample, which is useful for diagnostic and treatment goal decision-making.

This workshop describes how the Symptom Inventories are used in real-world clinical settings to evaluate patients, inform diagnostic decision-making, and monitor response to treatment. The presentation demonstrates how clinical research findings can be used to solve many problems that clinicians often encounter. Adult psychiatry is almost completely reliant on patient self-report, and there are limited

practical ways to obtain additional sources of information about a patient's functioning. Child/adult psychiatrists are more likely to make use of information from multiple sources (parents, teachers) but are often left with questions about how to interpret discrepant reports. Various certification/monitoring agencies (government, hospital, insurance companies) require documentation of the presence of certain symptoms to justify specific diagnoses, evidence of clinical improvement to justify continued treatment, and outcome criteria to justify discharge. This workshop demonstrates how these and other clinical practice challenges can be addressed with the use of rating scales. A number of different disorders are discussed, but special emphasis will be given to ADHD in adults, autism, Tourette syndrome, anxiety, and depression.

REFERENCES:

1. Gadow KD, Sprafkin J, Weiss MD: Adult Self-Report Inventory 4 Manual. Stony Brook, NY, Checkmate Plus, 2004.
2. Sprafkin J, Gadow KD, Salisbury H, Schneider J, Loney J: Further evidence of reliability and validity of the Child Symptom Inventory-4: Parent Checklist in clinically referred boys. J Clin Child and Adol Psychology 2002; 31:513-524.

ISSUE WORKSHOP 65
COMPLEXITIES OF POST TERMINATION RELATIONSHIPS

Chairperson: Malkah T. Notman, M.D., *54 Clark Road, Brookline, MA 2445*
Presenters: Elissa P. Benedek, M.D., Carl P. Malmquist, M.D., Linda M. Jorgenson, J.D.

EDUCATIONAL OBJECTIVES:

Participants will be better able to evaluate and implement boundary limits to a variety of psychiatric relationships including psychopharmacology, consultations and intensive psychotherapy.

SUMMARY:

Although the APA ethics guidelines state that "once a patient always a patient" and this is understood to mean that ethical restrictions always apply to relationships with former patients, this does not address the range and variability of post termination encounters. During psychotherapy the boundary limits concerning certain kinds of relationships are not always clear. However sexual relationships during psychotherapy are always considered unethical. The limits to business relationships are less clear although exploitative relationships such as having a patient barter demeaning service for payment are certainly unethical.

Post termination boundaries and the ethical and clinical implications of post termination relationships are even less clear and are less addressed. Post termination sexual relationships are usually still considered unethical by the APA. Different professional groups such as psychology and social work have somewhat different guidelines. However friendships and social and collegial relationships remain an ambiguous area. In some situations they are inevitable. Sometimes they verge on intimacy; sometimes they become the basis of political alliances in departments or programs. The differences between relationships developed in long and intensive psychotherapy and those in more limited encounters, such as consultations or medications visits also need to be considered.

This workship will address the nature, implications and consequences of a variety of post termination relationships. Strategies for management will be considered. A videotape will present several vignettes of post termination relationships. They will be discussed by the workshop members in terms of a range of positions--a strict interpretation of ethical rules and a broader view. Audience participation and discussion will be enouraged.

Previous presentations by this group have considered other boundary issues such as the dilemmas created by small communities with overlapping relationships, non sexual boundary problems, and related topics, which have generated lively discussions.

REFERENCES:

1. Appelbaum PS, Jorgenson LM: Psychotherapist-patient sexual contact after termination of treatment: An analysis and a proposal. Am J Psychiatry 1991; 148: 1466-1473.
2. Malmquist CP, Notman M: Psychiatrist-patient boundary issues following treatment termination. Am J Psychiatry 2001; 1010-1018.

WEDNESDAY, MAY 23, 11:00 AM - 12:30 PM

ISSUE WORKSHOP 66
ETHNICITY, CULTURE, AND PSYCHOPHARMACOLOGY: RECENT ADVANCES

Chairperson: Pedro Ruiz, M.D., *1300 Moursund Street, Houston, TX 77030*
Presenters: William B. Lawson, M.D., Ph.D., Edmond H. Pi, M.D., Tarek A. Okasha, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to: understand the mechanisms that play a role in the ethnic and racial responses to psychopharmacological agents. Learn about the role of the Cytochrome P450 in ethnopsychopharmacology. Help to better design a pharmacological approach in the treatment of psychiatric disorders among ethnic minority groups.

SUMMARY:

The field of ethnopsychopharmacology has advanced a great deal in recent years and has gained much recognition from a research and evidence-based medicine during the last two decades. This recognition has resulted not only from the excellent investigative work that has taken place in the United States and other industrialized nations, but also as a result of the globalization process that is currently affecting all regions of the world.

Along with the globalization process, the migration pattern from evolving nations towards developed countries has intensified in the last decade. Particularly, toward the United States, Englan, Germany and most European countries.

In this workshop, attention will be given not only to the research outcomes vis-a-vis the ethnic minority populations who reside in the United States, but to other regiohns of the world as well.

REFERENCES:

1. Ruiz P: Recent Research Advances in the Field of Ethnopsychopharmacology. Psychiatriki, 16(2): 132-136, 2005.
2. Ruiz P (ed.): Ethnicity and Psychopharmacology. Washington, D.C., American Psychiatric Publishing, Inc., 2000.

ISSUE WORKSHOP 67
COGNITIVE BEHAVIOUR THERAPY FOR PSYCHOSIS IN PRACTICE: BASIC TECHNIQUES FOR PSYCHIATRISTS

Chairperson: Shanaya Rathod, M.D., *37-39 Mulfordds Hill, Tadley Hants RG26 3HX*
Presenters: David G. Kingdon, M.D., Douglas Turkington, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to:

1 Understand which of their patients with schizophrenia may benefit from cognitive behaviour therapy

2. Incorporate evidence-based elements of Cognitive behaviour therapy into their work with patients with schizophrenia.

SUMMARY:

Cognitive Behaviour therapy (CBT) as an adjunctive therapy for persistent symptoms of schizophrenia is now supported by meta-analyses and twenty two published Randomised controlled trials. Unfortunately, few training schemes exist and consequently trained therapists are rarely available. Psychiatrists may need to consider if they can adapt their practice to incorporate elements of CBT successfully (Turkington & Kingdon, 2000). They can build on general psychiatric engagement, assessment and formulation skills with a particular focus on the first episode of psychosis and its antecedents. General understanding of cognitive therapy processes and ways of working can be adapted. Specific work on voices, visions, delusions, thought disorder and negative symptoms can then be incorporated within the framework of identified clinical groups in clinic, community and inpatient settings. CBT compliments medication management by assisting with understanding and improving compliance with treatment and also the delusional elaboration sometimes associated, or simply faulty assumptions about the function and purpose of medication. It is also valuable in eliciting risk issues through its ways of drawing out connections between thoughts, feelings and actions, for example, in relation to passivity or command hallucinations. The workshop will use key strategies, case examples, video-interviews and allow plenty of opportunity for discussion.

REFERENCES:

1. Kingdon, DG, Turkington, D: A Casebook Guide to Cognitive Behaviour Therapy: practice, training and implementation. Chichester: Wiley, 2002.
2. Kingdon, DG, Turkington, D: Cognitive Therapy for Schizophrenia. Series Editor: J. Persons. NY: Guilford, 2005.

ISSUE WORKSHOP 68
PROMISING MEDICATIONS FOR THE TREATMENT OF COCAINE ADDICTION
National Institute on Drug Abuse

Co-Chairpersons: Ahmed Elkashef, M.D., *6001 Executive Boulevard, Bethesda, MD 20892*
Frank Vocci, Jr., Ph.D., *6001 Executive Boulevard, Bethesda, MD 20892*
Presenters: Kyle M. Kampman, M.D., Bankole Johnson, M.D., George F. Koob, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participants should be able to learn the recent findings from clinical trials to treat cocaine addiction. They should also be familiar with the neurobiology of cocaine and medications in the pipline and new targets to treat cocaine addiction.

SUMMARY:

Cocaine addiction remains a major public health problem for which there is no FDA approved medication. According to the 2004 National Survey on Drug Use and Health, approximately 34.2 million Americans, ages 12 and older, tried cocaine at least once in their lifetimes, representing 14.2% of the population ages 12 and older. Approximately 5.7 million (2.4%) had used cocaine in the past year and 2.0 million (0.8%) had used cocaine within the past month.

Multiple compounds have been tested in proof of concept clinical trials including marketed medications and new molecular entities. Positive signals have been published for modafinil, topiramate, and disulfiram for faciliating abstinence from cocaine use or in the case of topiramate maintaining abstinence in patients that were not using cocaine at randomization. These early promising signals are being folowed up by more confirmatory clinical trials. The data from a multi-site trial for modafinil is currently being prepared for analysis and will be presented. Interim data from two ongoing clinical studies, one for topiramate and the other for disulfiram/nalotrexone combination, will also be presented.

An overview of preclinical targets and proposed medications to pursue for further development for the treatment of different phases of cocaine addiction (e.g. CRF antagonist and D3 antagonist) will also be presented.

REFERENCES:

1. Vocci, F.J., Acri, J., Elkashef, A.E. Medications development for addictive disorders: State of the science. Am J. Psychiatry 162:1432-1440, 2005.
2. Kampman KM, Pettinati H, Lynch KG, Dackis C, Sparkman T, Weigley C, O'Brien CP.

ISSUE WORKSHOP 69
PSYCHIATRISTS WHO HAVE BEEN IN TREATMENT. AN INTERACTIVE DISCUSSION

Co-Chairpersons: Leah J. Dickstein, M.D., *3006 Dunraven Drive, Louisville, KY 40222-6126*
Michael F. Myers, M.D., *1081 Burrard Street, Vancouver, Canada V6Z 1Y6*
Presenters: Elizabeth A. Baxter, M.D., Francine Cournos, M.D., Raymond M. Reyes, M.D., Suzanne E. Vogel-Scibilia, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1. appreciate the types of illnesses with which psychiatrists struggle; 2. have had questions answered that relate to stigma, confidentiality, disclosure, licensure, prognosis and more.

SUMMARY:

The purpose of this workshop is to diminish the stigma that many psychiatrists feel when they develop a mental illness. Research shows that symptomatic psychiatrists often suffer silently and for a long time before seeking professional help. This enhances morbidity and treatment refractoriness. Psychiatrists living with untreated or undertreated or self-treated mood disorders are at risk for suicide, especially in the face of relapse or recurrence. This entire workshop is for attendees who are encouraged to come with questions to pose to the expert panel of psychiatrists (including the current president of NAMI) who have sought treatment for a mental illness. They speak openly about their journeys. And they are dedicated to reducing the institutional stigma that often accompanies the path to compassionate and state-of-the-art care as well as eliminating the internalized stigma that exists in many psychiatrists who fall ill. Sample questions might be: How do you protect your privacy and confidentiality? Do residents with a psychiatric diagnosis have to tell their training directors? How do you find a psychiatrist when you practice in a small community? What do you have to disclose on medical license applications? Does seeking treatment affect my obtaining disability insurance? Do IMGs and minority psychiatrists fight even more layers of stigma? Is there more resistance to taking psychotropic medication than engaging in psychotherapy? How safe is it to talk about suicide? Will you be forced into hospital involuntarily? Is there more shame associated with bipolar illness than unipolar? Can a psychiatrist with a psychotic disorder have a successful career? At the conclusion of this workshop, attendees will feel less stigma about illness in psychiatrists and appreciate the wisdom of seeking early treatment.

REFERENCES:

1. Baxter EA. The turn of the tide. Psychiatric Services 1998;49:1297-1298.
2. Cournos F. City of One: A Memoir. New York, NY, WW Norton& Company, 1999.

ISSUE WORKSHOP 70
ELECTRIFYING DISCOURSES: PRESENTATION AND COMMUNICATION SKILLS FOR PSYCHIATRISTS AND TRAINEES

Chairperson: Shyam K. Bhat, M.D., *P.O. Box 19642, Springfield IL 62974-9642*
Presenters: David S. Resch, M.D., Thomas O. Osinowo, M.D., Anjan Bhattacharyya, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to:

1. Review the importance and application of presentation and communication skills in psychiatry
2. Apply the techniques of effective presentation skills
3. Describe strategies of effective communication between psychiatrist and patient, as well as between colleagues.
4. Employ techniques of effective presentations to colleagues, as well as non-mental health professionals
4 . Identify the common pitfalls of presentations and how to avoid them

SUMMARY:

To enhance the presentation and communication skills of psychiatrists, and medical students interested in psychiatry

The X Factor: Importance of presentation skills to a psychiatrist's career: *It's not just Grand Rounds*:

Forums where presentation and communnication skills are indispensable: For enhanced patient care including an improved therapeutic alliance, improved adherence with treatment, communication with peers and supervisors, interactions with the systems of care.

Techniques:
Body Language
Voice Modulation
Delivery
Effective audiovisuals
Congruence between Internal Beliefs and Delivery of Material
Dialogue between Presenter and Audience

Presentation of the principles of an effective presentation, including body language, content delivery, matching content and style, use of audiovisuals.

Specific interactive modules that will allow participants an opportunity to practice and learn skills that are necessary for effective presentations

Structured interactive exercises, where workshop participants will be guided through presentations of their own, and offered suggestions for improvement.

At the end of the workshop, participants will be able to enhance the effectiveness of their presentations, as well as their interactions with colleagues and patients.

Presentation and Communication skills are an important but often ignored area; these skill sets are critical to the professional growth of psychiatrists and other mental health professionals

REFERENCES:

1. Green EH, Hershman W, DeCherrie L, Greenwald J, Torres-Finnerty N, Wahi-Gururaj S Developing and implementing universal guidelines for oral patient presentation skills.Teach Learn Med. 2005 17(3):263-7.
2. Haber RJ, Lingard LA. Learning oral presentation skills: a rhetorical analysis with pedagogical and professional implications J Gen Intern Med. 16(5):308-14.

ISSUE WORKSHOP 71
AIR FORCE SUICIDE PREVENTION PROGRAM: A COMMUNITY AND ORGANIZATIONAL APPROACH TO PREVENTION

Chairperson: Steven E. Pflanz, M.D., *6249 Auburn Leaf Lane, Alexandria VA 22312*
Presenter:

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize and apply both community and organizational concepts to suicide prevention, and be able to utilize community and organizational infrastructures to build effective suicide prevention programs.

SUMMARY:

Suicide is the eleventh leading cause of death in America, claiming roughly 30,000 lives each year. On average, someone takes his or her own life every 17 minutes in the United States. The greatest tragedy of suicide is that it is often preventable. However, both communities and organizations can take action to prevent suicide. The Air Force Suicide Prevention Program (AFSPP) has received international recognition as one of the few community suicide prevention programs to achieve proven results. Air Force suicides are down by 30% since the inception of the program in 1996. The 11 initiatives of the AFSPP represent a state-of-the art integrated system of policy and programs that incorporates both community and organizational elements. The cornerstone of the AFSPP is the recognition that suicide prevention is a community responsibility. The Air Force cultivates a culture that encourages and supports early help seeking behavior for personnel suffering from distress. The AFSPP trains Air Force personnel to better recognize individuals suffering from suicidal ideation and to immediately refer these individuals for necessary psychiatric care. The majority of this workshop will be devoted to an audience discussion of community and organizational approaches to suicide prevention.

REFERENCES:

1. Mann JJ et al: Suicide prevention strategies: A systematic review. JAMA 2005; 294:2064-2074.
2. Knox KL et al: Risk of suicide and related adverse outcomes after exposure to a suicide prevention program in the U.S. Air Force: A cohort study. British Medical Journal 2003; 327:1376-1378.

ISSUE WORKSHOP 72
DAY-TO-DAY VARIABILITY IN BIPOLAR DISORDER

Co-Chairpersons: Jan L. Scott, M.D., *De Crespigny Park, London SE58AF*
Michael Bauer, M.D., *Humboldt University Schumannstr 20121, Berlin, Geermany 10117*
Presenters: Mark S. Bauer, M.D., Tasha Glenn, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to:

- Understand the frequency and severity of inter-episode symptoms in bipolar disorder
- Describe recent research on the significance of inter-episode symptoms

- Be aware of benefits and issues associated with patient self-monitoring for both patients and physicians.

SUMMARY:

Bipolar disorder is characterized by recurrent acute episodes of mania and depression. However, subsyndromal symptoms commonly occur between episodes, and the presence of these inter-episode symptoms may impair day-to-day functioning and increase the risk of future relapse. Psychobiosocial models of bipolar disorder have attempted to explain the interactions of biological, cognitive and social factors that may determine relapse while emphasizing the presence of an underlying instability or dysregulation. This workshop will explore inter-episode symptoms and variability in bipolar disorder, including results from longitudinal studies, techniques to capture these symptoms, and approaches to analyze this data.

Jan Scott will report on three studies: the first explores the prevalence of inter-episode symptoms compared to major episodes. The other two studies use prospective monitoring of biological, behavior, cognition, and mood measures to explore inter-episode variability between patients with bipolar disorder, and with matched control subjects from the general population. Michael Bauer will report on the frequency and severity of subsyndromal symptoms of hypomania and depression reported from studies of patients with bipolar disorder, and on the clinical interpretation and use of daily self-monitoring data. Mark Bauer will address several problems associated with self-monitoring including whether patients with bipolar disorder have sufficient insight to rate their symptoms, and the need for instruments to reflect the co-existence of manic and depressive symptomology. Data are reviewed with regard to the Internal State Scale, which has been shown to provide valid and reliable mood self-assessment data in both research and public sector populations. With the widespread acceptance of technology by the general public, Tasha Glenn will review automated approaches to collecting daily self-reporting data, including the validated ChronoRecord software. Results from several studies that analyze inter-episode variability in mood or sleep in longitudinal data from patients with bipolar disorder using ChronoRecord will be presented.

REFERENCES:

1. Paykel ES, Abbott R, Morriss R, Hayhurst H, Scott J. Subsyndromal and syndromal symptoms in the longitudinal course of bipolar disorder. Br J Psychiatry 2006;189:118-23.
2. Bauer M, Grof P, Rasgon N, Bschor T, Glenn T, Whybrow PC. Temporal relation between sleep and mood in patients with bipolar disorder. Bipolar Disord 2006; 8 :160-167.

ISSUE WORKSHOP 73
FROM THE MISSISSIPPI TO THE GANGES: UNDERSTANDING THE CROSS CULTURAL CONTEXT OF TREATMENT FROM THE PERSPECTIVE OF THE SOUTH ASIAN PSYCHIATRIST IN AMERICA
Indo-American Psychiatric Association

Co-Chairpersons: Asha S. Mishra, M.D., *6801 Lucy Corr Boulevard, Chesterfield VA 23832*
Sudeepta Varma, M.D., *300 East 33rd Street New York, NY 10016*
Presenters: Surinder Nand, M.D., Nalini Juthani, M.D.

EDUCATIONAL OBJECTIVES:

1) By the end of the workshop the participants will be be able to better understand the areas of strenght sand challenges that impact the therapeutic work with or by South Asian professionals.

2) The participants will learn the value of examining one's own experiences and cultural framework within which a resident operates and formulates patients' problems.

3) Clinicians will be able to use the countertranference in a positive and therapeutic manner.

4) Discussants will demonstrate sensitive supervisory skills to help residents of South Asian origin become culturally aware and competent to treat patients.

SUMMARY:

Transference and counter-transferential issues are of utmost importance regardless of the type of therapy. Understanding one's background, strengths, weaknesses and early life experiences for a therapist are of paramount significance so that they may not present as barriers in treatment. The cultural context of the psychiatrist must also be examined as part of the process. In this workshop, we will discuss the cultural context of the South Asian doctor patient relationship with regards to the "mainstream" doctor patient-relationship, the South Asian doctor with American patient, and the doctor-patient relationship in cross gender dyads.

We will also look at residency training and what issues may come up that may affect the education of the South Asian resident from both a resident training director's point of view as well as learning from a South Asian resident's point of view. At times the therapy, or issues discussed may evoke negative or uncomfortable feelings on the part of the therapist. For the therapist, understanding one's self and the origin of ones own motives can make the difference between awareness and appreciation of feelings, some of which may be negative and unproductive to therapy if expressed versus actually acting upon them.

REFERENCES:

1. Roland, A: In Search of Self in India and Japan. Princeton, Princeton University Press, 1998.
2. McWilliams, N: Psychoanalytic Diagnosis: Understanding personality structure in the clinical process. New York, Guildford Press, 1994.

ISSUE WORKSHOP 74
RELIGIOUS AND SPIRITUAL ASSESSMENT IN CLINICAL PRACTICE

Co-Chairpersons: Francis G. Lu, M.D., *1001 Portrero Avenue, Suite 7M, San Francisco, CA 94110*
James L. Griffith, M.D., *2150 Pennsylvania Avenue, N.W., 8th Floor, Washington, DC 20037*
Presenter: Christina M. Puchalski, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to understand the importance of incorporating religious/spiritual issues in clinical work and to understand the practical methods of establishing rapport, assessment, and treatment planning involving religious/spiritual issues.

SUMMARY:

According to the American Psychiatric Association (APA) Practice Guidelines of the Psychiatric Evaluation of Adults, 2nd edition, which has incorporated the *DSM-IV TR* Outline for Cultural Formulation, cultural issues including religion/spirituality should be part of history taking, assessment, and treatment planning. Yet clinicians may be unfamiliar with methods of incorporating religion and spirituality into these normal clinical activities. This workshop will provide practical methods of incorporating religion and spirituality in clinical care in these areas as well as illustrate these methods through case vignettes. Participants will be invited to critique and comment on these case vignettes and use them as a stimulus for discussion of their own clinical work. Specific issues discussed will include the importance of respectful rapport to develop more empathic and meaningful relationships with patients, the use of the *DSM-IV TR* Outline for Cultural Formulation as a structured method for including reli-

gious/spiritual issues in assessment, the *DSM-IV TR* diagnosis of Religious or Spiritual Problems, the spiritual/religious issues arising from medical conditions and end of life.

REFERENCES:

1. Griffith J, Griffith M: Encountering the Sacred in Psychotherapy: How to Talk With People about Their Spiritual Lives. New York, Guilford Press, 2003.
2. Josephson A, Peteet J: Handbook of Spirituality and Worldview in Clinical Practice. Washington, DC, APPI Press, 2004.

ISSUE WORKSHOP 75
FROM EVIDENCE TO CLINICAL METHODS IN INTEGRATIVE MENTAL HEALTH CARE

Chairperson: James Lake, M.D., *P.O. Box 222577, Carmel CA 93922*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop participants will understand basic principles of integrative mental health care. Using an integrative approach based on research evidence and safety data, participants will learn practical clinical methods for managing major depressive disorder.

SUMMARY:

Non-conventional therapies are increasingly used to treat the range of psychiatric disorders. Many patients use *non-conventional* treatments in combination with conventional biomedical therapies, but seldom disclose these to their psychiatrists. Non-disclosure can lead to poor communication between psychiatrists and patients, misunderstandings about which treatments to use, safety and compliance problems, and poor treatment outcomes. A clear methodology for planning integrative treatment will result in improved communication, enhanced safety and better outcomes.

This workshop will provide a clinically oriented discussion of integrative methods in the management of psychiatric outpatients. Based on evidence from research, safety data, and emerging standards of practice in the U.S. and Western Europe, basic principles of integrative mental health care will be discussed. The integrative management of major depressive disorder will be reviewed in detail. Treatments discussed will include conventional medications, herbals, omega-3 fatty acids, vitamins and other non-conventional biological treatments, exercise, and mind-body practices. This workshop will be highly interactive and is intended for psychiatrists who wish to engage in a *critically open-minded* discussion of the medical evidence for combining specific treatment modalities in depression. Participants should be prepared to discuss cases from their own practice in which patients were using both conventional and non-conventional treatments. Handouts will include papers on safety and methodological issues in integrative medicine.

REFERENCES:

1. A Clinical Manual of Complementary and Alternative Treatments in Mental Health, Eds. J. Lake and D. Spiegel, American Psychiatric Press, (in press) 2006.
2. Textbook of Integrative Mental Health Care, J. Lake, Thieme Medical Publishers, (in press) 2006.

ISSUE WORKSHOP 76
GAY MEN AND CRYSTAL METHAMPHETAMINE: A REVIEW

*Co-Chairpersons:*Eugene Lee, M.D., *8730 Alden Drive #W-101, Los Angelos, CA 90048*
Waguih W. Ishak, M.D., *8730 Alden Drive #W-101, Los Angelos, CA 90048*
Presenters: Jeffery N. Wilkins, M.D., Douglas Braun-Harvey

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to:

-*recognize* prevalence rates of crystal methamphetamine use amongst men who have sex with men (MSM)

-*differentiate* between crystal methamphetamine use, abuse, and dependence

-*understand* the factors that are likely to predispose, precipitate, perpetuate, and prevent the use of crystal methamphetamine among MSM and gay men

-*apply* both motivational interviewing techniques and sexual health-based clinical approaches to optimize patients' disclosure of crystal meth use

-*devise a multidisciplinary treatment plan* encompassing evidence-based biopsychosocial therapies for crystal methamphetamine dependence, including strategies that may be specific to gay men and MSM

SUMMARY:

Men who have sex with men are identified as at-risk for use of crystal methamphetamine. This workshop will review the biological aspects of crystal methamphetamine, as well as the psychosocial trends among gay men, that may predispose, precipitate, and perpetuate patterns of use. Specific treatment modalities will be discussed, including motivational interviewing, gay-specific cognitive behavioral therapy, pharmacotherapy, contingency management, a sexual health-based relapse prevention model, and the Matrix Model. In particular, the integration of sexual health approaches, loneliness management, and awareness of shame, may improve crystal methamphetamine treatment outcomes.

REFERENCES:

1. Levounis P and Ruggiero JS: Outpatient Management of Crystal Methamphetamine Dependence Among Gay and Bisexual Men: How Can it Be Done? Primary Psychiatry 2006; 13(2):75-80.
2. Rawson RA et al: A multi-site comparison of psychosocial approaches for the treatment of methamphetamine dependence. Addiction 2004; 99:708-717.

THURSDAY, MAY 24, 9:00 AM - 10:30 AM

ISSUE WORKSHOP 77
USING AUDIOVISUAL TECHNOLOGY TO TEACH BEHAVIORAL SCIENCES

Chairperson: Jonathan S. Davine, M.D., *2757 King Street East, Hamilton, ON L8G 5E4*

EDUCATIONAL OBJECTIVES:

1. Develop techniques to use audiovisual technology to teach behavioural sciences.

2. Learn about a case-based small group longitudinal program for teaching behavioural sciences to family medicine residents.

3. Directly experience and practice feedback techniques to an audiovisual presentation.

SUMMARY:

In this workshop, we describe the approach to the teaching of behavioural sciences to family medicine residents at McMaster Uni-

versity in Hamilton, Ontario. Instead of a block placement in the psychiatric unit, teaching takes place on a weekly half-day devoted to behavioural sciences, for the entire duration of the two year residency. During the teaching time, a psychiatric consultant is present on site in the family medicine unit. The training is problem-based, usually within small groups, utilizing cases residents are seeing in their practice. Multi-discilpinary teaching is emphasized.

The bulk of each half-day consists of a review of cases the residents have been involved with, very often on videotape. We will discuss audiovisual medium as a teaching tool. We focus specifically on giving feedback on the interview process in order to foster cohesive doctor-patient relationships and develop diagnostic acumen in a time efficient yet empathic manner. We will look at ways in which learners can develop comfort levels to present themselves on tape in front of a small group.

A significant portion of the workshop will involve an experiential process where the group will participate in a direct viewing of an audiovisual tape depicting the patient encounter. Many of the techniques used in giving feedback will be illustrated.

REFERENCES:

1. Walsh A, Davine J, Kates N. Teaching Behavioural Sciences to Family Medicine Residents: integrating training into the family practice unit. Isr J Psychiatry Relat Scie 1998; 345:114-119.
2. Westburg J, Hilliard J: Teaching Creatively With Video. New York, NY, Springer Series on Medical Education, Springer Publishing, 1994.

ISSUE WORKSHOP 78
THE PORTRAYAL OF PSYCHIATRY IN RECENT AMERICAN FILM

Chairperson: Steven E. Pflanz, M.D., *6249 Auburn Leaf Lane, Alexandria, VA 22312*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the impact of the portrayal of psychiatry in film on the public perception of psychopathology and the profession of psychiatry, as well as be able to critically analyze films containing psychiatric content.

SUMMARY:

The American film industry has long had a fascination with psychiatry. The history of film is replete with vivid images of psychiatrists and their patients. Perhaps unlike any other force in America, major motion pictures have the power to enduringly influence the public perception of mental illness, its treatments and the profession of psychiatry. In particular, the far-reaching appeal of films with success at the box office gives them a unique opportunity to shape the attitudes of everyday Americans. In order to understand the forces shaping the public perception of our profession, it is necessary to examine the images of mental illness and the mentally ill in commercially successful films. In this workshop, the audience will discuss the portrayal of psychiatry in contemporary films from the past decade, including such films as *A Beautiful Mind*, *K-Pax*, *The Hours*, *Unfaithful*, *Antwone Fisher*, *Analyze That*, *About Schmidt*, and *In Her Shoes*. Each of these films achieved a certain degree of both critical acclaim and box office success and was seen by millions of Americans. The audience will view short film clips from each of these movies, discussing each in turn. The majority of the session will be devoted to audience discussion of how we understand contemporary film to influence the image of psychiatry in America.

REFERENCES:

1. Gabbard GO, Gabbard K: Psychiatry and the Cinema, 2nd Edition. Washington, DC, American Psychiatric Press, 1999.
2. Hesley JW, Hesley JG: Rent Two Films and Let's Talk in the Morning: Using Popular Movies in Psychotherapy. New York, John Wiley & Sons, Inc., 1998.

ISSUE WORKSHOP 79
INNOVATIVE CHILD PROGRAMS DESIGNED TO INCREASE ACCESS TO CARE IN DIVERSE SETTINGS.

Chairperson: Radmila Bogdanich, M.A., *901 West Jefferson Street, P.O. Box 19642, Springfield, IL 62794-9642*
Presenters: Mary I. Dobbins, M.D., Deborah E. Seale, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium workshop, the participant should be able to: identify 3 model programs to improve patient access in underserved populations, recognize how to effectively meet the needs of providers and patients in diverse settings, identify resources to utilize telehealth technology, and learn how to overcome financial barriers to provide services to patients who are under/uninsured.

SUMMARY:

Nationally, there is a shortage of child psychiatric services. This shortage is especially evident in central and southern Illinois. In an effort to provide services to as wide a population as possible, the Department of Psychiatry developed a model child psychiatry consultation program within three diverse settings: an alternative school for emotionally and behaviorally disabled children, an academic family practice clinic, and a rural telehealth program in a commmunity health center setting. This presentation will discuss how to use existing systems of care in innovative ways to provide sustainable and affordable services.

REFERENCES:

1. Journal Article- Gazewood JD, Rollins L, Glalzka S: Beyond the Horizon: The Role of Academic Health Centers in Improving the Health of Rural Communities. Academic Medicine 2006, 81: 793-797.
2. Bower P, Garralda E, Kramer T, Harrington R, Sibbald B: The Treatment of Child and Adolescent Mental Health Problems in Primary Care: A Systematic Review. Family Practice 2001; 18:373-382.

ISSUE WORKSHOP 80
CONFIDENTIALITY IN OVERSEAS SETTINGS: THE PRIORITIZATION OF THE INDIVIDUAL VERSUS THE INSTITUTION VERSUS THE COMMUNITY

Chairperson: Herbert L. Campbell, M.D., 9300 Pretoria Place, Dulles, VA 20189

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the partipant should be able to:
--define the term confidentiality and know it is a basic patient need
--recognize that sometimes the patient may not be only an individual but may be a group, i.e. a community or an institution or company
--better understand the complexities of balancing different parties' confidentialities and rights for treatment

SUMMARY:

Confidentiality is considered a prime patient need and therefore essential for successful treatment. There are many words and concepts associated with confidentiality. Of these, trust, discretion, and

confidence all have positive connotations while secret and restricted boundaries can be seen as negative. Confidentiality in the health field is not based on a set boundary. The boundary of disclosure is flexible when security and safety are an issue. As we all know the boundary is flexible when insuarance matters are involved. A psychaitrist as a company doctor must also be flexible when setting boundaries. The five presentations of this workshop demonstrate how to adapt boundaries of confidentiality to fit different situations.

Five U.S. Department of State psychaitrists will each present a short clinical case that represents different aspects of our work as doctors overseas who have to balance the interests and confidentialities of the individual, the community, and the company. The topics of the cases include: being in the same social group as one's patient, treating the community as a patient, abuse, and managing the workplace as a treatment modality.

The key concept in each of the cases is: though the boundaries may change per situation the outcomes were therapeuticly successful because each time the boundary of confidentialty was respected due to trust, discretion, and confidence being maintained.

REFERENCES:

1. Hartmann L: Confidentiality. In Ethics Primer of the American Psychiatric Association, by the American Psychiatric Association, Arlington, VA, American Psychaitris Publishing Inc, 2001, pp39-44.
2. Beck JC: Confidentiality Versus the Duty to Protect; Foreseeable Harm in the Practice of Psychaitry, Arlington, VA, American Psychaitric Publishing Inc, 1990.

ISSUE WORKSHOP 81
SPIRITUALLY AUGMENTED WELL-BEING COGNITIVE-BEHAVIOR THERAPY
American Psychiatric Association and the World Psychiatric Association

Co-Chairpersons: Jack S. McIntyre, M.D., *2000 Winton Road South, Rochester, NY 14618*
Russell F. D'Souza, M.D., *Northern Hospital, 185 Coopers Street, Epping, Melbourne, Australia 3073*

EDUCATIONAL OBJECTIVES:

1. To describe the evolution of the spiritually Augmented Cognitive Behavior Therapy.
2. To understand the science and neurobiology of well-being
3. To understand the components of the SACBT and well being psychiatry
4. To study the randomized controlled studies that have been conducted
5. To provide a framework for the utilization of the SACBT well being Concept.

SUMMARY:

This evidence based intervention focus on the development of health and happiness, rather than merely to fight disease and distress. These effective methods focus on positive emotions and the character traits that underlie well being. The SAWCBT in seeking its objectives of well being goes beyond the conventional principles of Cognitive behavior Therapy that enables the fostering and exercising the branches of mental self governance measured as character traits in the Temperament and Character Inventory that are associated with well-being The focuss on the self transcendental character trait by adding the important dimension of existential, spiritual resources and positive emotions brings significant positive outcomes. The key cognitive areas focus on Self Acceptance, Hope, Finding meaning and seeking purpose and traversing the dimensions of forgiveness. The behavioral components include meditation and incorporating the individual's appropriate belief system including rituals and prayers which are incorporated into the treatment, useing the meditation and ritual monitoring forms. It further involves the use of a catalytic sequence of 7 well-being exercise modules for each day of the week to guide a person along the path to well-being.

The SAWCBT incorporates the longitudinal blend of physics and philosophy, the practical and the spiritual, venerable Eastern Wisdom and the cutting edge western science with the evidence of dynamic results.

The components of Acceptance, the dimensions of hope with principals of invoking and instilling hope, use of the meaning matrix together with the use of experiential values creative values and attitudinal values in helping one find new meaning and purpose beyond the catastrophic aspects of illness and set back, with in the constrains that illness and set backs might leave one in order that maximization of the reintegration on the journey that transcends successfully the task of facing mortality and set backs - a meaning and purposeful journey.

REFERENCES:

1. D'Souza Russell, Rodrigo Angelo, Spiritually Augmented Cognitive behavioral therapy Australasian Psychiatry Vol 12, No 2 June 2004.
2. D'Souza Russell, Incorporating a spiritual history in a psychiatric assessment- Australasian Psychiatry Vol 11, no 1 March 2003.

ISSUE WORKSHOP 82
PSYCHIATRIC ISSUES IN ARGENTINA

Co-Chairpersons: Michelle B. Riba, M.D., *1500 East Medical Center Drive, Ann Arbor, MI 48109-0295*
Rodolfo D. Fahrer, Sr., M.D., *J. Salguero 2436, Buenos Aires, Argentina 1425*
Presenters: Salvador M. Guinjoan, Alfredo O. Fragola, Sr., M.D., Alicia B. Vittone, M.D.

EDUCATIONAL OBJECTIVES:

1. Review several clinically important psychiatric issues in Argentina
2. Provide epidemiologic data on several major psychiatric problems, including adolescent substance abuse and dependence, and treatment resistant depression
3. Give a perspective on research in an area of psychosomatic medicine, specifically cardiac response in patients with schizophrenia.

SUMMARY:

This workshop will bring several leading psychiatrists from Argentina to discuss epidemiologic and treatment data on clinically important psychiatric issues. Topics presented will include: adolescent drug abuse, including illicit drugs and their use, abuse and dependence among adolescents and young adults; treatment of refractory depression and obsessive compulsive disorder, including vagal nerve stimulation, transcranial magnetic stimulation, deep brain stimulation and electroconvulsive therapy; and research on cardiac autonomic response in patients with schizophrenia and their unaffected first degree relatives. Members of the workshop panel, representing several psychiatric hospitals and medical schools in Argentina, will provide an overview on their research findings; clinical issues; and differences and similarities between care in Argentina and in the United States. Audience members will have an opportunity to engage in a question and answer period that will help provide perspectives on ways to organize care.

REFERENCES:

1. Ortiz Fragola A, Depression in Adolescence and Vulnerability to Addictive Disorders, Addic Disord Their Treatment, 5, 2006, 1, pp 27-34.

2. Rush JA, et al, Vagus Nerve Stimulation for Treatment Resistant Depression: A Randomized, Controlled Acute Phase Trial. Biological Psychiatry, Vol. 58, Issue 5, 2005.

ISSUE WORKSHOP 83
BUDDHIST TEACHINGS AND TECHNIQUES APPLIED TO DISASTER RELIEF; A 2 YEAR FOLLOW-UP ON SRI LANKAN TSUNAMI VICTIMS

Chairperson: Syed S. A. Naqvi, M.D., *8730 Alden Drive, Los Angelos, CA 90048*
Presenters: Viet Bui, M.D., Amy R. Dewar, M.D., Norana Caivano, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to:

1. Be familiar with basic Buddhist concepts
2. Recognize cultural variations in response to tragedy.
3. Demonstrate simple meditation techniques.

SUMMARY:

On December 26th 2004, the nation of Sri Lanka experienced a devastating tsunami where at least 38,000 died, 15,000 were injured, and 483,000 were displaced. This catastrophe left thousands of families having to cope with an incredible trauma. As the predominant religion for the largest ethnic group, Theravadan Buddhism offers individuals ways of dealing with existential questions and psychological trials. We will identify Buddhist concepts relevant to tragedy. We will review the disaster relief efforts and discuss whether Buddhist notions were incorporated into this process. We will interview psychiatrists, public health officials and Buddhist monks who live in Sri Lanka in a descriptive study. We will use a pre-identified set of questions exploring mechanisms of dealing with tragedy. These results will be reviewed. Finally, this workshop will describe Buddhist techniques of coping, primarily Vipassana meditation. The participants will receive basic instruction on meditation which can be incorporated into their own clinical practices. In conclusion, we will explore the possibilities of making a model for future disasters in the U.S.

REFERENCES:

1. Kaplan, Arline; Tsunami Aftermath in Sri Lanka-Providing Psychiatric and Psychological Assistance. Psychiatric Times 2005;22: 1-6.
2. Goenka, S.N.: The Art of Living. S.F., C.A., Harper Collins Publishers. 1987.

ISSUE WORKSHOP 84
MINORITY MENTAL HEALTH POLICY TRAINING: DEVELOPING PSYCHIATRIC LEADERS FOR CAREERS ABOUT CULTURAL COMPETENCE AND DISPARITIES REDUCTION

Chairperson: Francis G. Lu, M.D., *1001 Potrero Avenue, Suite 7M, San Francisco, CA 94110*
Presenters: Joan Y. Reede, M.D., Octavio N. Martinez, Jr., M.D., Richard J. Nunes, M.D., Katherine G. Ruiz-Mellott, M.D.

EDUCATIONAL OBJECTIVES:

Educational Objectives: At the conclusion of this workshop, the participant should be able 1) to understand the rationale and need for training leaders in minority mental health policy for cultural competence and disparities reduction 2) to understand the experiences of three ECP psychiatrists who have developed their careers in these areas through the Harvard University Fellowship in Minority Health Policy

SUMMARY:

The 2001 Surgeon General Report on "Mental Health: Culture, Race and Ethncity" documented the pervasive disparities in mental health care for ethnic minorites. Among one of the six over-arching reccomendations to reduce these disparities was workforce training at clinical, research, teaching, as well as administrative and policy-levels about cultural competence and disparities reduction. The need for a culturally diverse workforce in healthcare has also been noted in the Institute of Medicine 2004 report "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce." Yet very few training programs exist for physicians to develop their careers in minority health policy and for psychiatrists to develop their careers in minority mental health policy. This workshop will present the experiences of three ECP psychiatists who attended this one-year post-residency fellowship under the auspices of the Minority Faculty Development Program at Harvard Medical School funded by the Commonwealth Fund and the California Endowment. The training leads to a MPH or a MPA degree at Harvard and prepares the trainee to take important leadership roles in developing cultural competent systems of care aimed at reducing mental health disparities.

REFERENCES:

1. Institute of Medicine: In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce. Washington, DC, National Academies of Science Press, 2004.
2. Institute of Medicine: Unequal Treatment: Confronting RAcial and Ethnic Disparities in Health Care. Washington, DC, National Academies of Science Press, 2002.

ISSUE WORKSHOP 85
RESEARCH ON PROCEDURAL MEMORY: PRACTICAL APPLICATIONS IN DEMENTIA CARE

Co-Chairpersons: Sheila M. Loboprabhu, M.D., *116 MHCL, 2002 Holvombe Boulevard, Houston, TX 77030*
Theron C. Bowers, Jr., M.D., *2002 Holcombe Boulevard, Houston, TX 77030*
Presenters: Ellen F. Barr, L.C.S.W., Victor A. Molinari, Ph.D.

EDUCATIONAL OBJECTIVES:

Educational objectives: At the conclusion of this workshop, the participant should have a better understanding of current research on procedural memory, recognize the role of different types of memory in carrying out activities of daily living; appreciate the effect of dementia on declarative and procedural memory, and use practical applications of these concepts to care for patients with dementia.

SUMMARY:

Memory is broadly divided into declarative memory (facts) and procedural memory (skills). Another way to classify memory is explicit (conscious) and implicit (unconscious). Explicit memory can be episodic or generic; implicit memory can be procedural or associative. Declarative and procedural knowledge can be explicit or implicit. In this workshop, we consider Mizumori's hypothesis of a multiple memory system with parallel processing across neural systems (hippocampus, amygdala, and striatum play different roles). This is supported by the mouse model of Middei it al. who found that intact striatal function associated with impaired hippocampal function provides neural conditions favorable to procedural learning. Focusing on preserved forms of learning in Alzheimer's dementia (AD) may help us to understand the brain's functional reorganization when one memory system is selectively compromised by neurological disease. In normal aging, procedural memory is well preserved. In amnesia, procedural memory is spared while declarative memory

is impaired. In AD, there are multiple cognitive deficits, i.e., amnesia with at least one of the following: aphasia, apraxia, agnosia or loss of executive functioning. In AD, procedural memory is relatively preserved while declarative memory and executive functioning are impaired. A young child has only a few years of learned procedural skills, and lacks executive functioning. But in a degenerative condition like dementia, the elderly patient has a lifetime of procedural skills, and lacks executive functioning (mediated by the frontal lobe). The procedural skills of the patient with dementia can now be both an asset and a liability. Cases are discussed where preserved procedural memory in the absence of executive skills could be harmful (driving or cooking); and others where procedural memory can be used to help a patient adjust in a new setting by letting him perform familiar tasks. We make practical suggestions how to integrate literature findings and clinical practice.

REFERENCES:

1. Middei S, Geracitano R, Caprioli A, Mercuri N, Ammassari-Teule M. Preserved fronto-striatal plasticity and enhanced procedural learning in a transgenic mouse model of Alzheimer's disease overexpressing mutant hAPPswe. Learn Mem 2004;11(4):447-52.
2. Mizumori SJ, Yeshenko O, Gill KM, Davis DM. Parallel processing across neural systems: implications for a multiple memory system hypothesis. Neurobiol Learn Mem. 2004; 82(3):278-98.

ISSUE WORKSHOP 86
VIETNAM VETERANS AND THE IRAQ WAR: IS THE PAST EVER THE PAST?

Co-Chairpersons: Eric Glessner, L.C.S.W., *2196 Candlebarry Lane, Aurora, IL 60506*
Laura C. Kordon, M.D., *541 North Fairbanks, Chicago, IL 60611*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant will be able to recognize how current events and issues effect patients with Posttraumatic Stress Disorder, how past traumatic events impact interpretaion of the present, and how the clinician can effectively respond to these complaints.

SUMMARY:

Vietnam Veterans with Post Traumatic Stress Disorder (PTSD) have unique emotional reactions and responses to the US war in Iraq. This workshop will address the experiences of these patients, specifically, the presentation and manifestation of PTSD, how current issues trigger the past and how the past impacts interpretation of the present. These veterans' interpretation of current events is implicitly connected to and colored by past events. Predominant complaints of combat veterans with PTSD include sensitivity to reminders of the war, re-experiencing of past military events, and persistent avoidance of these reminders resulting in social isolation. Discussion of this topic will enhance the clinician's ability to recognize the impact and ramifications of trauma on trauma survivors. General presentations of patients with trauma and specific cases will be discussed with an emphasis on understanding how the past impacts the present and affects the patient's ability to benefit from treatment and make a connection with his/her treatment team. Both general characteristics of trauma and specific cases will be presented. Participants are encouraged to discuss case material, and are encouraged to ask questions about evaluation and diagnosis of trauma and PTSD. The workshop is designed to clarify the presentation of trauma and PTSD in the context of current events and to demonstrate the interplay of past and present in these patients.

REFERENCES:

1. Shay J: Odysseus in AMerica: Combat Trauma and the Trials of Home Coming. Schribner, 2002.
2. Holman, Alison: Getting "Stuck" in the Past: Temporal Orientation and Coping With Trauma. J of Personality and Social Psychology, 1998; 74 5:1146-1163.

ISSUE WORKSHOP 87
A ROLE FOR SELF-AWARENESS, MINDFULNESS AND MEDITATION IN PSYCHIATRIC EDUCATION

Chairperson: Robert S. Marin, M.D., *3811 O'Hara Street, Pittsburgh, PA 15213*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to:
1. Appreciate more fully the importance of self-awareness in the education and practice of psychiatry.
2. Know specific methods to use in developing courses and workshops that promote self-awareness among mental health professionals.
3. Understand some ways in which mindfulness and meditation can make for more effective and compassionate psychiatric care.

SUMMARY:

This workshop demonstrates the principles and methods of a course designed to help residents appreciate the importance of self-awareness in psychiatric education and professional growth. The course uses experiential learning - self-reflection, self-disclosure and an introduction to mindfulness meditation - to deepen participants' appreciation of the role of self-awareness in mental health care. The workshop includes some of the exercises that are actually employed in the course. The premises of the course are that: 1) Self-awareness is a cornerstone of personal and professional satisfaction. 2) Contemporary psychiatry fails to provide residents with the skills and knowledge to make use of self-awareness; 3) Residents' discontent with their education, with contemporary psychiatry, and with the world reflects uncertainty about who they are, what is really important to them, and how in daily life to realize and integrate their deepest sense of humanity; 4) Rectifying this predicament requires experiential learning; didactics, intellectual curiosity, and analytic understanding are necessary but insufficient. This is the downfall of traditional training. It is didactic, objectivist and impersonal. The antidote is learning that is experiential, subjective and personal. The workshop will introduce participants to some of the methods used to help residents integrate self-awareness into their personal and professional lives.

REFERENCES:

1. Ferrucci, P: What We May Be. New York, NY, Penguin Putnam Inc., 1982.
2. Kabat-Zin, J: Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life. New York: Hyperion, 1994.

ISSUE WORKSHOP 88
FRONTIER PSYCHIATRY: WORKING WITH STREET-INVOLVED YOUTH

Co-Chairpersons: John H. Langley, M.D., *76 Colin Avenue, Toronto, ONM5P 2C2*
Seena S. Grewal, M.D., *763 Bay Street, Toronto, ON M5G 2R3*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the key barriers involved in treating street-involved youth. They should be able to demonstrate an understanding of the common psychiatric illnesses facing street-involved youth. In addition, the workshop should provide participants with strategies

that will strengthen their skills when interacting with these youth in their own community.

SUMMARY:

According to UNICEF, tens of millions of children spend their lives on the streets (UNICEF, 2006). It is a global issue and has implications for those in the mental health field given the high incidence of psychiatric illnesses amongst these youth. Unfortunately, the psychiatric literature on mental health interventions with street-involved youth is in its infancy resulting in diverse and creative attempts to provide care. As Karabanow and Clement (2004) mention, most of the literature in this area has focused on the traits that differ between street and non-street youth as opposed to what the effective psychiatric treatments are. The purpose of this workshop is to contribute helpful and relevant information for those who work with this population.

This workshop will review the existing literature on mental health treatments for street-involved youth. Practitioners from Toronto, Canada, who provide mental health services to street-involved youth, will discuss clinical examples and experiences in setting up services for a variety of different social organizations. Recent research undertaken in these organizations will be presented which involved identifying the mental health needs of youth. It was found that a significant percentage of youths experience depression, substance abuse and suicidal ideation but that they may have moderately high levels of resilience and self-esteem. The workshop is designed to encourage others to discuss the problems affecting street-involved youth and to provide an engaging discussion where participants from around the world can share their experiences in treating this population.

Street-involved youth are a marginalized population and their health is of importance to all of psychiatry as these individuals grow up, enter the adult system and have children of their own. It is only through creating effective treatment programs that we have a chance of providing early intervention to these at-risk youth and making a difference in their lives.

REFERENCES:

1. UNICEF: The state of the world's children 2006: Excluded and invisible. New York, Unicef, 2005.
2. Karabanow and Clement: Interventions with street youth: A commentary on the practice-based research. Brief Treatment and Crisis Intervention 2006; 4:93-108.

ISSUE WORKSHOP 89
FIBROMYALGIA: CURRENT UNDERSTANDING AND FUTURE DIRECTION

Co-Chairpersons: Alan Z. A. Manevitz, M.D., *60 Sutton Place South, New York, NY 10022*
James P. Halper, M.D., *130 East 77th Street, New York, NY 10021*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to: learn to diagnose Fibromyalgia, to learn approaches to current and future clinical treatment of Fibromyalgia and to understand the pathophysiology and new research of Fibromyalgia.

SUMMARY:

Fibromyalgia syndrome (FMS) is a common, chronically painful, frequently disabling disorder of unknown origin. Epidemiologic data indicates that FMS affects at least 2-6% of the general population in the U.S. (approximately 5-12 million persons). Six to ten percent of all individuals in a medical physician's waiting room may have FMS. In addition to the pain classification criteria, FMS patients report a variety of other clinical symptoms, including psychiatrically relevant anxiety, depression, headaches, and dysfunctional sleep.

Fibromyalgia is associated with high rates of disability, increased health care utilization, more frequent psychiatric consultations and a greater number of lifetime psychiatric diagnoses than controls. More and more patients with this frustrating disorder present themselves or are referred to psychiatrists, and/or even diagnosed for the first time by psychiatrists, and are treated with psychotropic medications. In the past there was a common perception that FMS was just a manifestation of depression. We now understand the prevalence of depression in FMS is about 40%. The pain associated with FMS appears to involve many physiologic components of nociception, so the earlier perception that patients were psychosomatic malingerers has been replaced by the recognition of neurophysiologial abnormalities such as abnormal brain imaging and abnormal levels of CSF substance P. During the presentation, presenters and audiences will share cases of psychiatric disorder and abnormal pain so the psychiatrist will (1) better be able to recognize and diagnose FMS; (2) learn up-to date- clinical approaches to treatment of this complex disorder including the latest information about the use of MILNACIPRAN, PREGABLIN and DULOXATINE; (3) learn about new research findings that indicate FMS is a primary CNS disorder and thus may be better treated by psychiatrists rather than rheumatologists.

REFERENCES:

1. Arthritis Research and Therapy. Vol. 8; Issue 3; 2006.
2. Campbell LC. Clauw DJ. Keefe FJ.: Persistent pain and Depression: a biopsychosocial perspective. Bio. Psychiatry. 2003; 54(3): 399-409.

ISSUE WORKSHOP 90
PERCEPTION AND COLOR IN AFFECTIVE STATES

Chairperson: Lina I. Augius, M.D., *224 South Venice Boulevard, Suite A, Venice, CA 909291-4537*
Presenters: Suzanne Silverstein, M.A., Nima A. Fahimian, M.D.

EDUCATIONAL OBJECTIVES:

1. Review of clinical evidence for altered processing in affective disorders.
2. Review the neurophysiology of reward
3. Understand why color matters; including its implications in attention, memory and mood regulation
4. Discuss how color can be used therapeutically

SUMMARY:

An emerging field of study, psychoneuroimmunology, is being embraced by pioneering interior designers to enhance well-being, creativity and performance. This approach combines color, art, design, music and science to produce wellness-enhancing environments. Given that eighty percent of visual information is related to color, investigating the empirical evidence about the human response to color and how it can influence perception or behavior in a specific setting has implications for healthcare environments. Patients in healthcare settings are susceptible to fear, uncertainty and stress which can lead to symptoms of anxiety and depression impeding recovery.

In psychiatry, research has shown that affective disorders have a different perceived value of emotion, shape and face recognition as indicated by altered stimulus processing. Performance on the Stroop-Color-Wood test has reliably shown impairment in depression. Color can affect mood regulation by decreasing stress levels, stimulating neurocognitive pathways and creating a reward center by increasing dopamine levels. A review of the literature to better define how color is perceived in affective states, as well as how color can influence mood will inform both the worlds of design and psychiatry.

Ultimately, creating more therapeutic environments supports the biopsychosocial needs of patients, families and practitioners.

REFERENCES:

1. Lemelin S, Baruch P, Vincent A, Everett J, Vincent P.
2. Evidence for two deficient attentional processing models.

ISSUE WORKSHOP 91
MEDICAL BOARD OF CALIFORNIA MEDICAL EXPERT WITNESS TRAINING

Chairperson: Matthew F. Carroll, M.D., *3131 Camino del Rio North, Suite 270, San Diego, CA 92108*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to demonstrate an awareness of how the medical board functions. The participant will understand issues including quality of care, documentation, sexual misconduct, boundary violations, drug and alcohol violations and standards of care. The particiapnt will recognize the psychiatrists role in assisting the medical board.

SUMMARY:

This workshop will include presentations by the Supervising Investigator of the Medical Board, the District Medical Consultant, and the Deputy Attorney General of the Office of the Attorney General, Health Quality Enforcment Section, San Diego. We will address the Board's history, the enforcement process, the case review process, and the role of the expert reviewer. The workshop will address issues including quality of care and physician misconduct. The workshop will also discuss what the board expects in a psychiatric examination and professional competency examinations.

REFERENCES:

1. Sweet L: Preventive medicine and the seven deadly sins: avoiding discipline against your medical license. Medical Board of California Action Report, July 2006: 6-7.
2. Morrison J, Morrison T: Psychiatrists disciplined by a state medical board. Am J Psychiatry 2001 ;158:474-478.

ISSUE WORKSHOP 92
RACIST REALITY: AN ASSESSMENT OF REPRESENTATIONS OF MINORITIES IN REALITY TELEVISION PROGRAMMING.

Chairperson: Curley L. Bonds II, M.D., *1720 East 120th Street, Los Angelos, CA 90059*
Presenters: Austina Cho, M.D., Eve Maremont, M.D.

EDUCATIONAL OBJECTIVES:

1. At the conclusion of this workshop, the participant should be able to better understand and recognize racism in the media and the stressors related to being victimized by racism.

2. At the conclusion of this workshop, the participant should be able to understand how negative media portrayals of minorities may negatively impact self-esteem and body image of minority patients.

3. Participants will learn about the negative psychological and physiological responses to racism.

SUMMARY:

The current proliferation and success of "reality television" shows raise many opportunities for new insights into human behavior, but they simultaneously raise numerous questions about media portrayals of minorities. The recent controversy surrounding the producers' decision to racially divide tribes on the popular series *Survivor* points to the reality that these shows often capitalize and encourage racial comparisons and conflicts. While shows such as *Big Brother, The Apprentice, Fear Factor* and *The Real World* can offer unique insights into personality and human responses under duress, they often cast minority contestants in a negative and stereotypical light. Other shows including *Extreme Makeover* and *The Swan* promote Western concepts of idealized beauty attained through the use of cosmetic surgery with limited consideration for cultural variability or the potential for psychiatric diagnoses such as Eating Disorders or Body Dysmorphic Disorder. The groundbreaking FX series *Black.White* took racial exploration to a new level by having a black and white family change places using extensive makeup. While thought provoking, these same shows may be sending undesirable conscious and unconscious messages about ethnicity. It is well established that racism and the viewing of racist imagery adversely affects physical and psychological wellbeing. As reality show audiences grow, so does their influence on perceptions of people of color for those who have limited exposure to minorities. This workshop is intended to allow participants to discuss what impact the 60-minute packaging of human experience on reality shows may have on the expectations and psychological health of their viewers, our patients.

REFERENCES:

1. Narin R, Pega F, Mccreanor T: Media, Racism, and Public Health Psychology. Journal of Health Psychology 2006 Mar;11(2):183-96.
2. Harrell JP, Hall S, Taliaferro, J: Physiological Responses to Racism and Discrimination: An Assessment of the Evidence. American Journal of Public Health. 2003; 93:243-248.

ISSUE WORKSHOP 93
THE 4 A'S OF COLLABORATIVE MENTAL HEALTH CARE: ACCESSIBLE, ACCOUNTABLE, APPROPRIATE AND AFFABLE.

Chairperson: John M. Haggarty, M.D., *580 North Algoma Street, Thunder Bay, ON P7B 5G4*
Presenters: Jennifer Lehto, R.N., James Goertzen, M.D., Randy B. Goossen, F.R.C.P.C., Tammy E. McKinnon, M.S.W., Jatinder Takhar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to:

1. Demonstrate an understanding of the critical and essential components (4 A's) of successful collaborative mental health care in the primary care setting.

2. Recognize and anticipate pitfalls/barriers within the collaborative experience, and display an understanding of how to respond to these occurrences.

3. Realize the value of the diverse perspectives of each clinician in the mental health team.

SUMMARY:

This interactive workshop will address critical and essential components for any psychiatrist or mental health clinician undertaking Collaborative, Integrative, or Shared Mental Health care in the primary care setting. Each presenter will cover the four A components as they relate to :

1. Start-up
2. Maintaining
3. Evaluating and
4. Growing mental health care within primary care settings.

Perspectives from a panel of Canadian experts in the field will include: family physician, social work, nursing, and psychiatry. Each will provide important insights and practical guidance to tackle many of the challenges of delivering mental health care in the primary care setting. Each component of access, accountability, appropriate-

ness, and affability will be threads through the stages of developing and maintaining collaborative relationships with primary care providers. The workshop will include a panel presentation from members' diverse perspectives, a review of the literature, research from the field, and a summary of recent Canadian qualitative and quantitative findings. An active exchange with participants should be expected, as we hope to share the experiences of those attending. The success of collaborative mental health care can be greatly enhanced with attention to the four A's.

REFERENCES:

1. Strathdee G, Brown RM, Doig RJ.: Psychiatric clinics in primary care. The effect on general practitioner referral patterns. Soc Psychiatry Psychiatr Epidemiol 1990; 25:95-100.
2. Emmanuel JS, McGee A, Ukoumunne OC, Tyrer P. : A randomised controlled trial of enhanced keyworker liaison psychiatry in general practice. Soc Psychiatry Epidemiol 2002; 37:261-266.

ISSUE WORKSHOP 94
REFRACTORY SCHIZOPHRENIA: TREATMENT ISSUES
American Association of Practicing Psychiatrists

Co-Chairpersons: Michael Y. Hwang, M.D., *385 Tremont Avenue (116A), East Orange, NJ 07018-1095*
Miklos F. Losonczy, M.D., *385 Tremont Avenue (116A), East Orange, NJ 07018-1095*
Presenters: Jean-Pierre Lindenmayer, M.D., Naveed Iqbal, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of workshop participant will be familiar with the current state of knowledge regarding diagnostic and treatment issues in chronic, treatment refractory schizophrenia.

SUMMARY:

Schizophrenia spectrum disorder encompasses diverse clinical phenomena and biological pathogenesis. These clinical and biological diversity in schizophrenic illness continue to challenge practicing clinicians in their assessment, treatment, and rehabilitation.

Current clinical evidence suggest that the schizophrenic spectrum disorder consist substantial proportion of treatment refractory schizophrenic patients possess co-existing psychiatric symptoms such as depression, anxiety, and impulsive-aggressive behaviors. Furthermore, a comorbid medical condition challenge practicing clinicians in the phamacological treatment chronic, elderly patients with schizophrenia. In addition, wide of teh new atypical antipsychotic medication and wide spread use of the adjunctive phamacotherapy further confounded their care. Recent clinical and research evidence increasingly suggests in-depth clinical psychosocial assessment and long-term rehabilitation therapy result in the optimal, long-lasting outcome.

The proposed workshop will review the recent research evidence and discuss the treatment issues in management of chronic treatment refractory schizophrenia. Dr. Hwang will review the treatment of refractory schizophrenia with co-existing psychiatric symptoms. Dr. Iqbal will review and discuss the clinical issues in management of high-risk impulsive-aggressive schizophrenia. Dr. Lindenmayer will review and discuss common pharmacotherapeutic issues in treatment refractory schizophrenia. Dr. Losonczy will present the current research findings and clinical issues of psychotherapy and rehabiluitation in chronic institutionalized patients with schizophrenia.

At end of the presentation participants will be encouraged to share their clinical experience.

REFERENCES:

1. Hwang MY, Bermanzohn PC: Schizophrenia and comorbid conditions: diagnosis and treatment, Washington, DC, American Psychaitric Press,2001.
2. Hwang MY (Gust Editor): Management of schizophrenia. Psychiatric Annals 2004.

THURSDAY, MAY 24, 2007

ISSUE WORKSHOP 95
CAREGIVERS IN BIPOLAR FAMILIES: PATIENTS AND PARTNERS IN TREATMENT

Co-Chairpersons: Igor I. Galynker, M.D., *First Avenue at 16th Street, New York, NY 10003*
Susan Tross, Ph.D., *First Avenue at 16th Street, New York, NY 10003*
Presenters: Nancy C. Maruyama, M.D., Ramin Mojtabai, M.D., Ph.D., Lucy Lamphere, B.A., Katherine DuHamel, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to (1) recognize the key features of caregiver burden in Bipolar Disorder including caregiver psychiatric morbidities (2) discuss successful models for family approaches to treatment, and (3) sustain involvement of Bipolar patients and their caregivers in family-oriented treatment.

SUMMARY:

Two compelling factors press for active engagement of caregivers in bipolar families. First, Bipolar Disorder can become a catastrophic stress on caregivers in bipolar families. Because of caregiver burden strain and due to caregivers' own psychiatric morbidity (i.e., expressed emotion), caregivers can, themselves, become 'hidden' patients, in need of treatment and support. Second, engagement of caregivers, as a regular feature of treatment, can help support the bipolar patient's recognition of early signs of illness, enhance treatment adherence, and avert crises as they evolve.

Yet there is little precedent for family approaches to treatment of bipolar patients. In this workshop, we will: (1) review the literature on caregiver burden and psychiatric morbidity in caregivers of persons with Bipolar Disorder; (2) examine the current models of self-help and support available through organizations like the National Alliance for the Mentally Ill; (3) review the existing literature on family treatment of bipolar patients; and (4) discuss a comprehensive model for caregiver involvement in the treatment of bipolar patients, which matches intervention strategy to stage of illness, throughout the course of illness.

The panel will also discuss recommendations for: engaging bipolar patients and caregivers in family treatment; sustaining involvement; pitfalls in involving caregivers; and solutions for these pitfalls.

REFERENCES:

1. Clarkin, JF, Carpenter D, Hull J, Wilner P, Glick I: Effects of psychoeducational intervention for married patients with bipolar disorder and their spouses. Psychiatric Services 1998; 49(4): 531-533.
2. Miklowitz DJ, Simoneau TL, George EL, Richards JA, Kalbag A, et al.: Family-Focused Treatment of Bipolar Disorder: 1-Year Effects of a Psychoeducational Program in Conjunction with Pharmacotherapy. Society of Biological Psychiatry 2000; 48: 582-592.

ISSUE WORKSHOP 96
GENDER BENDERS IN FORENSIC PSYCHIATRY

Chairperson: Susan J. Hatters-Friedman, M.D., *11100 Euclid Avenue, Hanna Pavilion, Cleveland, OH 4410*
Presenters: Renee M. Sorrentino, M.D., Joy Stankowski, M.D., Charles Scott, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to: demonstrate knowledge of alternate offenders and victims than often considered. The participant will (a) review common features of paternal filicide, (b) understand current research about female sex offenders, (c) become more aware of sexual harassment of men, and (d) consider sexual issues between female therapists and male patients.

SUMMARY:

"Gender Bender" will cover topics in forensic psychiatry, presenting information about the opposite gender than is usually discussed. Though most homicide is committed by men, perpetrators of filicide (child murder by parents) have a more even sex distribution. Among US children under age 5 who were murdered in the last quarter of the twentieth century, 31% were killed by their fathers, and 30% by their mothers. faculty will discuss common factors in a review of paternal neonaticide and filicide. Although men commit the majority of sexual offenses, research indicates that women commit approximately one-fifth of sex offenses against children. Research about female sex offenders, evaluation, pathophysiology, and treatment will be explored. Claims of sexual harassment against men include same-sex harassment and female-on-male harassment. Over the past decade, claims made to the EEOC about sexual harassment against men have increased. We will discuss male victims of sexual harassment. Finally, female therapist-male patient scenarios will be discussed.

REFERENCES:

1. Friedman SH, Hrouda DR, Holden CE, Noffsinger SG, Resnick PJ: Filicide- Suicide: Common Characteristics of Parents who Kill their Children and Themselves. Journal of the American Academy of Psychiatry and the Law. 2005, 33(4):496-504.
2. Kaplan MS, Green A: Incarcerated female sexual offenders: A comparison of sexual history with eleven female nonsexual offenders. Sexual Abuse: A Journal of Research and Treatment, 1995; 287-300.

ISSUE WORKSHOP 97
A STIGMA OF MUCH SUBSTANCE: EDUCATIONAL SKILLS TO ENHANCE TRAINEES ATTITUDES AND APPROACHES TO SUBSTANCE USE AND CONCURRENT DISORDERS

Chairperson: Heather Flett, M.D., *250 College Street, Toronto, ON M5T 1R8*

EDUCATIONAL OBJECTIVES:

At the end of this workshop attendees should be able to:

1) Describe the concepts of addiction stigma within healthcare and the impact on individuals with substance use disorders.

2) Acquire teaching methods to help learners develop professional attitudes towards this population

3) Understand their attitudes regarding substance use disorders and the impact of such attitudes.

SUMMARY:

Common stereotypes of the "addict" include personal responsibility for mental illness and substance use, amorality, dangerousness, and can conjure up images of dishevelled street people injecting HIV infected needles. It is a sad reality that within the hidden medical curriculum such attitudes exist. When these thoughts exist within a health care provider, it can interfere with their ability to provide proper care

A learning objective identified as very difficult to teach is the development of professional attitudes towards individuals with substance use and concurrent disorders. This requires the ability to reflect on personal views and prejudices and see persons with substance use disorders as bona fide patients.

This workshop addresses techniques on identifying and dealing with the stigma that exists for individuals with "addictions."

The presenters will review the current literature on the topic to help frame interactive, experiential learning exsercsies. These exercises/ methods have shown to be of great utility for helping learners develop professional attitudes towards people suffering from addiction issues. These include exposure tehcniques, reflection, and role-play scenarios. Particpants will leave the workshop with some methods to teach professionalism and support the development of positive attitudes towards their patients.

REFERENCES:

1. Journal Article: Karam-Hage et al. : Modifying Residents' Professional Attitudes about Subtance Abuse Treatment and Training. Am J Addictions 2001;10:40-47.
2. Chapter in book:- Rasinski et. al. Stigma and Substance Use Disorders. In On the stigma of mental illness : Practical Strategies for Research and Social change, edited by Patrick Corrigan, Washington, APA Publishing, 2005, pp219-237.

ISSUE WORKSHOP 98
ADAPTING THE ACT MODEL FOR THE NEEDS OF DIFFERENT COMMUNITIES: A COMPARATIVE CASE STUDY OF TWO JAPANESE AND CANADIAN ACT TEAMS

*Co-Chairpersons:*Molyn Leszcz, M.D., *600 University Ave., Toronto, ON M5G 1X5*
Wendy S. Chow, M.S.W., *260 Spadina Avenue, Totonto, ON M5T 2E4*
Presenters: Miyuki Shiida, M.S.W., Joel Sadavoy, M.H.S.C.

EDUCATIONAL OBJECTIVES:

This paper, explores the generalization and adaptability of Assertive Community Treatment (ACT) model in ethno-specific populations by comparing the adherence to ACT models, patients' demographic and clinical profiles, treatment outcomes of two ACT teams from tadapatations of ACT in response to the specific needs of each communitywo countries - Mount Sinai Hospital ACT Team in Toronto, Canada and the Kuina Center ACT Team in Hitachinaka, Japan.

Participants will learn ACTT model is also effective in ethnospecific populations as well as the adapatations of ACT in response to the specific needs of ethnospecific communities.

SUMMARY:

The ACT model, as implemented in various jurisdictions, has very specifically defined and prescribed structures and clinical interventions (Stein, 1980). The MSH ACT Team (ACTT), which adapted the ACT guidelines to ethno-specific populations, has demonstrated the effectiveness of its model despite modifications to the prescribed ACT model (Yang, 2005). This successful outcome suggested that there is flexibility within the model which allows it to be adapted to different cultural and clinical environments while maintaining or enhancing clinical effectiveness.

This study was undertaken to determine if the successful outcomes of Mount Sinai ACTT can be generalized to Japanese ACTT. We expect that the study will begin to lead us to understand which of

the ACT elements are essential versus those which can be modified. These questions were viewed as especially important for those countries which are new to the ACT model and are considering using the ACT model to enhance their community support and treatment programs.

We found that the reduction of hospitalization relapses and severity of symptoms are significant and comparable in both teams. It is suggested that the ACT model is effective in ethno-specific populations and Asian countries. While both teams scored high in the fidelity scale developed by Dartmouth Assertive Community Treatment Team, certain modifications have been made to tailor the treatment model for the patients living within different cultural contexts. The adaptation models, such as cultural competency model and structural adaptations for both teams in response to the specific cultural needs of the clients, were discussed in the workshop.

REFERENCES:

1. Yang J, Law S, Chow W. et al: Assertive Community treatment for persons with severe and persistent mental illness in ethnic minority groups, Psychiatric Services, pp 56, 1053-1055, 2005.
2. Bond GR, Drak RE, Mueser KT, et al.: Assertive community treatment for people with severe mental illness: Criticual ingredients and impact on patients. Disease Management & Health Outcomes 9:141-159, 2001.

ISSUE WORKSHOP 99
CLINICAL PATHWAYS FOR MOOD AND ANXIETY DISORDERS

Chairperson: Waguih W. IsHak, M.D., *8730 Alden Drive, W101, Los Angelos, CA 90048*

EDUCATIONAL OBJECTIVES:

1. Recognize the importance of evidence-based techniques for effective treatment of mood and anxiety disorders.
2. Demonstrate basic skills of using clinical pathways
3. Develop an understanding of the main lessons learned from large trials that utilize pathways such as STAR*D.

SUMMARY:

Clinical pathways document potential steps in the diagnosis and treatment of a condition or procedure for individual patients. Their usefulness in guiding clinicians through the steps of non-response or partial response to interventions has been documented. These are predominantly management tools and are based on clinical information developed from evidence-based psychiatry, practice guidelines or expert consensus statements. Pathways may not be appropriate for use in all circumstances, nor are they a substitute for the practitioner's experience and judgment. Their applicability must be assessed by the responsible practitioner in light of relevant circumstances presented by individual patients in order to optimize treatment. The NIMH STAR*D trial is the first large trial in the field to use this approach with the goal of developing clinical strategies to improve outcomes in depression.This presentation will focus on the use of clinical pathways in mood and anxiety disorders. The participants will become familiar with examples of an outcome monitored depression treatment pathway and an outcome monitored anxiety treatment pathway in addition to relevant NIMH STAR*D findings.

REFERENCES:

1. IsHak WW: Clinical Pathways in Mood and Anxiety Disorders. CNS Spectrums, December 2004.
2. Fava M, Rush AJ Current Status of Augmentation and Combination Treatments for Major Depressive Disorder: A Literature Review and a Proposal for a Novel Approach to Improve Practice. Psychotherapy and Psychosomatics 75:139-153, 2006.

ISSUE WORKSHOP 100
FINDING BALANCE; THE APPLICATION OF YOGA TO MENTAL HEALTH

Co-Chairpersons: Syed S. A. Naqvi, M.D., *8730 Alden Drive, Los Angelos, CA 90048*
Tara A. Klein, M.D., *8730 Alden Drive, Los Angelos, CA 90048*
Presenters: Monisha Vasa, M.D., Carla Mandili, M.D.

EDUCATIONAL OBJECTIVES:

This workshop is intended for all mental health professionals. Forty-five minutes will be lecture-based, followed by a twenty minute guided meditation and yoga demonstration to provide the audience with a first hand experience of the techniques discussed.

At the conclusion of this symposium workshop, participants will have an understanding of the language of Vedic science that will allow them to engage in a dialogue with their patients about the practice of yoga, and the participants will be able to recognize which patients and conditions would most benefit from a practice of yoga.

SUMMARY:

More than 10 million Americans engage in a regular practice of yoga and meditation, and the body of knowledge demonstrating the biochemical, physiological, and psychological benefits of this practice continues to grow. Evidence has shown that pranayama, yogic breathing, can improve memory and decrease anxiety, asanas, yoga poses, can boost the immune system leading to an increased number of natural killer cells, and dhyana, the development of awareness through meditation, is associated with lower levels of cortisol and a reduction in relapse rates of recurrent depression. The objective for this workshop is to introduce the psychiatrist to the system of Indian philosophy called Vedic science, which describes mental health as a balance of energy that unifies the body, mind, and soul, and to describe how the practice of yoga, through pranayama, asanas, and meditation, can create the balance and flexibility essential to mental health. After discussing the theory behind the practice of yoga, we will review the evidence based data examining the application of yoga in the treatment and prevention of mental illness. We will demonstrate that a regular practice of yoga can lead to significant improvements in mental health, and that as psychiatrists, we need to have an understanding of this practice so that we know when to recommend it as a primary or complimentary therapy to optimize the mental health of our patients.

REFERENCES:

1. Chopra D, Simon D: The Seven Spiritual Laws of Yoga - A practical Guide to Healing the Bod, Mind, and Spirit.
2. Mason O:A qualitati ve study of mindfulness-based cogntive therapy for depression. Br J Med Psychology 2001; 74(Pt 2):197-212.

ISSUE WORKSHOP 101
AKATHISIA: AN ELUSIVE PHENOMENON

Co-Chairpersons: Naveed Iqbal, M.D., 5 West Main Street, Elmsford, NY 10523
Peter Weiden, M.D., *450 Clarkson Avenue, Brooklyn, NY 11203*
Presenter: Gabe Goldfeder, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to: Understand how to diagnose akathasia as well as appreciate the pathophysiology of this phenomenon. In addition participants will be able to understand different sub-types of akathasia. Furthermore, the participants will be able to appreciate the usefulness of using various rating scales to diagnose akathasia in

clinical practice. Ultimately the participants will be able to optimally treat akathasia.

SUMMARY:

Akathasia was first reported by Haskovic in 1902, in the pre antipsychotic era. However more recently the term akathasia is used mainly to describe the medication related side effect. Clinically the recognition as well as the treatment of akathasia is not very well understood. Akathasia is often mistaken for agitation or withdrawal symptoms; this confusion often leads to unsuccessful treatment of the phenomenon. This workshop will aim to give a better understanding of the pathophysiology of akathasia. In addition the audience will gain skills in recognizing and treating various subtypes of akathasia. We will discuss how to utilize rating scales in recognizing and treating akathasia.

REFERENCES:

1. Stroup ST, Krauss JE, Marder SR: Pharmacotherapies. In a Textbook of Schizophrenia, edited by Lieberman, JA, Stroup, TS, Perkins, DO,Washington D.C., 2006, pp 303-325.
2. Sachdev P:The development of the concept of akathasia: a historical overview. Schizophrenia Research 1995; 16: 33-45.

ISSUE WORKSHOP 102
A MALPRACTICE LAWSUIT PRIMER

Co-Chairpersons: Abe M. Rychik, J.D., *233 Broadway, New York, NY 10279*
Eugene Lowenkopf, M.D., *150 East 77th Street, New York, NY 10021*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: (1) understand the process of a medical malpractice suit; (2) participate more effectively within the legal system; (3) know the relevant legal issues and the standards in responding to accusations in a court of law.

Each presenter will speak for 30 minutes followed by a 30 minute quesiton and answer period.

SUMMARY:

In every malpractice lawsuit there are a number of critical junctures at which time the physician and the attorney can positively or negatively affect the outcome of the suit, regardless of the merits of the case. This workshop presents one case from the viewpoint of the defendant psychiatrist and the defendant's attorney, with emphasis on the decisions and actions to be taken, which in this case contributed to a verdict in favor of the defendant.

The workshop presents the general legal framework and discusses the issues that arise. It offers concrete recommendations for a successful litigation outcome.

Included in this workshop are an examination of the following issues:

a. What constitutes malpractice?
b. Venue (State or Federal) considerations.
c. Reporting requirements and insurance policy concerns.
d. Role of the insurer vis-à-vis the lawyer and the defendant.
e. Pre-litigation discovery.
f. The pleadings.
g. The discovery process (depositions, interrogatories, fact and expert documents).
h. Plaintiff and Defendant strategies.
i. Trial proceedings.
j. Post-trial activity.
k. Issues of licensure and the National Practitioner's Databank.

In summary, this workshop will provide the audience with basic knowledge and recommendations on how to most effectively proceed in a malpractice litigation.

REFERENCES:

1. Lowenkopf, EL, Memoirs of A Malpractice Suit, Jnl of Am Acad. Psychoanalysis, 23(4): 731-748, 1995.
2. Simon, RI Concise Guide to Psychiatry and Law for Clinicians, Second Edition. Washington D.C.: American Psychiatric Press, 1998.

ISSUE WORKSHOP 103
MULTIDISCIPLINARY TREATMENT OF CHRONIC PAIN

Chairperson: Vladimir Bokarius, M.D., *8730 Alden Drive, Room E123, Los Angelos, CA 90048*
Presenters: Steven Richeimer, M.D., Ali Nemat, M.D., Lisa Victor, Ph.D., Yogi Matharu, O.C.S, Mary Kay Wolfe, O.T.D

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate the knowledge of the methodology of management of chronic pain in the multidisciplinary clinic including state of the art interventional pain management, pharmacological and psychopharmacological treatment, psychotherapy, physical therapy, and occupational therapy.

SUMMARY:

Chronic pain is estimated to affect 15% to 33% of the U.S. population. Pharmacological or other types of treatments help most people control their pain. However, for many patients currently available methods of pain treatment are either not effective or can cause serious side effects. Besides, comorbid mental disorders may significantly complicate the course of treatment. Our center utilizes the most advanced technology for patient's physical improvement, as well as treatment to strengthen the patients' emotional ability to cope with debilitating effects of pain, and to promote the patients' return to a fully productive life. The goal of this presentation is to show the role of the combined effort of different healthcare professionals in the treatment of chronic pain.

REFERENCES:

1. Coughlin AM, Badura AS, Fleischer TD, Guck TP: Multidisciplinary treatment of chronic pain patients: its efficacy in changing patient locus of control. Arch Phys Med Rehabil 2000; 81: 739-40.
2. Victor L, Richeimer SM: Psychosocial therapies for neck pain. Phys Med Rehabil Clin N Am 2003; 14:643-57.

ISSUE WORKSHOP 104
ADDRESSING THE NEEDS OF COMMUNITY DWELLING OLDER SCHIZOPHRENIC PERSONS

Chairperson: Carl I. Cohen, M.D., *450 Clarkson Avenue, Brooklyn, NY 11203*
Presenters: Ipsit Vahia, M.D., Azziza O. Bankole, M.D., Shilpa P. Diwan, M.D., Pia N. Reyes, M.D., Colin Depp, Ph.D., John Kasckow, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to understand the multiple factors that can affect outcome in older adults with schizophrenia. They should also be able to appreciate the need for interventions that can be implemented at minimal cost without significant infrastructure requirements that can positively affect outcome of illness and comorbidity in the older schizophrenia patient.

SUMMARY:

It is estimated that the number of persons aged 55 and over with schizophrenia will double over the next two decades to over 1 million

persons, and more than 85% of these persons will be living in community settings. Nevertheless, only 1% of the schizophrenia literature has been devoted to older adults, and the treatment intervention research is especially sparse. There is a pressing need to identify points of intervention that will impact care of these patients, and to develop cost effective models that can be implemented to reduce morbidity and mortality associated with schizophrenia.

In this workshop, we will briefly review the literature including findings from our recent studies. We will address the following topics: the epidemiology of schizophrenia in later life; the various complexities of outcome such as the 4 categories of psychoses and depression and their association with cognitive, adaptive functioning, and quality of life; recent cross-national data on various outcome measures in later life; and factors that influence the adequacy of health care in this population. With respect to the latter, we also present recent findings on communication difficulties arising between psychiatrists and primary care providers in the care of this population. We will next describe various psychosocial and pharmacological approaches that have been used with respect to the various outcome dimensions. Finally, we will explore with workshop participants ideas for developing novel strategies for assisting this population.

REFERENCES:

1. Cohen CI: Schizophrenia into Later Life, New York, American Psychiatric Publishing Inc, 2003.
2. Folsom DP, McCahill M, Bartels SJ, Lindamer LA, Ganiats TG, Jeste DV.: Medical comorbidity and receipt of medical care by older homeless people with schizophrenia or depression.Psychiatr Serv. 2002 Nov;53(11):1456-60.

ISSUE WORKSHOP 105
FROM LAB TO CLINICAL PRATICE: BIOLOGY AND TREATMENT OF DEPRESSION AND POST TRAUMATIC STRESS DISORDER

Co-Chairpersons: Marlene A. Wilson, Ph.D., *USC School of Medicine, Building 1, Room D26, Columbia, SC 29208*
Meera Narasimhan, M.D., *3555 Harden Street, Suite 104-A, Columbia, SC 29203*
Presenters: Travis O. Bruce, M.D., Lawrence P. Reagan, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium workshop, the participant should be able to demonstrate an understanding of new advances in research involving the neurobiology of depression and post-traumatic stress disorder. This understanding should help the participant with successful integration of future research developments as they continue to change the direction of treatment for these illnesses.

SUMMARY:

The neurobiology of stress has implication on the development of mood and anxiety disorders. Major Depressive Disorder and Post Traumatic Stress Disorder show a significant overlap in the pathophysiology as well as clinical presentation. Given the rising prevalence rates of both these disorders there is an urgent need to identify biomarkers and neurobiological correlates of treatment response.

Advances in the neurobiology of posttraumatic stress disorder and depression are rapidly increasing our understanding of the physiological mechanisms involved in these devastating illnesses. Recent studies have expanded upon the knowledge of the relationship between the hypothalamic-pituitary-adrenal axis, the sympathetic nervous system, and the relationship between hypocortisolaemia despite hypersecretion of corticotropin-releasing factor (CRF). Preclinical studies suggest that morphological and neurochemical changes in the amygdala and hippocampus may contribute towards the pathophysiology of anxiety and depression. The effects of antidepressants on monoamines, intracellular protein, neurotrophic factors, and SERT regulation and expression as well as novel treatment options such as CRF-antagonists provide hope for a cure as opposed to palliative symptom-based treatment.

A clear understanding of integrative model of resilience and vulnerability that encompasses the neurochemical response may shed some light on the neurobiological underpinnings of both these illnesses. Novel developments in the field of depression and PTSD research in identifying these biomarkers, their utility in clinical practice and future drug development are exciting arenas that would help us get a step closer to the potential etiology and understanding the intricacies of their action.

REFERENCES:

1. R.S Duman, J Malberg S et al: Neuronal plasticity and survival in mood disorders. Biological Psychiatry 2000; 48: 732-739.
2. Newport, DJ and Nemeroff CB: Neurobiology of posttraumatic stress disorder. Current Opinion in Neurobiology. 2000; 10:211'218.

ISSUE WORKSHOP 106
THE ULTIMATE GOAL: A MODULAR APPROACH TO PSYCHOSIS?

Chairperson: Wolfgang Gaebel, M.D., *Bergische Landstrasse 2, Duesseldorf, Germany D-40629*
Presenters: Juergen Zielasek, M.D., Franz Müller-Spahn, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to describe novel diagnostic approaches towards psychotic disorders, including the current development of new psychiatric classification systems, and modular approaches in the cognitive neurosciences using functional psychopathology as a diagnostic and research tool.

SUMMARY:

Increasing evidence obtained with genetic and neurobiological methods generates the need to rethink our current psychiatric classification systems. In this symposium, we will focus on the pathophysiology of psychotic psychopathology. Some genetic risk factors like neuregulin-1 seem to predispose individuals to a psychotic phenotype beyond the traditional classificatory boundaries between organic psychoses in Alzheimer's disease, bipolar affective disorder, and schizophrenia. Still, there is a large gap between neuroscientific findings and psychopathological phenomenology.

This workshop aims to understand the implications of these findings for the classification and diagnosis of psychotic disorders. We will first describe the current effort to deconstruct the term,psychosis" based on findings from genetics and neurobiology. We will then review the current approach towards redefining psychosis for the new psychiatric classification systems DSM-V and ICD-11, which are currently being developed. We will review concepts of modularity in the neurosciences and will describe how dynamic networks of brain modules may act as substrates for noxious stimuli leading to psychotic phenomenology. We will then discuss concepts bridging the gap between neurobiological findings and clinical psychiatric phenomenology using a functional approach towards psychopathology as the main method both for psychiatric classification and research purposes.

REFERENCES:

1. Fodor J: The modularity of mind. Cambridge, MA, MIT Press, 1983.
2. Murphy D, Stich S: Darwin in the madhouse: evolutionary psychology and the classification of mental disorders. In Evolution

and the human mind. Modularity, language and meta-cognition. Cambridge, Cambridge University Press, 2000, pp. 62-92.

ISSUE WORKSHOP 107
CASE STUDIES USING VIDEO PLAYBACK IN COUPLES' THERAPY

Chairperson: Ian E. Alger, M.D., *500 East 77th Street, New York, NY 10162-0021*
Presenter: Anita Menfi, R.N.,

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should be able to (1) identify critical stages of couples therapy and (2) have developed an increased awareness of the clinical benefits of video playback.

SUMMARY:

Participants will have the opportunity to view clinical examples of couples treatment with the leader. Through the use of video playback they will identify issues of impasse and stress during different stages of couples treatment, including engagement, problem identification, change facilitation and termination. Workshop participants will have the opportunity of discussing their own clinical experiences relating to problems of dual career couples; sexuality and intimacy; and issues involving children as well as extended family members, and peer and friendship networks.

REFERENCES:

1. Alger, I: Marital Therapy with dual career couples. Psychiatric Annals 1991:21:8.
2. Rynearson, Robert: Profile Self-Confrontation Handbook for Marital Professionals; in press.

ADVANCES IN TREATMENTS OF PSYCHIATRIC DISORDERS

TREATMENTS OF PSYCHIATRIC DISORDERS

Chairperson: Glen O. Gabbard, M.D., *Baylor College of Medicine, Department of Psychiatry, Houston, TX 77030*

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant will demonstrate knowledge of the current treatments for PTSD, histrionic personality disorder, depression, body dysmorphic disorder, and antisocial personality disorder.

SUMMARY:

This symposium provides a state-of-the-art overview of specific treatments for five different psychiatric disorders. Charles Marmar presents the latest findings on the pharmacotherapy and psychotherapy of Post-Traumatic Stress Disorder; Glen Gabbard discussed psychotherapeutic strategies with patients who have histrionic personality disorder; Jan Fawcett outlines the optimal combined treatment approach to depression using both psychotherapy and pharmacotherapy; Katherine Phillips provides the latest data on medication and psychotherapy in the treatment of body dysmorphic disorder; and Reid Meloy discusses the current thinking on the treatment for antisocial personality disorder.

ADVANCES IN TREATMENT OF PSYCHIATRIC DISORDERS

Presenter: Katharine A. Phillips, M.D., *Butler Hospital/Brown Medical School, 345 Blackstone Blve., Prividence, RI 02906*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to diagnose BDD and be familiar with medication and psychotherapy treatment strategies for this disorder.

SUMMARY:

Body dysmorphic disorder, a preoccupation with an imagined or slight defect in physical appearance, is a relatively common disorder that often goes unrecognized and untreated in clinical practice. It is important to recognize BDD and target it in treatment, because this disorder is associated with poor functioning, markedly poor quality of life, and high rates of suicidality. Patients with BDD can be very challenging to treat, however, because they often are severely ill, reluctant to reveal their BDD symptoms, have poor insight, and pursue cosmetic treatment (e.g., surgical or dermatologic), which is usually ineffective for BDD symptoms. This presentation, which will be based on empirical data and informed by clinical experience, will provide an up-to-date overview of the treatment of BDD. It will focus on the following: 1) How to recognize and diagnose this often-secret disorder; 2) The importance of establishing an alliance and providing psychoeducation as an essential first step; 3) Data on cosmetic treatments for BDD and approaches to encouraging patients to accept psychiatric treatment instead; 4) Treating BDD with medication, with a focus on serotonin-reuptake inhibitors, which are currently considered the medication of choice for BDD; 5) Psychotherapeutic approaches to treating BDD, with a focus on cognitive-behavioral therapy, which is currently considered the first-line psychotherapy for BDD; the potentially helpful role of other psychotherapeutic approaches will also be discussed. Although BDD has historically been considered "extremely difficult" to treat, the treatments that will be discussed appear efficacious for a majority of patients.

REFERENCES:

1. Phillips KA: "I look like a monster": pharmacotherapy and cognitive-behavioral therapy for body dysmorphic disorder. In DSM-IV-TR Case Book, Volume 2, edited by Spitzer RL, First MB, et al, Washington, DC, American Psychiatric Publishing, Inc, 2006.
2. Phillips KA: Body dysmorphic disorder. In Treatments of DSM-IV-TR Psychiatric Disorders, edited by Gabbard G, Washington, DC, American Psychiatric Publishing, Inc, in press.

ANTISOCIAL PERSONALITY DISORDER AND PSYCHOPATHY

Presenter: Reid Meloy, Ph.D., *UCSD, PO Box 90699, San Diego, CA 92169*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to distinguish between the DSM-IV-TR diagnosis of antisocial personality disorder and psychopathy, and understand the contemporary findings concerning the treatment and risk management of this personality disorder.

SUMMARY:

Antisocial personality disorder is notoriously difficult to treat, but also the most widely researched of the personality disorders. Contemporary research indicates that measurement of *psychopathy*, an empirically reliable and valid construct, predicts the degree to which any mental health treatment will succeed in this population, and also contributes to a much more refined understanding of violence risk, the usefulness of pharmacological interventions, the core personality traits of antisocial behavior, and the various transference and countertransference issues that are likely to present during treatment. Treatment outcome studies for psychopaths, the most severe variant of antisocial personality disorder, indicate no effect, and in a few studies, a negative treatment effect. Antisocial personality disordered patients, however, who are not severely psychopathic can show a positive response to treatment, particularly if there are clinical indicators of anxiety, bonding, and conscience: the ABCs that are sorely missing from the psychopath.

REFERENCES:

1. Meloy JR: Antisocial personality disorder. In Treatments of Psychiatric Disorders, Volume 4, edited by Gabbard G. Washington, DC, American Psychiatric Press.
2. Meloy JR: The empirical basis and forensic application of affective and predatory vilence. Aust N Z J Psychiatry 2006; 40:539-547.

COMBINED MEDICATION AND PSYCHOTHERAPY FOR MOOD DISORDERS

Presenter: Jan Fawcett, M.D., *University of New Mexico School of Medicine, 2400 Tucker NE Albuquerque, NM 87131*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the indications for combined therapy, the advantages of combined therapy of different types, and the possible advantages of adding behavioral activation, cognitive, and interpersonal interventions to medication management.

SUMMARY:

Both medications and psychotherapies have been shown to be sucessful in the treatment of mood disorders. The combination of medication and psychotherapy has been recommended by the APA Guidelines (2000) as most strongly indicated in complex depressions with multiple problems and in chronic depression cases that show less than complete response to monotherapy. There are at least four

ways that combined treatment may prove superior to single modality therapy: 1) By increasing the magnitude of response 2) By increasing the probability of response 3) By increasing the breath of response across domains of socialization and function. 4) By increasing the acceptability of adherence to treatment. Studies illustrating these effects will be reviewed. Types of psychotherapy combined with medication include psychodynamic psychotherapy, interpersonal therapy, marital therapy, behavioral therapy, and cognitive therapy which include several subtypes. These therapies may be administered by separate therapists (split therapy) or both modalities can be administered by a psychiatrist. The advantages and disadvantages of both will be discussed. One aspect of cognitive therapy behavioral activation, will be discussed as a possible addition to medication therapy in the framework of current practice. Opportunities for adding cognitive, behavioral and interpersonal interventions in the context of current practice which is skewed toward medication management will also be discussed.

REFERENCES:

1. Fawcett J,Epstein P, Fiester SI et al: Clinical management-imipramine/placebo administration manaul:NIMH Treatment of Depression Collaborative Research Program. Psychopharmacl Bull 23.309-324.1987.
2. Dimidjian S, Hollon SD, Dobson KS et al: Randomized trial of behavioral activation, cognitive therapy,and antidepressant medication in the acute treatment of adults with major depression. J Consult Clin Psychol 74.658-70, 2006.

ADVANCES IN TREATMENT OF PTSD

Presenter: Charles R. Marmar, M.D., *UCSF, 401 Parnassus Avenue, San Francisco, CA 9494*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to:

(1) Identify evidenced based practices for psychopharmacologic treatment of acute and chronic PTSD; (2) Identify evidenced based practices for behavioral treatment of acute and chronic PTSD; (3) Be familiar with translational research informing new treatments for PTSD

SUMMARY:

Advances in evidence based treatment for PTSD will be presented. Various forms of behavioral, cognitive and cognitive behavioral techniques (CBT) are the most studied and clinically effective treatments. Research studies of CBT indicate modest effects on male veterans with PTSD as compared with female assault victims. EMΔP σηαρεσ α νυμβερ οφ τεχηνιθυεσ ιν χομμον ωιτη οτηερ XBT τρεατμεντσ, ανδ ειψε μοτιεμεντ ισ νοτ αν εσσεντιαλ χομπονεντ οφ τηε τρεατμεντ. Research has identified a number of pharmacological agents capable of significantly reducing PTSD symptoms, principally among the antidepressant medications. Further research is required to determine the efficacy and effectiveness of anti-adrenergic agents, anticonvulsants, the new generation of antipsychotics, and newer drugs that target normalizing neuropeptide components of human stress response. While promising, preventative pharmacotherapy targeting glucocorticoid and catecholamines systems is at an early stage of development. Caution is necessitated in using emotion focused approaches in "hot debriefings" with trauma survivors in the first hours after traumatic exposure who are experiencing prolonged terror, horror and panic like reactions. Adrenergic blocking medications hold promise for immediate treatment of trauma victims with persistent elevations and heart rate, greater panic and greater dissociation at the time of traumatic exposure. Reversible and selective monoamine oxidase inhibitors (MAOIs) are safer and better tolerated than traditional MAOIs and are promising treatments requiring further validation. Multimodal treatment for complex PTSD will aslo be discussed.

REFERENCES:

1. 2004 F.B. Schoenfeld, T.C. Neylan, C. R. Marmar. Current Concepts in Pharmacotherapy for Posttraumatic Stress Disorder. Psychiatric Services 55, 519-531.
2. Marmar, C.R. & Spiegel, D. (in press). Posttraumatic stress disorder and acute stress disorder. In press: Gabbard, G.O., (Ed) .Gabbard's Treatments of Psychiatric Disorders, Fourth Edition. Arlington, Virginia: American Psychiatric Publishing, Inc.

HISTRIONIC PERSONALITY DISORDER

Presenter: Glen O. Gabbard, M.D.,*Baylor College of Medicine, Department of Psychiatry, Houston, TX 77030*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate knowledge of the optimal psychotherapeutic approach to histrionic personality disorders.

SUMMARY:

Histrionic personality disorder is a common entity encountered in clinical practice. However, there is almost no efficacy data available stemming from randomized controlled trials. As a result, much of the literature focuses on clinical wisdom derived from experienced psychotherapists. No medication has been demonstrated to be effective with these patients. In the absence of placebo-controlled trials, psychotherapy is considered the mainstay of treatment. The psychotherapy needs to be tailored to the level of organization--higher level or "hysterical" patients generally can use expressive dynamic therapy while the more primitively-organized histrionic patient may require a predominantly supportive treatment. Specific therapeutic strategies are described and common psychodynamic themes will be discussed. Cognitive therapy approaches will be covered as well.

REFERENCES:

1. Gabbard GO: Psychodynamic Psychiatry in Clinical Practice: Fourth Edition. Arlington, VA, American Psychiatric Publishing, 2005.
2. Freeman A, Freeman SM, Rosenfeld B: Histrionic personality disorder, in Gabbard G, Beck J, Holmes J (Eds): Oxford Textbook of Psychotherapy, Oxford, Oxford University Press, 2005, pp. 305-310.

ADVANCES IN ASSESSMENT AND MANAGEMENT OF SUICIDE

SUICIDE RISK ASSESSMENT AND MANAGMENT

Chairperson: Robert I. Simon, M.D., *Georgetown University School of Medicine, Potomac, MD 20854*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to:

(1) Perform systematic suicide risk assessments; (2) Recognize adolescent suicide risk factors; (3) Understand gender differences in suicide risk; (4) Recognize need for close collaboration between psychiatrist and mental health clinician; (5) Understand variety of coping styles clinicians employ following a patient's suicide.

SUMMARY:

The purpose of suicide risk assessment is to identify modifiable and treatable risk and protective factors that inform the patient's overall treatment and management requirements. Many principles of suicide risk assessment and treatment of adults are relevant to the suicidal adolescent, but differences exist in risk factors, diagnosis, symptoms, treatment and legal status. In split treatment, risk assessment and risk management of suicidal patients is a process to be performed collaboratively with other mental health clinicians sharing clinical data and decision-making.

Despite women's low suicide mortality rates, women have consistently higher rates of two critical risk factors, depression and suicide attempts. Gender differences must be considered in the suicide risk assessment and management of female patients at risk for suicide. It is a clinical axiom that there are two kinds of clinical psychiatrists: those who have had patients commit suicide and those who will have patients commit suicide. Optimal coping with a patient's suicide involves a number of different interactions and techniques. Losing a patient to suicide will likely affect the clinician's approach to the assessment and management.

SUICIDE AND GENDER

Presenter: Liza H. Gold, M.D., *Georgetown University Medical Center, Arlington, VA 22207*

EDUCATIONAL OBJECTIVES:

(1) To review the differences between suicide mortality rates across gender and ethnicity; (2) To explore the reasons for differences among gender regarding suicide mortality rates; (3) To understand the implications of the differences in suicide mortality rates in regard to reducing suicide risk across gender, age and ethnicity.

SUMMARY:

Suicide is a gendered phenomenon. About 80% of all suicides are committed by males. Statistical data consistently demonstrate that male deaths by suicide exceed those for females in every country except China. Despite womenâ€™s low suicide mortality rates, women have consistently higher rates of two of the most significant suicide risk factors, depression and suicide attempts. Approximately 90% of individuals who commit suicide have a diagnosable psychiatric disorder. Affective illness (major depression, bipolar disorder and schizoaffective disorder) is the most common diagnosis among completers, accounting for up to 60-70% of suicide deaths. Depression is about twice as common in women as in men. A history of nonfatal attempts is also a well recognized risk factor for suicide. Between 18% and 38% of persons who commit suicide have made previous attempts.

Given womenâ€™s increased incidence of depression and suicide attempts, womenâ€™s suicide mortality rates are remarkably low compared to men, particularly those of white men, the group most studied. This inverse relationship has not been adequately investigated or explained. Why are other populations less vulnerable to suicide than white males, despite having many of the recognized demographic risk factors associated with suicide mortality? Which factors or behaviors protect women (and other ethnic and racial groups) from the high suicide mortality rates of white males. The answers to these question could lead to insights that expand our understanding of suicide as well as therapeutic interventions that could decrease suicide risk.

REFERENCES:

1. Gold LH: Gender issues in suicide. In The American Psychiatric Publishing Textbook of Suicide Assessment and Management, edited by Simon RI, Hales RE, Washington, DC, American Psychiatric Publishing, Inc., 2006.
2. Simon RI: Assessing and Managing Suicide Risk: Guidelines for Clinically Based Risk Management. Washington, DC, American Psychiatric Publishing, Inc., 2004.

SUICIDE IN CHILDREN AND ADOLESCENTS

Presenter: Peter Ash, M.D.. *Emory University, 1256 Briarcliff Rd., Atlanta, GA 30306*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to:

(1) Recognize risk factors for suicide in adolescents and appreciate how these differ from risk factors for adults; (2) Understand the general principles in treating suicidal adolescents, and appreciate how these principles differ from work with adults.

SUMMARY:

While many of the principles pertinent to the assessment and treatment of suicidal adults are pertinent to work with suicidal adolescents, because of developmental differences, different living circumstances, and different legal status, approaches to younger patients are different from those used with adults. This presentation will focus on those differences and their implications for prevention, assessment, and treatment. For example, epidemiologic studies suggest that about 1 in 6 high school students have seriously considered suicide in the past year, while less than 1 in 2000 of those youth will actually kill themselves in that year. This low specificity of suicidal ideation as a risk factor in adolescents complicates risk assessment. The legal status of being a minor affects treatment both in ways that simplify (it is easier to hospitalize over the patient's objection) and complicate (issues of consent and confidentiality are more complex). And treatment approaches differ along a number of dimensions, both psychosocial (as with an emphasis on involvement of the family) and pharmacological (as with the FDA black-box warning for SSRIs).

REFERENCES:

1. American Academy of Child and Adolescent Psychiatry: Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. Journal of the American Academy of Child & Adolescent Psychiatry 2001; 40(7 Suppl):24S-51S.
2. Ash P: Children and adolescents, in The American Psychiatric Publishing textbook of suicide assessment and management. Edited by Simon RI, Hales RE. Washington, DC, American Psychiatric Pub., 2006, pp 35-55.

PSYCHIATRISTS' REACTIONS TO PATIENT SUICIDES

Presenter: Michael Gitlin, M.D., *UCLA, 300 UCLA Medical Plaza, Los Angelos, CA 90095*

EDUCATIONAL OBJECTIVES:

Participants should be able to identify the most common reactions in psychiatrists after a patient suicide. Participants should also be able to identify the optimal coping strategies and how to help younger colleagues with this issue

SUMMARY:

Over the course of a professional career, a substantial proportion of psychiatrists will experience the suicide of a patient at some point. Typical responses to patient suicide resemble reactions to other meaningful losses, including denial, grief and anger exacerbated by shame, guilt and fear of blame. The most important predictor of distress after a patient suicide is younger age and lesser experience of the treating psychiatrist. The most important coping technique after patient suicide is decreasing isolation of the treating psychiatrist. Most importantly, training programs should institute formal instruction for trainees in anticipating and coping with patient suicide.

REFERENCES:

1. Gitlin M. A psychiatrist's reaction to patient suicide. American Journal of Psychiatry, 156:1630-1634, 1999.

ADVANCES IN NEUROPSYCHIATRY AND CLINICAL NEUROSCIENCES

NEUROPSYCHIATRY AND CLINICAL NEUROSCIENCES

Chairperson: Stuart C. Yudofsky, M.D., *Baylor College of Medicine, 6655 Travis Street, Houston, TX 77030*

EDUCATIONAL OBJECTIVES:

The educational objectives are for the attendee to be familiar with the most recent basic science and clinical science research advances in key areas of neuropsychiatry and to understand how these advances can be applied to his or her clinical practice of psychiary and/or neuropsychiatry.

SUMMARY:

This session will review the highlights of the 5th Edition of the American Psychiatric Publishing Textbook of Neuropsychiatry and Behavioral Neurosciences. To be included will be the latest basic science and research advances in key areas of neuropsychiatry to include: functional brain imaging, diagnositic testing, the diagnosis and treatment of mood disorders in neuropsychiatric patients, and the diagnosis and treatment of psychiatric aspects of stroke. Emphasis will be placed on the translation of recent research advances into practical clinical practice.

UPDATE ON FUNCTIONAL BRAIN IMAGING IN NEUROPSYCHIATRY

Presenter: Robin Hurley, M.D., *Department of Veteran Affairs, Washington, DC 20009*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the attendee will understand the functional imaging techniques available clinically to view the human brain in relation to emotion, behavior, and cognition.

SUMMARY:

As the radiological sciences have advanced over the past decade, so has our understanding of the circuits of cognition, emotion, and behavior. As one thinks a thought or responds to an environmental que, functional changes occur in the neuronal circuits of the brain. Functional imaging now allows one to view the living brain. This presentation will review the newest and most state-of-the-art structural and functional imaging techniques available to the practicing psychiatrist for use both clinically and for research purposed. The basics of the techniques, reasons for use, advantages and disadvantages for all will be discussed. Clinical case examples will be presented and discussion of clinically pertinent added value will be reviewed. In summary, the attendee will be presented a review of the neuroanatomical circuits critical for mental health functioning and how to examine these circuits with imaging procedures.

REFERENCES:

1. Hurley RA, Taber KH, Hayman LA. Chapter 8: Clinical Imaging in Neuropsychiatry. In Yudofdky SC, Hales RE (eds): The American Psychiatric Press Textbook of Neuropsychiatry, 4th ed. Washington, DC: American Psychiatric Press, Inc. 2002: 245-283.
2. Hurley RA, Boutros N, Taber KH. Rational Approach to Brain Imaging and Electrophysiology. In: Coffey CE, McAllister T, Silver J (eds). Manuel of Neuropsychiatric Therapeutics. Lippincott Williams & Wilkins 2006.

UPDATE ON DIAGNOSTIC TESTING IN NEUROPSYCHIATRY

Presenter: H. Florence Kim, M.D., *Baylor College of Medicine, 6655 Travis Street, Houston, TX 77030*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to appreciate the clinical utility of laboratory testing in the patient with neuropsychiatric issues, and become familiar with the uses of newer laboratory testing methods such as pharmacogenetic and biomarker testing.

SUMMARY:

Laboratory assessment and imaging studies are particularly important to the evaluation of the psychiatric patient. Their influence and scope, though of limited clinical use in the past, have the potential to increase tremendously, as promising new modalities become more widely available and demonstrate ever-increasing clinical possibilities.

Judicious choice of laboratory testing guided by a complete psychiatric assessment--including a thorough medical and psychiatric history, review of systems, and physical examination--may often uncover an unsuspected medical or neurological etiology underlying primarily psychiatric symptomatology. Likewise, structural and functional neuroimaging are powerful tools that can provide evidence of tangible abnormalities that might underlie psychiatric symptoms. One hopes that through advances in neuroimaging and laboratory testing, promising genetic and biological markers will be discovered and will attain a level of clinical utility so that a new and important dimension may be added to the uses of laboratory testing: the identification, biological treatment, and ultimately prevention of psychiatric illnesses.

REFERENCES:

1. Yudofsky SC, Kim HF, eds. Neuropsychiatric Assessment (Review of Psychiatry Series, Volume 23; Oldham JM and Riba MB, series editors). Washington, DC, American Psychiatric Publishing, 2004.
2. P Baumann, C Hiemke, S Ulrich et al. The AGNP-TDM expert group consensus guidelines: therapeutic drug monitoring in psychiatry. Pharmacopsychiatry 2004; 37:243-265.

UPDATE ON THE NEUROPSYCHIATRY OF DELIRIUM

Presenter: Paula Trzepacz, M.D., *Lilly Research Laboratory, Lilly Corporate Center, Indianapolis, IN 46285*

EDUCATIONAL OBJECTIVES:

To learn about the role of the brain in production of delirium symptoms.

SUMMARY:

The neuropathogenesis of delirium involves both cortical and subcortical brain regions. Electroencephalography and evoked potential studies reveal slowing that implies thalmic dysfunction. Lesion and neuroimaging studies suggest that prefrontal cortex, thalamus, posterior parietal cortex and basilar temporolimbic regions—especially on the right—are involved in producing delirium symptoms. Dysfunction of two neurotransmitter, acetylcholine and dopamine, may explain the broad range of behavioral, cognitive, sleep and motor symptoms of delirium which, along with particular brain regions and circuitry, may comprise a "final common neural pathway" affected by the large variety of etiologies that cause delirium. Inflammatory agents including certain cytokines may also directly alter neurotransmission. Whether delirium itself causes enduring brain damage is an open question given the so-called"persitent cognitive effects" described in the geriatric literature. However, confounds to this

theory include inadequate resolution of the index episode, progressive effects of an underlying comorbid dementia, and direct damage from the medical etiologies that cause delirium. Studies in younger age groups that account for baseline cognition are needed to elucidate this controversial matter.

REFERENCES:

1. Trzepacz PT: Is there a final common neural pathway in delirium? Focus on acetylcholine and dopamine. Seminars in Clinical Neuropsychiatry 2000; 5:132-148.

UPDATE ON THE NEUROPSYCHIATRY OF MOOD DISORDERS

Presenter: Helen S. Mayberg, M.D., *Emory University, 101Woodruff Circle, Atlanta, GA 30322*

EDUCATIONAL OBJECTIVES:

At the conclusion of this activity, participants should be able to specify the differential brain changes identified using functional neuroimaging associated with various antidepressant treatments including medication, cognitive behavioral therapy and deep brain stimulation.

SUMMARY:

Functional neuroimaging has provided an important platform to define critical brain circuits involved in both depression pathogenesis and treatment response. This presentation will present findings from positron emission tomography and functional magnetic resonance imaging studies of brain changes mediating these effects. Differences between various treatment interventions will be discussed in the context of limbic-cortical network model of depression. Converging findings will be reviewed from these perspectives highlighting disease, state, and treatment-specific effects using pharmacotherapy, cognitive behavioral therapy and deep brain stimulation.

REFERENCES:

1. Mayberg HS. Modulating Dysfunctional Limbic-Cortical Circuits in Depression: Towards Development of Brain-based Algorithms for Diagnosis and Optimised Treatment. British Medical Bulletin 2003; 65:193-207.
2. Mayberg, HS, Lozano A, Voon V, McNeely H, Seminowicz D, Hamani C, Schwalb J, Kennedy S,. Deep Brain Stimulation for Treatment Resistant Depression; Neuron, 2005; 45:651-660.

UPDATE ON THE NEUROPSYCHIATRY OF STROKE

Presenter: Robert G. Robinson, M.D., *The University of Iowa, 200 Hawkins Drive, Iowa City, Iowa 52242*

EDUCATIONAL OBJECTIVES:

Participants of this study will be able to identify the effect of poststroke depression on recovery; Assess the utility of antidepressants for poststroke depression; Recognize the risk of depression on the incidence of stroke; Recognize the benefit of antidepressants on recovery; Assess the role of antidepressants in poststroke therapy.

SUMMARY:

The study of psychiatric disorders associated with stroke has primarily examined prevalence rates of depression among patients in communities, acute and rehabilitation hospitals and outpatient clinics. Among more than 7,000 patients, the mean prevalence rate for major depression was 21.7%. There is also a growing consensus concerning the risk factors for poststroke depression. These include greater severity of physical impairment, prior history of depression, family history of psychiatric disorder, impaired social support and lesion factors. There are now 7 double-blind placebo controlled trials examining the benefit of antidepressant treatment.

Recent studies, however, have examined the effect of poststroke depression on short- term and long-term outcome or the effect of premorbid depression on stroke occurrence. For example, 5 studies have found increased mortality associated with poststroke depression and 6 studies have found increased frequency of stroke among patients with premorbid depression. Perhaps the most provocative new area of investigation, however, is the effect of antidepressant treatment on stroke outcome. For example, physical recovery following stroke was enhanced by antidepressants given within one month compared to 2 or more months poststroke, independent of depression. Furthermore, antidepressants improved recovery of executive function over 21 months, independent of depression. Finally, that antidepressants significantly decreased mortality over 7 years following stroke, independent of depression. These data suggest that antidepressants can play a major role in poststroke therapy. Antidepressants may produce important neurophysiological effects which may last for many years and are not associated with their antidepressant function.

REFERENCES:

1. Robinson RG, Starkstein SE: Neuropsychiatric aspects of cerebrovascular disorders, edited by Yudofsky SC, Hales RE in The American Psychiatric Publishing Textbook of Neuropsychiatry and Clinical Neurosciences. Washington, DC, APP in press.
2. Narushima K, Paradiso S, Moser DJ, Jorge RE, Robinson RG. Antidepressants improve executive function after stroke. Br J Psychiatry (in press).

ADVANCES IN GERIATRIC PSYCHIATRY

ADVANCES IN GERIATRIC PSYCHIATRY

Chairperson: Dan Blazer, M.D., *Duke University Medical Center, Box 3003, Durham, NC 27710*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the major diagnostic symptoms and signs of major depression, generalized anxiety, panic disorder and psychotic disorders in late life and should be aware of the most recent approaches to diagnosis and treatment.

SUMMARY:

Older adults are the fastest growing age group in the United States and carry a significant burden of psychiatric morbidity. The session will open with a presentation of the "aging imperative" for psychiatry given changing demographics and the complexities of caring for the psychiatrically impaired older adult. This introduction will be followed by three reviews of the latest clinically relevant findings which inform the screening, diagnostic workup, diagnosis, and treatment of specific psychiatric disorders in late life: Mood Disorders; Anxiety Disorders; and Psychotic Disorders. The final presentation will focus upon the unique challenges to psychiatrists who treat older adults with psychotropic medications. Ample time will be available for questions and comments.

DEPRESSION IN LATE LIFE: COMPLICATING FACTORS AND THE ROLE OF MEDICAL ILLNESS

Presenter: Harold W. Goforth, M.D., *Duke University Medical Center, Psychiatry and Behavioral Sciences, Durham, NC 27710*

EDUCATIONAL OBJECTIVES:

To better understand the epidemiology and special circumstances including medical illness in the role of generating and sustaining late life depression.

SUMMARY:

Older adults are the fastest growing age group in the United States and carry a significant burden of depressive illness due to a variety of reasons including co-morbid physical illness. This session will focus upon the epidemiology of depressive features in late life, and the influence of comorbid medical disease upon depression and treatment outcomes. Significant attention will be given to the presence of vascular risk factors that may complicate depressive illness in aged adults.

REFERENCES:

1. O'Brien JT, Firbank MJ, Krishnan MS, et al., White Matter Intensities Rather.
2. Steffens DC, Otey E, Alexopoulos GS, et al. Perspectives on depression, mild cognitive impairment, and cognitive decline. Arch Gen Psychiatry. 2006;63:130-8.

ANXIETY DISORDERS IN LATE LIFE

Presenter: John L. Beyer, M.D., *Duke University Medical Center, Box 3519 DUMC, Durham, NC 27710*

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to recognize the different anxiety disorders in geriatric patients, as well as the impact that subsyndromal anxiety has on both physical health and functional status.

SUMMARY:

Anxiety disorders are the most common psychiatric disorders in older Americans. They can be present independently, but most often are present as a comorbid condition. The presence of anxiety and anxiety disorders directly impacts the treatment and functional recovery of most patients. This presentation will review the prevalence, etiology, impact and treatment of anxiety in late life.

REFERENCES:

1. Beyer JL : Anxiety and panic disorders. In Textbood of Geriatric Psychiatry, edited by Blazer DG, Steffens DC, Busse EW, Washington DC, American Psychiatric Publishing, 2004, pp283-294.
2. Sable JA, Jeste DV: Anxiety disorders in older adults.Curr Psychiatry Rep. 2001 Aug;3(4):302-7.

PSYCHOTIC DISORDERS IN LATE LIFE

Presenter: Dilip V. Jeste, M.D., *UCSD, 3350 La Jolla Village Drive, San Diego, CA 92161*

EDUCATIONAL OBJECTIVES:

The audience will learn about:

(1) Differential diagnosis of psychotic disorders in older people and; (2) Use of pharmacologic and psychosocial treatments in older people with psychotic disorders.

SUMMARY:

Psychosis in late life may be a primary psychotic disorder such as schizophrenia or, more often, a secondary one such as psychosis of Alzheimer disease (AD). Contrary to expectation, aging of patients with schizophrenia is often associated with improvement in mental health-related quality of life even as physical health declines. At the same time, approximately 25% of patients manifest symptoms of schizophrenia for the first time after age 40. Psychosis occurs in 50% of AD patients, and is associated with increased risk of institutionalization. Antipsychotics are a commonly used pharmacologic option for the treatment of various psychotic disorders, although these medications have been approved by the FDA only for schizophrenia and bipolar disorder. Trials of atypical antipsychotics in older psychotic patients report inconsistent efficacy compared to placebo. An advantage in terms of extra-pyramidal symptoms and tardive dyskinesia has been noted compared to conventional neuroleptics. However, atypical antipsychotics carry an increased risk of metabolic side effects in various age groups, and the FDA has issued black-box warnings regarding the risk of strokes and mortality in elderly persons with dementia. A careful consideration of risk:benefit ratio of atypical antipsychotics as well as that of available alternative treatments is needed in each patient. When used, these drugs should be prescribed in lowest effective doses and for shortest periods necessary. Regular monitoring for side effects is critical. Psychosocial treatments have an important role to play in older psychotic patients. Shared decision making involving patients and caregivers is necessary for choosing specific treatments.

REFERENCES:

1. Granholm E et al: A randomized controlled trial of cognitive behavioral social skills training for middle-aged and older outpatients with chronic schizophrenia. Am J Psychiatry 2005; 162:520-529.
2. Ropacki S and Jeste DV: Epidemiology of and risk factors for psychosis of Alzheimer Disease: A review of 55 studies published from 1990 to 2003. Am J Psychiatry 2005; 162:2022-2030.

PSYCHOPHARMACOLOGICAL TREATMENT OF LATE LIFE PSYCHIATRIC DISORDERS

Presenter: Bruce G. Pollock, M.D., *University of Toronto, 3560 Bathhurst Street, Toronto, Ontario M6A2E1, Canada*

EDUCATIONAL OBJECTIVES:

(1) Review the pharmacokinetic and pharmacodynamic factors that may affect drug response and predisposition to adverse drug effects in elders; (2) Identify factors related to drug-drug interactions in the elderly; (3) Discuss the limited evidence base of double-blind trials of pharmacotherapy for older adults.

SUMMARY:

Patients aged 65 and older receive 40% of all prescription medication even though they account for only 13% of the total population. The elderly are at increased risk of medication-related adverse events because of co-morbid medical illness, concurrent medication usage, age-associated physical changes, and cognitive impairment. Diversity in drug concentration due to poor compliance and/or pharmacokinetic differences among patients may have important therapeutic and toxic consequences. New data and methods for capturing pharmacokinetic and pharmacodynamic heterogeneity in elders will be reviewed. While many new psychotropics have become available, age-associated pharmacokinetic or pharmacodynamic differences prevent the "simple" extrapolation to the elderly of data acquired in younger patients.

REFERENCES:

1. Pollock BG: Geriatric Psychiatry: Psychopharmacology: General Principles. In: Sadock BJ, Sadock VA, eds. Kaplan & Sadock's Comprehensive Textbook of Psychiatry/VIII. Baltimore: Williams & Wilkins pp 3716-3720, 2005.
2. Nebes RD, Pollock BG, Meltzer CC, et al:Cognitive effects of serum anticholinergic activity and white matter hyperintensities, Neurology 65:1487-1489, 2005.

ADVANCES IN C-L PSYCHIATRY AND PSYCHOSOMATIC MEDICINE

LEGAL ISSUES AT THE INTERFACE OF PSYCHIATRY AND MEDICINE

Chairperson: James L. Levenson, M.D., *Virginia Commonwealth University, Box 980268, Richmond, VA 23298*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: (1) Identify the most important legal issues at the interface of psychiatric and medical practice; (2) Develop a realistic and proportionate response to legal concerns

SUMMARY:

Psychiatrists and physicians providing psychiatric care in medical settings regularly encounter difficult legal issues. While these are not unique, there are special challenges in caring for patients with multiple co-morbid medical and psychiatric illnesses in settings in which multiple disciplines are involved.This presentation reviews confidentiality and HIPAA, informed consent, competency, guardianship, substituted judgment, end-of-life decisions, advance directives, maternal "competency," voluntary and involuntary treatment, EMTALA, AMA discharges, and the use of physical restraints.

SOMATIZATION AND SOMATOFORM DISORDERS

Presenter: Steven A. Epstein, M.D., *Georgetown University Hospital, 3800 Reservoir Road, Washington, DC 20007*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate understanding of diagnosis and management of individuals with somatoform disorders

SUMMARY:

Psychiatrists and other medical specialists frequently encounter patients with medically unexplained symptoms. Patients who somatize can be challenging for even the most skilled practitioner. This presentation will review theoretical and diagnostic approaches to the major Somatoform Disorders, including Somatization Disorder, Hypochondriasis, and Conversion Disorder. Problems with current diagnostic schema will be highlighted. Management and treatment approaches will also be emphasized

REFERENCES:

1. Abbey SE: Somatization and Somatoform disorders, in Textbook of Psychosomatic Medicine. Edited by JL Levenson. Washington, DC, American Psychiatric Press, 2005.
2. Mayou R, Kirmayer LJ, Simon G, Kroenke K, Sharpe M: Somatoform disorders: Time for a new approach in DSM-V. Am J Psychiatry 2005; 162: 847-855.

DEPRESSION IN THE MEDICALLY ILL

Presenter: Gary Rodin, M.D., *Princess Margaret Hospital, 610 University Avenue, Toronto, Ontario M5G 2M9, Canada*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: (1) appreciate multiple risk factors for depressive disorders in medical populations; (2) diagnose these disturbances, taking into account comorbid and overlapping conditions; (3) implement a feasible and effective approach to screen for and treat depression in medical settings

SUMMARY:

Depressive disorders have been found in most studies to be 2-3 times more common in individuals with major medical conditions than in the general population. Many of the usual risk factors for depression have been shown to contribute to this increased risk, but controversy persists regarding the association of depressive disorders with specific symptoms and medical conditions, and with medical outcomes and mortality. Evidence for these relationships will be reviewed, together with that from research that has examined the role of specific neurobiological, psychological and contextual factors. Implications of these findings for a more comprehensive approach to the etiology and treatment of depressive disorders in medical patients will be discussed. Problems related to the diagnosis and treatment of depression in medical populations will be reviewed and evidence for the cost-effectiveness of depression screening and of pharmacological and psychotherapeutic interventions will be critically examined. Guidelines for the treatment of depressive disorders in medical populations will be reviewed, taking into account the acceptability, tolerability, and benefit associated with recommended treatments.

REFERENCES:

1. Peveler, R., Carson, A., Rodin, G: Depression in medical populations. British Medical Journal 2002; 325:149-152.
2. Rodin, G, Nolan, RP Katz, MR: Depression (in the Medically Ill). In APPI Textbook of Psychosomatic Medicine, edited by J. Levenson, American Psychiatric Press, Inc., 2004, pp 113-217.

PSYCHOSIS IN THE MEDICALLY ILL

Presenter: Prakash S. Masand, M.D., *Ingenix, 1001 Winstead Drive, Cary, NC 27513*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: (1) Be familiar with the differential diagnosis of psychosis in the medically ill; (2) Analyze the evidence for the management of psychosis in the medically ill.

SUMMARY:

In addition to their occurrence in major psychiatric disorders such as schizophrenia and mood disorders, psychotic symptoms frequently occur as a part of several medical illnesses. Psychotic symptoms may also be induced by psychoactive substances or by medications that are used to treat medical disorders. Psychotic symptoms in the medically ill patients can complicate the diagnosis and management of the medical condition in several ways but can usually be ameliorated with appropriate interventions. A careful workup of secondary psychosis includes chart review, history, physical examination, and laboratory and radiological investigations (Patkar and Kunkel 1997). The overall goas are to maintain the safety of the patient and others, to identify and treat the underlying medical condition, and to treat the psychotic symptoms. Close collaboration between the psychiatrist and the medical staff involved in the care of the patient is required.

REFERENCES:

1. Masand PS: Atypical agents in nonschizophrenic disorders. J Clin Psychiatry 1998; 59:322-328.
2. Robinson MJ, Levenson JL: The use of psychotropics in the medically ill. Curr Psychiatry Rep 2000; 2:247-255.

DECEPTION SYNDROMES

Presenter: Charles V. Ford, M.D., *University of Alabama at Birmingham, 1700 7th Avenue South, Birmingham, AL 35294*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to recognize the phenomenology of the major deception syndromes and describe features of personality disorders that charcteristically underlie these types of misbehavior. Further, the participant should also be able to identify problems with current diagnostic criteria for factitious disorders.

SUMMARY:

Commonalities in the syndromes of factitious disorders, imposture, pathological lying, malingering and "Angel of Death" have led to the conceptulization of grouping them as the "Deception syndromes." Frequently noted are Cluster B personality characteristics; especially prominent are defects in the sense of self and lack of remorse for the effects of misbehavior on others. An arguement is proposed for categorizing these syndromes as behavioral syndromes secondary to personality disorders rather than as Axis I disorders. Recent functional neuro-imaging findings referable to lying may help clarify or understanding of these perplexing behaviors.

REFERENCES:

1. Ford CV: Deception syndromes: factitious disorders and malingering. In, Textbook of Psychosomatic Medicine, edited by Levenson JL, Washington D.C., American Psychiatric Publishing, 2005, pp297-309.
2. Turner MA: Factious disorders: reformulating the DSM-IV criteria. Psychosomatics 2006;47:23-32.

ADVANCES IN RESEARCH

RESEARCH ADVANCES IN PSYCHIATRY

Chairperson: Herbert Pardes, M.D.
Co-Chairpersons: Robert W. Guynn, M.D.
Presenters: Jeffrey Lieberman, M.D., Karen D. Wagner, M.D., Susan G. Kornstein, M.D., Barnett S. Meyers, M.D.

EDUCATIONAL OBJECTIVES:

1) To make available to clinicians the latest in knowledge regarding key psychiatric areas. 2) To appeise attendees of most productive areas of research in schizophrenia, depression, and women's mental health, and geriatrics.

SUMMARY:

This symposium will focus on updating APA members regarding current therapeutics in a number of different areas including schizophrenia, women's mental health issues, treatment of childhood depression and geriatric psychiatry. It will feature seccinct factual presentations to foster clinicians' knowledge and ability to give the most current and best therapeutic attention to patients. It will highlight the linkage between research findings and clinical application.

REFERENCES

1. Stroup TS, Lieberman JA, McEvoy JP, Swartz MS, Capuano GA, Rosenheck RA, Keefe RSE, Miller AL, Belz I, Hsaio JK, for the CATIE Investigators: Effectiveness of olanzapine, quetiapine, and resperidone in patients with chronic schizophrenia after discontinuing perphrenazine. Am J Psychiatry 2007; 164(3): 415-427.
2. Alexopoulos GS: Depression in the elderly. Lancet 365:1961-1970, 2005.

ADVANCES IN MEDICINE

1. "NEW INTEGRATIVE TREATMENTS FOR PTSD AND CHRONIC FATIGUE, DISORDERS OF AUTONOMIC FUNCTION"

Chairperson: Patricia L. Gerbarg, M.D., *Boston Psychoanalytic, Boston Psychoanalytic, Kingston, NY, 12401-4724 Presenter:* Richard P. Brown, M.D.

SUMMARY:

This session will explore inovative ways to use herbs, nutrients, and mind-body techiniques to correct the autonomic dysfunctions that underly many of the symptoms of Posttraumatic Stress Disorder and Chronic Fatigue. Evidence of efficacy and mechanisms of action for each treatment will be presented. The integration of these approaches with standard treatments to optimize outcomes will be discussed.

REFERENCES:

1. Sageman S and Brown RP. 3-acetyl-7-oxo-dehydroepiandrosterone for healing treatment-resistant posttraumatic stress disorder in women: 5 case reports. J Clin Psychiatry. 2006; 67:493-496.
2. Brown RP, Gerbarg PG, Muskin PR. Alternative Treatments in Psychiatry in Psychiatry 2nd Edition edited by Tasman A, Kay J, and Lieberman. London, UK, J. John Wiley & Sons, Ltd, Chapter 104, 2003, pp2147-2183.

2. MEDICINE IN REVIEW: A JOURNAL ROUNDUP FOR 2006

Chairperson: Robert J. Boland, M.D., *The Miriam Hospital/Brown University, Residency Training, The Miriam Hospital/Brown University, Residency Training, Providence, RI, 02906 Presenter:* Monique Yohanan, M.D.

EDUCATIONAL OBJECTIVES:

1. To familiarize participants with internal medicine publications and guidelines from 2006 which are likely to have a strong influence on medical practice;

2. To provide a critical review of the evidence base underlying this literature.

SUMMARY:

This session will provide a review of the medical literature and guidelines in Internal Medicine published in 2006. Areas covered will include those representing important findings likely to impact clinical medical practice, with a special focus on topics common to patients with comorbid psychiatric and medical illness. Additionally, a critical appraisal of the evidence presented in these publications will be offered.

REFERENCES:

1. Straus S, I-Hong Hsu S, Ball C et al. Evidence-Based Acute Medicine. : Oxford Medical Knowledge, 2002.
2. Echinacea for preventing and treating the common cold.

3. ADVANCES IN THE CAUSE & TREATMENT OF HYPERTENSION

Chairperson: Daniella David, M.D,, *Miami VAMC, University of Miami, Miami, FL 33156*
Presenter: Michael G. Ziegler, M.D.

EDUCATIONAL OBJECTIVES:

This talk should help you:

1) Diagnose the common causes of hypertension rather than chasing esoteric syndromes. 2) Get an honest appraisal of how well patients comply with lifestyle and drug treatments. 3) Treat with the right dose of drugs and use effective drug combinations.

SUMMARY:

Patients in North America have the best blood pressure control of anywhere in the world. Nevertheless, only about a third of North American hypertensives have good blood pressure control. It is possible to do better when we:

1) Diagnose the common causes of hypertension rather than chasing esoteric syndromes.

2) Get an honest appraisal of how well patients comply with lifestyle and drug treatments for hypertension and talk with the patient to establish a treatment regimen they can accept.

3) Treat with the right dose of drugs and use effective drug combinations.

Textbook lists of secondary causes of hypertension often begin with renal artery stenosis and pheochromocytoma. However, hypertension in industrialized countries is usually secondary to:

Obesity; Lack of exercise; Sleep apnea; Alcohol; Dietary sodium; Excess aldosterone

When treatment fails to lower blood pressure to goal levels, the most common cause is patient noncompliance and the second most common cause is inappropriate therapy.

Over 100,000 patients have taken part in antihypertensive drug therapy trials that compared differing doses of drug. The combined data from those trials indicate that low drug doses are nearly as effective as large doses.

When a treated hypertensive patient presents with poorly controlled blood pressure, it is appropriate to think first of what causes the hypertension, and then find out if the patient is actually complying with therapy. If the patient is taking prescribed medications, then the drug regimen can be altered to provide rational drug combinations in appropriate doses.

REFERENCES:

1. Ziegler MG: Sleep disorders and the failure to lower nocturnal blood pressure. CURR OPIN NEPHROL HYPERTENS 2003 12(1):97-102.
2. Law MR, Wald NJ, Morris JK, Jordan RE: Value of low dose combination treatment with blood pressure lowering drugs: analysis of 354 randomized trials. British Med J: 2005; 326: 1427-1435.

4. CONGESTIVE HEART FAILURE: ADVANCES IN DIAGNOSIS AND MANAGEMENT

Chairperson: Julio Licinio, M.D,, *Universtiy of Miami Miller School of Medicine, Miami, FL 33136*
Presenter: Alan S. Maisel, M.D.

EDUCATIONAL OBJECTIVES:

To understand the recent advances in both the diagnosis and management of patients with congestive heart failure.

SUMMARY:

The talk will focus on both the diagnostic and therapuetic advances in congestive heart failure. In the diagnostic category the biomarker B type natriuretic peptide will be discussed as a major advance. Therapeutically, ACE inhibitors, beta blockerw and aldosterone antagonists will be discussed, along with new devices for the heart failure patient.

REFERENCES:

1. Maisel A, Krishnaswamy P, Nowak RM, McCord J, Hollander JE, Duc P, Omland T, Storrow AB, Abraham WT, Wu AHB, Clopton P, Steg PG, Westheim A, Knudsen CW, Perez A, Kazanegra R, Herrmann HC, McCullough PA, Rapid measurement of B-type natriuretic peptide.
2. Maisel A. Algorithms for using B-type natriuretic peptide levels in the diagnosis and management of congestive heart failure. Critical Pathways in Card 1(2):67-73, June 2002.

CASE CONFERENCES

1. PSYCHODYNAMIC PSYCHOTHERAPY OF BORDERLINE PERSONALITY DISORDER

Moderator: Glen O. Gabbard, M.D.; *Presenters:* John G. Gunderson, M.D., Lois W. Choi-Kain, M.D.

EDUCATIONAL OBJECTIVES:

To inform participants about the key elements lf technique in the psychodynamic approach to the treatment of patients with borderline personality disorder.

SUMMARY:

A case of psychodynamic psychotherapy of borderline personality disorder will be presented by Dr. Lois Choi-Kain. She will illustrate psychodynamic techniques that are particularly applicable to patients with BPD. Drs. Gunderson and Gabbard will discuss the presentation, and both will elaborate on their own paychodynamic strategies and their theoretical underpinnings and rationales.

REFERENCES:

1. Gunderson JG: Borderline Personality Disorder: a Clinical Guide. Washington, DC; APPI, 2001.
2. Gabbard GO, Wilkinson S: Management of Countertransference with Borderline Patients. Washington, DC: APPI, 1994.

2. COGNITIVE THERAPY FOR CHRONIC DEPRESSION

Moderator: Judith S. Beck, Ph.D.; *Presenters:* Jesse H. Wright III, M.D., Donna M. Sudak, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: (1) Describe the cognitive model of depression; (2) Identify several basic cognitive and behavioral techniques; (3) State a strategy to decrease suicidal risk; (4) Use cognitive interventions to enhance treatment adherence

SUMMARY:

A chronically depressed woman will be presented. The case will be formulated according to a cognitive framework, emphasizing the cognitive model of depression and the specific conceptualization for this patient. A treatment plan, based on this formulation, will be outlined and specific cognitive and behavioral techniques, also based on the formulation, will be described. Three additional areas will be emphasized: the identification and modification of dysfunctional beliefs that interfere with treatment, specific interventions for suicidal ideation, and methods for integrating cognitive therapy with medication, ECT, and other treatment modalities, along with techniques to enhance treatment adherence. Presenters will illustrate specific interventions with roleplays.

REFERENCES:

1. Clark, DA, Beck AT: Scientific Foundations of Cognitive Theory and Therapy of Depression. Philadelphia, John Wiley & Sons, 1999.
2. Beck, JS Cognitive Therapy: Basics and Beyond. New York: Guilford Publications, 1995.

3. "FROM MATERNAL BLISS TO MATERNAL BLUES: A CASE OF INFANTICIDE"

Moderators: Nicole F. Wolfe, M.D.; *Presenters:* John J. Worthington, M.D., Alyson Kuroski-Mazzei, M.D., Jeffrey Childers, M.D.

EDUCATIONAL OBJECTIVES:

Recognize and diagnose post-partum psychosis -Understand mood disorders as they pertain to the perinatal period -Understand approaches to sentencing and treatment considerations in infanticide

SUMMARY:

The case is of a first time mother who was treated for post-partum depression and psychosis. The conference will include a discussion of her treatment and her presentation, and the legal events that unfolded.

Forensic psychiatrists and experts on mood disorders will discuss approaches to correctly diagnosing, and developing an understanding of legal dispositions and informed consent in similar cases.

REFERENCES:

1. Spinelli MG Infanticide: Psychosocial and legal perspectives on Mothers who kill. Arlington VA : American Publishing, Inc, 2004.
2. Anxiety symptoms during pregnancy and postpartum.

4. TRANSFERENCE FOCUSED PSYCHOTHERAPY FOR BORDERLINE PATIENTS

Moderator: Otto F. Kernberg, M.D.
Presenters: Glen O. Gabbard, M.D., John M. Oldham, M.D., Frank E. Yeomans, M.D.

EDUCATIONAL OBJECTIVE:

To acquire information about the strategies, tactics and techniques of Tranference Focused Psychotherapy, a psychodynamic psychotherapy specifically geared to the treatment of personality disorders; also to learn indications and contraindications, and relevant prognostic considerations. The extended case presentation by Dr. Frank Yeomans, will illustrate all these elements.

SUMMARY:

The case presentation and discussion will focus on the psychotherapeutic treatment of a patient with serious personality pathology.

The patient was a single, unemployed Asian American woman who started therapy at age 36 after years in other treatments for bipolar disorder. Before beginning the current therapy, her condition had worsened to the point where she remained isolated in her apartment, lying in bed with chronic suicidal ideation, gaining weight and not attending to her hygiene.

The patient was from an eduated family of professionals. She had dropped out of college and then held a series of jobs as a lab tech. She was repeatedly fired from these jobs because of difficulty getting along with others and stopped working when news of her belligerent character spread throughout her field.

The patient felt that her difficulties with others stemmed from racial prejudice. She had no history of sexual relations except for one occasion when a man invited her on a date and then began to make love to her. The patient panicked and stopped the interaction before intercourse. After that event, she brought formal rape charges against him.

The patient had a limited history of overt self-destructiveness, with three psychiatric hospitalizations. She had been on many medications for depression and bipolar disorder. The discussion will focus on diagnosing severe personality pathology and establishing an appropriate treatment frame and formulation to allow for the therapeutic understanding and resolution of her personality pathology.

REFERENCES:

1. Otto F. Kernberg. Aggressivity, Narcissism, and Self-destructiveness in the Psychotherapeutic Relationship: New Developments in the Psychopathology and Psychotherapy of Severe Personality Disorder. New Haven Yale University Press, 2004.
2. John F. Clarkin, Frenk E. Yomans and Otto F. Kernberg. Psychotherapy for Borderline Personality: Focusing on Object Relations. Washington, DC: American Psychiatric Publishing, Inc. 2006.

FOCUS LIVE

1. PSYCHOPHARMACOLOGY

Moderators: Deborah J. Hales, M.D., Mark H. Rapaport, M.D.
Presenter: Stephen M. Stahl, M.D.

EDUCATIONAL OBJECTIVES:

This FOCUS LIVE session will assist clinicians in testing their knowledge and in staying current regarding pharmacological treatments for psychiatric disorders. Participants will answer board-type questions designed to inclrease their knowledge and help them identify areas there they might benefit from more study.

SUMMARY:

The amount of new knowledge in psychopharmacology is tremendous. New and established pharmacologic options are available to treat patients with psychiatric disorders. There are recently published important new reports. CATIE, STAR*D, STEP-DB that present results of current clinical studies. There is new information about treatment for pain, sleep disorders, alcohol abuse, as well as increased evidence regarding treatments for bipolar and major depression and anxiety. In this FOCUS LIVE session the emphasis will be on general pharmacologic management of patients. Multiple choice questions will be presented about efficacy, management, side effects and drug interactions, and mechanism of action.

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

REFERENCES:

1. Stahl SM, Grady M, Santiago S, Davis RL. Optimizing outcomes in psychopharmacology continuing medical education (CME): Measuring learning and attitudes that may predict knowledge translation into clinical practice. Psychopharmacology: FOCUS: The Journal.

2. SUBSTANCE RELATED DISORDERS

Moderators: Deborah J. Hales, M.D., Mark H. Rapaport, M.D.
Presenter: Thomas R. Kosten, M.D.

EDUCATIONAL OBJECTIVES:

As a result of participation in this interactive FOCUS LIVE workshop, participants will review multiple choice questions, test their knowledge of the clinical management of patients, and have increased understanding of approaches to the treatment of substance use disorders.

SUMMARY:

Substance use disorders have great impact and cost on society. FOCUS LIVE presents multiple choice questions for the psychiatrist interested in keeping up to date with clinical innovations in the treatment of substance use disorders. Treatments include both evidence based pharmacotherapies and behavior interventions that can enhance medication efficacy. Questions will be presented around general treatment principles, treatment setting, evidence based pharmacotherapies and psychosocial treatments.

In FOCUS LIVE! sessions, expert clinicians lead lively multiople choice question-based discussions. Participants test their knowledge with an interactive audience response system, which instantly presents the audience responses as a shistogram on the screen.Questions cover existing knowledge on a clinical topic important to practicing general paychiatrists, including diagnosis, treatment, and new developments.

REFERENCES:

1. Work Group on Substance Use Disorders; Kleber HD, Weiss RD, Anton RF, Rounsaville BJ, George TP, Strain EC, Greenfield SF, Ziedonis DM, Kosten TR, Hennessy G, O'Brien CP, Connery HS; American Psychiatric Association Steering Committee on Practice Guidelines.
2. Substance Related Disorders: FOCUS: The Journal of Lifeling Learning in Psychiatry 2007;2: in press.

3. GENETICS AND PSYCHIATRY

Moderators: Deborah J. Hales, M.D., Mark H. Rapaport, M.D.
Presenter: John Kelsoe, M.D.

EDUCATIONAL OBJECTIVES:

This FOCUS LIVE session will assist physicians in testing their knowledge and having an increased understanding of genetics and psychiatry. Participants will answer board-type questions designed to increase their knowledge and help them identify areas where they might benefit from more study.

SUMMARY:

What role does genetic etiology play in the development of psychiatric disorders, and how much is known? Psychiatric disorders are complex genetic disorders; there is not a clear pattern of inheritance and it is likely multiple genes are involved. This FOCUS LIVE session will present multiple choice questions and discussion to familiarize the psychiatrist with concepts in psychiatric genetics and what is currently known. Recent advances in genetics present an opportunity to identify genes that confer risk or that are involved in treatment response for psychiatric disorders; and new research tools have advanced our understanding. This FOCUS LIVE session emphasizes the implications of this science for psychiatry.

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

REFERENCES:

1. Evans L, Akiskal HS, Keck PE Jr, McElroy SL, Sadovnick AD, Remick RA, Kelsoe JR. Familiality of temperament in bipolar disorder: support for a genetic spectrum. J Affect Disord. 2005 Mar;85(1-2):153-68.
2. Burmeister M. Genetics of psychiatric disorders: a primer: FOCUS 2006.4: 317-326.

RESEARCH PLANNING FOR DSM-V
APA Committee on Psychiatric Diagnosis and Assessment

Chairperson: Darrel A. Regier, M.D., *Presenters:* David J. Kupfer, M.D., Eric Hollander, M.D., Helena Chmyra Kraemer, M.D., Joel Dimsdale, M.D., David Shaffer, M.D., Norman Sartories, M.D.

EDUCATIONAL OBJECTIVES:

Members will be able to glimpse the global "state of the science" of areas within psychiatric classification, identify current research challenges; & understand the 3 phases of the DSM research planning effort. Products of these efforts & the current activities of the DSM-V Task Force will also be reviewed.

SUMMARY:

12 years prior to the anticipated 2012 publication of DSM-V, processes were set in motion to assess the research and clinical issues that would best inform future diagnostic classification of mental disorders. The goals of these efforts were to identify the clinical and research needs within various populations, utilize the current state of the science to highlight empirical evidence for improving criteria within and across disorders, and stimulate research in areas that could potentially provide evidence for change prior to formation of DSM revision groups. This forum will 1) summarize progress to date, including publications; 2) provide an overview of an ongoing series of international research planning conferences being convened by APA/APIRE in collaboration with the World Health Organization and the National Institutes of Health under a cooperative grant funded by NIH. Presentation topics include: a review of research recommendations generated since the last APA annual meeting that have examined the obsessive-compulsive behavior spectrum; the feasibility of incorporating dimensional aspects within the categorical diagnostic system; somatic presentations of mental disorders; and externalizing disorders of childhood; as well as anticipation of the global public health implications of the evolving research base in diagnosis related areas, a topic that will be the focus in 2007 of the concluding conference in the series); and 3) review the current status of the DSM-V Task Force and its workgroups.

REFERENCES:

1. Helzer JE, Kraemer HC, Krueger RF: The feasibility and need for dimensional psychiatric diagnoses.Psychol Med. 2006;36(12):1671-80.
2. Kupfer DJ, First MB, Regier DA (eds.): A Research Agenda for DSM-V. Washington, DC, American Psychiatric Association, 2002.

AUTOBIOGRAPHY YOUNG ADULT: METAPHORS FOR PUTTING A FACE ON HUMAN HISTORY

Chairperson: JoAnne Isbey, ABD, *Presenters:* Dorothy Bates, Daniel Dickstein, M.D., Leah J. Dickstein, M.D., Cheryl C. Munday, M.D., Eva Szigethy, M.D., Theresa Yuschok, M.D.

EDUCATIONAL OBJECTIVES:

1. Participants will be able to recognize contemporary archetypes in young adult autobiography and biography; 2. The audience will be invited to explore the clinical relevance of political differences in narratives and how these political differences resonate and represent the inner/outer reality of today's young people; 3. The participants will recognize the healing power of stories to promote the individualization process and character development of adolescents.

SUMMARY:

This interactive, intergenerational forum will explore the mythic and symbolic autobiographical and biographical texts as clinical narratives of faith and hope. As these ordinary persons navigate the confusing, chaotic political trajectories of their extraordinary times, they suffer abandonment, betrayal, and violence in their struggles to stay alive and true to their own souls. Professor JoAnne Isbey wil present an overview of the complex forces that mirror the ongoing human conflict between the individual and the collective tensions that mark all adolescent coming of age experiences across time. Dorothy Bates will identify the determination and spirit that enabled Frederick C. Douglass to prevail against overwhelming collective political forces. Leah Dickstein, M.D. will analyze the nodal transformative responses of Anne Frank to an epoch of cultural madness, determined to destroy her both physically and spiritually. Cheryl Munday, Ph.D. will reflect on the violence that permeated Anne Moody's identity formation, as she prevailed against unjust society. Theresa Yuschok, M.D. will illustrate the everyday encounters that mark the determination of the emergent heroic consciousness of Nafisi's refusal to submit to Tehran's proscribed oppression. Steven Dickstein, M.D. will assess the protective and risk factors that mediate Obama's path to growing toward adulthood. Daniel P. Dickstein, M.D. will analyze the complex collective pressures that militated against Malcolm X's profound courage and integrity. Eva Szigethy, M.D. will explore the cautionary tale of Kate Millett's indictment of homophobia and psychiatry's failure to confront it - a story that needed to be told. As we review the stories, we will search out analogues athat metaphorically resonate with this world's children in 2007.

REFERENCES:

1. Douglass F: Narrative of the Life of Frederick Douglass, An American Slave Written by Himself. New Haven, Yale University Press, 2001.
2. Frank A: The Diary of a Young Girl: The Definitive Edition. New York, Bantam Books, 1997.

ON THE FRONTLINE IN AMERICA: TREATING VIOLENT PATIENTS AND THE ETHICS OF PROVIDING CARE
Presidential Forum

Chairperson: Paul S. Appelbaum, M.D., *Presenters:* Ken Duckworth, M.D., Thomas G. Gutheil, M.D., Renee Binder, M.D.

EDUCATIONAL OBJECTIVES:

To review the risk factors for violence by persons with mental illnesses, approaches to managing violence risk, and the impact of violence potential on the psychiatrist-patient relationship.

SUMMARY:

This forum is being held in memory of Wayne Fenton, MD, whose tragic death highlights the challenges associated with the assessment and management of potentially violent patients with mental disorders. Although only a small percentage of persons with mental illness commit violent acts, and violence by such persons makes a minor contribution to the overall level of violence in the U.S., psychiatrists are often asked to deal with the confluence of mental disorder and violence. After honoring the memory of Dr. Fenton, the forum will begin with a review of the research on variables associated with violence by persons with mental disorders. Given the heterogeniety of violence as a behavior, a large number of risk factors have been identified, including such important determinants as age, gender, psychopathy, substance use, and impulsivity. But success in predicting violence has been constrained by the relatively small contribution made by any one risk factor to the overall variance. In the context of this uncertainty, the forum will next consider practical

approaches to managing potentially violent patients, including both psychotherapeutic and psychopharmacologic approaches. Understanding the limits of psychiatrists' abilities to predict and prevent violence is an important step toward avoiding tragic outcomes. Finally, the forum will address the impact of potential violence on the ethic of care for persons with mental illness. The relatively small risk of violence should not become an excuse for the abandonment of persons with serious mental illnesses; rather, psychiatrists must become comfortable with addressing and managing patients' propensities to violence.

REFERENCES:

1. Monahan J, Steadman H, Silver E, Appelbaum PS, Robbins PC, Mulvey EP, Roth LH, Grisso T, Banks S: Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence. New York, Oxford University Press, 2001.
2. Tardiff K: Concise Guide to Assessment and Management of Violent Patients, 2nd ed. Washington, DC, American Psychiatric Publishing, 1996.

SUBSTANCE ABUSE IN YOUR PATIENTS: BEYOND WHAT IS TAUGHT IN YOUR RESIDENCY

National Institute on Drug Abuse

Chairperson: Nora Volkow, M.D., *Presenter:* Paula D. Riggs, M.D., Herbert D. Kleber, M.D., Charles P. O'Brien, M.D., Thomas R. Kosten, M.D.

EDUCATIONAL OBJECTIVES:

(1) Gain a deeper understanding of the neurobiological underpinnings of addiction; (2) Learn strategies for recognizing addiction in your patients; (3) Learn about effective treatments for addiction.

SUMMARY:

According to the most recent National Survey on Drug Use and Health, an estimated 19.7 million Americans or 8.1% of the population aged 12 or older were current (past month) illicit drug users and nearly 8 million are in need of treatment. Drug abuse has far reaching consequences for individuals, families, communities and society at large. Research has demonstrated that addiction is a disease that can be successfully treated, but not if the symptoms are undetected and the problem undiagnosed. This Forum will bring together leading experts in the treatment of drug abuse and addiction to discuss how to recognize drug abuse problems as well as introduce participants to most recent discoveries about the neurobiology of addiction and how those are discoveries are contributing to the development of new, effective addiction treatments.

REFERENCES:

1. Volkow, ND, Li, TK. The neuroscience of addiction. Nature Neuroscie, 11: 1429-30, 2005.
2. Volkow, ND, Li, TK. Drugs and alcohol: treating and preventing abuse, addiction and their medical consequences. Pharmacol Ther. 108: 3-17, 2005.

WEST SIDE STORY AT 50 : THE MIND AND MUSIC OF LEONARD BERNSTEIN

Chairperson: Richard Kogan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant will be able to: (1) recognize the connection between hyperthymic temperament and bipolar disorder; (2) understand music's role in alleviating depression and accessing ecstatic states; (3) appreciate the challenges involved in artistic collaboration

SUMMARY:

Leonard Bernstein (1918-1990) was perhaps the most influential and versatile American musician of the 20th century. He was an outstanding conductor, an accomplished pianist, a renowned educator, and a composer who made significant contributions to Broadway, Hollywood and the concert hall. The year 2007 marks the 50th anniversary of the world premiere of Bernstein's best known work, the musical *West Side Story*, which was the product of his extraordinary collaboration with lyricist Stephen Sondheim, choreographer Jerome Robbins, and playwright Arthur Laurents. The musical score of *West Side Story* is a remarkable blend of the most sophisticated techniques expressed in a manner which insured its universal popularity. Such duality is at the essence of Bernstein. Throughout his life he sought to sustain the contradictions between elite and mass appeal, composing and performing, tradition and innovation, intellect and emotion. He experienced a similar contradiction in his personal life as he attempted to balance homosexuality and a traditional marriage and family life.

Psychiatrist and award-winning concert pianist Dr. Richard Kogan will perform musical examples that illuminate the arc of Bernstein's career and intrapsychic struggles. There will be a focus on concepts of particular interest to mental health professionals - hyperthymic temperament, histrionic personality disorder, and music's role in relieving depression and accessing ecstatic states.

REFERENCES:

1. Burton, Humphrey Leonard Bernstein.
2. Peyser, Joan Bernstein : A Biography.

ONGOING MENTAL HEALTH NEEDS FOLLOWING THE DEVASTATION OF HURRICANE KATRINA

Chairperson: Howard Osofsky, M.D. *Presenters:* Joy Osofsky, Ph.D., Robert S. Pynoos, M.D., Robert J. Ursano, M.D., Betty Pfefferbaum, M.D.

EDUCATIONAL OBJECTIVES:

To understand crisis intervention and psychological first aid in response to children and families following major disasters; To understand the effects of major trauma on children of different ages and the short and long term effects related to outcomes; Learn about reported symptoms following displacemdnt from trauma; Learn about implementation of resilience and efficacy building activities following trauma.

SUMMARY:

Hurricane Katrina, arguably the worst natural and man-made disaster in the United States, struck the Gulf Coast on August 29, 2005, devastating Metropolitan New Orleans and surrounding areas. Unlike many disasters with a limited crisis period followed by gradual recovery, progress toward recovery and resultant stability remains slow. Factors contributing to the ongoing state of chronic crisis include the extent of devastation, ongoing displacement of families and community supports, significant economic losses, lack of clarity and concrete plans for rebuilding, and questions about federal commitment to providing adequate levee and coastal protection. The amount of uncertainty and demoralization, even in a population relilient and desirous of rebuilding, is significant. The presentations will focus on the experiences and mental health impact on children, adolescents and families returning to Metropolitan New Orleans and on first responders who continue to cope with the aftermath including the slowness of the recovery. Delivery of evidence based Psychological First Aid, resilience building, and therapeutic services will be discussed. Lessons learned following this disaster that can be used to inform mental health immediate and continuing responses for future disasters will be presented.

REFERENCES:
1. Masten, A. (2001). Ordinary magic: Resilience processes in development. American Psychologist, 56, 227-238.
2. National Child Traumatic Stress Network and National Center for PTSD, Psychological First Aid: Field Operations Guide, September 2005.

MOVING NATIONAL HEALTH INFORMATION TECHNOLOGY AGENDA FORWARD

Chairperson: Robert Kolodner, M.D.

EDUCATIONAL OBJECTIVES:

1. Participants will expand their understanding of health information technology and its potential impact on the field of medicine and the practice of psychiatry. 2. Participants will become familiar with the Federal activities related to health information technology, and the role and function of the Office of the National Coordinator for Health Information Technology.

SUMMARY:

Dr. Kolodner has been actively involved in overseeing, promoting, and guiding health information technology initiatives in the VA for many years. His project work at the VA related to the establishment of a life-long, comprehensive, computerized clinical record for military personnel and our nation's veterans. He fostered the idea for the creation of My HealtheVet – a health portal for veterans and their families to access health information, tools and services via the Internet. As Interim National Coordinator for Health Information Technology and a psychiatrist, Dr. Kolodner will provide: an overview of the various activities of the Office of the National Coordinator for Health Information Technology; a psychiatrists's perspective on the national vision and direction for Health Information Technology (HIT); an outline of some of the beneifts of increased HIT to the practice of psychiatry (improved communication with other providers and improved continuity of care, better access to historic records, automated medication interaction checking, etc.); and commentary on the key concerns (privacy protection of electronic health information, cost and training burden to physicians, disruption of clinical workflow, etc.).

REFERENCES:

1. US Department of Health and Human Services – Health Information Technology website: http://www.hhs.gov/healthit.
2. Stead WW, Kelly BJ, and Kolodner RM. Achievable Steps Toward Building a National Health Information Infrastructure in the United States. J Am Med Inform Assoc 2005; 12: 113–120.

SHOCK: THE HEALING POWER OF ELECTROCONVULSIVE THERAPY: DOCUMENTARY AND DISCUSSION

Chairpersons: Kitty Dukakis, Larry Tye

EDUCATIONAL OBJECTIVE:

This presentation is designed to give participants a sense of one woman's experience with ECT, how that compares to benefits and risks afforded other patients, and how all that should influence a practitioner's decision on when and for whom to recommend the treatment.

SUMMARY:

Shock is two stories in one. The first half is Kitty Dukakis' 20-year battle against depression, along with alcohol and drug addictions. She tried every medication and treatment available, but it was not until she got electroconvulsive therapy five years ago that she could reclaim her life. In the other half of the book, Larry Tye looks at the science behind ECT and its dramatic yet subterranean comeback. Shock shows how ECT offers a better chance of overcoming depression and other disabling mental illnesses than the best antidepressant or therapy, but it also talks about memory loss and other potential risks.

"WALLY", A Film by Bob Fink, M.D.

Chairperson: Bob Fink

EDUCATIONAL OBJECTIVE:

The viewer will be more aware of the problems of disabled adults living with their aged parents and the issues facing their siblings before and after the parents' deaths. Additionally the viewers will be asked to look into their own minds and hearts and ask themselves, "What would you do?" The film speaks to the ever-growing issues faced by baby-boomers as their parents age and become infirmed.

SUMMARY:

"Wally" is a film named after a middle-aged man, who, in spite of a mental disability since birth, has made a life on the land he loves surrounded by neighbors and family who care for him and help to support him. Wally is an extremely engaging character, and we learn about his history, his interests and struggles as the film unfolds.

It is also the story of his sister, Cassie, who when crisis strikes is forced to try to resolve difficult decisions concerning the future of her brother as she tries to manage pressure from other relatives. It is a film about a woman trying her best to care for a disabled brother.

"Wally" is a film about the vicissitudes of family, common to everyone: about divided loyalties, fear and courage, dependency and autonomy—the dilemmas from which none of us can escape. It is a film about the enormous complexity of loving and being loved.

Cassie and Wally's story is told from a viewpoint that is both compassionate and generous. Perhaps, more than anything, this is a film that invites all of us to reflect upon our own humanity and capacities for finding our way in situations that offer no "good solutions," those times in a life when we feel forced to choose the way "of least suffering." It is a film about the implications and ramifications of those terrible choices we all eventually must face.

REFERENCES:

1. "When parents die, disabled adults need help."
2. "Children with Disabilities: Understanding Sibling Issues"

LECTURES

LECTURE 1—HISPANICS AND AIDS
APA'S Simon Bolivar Award Lecture

Presenter: Francisco Fernandez, M.D.

EDUCATIONAL OBJECTIVE:

Upon completion of this presentation, participants will be able to describe and discuss the: 1. Epidemiology of HIV/AIDS among Hispanics; 2. Economic and reproductive; implications of HIV/AIDS in the Hispanic Community; 3. Psychological and neurobehavioral effects of HIV/AIDS in Hispanics; 4. Special considerations for treatment of HIV/AIDS in Hispanics.

SUMMARY:

During the last several decades, the HIV/AIDS epidemic nationally and globally has become a major threat to the Hispanic community. Currently, in the USA, the Hispanic population is 35.3 million or about 12.5% of the total population. Yet, HIV/AIDS is rated as the third leading cause of death among Hispanic men aged 35 to 44 and the fourth leading cause of death among Hispanic women in the same age group. The current growth rate among Hispanics in the United States is 58%, which is the highest growth rate in any subgroup of the population. In this regard, it has been postulated that a certain number of AIDS-indicator conditions are more common in Hispanics and that the relative frequency and patterns of AIDS-indicator conditions in the Hispanic community are most influenced by differences in a) underlynig prevalence or exposure to various ediologic agents causing these conditions, b) diagnosis and reporting of conditions, and c) access to care and therapy for HIV-related conditions. Given these possibilities for risk, it is of utmost importance that we give full attention when assessing risk factors and securing epidemiological data related to HIV/AIDS among ethnic/racial groups, especially Hispanics. This presentation will define the HIV/AIDS epidemic in the Hispanic population, address the most important risk factors pertaining to HIV/AIDS among Hispanics, and review the most relevant clinical considerations related to this growing group in the epidemic.

REFERENCES:

1. Diaz R. Latino gay men and psycho-cultural barriers to IADS prevention. In Levin MP, Nardi PM, Gagnon JH, eds. Changing Times: Gay Men and Lesbians Encounter HIV/AIDS. Chicago: University of Chicago Press; 1997.
2. Ruiz P and Fernandez F: HIV/AIDS Among Hispanic Americans. In Psyghiatric Aspects of HIV/AIDS, edited by Fernandez F, Ruiz P, Baltimore, Lippincott, Williams and Wilkis, 2006, pp. 215-225.

LECTURE 2—ADOLESCENT PARRICIDE
AAPL/APA's Manfred S. Guttmacher Award Lecture

Presenter: Carl Malmquist, M.D.

EDUCATIONAL OBJECTIVES:

This presentation will first discuss the phenomena of adolescents who kill a parent. Clinical examples will be given, and questions rised about the significance of diverse types of maltreatment which have often been posited as contributory or causal factors. Difficulties will be illustrated when the clinical and developmental models are introduced into courtrooms in the form of Battered Child Syndrome with the goal of establishing that the parricide was a justified killing.

SUMMARY:

This is one type of adolescent homicide among others such as gang killings, school shootings, and confrontational murders. Parricide touches on diverse areas to be discussed, such as adolescent development, murder, family relationships, and special issues in law, such as an insanity defense and battered child syndrome defenses.

REFERENCES:

1. Chapter in Book--Malmquist CP: Juveniles and homicide, Homicide: A Psychiatric Perspective, American Psychiatric Publishing, 2006, pp 283-329.
2. Chapter in Book--Heide KM: Juvenile homicide encapsulated. In Juvenile Justice Sourcebook, edited by Roberts AR, new York, Oxford University press,2004, pp 424-474.

LECTURE 3—FROM PSYCHOPHARMACOLOGY TO ETHNOPSYCHOPHARMACOLOGY BACK TO PSYCHOPHARMACOLOGY
APA's Solomon Carter Fuller Award Lecture

Presenter: David C. Henderson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the need to integrate similarities and differences of diverse populations, in the United States and worldwide, into the mainstream psychiatry literature and training.

SUMMARY:

Psychiatry has experienced a tremendous growth and advancement in psychotropic medications to treat mental illnesses over the last 50 years. The United States has been a leader in this advancement. The United States also serves as the major psychiatric resource for much of the world. Many countries with limited resources, looks to the United States for guidance on how to treat psychiatric disorders and how to safely and effectively prescribe psychiatric medications. Unfortunately, much of the research performed in clinical trials do not include enough non-white subjects, so prescribing practice recommendations are based on the white US population. However, there is sufficient data that suggests that some non-white populations have differences in metabolic rates on CYP450 enzymes such as the 2D6. These differences (intermediate or slow metabolizers), which have been found in African American and African Blacks, and various Asian American and Asian populations, should result in different prescribing practices to reduce adverse events, improve compliance, and to allow a clinician to appropriately treat patients. This area has been called "Ethnopsychopharmacology" . However, data such as this must be integrated into the general psychopharmacology literature, teaching and training. Additionally, regulatory bodies such as the FDA and funding sources such as NIH/NIMH must vigorously adhere to their mandate of the inclusion of minorities and women and clinical trials.

REFERENCES:

1. Bradford LD: CYP2D6 allele frequency in European Caucasians, Asians, Africans and their descendants. Pharmacogenomics 2002; 3(2):229-43.
2. Lin KM: Psychopharmacology in cross-cultural psychiatry. Mt Sinai J Med 1996; 63(5-6):283-4.

LECTURE 4—THE ROAD TO EQUITY: MARCHING TOWARD A JUST TREATMENT OF MENTAL ILLNESS AND ADDICTION IN AMERICA.
National Institute on Drug Abuse

Presenter: Patrick J. Kennedy, B.A.

EDUCATIONAL OBJECTIVES:

1) Gain a better understanding of the disease burden of addiction and mental illness, particularly if untreated; 2) Emphasize the need

for more equitable treatment of these brain diseases; 3) Address the need to eliminate associated stigma, to get people the help they need.

SUMMARY:

Addiction and mental illness are a major public health problem in the country, affecting large segments of the population.

These diseases of the brain are tremendously costly, to individuals, their families, and society as a whole. Every year, nearly twice as many Americans die of suicide than homicide. Two-thirds of men and women arrested test positive for illegal drugs and the single largest mental health provider in the United States is the Los Angeles County Jail. Untreated mental illnesses and addictions are implicated in everything from homelessness and unemployment to teen pregnancy and special education. Indeed, according to the World Health Organization mental illnesses, including substance abuse, are far and away the most burdensome diseases in the world, far outstripping even cardiac disease.

Despite these prohibitive costs we choose as a society to restrict access to this needed health care. Providing just treatment of mental illness and addiction in this country is not only humane and right, it is also a path toward mitigating the devastating consequences that can occur for individuals, their families, friends, and neighbors, and society as a whole. With a rapidly improving understanding of the science of mental illnesses and addictions helping break down stigma and a new majority in Congress, 2007 can - and hopefully will -- be a turning point in finally extending America's promise to the millions of Americans living with these diseases.

LECTURE 5—FRONTIERS OF SCIENCE LECTURE SERIES
A NEUROTROPHIC HYOTHESIS OF DEPRESSIONS AND ANTIDEPRESSANT RESPONSE
Frontiers of Science Lecture Series

Presenter: Ronald S. Duman, Ph.D.

SUMMARY:

Evidence from basic and clinical research has contributed to the development of a neurotrophic hypothesis of depression and antidepressant response. These studies demonstrate that stress decreases neurotrophic factor expression, and causes atrophy and loss of neurons and glia in limbic brain regions implicated in mood disorders, most notably the hippocampus and prefrontal cortex. These effects could contribute to decreased volumes of hippocampus and prefrontal cortex observed in depressed subjects. In contrast, antidepressant treatment increases neurotrophic factor expression and increases the proliferation and survival of neurons in the hippocampus and glia in the prefrontal cortex, effects that block or reverse the actions of stress and depression. Brain derived neurotrophic factor (BDNF) has been the focus of this work, and consistent reports of reduced serum BDNF in depressed subjects suggests that this factor could be a biomarker, as well as functional determinant of depression and antidepressant response. In addition, recent work has demonstrated an essential role for vascular endothelial growth factor (VEGF), in the neurogenic and behavioral actions of antidepressants. VEGF increases the proliferation and survival of neurons, as well as endothelial cells, and increases synaptic plasticity of hippocampal neurons, effects that could contribute to neurogenesis-dependent and independent actions of antidepressants. Studies of these, as well as other trophic factors, further characterize the molecular and cellular mechanisms underlying the actions of stress, depression, and antidepressant responses, and provide novel targets for therapeutic intervention.

REFERENCES:

1. Duman RS, Monteggia L: A neurotrophic hypothesis for stress related mood disorders. Biol Psychiatry 2006; 59: 1116-1127.
2. Warner-Schmidt JL, Duman RS: Hippocampal neurogenesis: Opposing effects of stress and antidepressant treatments. Hippocampus 2006; 16: 239-249.

LECTURE 6—APA'S OSKAR PFISTER AWARD LECTURE
SPIRITUS CONTRA SPIRITUM: THE STRANGE CASE OF SPIRITUALITY AND ADDICTION
APA's Oskar Pfister Award Lecture

Presenter: William R. Miller, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to explain some overlaps between spirituality and addiction, and summarize what the science has shown thus far.

SUMMARY:

It is widely believed that spiritual factors play a key role in the etiology, course of, and recovery from addictions. What is the scientific basis for this relationship? How is spirituality different from religion, and how can these constructs be measured in health research? What is known about the outcome of "faith-based" treatment and recovery programs? Should spiritual considerations be integrated with other therapeutic approaches, and if so, how?

REFERENCES:

1. Miller WR: Spirituality, treatment and recovery. In Recent Developments in Alcoholism (Vol 16, Research on Alcoholism Treatment), edited by M. Galanter, New York, Kluwer Academic/ Plenum, 2003, pp391-404.
2. Miller WR, Thoresen CE: Spirituality, religion and health: An emerging research field. Am Psychologist 2003; 58:24-35.

LECTURE 7—LET'S LEAD: FROM CLINICAL INSIGHT TO CARING SYSTEMS
APA's Administrative Psychiatry Award

EDUCATIONAL OBJECTIVES:

The lecture objective is to illustrate how we, as psychiatrists and mental health professionals, can provide leadership and reclaim territory in going from an understanding of mental illness, treatment and rehabilitation to develop systems of care which meet the needs of our patients.

SUMMARY:

Mental illness is often devasting. We begin our work by having our patients talk and we listen. Biologic, psychologic, socio-educational, existential and recovery perspectives guide our treatment. Mental health administration is different from the clinical practice, because it requires knowledge about organizational economics, financing, policy and politics, public relations, evidence-based management information and others. Leaders in administration need both clinical and managerial skills to make a difference.

Excellent leadership is being able to go from an understanding of individual to develop wonderfully effective systems of care. Although some patients require medication and therapy only, others require much more help to live, learn, love, work and play. There are broad principles that can apply.

Today, the community must be seen as an extension of the hospital and the hospital an extension of the community. Mental illnes has its progression and repression and services must meet this need. Central authority and management are essential to prevent fragmentation, duplication and unnecessary competition. To help people achieve their highest level of functioning, there must be levels of care. These must be linked, not as separate hot dogs lined up but

as a continuum. There must be seamless continuity of care, fixed responsibility and a continuum. Barriers to access and failures of funding for a broad based system must be minimized. These principles for success will be illustrated and discussed in the context of patient care.

Leadership by psychiatrists in administration requires translating clinical care and understanding of systems, based on experience, into exciting program development. Patients need our expertise.

REFERENCES:

1. Gudeman, Jon (2003), Mental Health Management Environments: The Community Mental Health Center Medical Director, pp. 134-148 in Reid, W & Silver S. Handbook of Mental Health Administration & Management, Bruner Routledge, N.Y.
2. Gudeman, Jon, The Evolution of a Public Psychiatric Hospital in Shore, M. & Gudeman, J., Serving the Chronically Mentally Ill in an Urban Setting, New Directions for Mental Health Services, No.39, Fall 1988, Jossey Bass, San Francisco, CA.

LECTURE 8—STRESS RESPONSIVITY, GENE VARIANTS, AND PERSISTENCE OF ADDICTIONS STRESS RESPONSIVITY, GENE VARIANTS, AND PERSISTENCE OF ADDICTIONS

National Institute on Drug Abuse

Presenter: Mary J. Kreek, M.D.

EDUCATIONAL OBJECTIVES:

To share very current information about the neurobiology of stress as related to addiction and update what is known about functional variants of genes related to stress response and their relationship to specific addictions.

SUMMARY:

Basic clinical and laboratory research have provided extensive evidence that acute, subacute, and chronic exposure to short-acting drugs of abuse alter specific molecular biological (gene expression), hormonal (e.g., vasopressin, CRF, ACTH, and gluccocorticoids), and integrated physiology of stress responsivity. Other clinical and laboratory studies suggest that altered stress responsivity, on a genetic, environmental, or (after self-exposure) on a drug-induced basis, may contribute to the acquisition, persistence of, and relapse to an addiction. In related studies, it has been shown that stress and stressors contribute to relapse to drug self-administration in animal models and in humans. Recent human molecular biological studies from our laboratory and others have discovered that a common variant of the mu opioid receptor gene is functional, alters stress responsivity in normal healthy humans, and is strongly associated with heroin addiction and with alcoholism in minimally admixed populations. Other genetic variants also may contribute to altered stress responsivity and thus to increased vulnerability to develop, or protection from developing, an addiction. NIH DA-K05-00049 (MJK), DA P60 05130 (MJK), MH-79880 (MJK), and UL1-RR024143 (Barry Coller).

REFERENCES:

1. Kreek, M.J., Bart, G., Lilly, C., LaForge, K.S., and Nielsen, D.A.: Pharmacogenetics and human molecular genetics of opiate and cocaine addictions and their treatments. Pharmacol. Rev. 57:1-26, 2005.
2. Kreek, M.J., Nielsen, D.A., Butelman, E.R., and LaForge, K.S.: Genetic influences on impulsivity, risk-taking, stress responsivity, and vulnerability to drug abuse and addiction. Nat. Neurosci. 8:1450-1457, 2005.

LECTURE 9—THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY: IMPACT ON PSYCHIATRIC EDUCATION: PAST, PRESENT AND FUTURE

APA/NIMH Vestermark Psychiatry Educator Award Lecture

Presenter: Stephen C. Scheiber, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate his knowledge of the evolution of the American Board of Psychiatry's influence on psychiatric education since its inception in 1934 to the present and understand what to expect in the future.

SUMMARY:

The American Board of Psychiatry and Neurology has played a significant role in the education of residents since its inception in 1934. Initially it took responsibility for both certification of individuals as well as reviewing residency programs in the two clinical disciplines. The history of the evolution of its responsibilities and leadership role in psychiatric education will be traced. The recent evolution of subspecialty recognition will be presented.. The challenges of maintenance of certification are currently being addressed with the Board establishing requirements for continuing medical education, self assessment and lifetime learning, and measuring practice parameters. The Board has played a critical role in documenting core competencies in the specialty. All this occurs at the same time that changes are being made and others contemplated for the certification process. The influence of the Board: past, present and future will be highlighted.

REFERENCES:

1. Scheiber, SC,Kramer,AM,Adamowski, SE: Core Competencies for Psychiatric Practice:What Clinicians Need to Know. Washington, D.C. Amerian Psychiatric Press, 2003.
2. Shore JH, Scheiber SC:Certification, Recertification and Lifetime Learning in Psychiatry, American Psychiatric Press, 1994.

LECTURE 10—ADVANCING PATERNAL AGE AND OFFSPRING RISKS FOR PSYCHIATRIC DISORDERS: A TRANSLATIONAL PERSPECTIVE

Distinguished Psychiatrist Lecture Series

Presenter: Dolores Malaspina, M.D.

EDUCATIONAL OBJECTIVES:

To describe relationship between later paternal age and the risk for psychiatric diseases

To describe how the interaction between genetic factors and the environment, particularly the intrauterine environment, may increase the risk for schizophrenia

To describe ''epigenetic'' regulation of gene expression, including how environment may influence the expression of genes.

SUMMARY:

In a controversial era of modern psychiatry, a ''schizophrenogenic'' mother was thought to contribute to the risk for schizophrenia. In part, this observation rested on an excess risk of the disease for the younger children in large sibships. It was presumed that mothers of these children were less emotionally available. In fact, older fathers are a more likely explanation for this excess risk.

Paternal age at conception is a robust risk factor for schizophrenia. Possible mechanisms include de novo point mutations or defective epigenetic regulation of paternal genes. the predisposing genetic events appear to occur probabilstically (stochastically) in proportion to advancing paternal age, but might also be induced by toxic exposures, nutritional deficiencies, suboptimal DNA repair enzymes, or

other factors that influence the fidelity of genetic information in the constantly replicating male germ line. We propose that de novo genetic alterations in the paternal germ line cause an independent and common variant of schizophrenia.

REFERENCES:

1. Malaspina D, Harlap S, Fennig S, Heiman D, Nahon D, Feldman D, Susser ES. Advancing paternal age and the risk of schizophrenia.Arch Gen Psychiatry. 2001 Apr;58(4):361-7.
2. Reichenberg A, Gross R, Weiser M, Bresnahan M, Silverman J, Harlap S, Rabinowitz J, Shulman C, Malaspina D, Lubin G, Knobler HY, Davidson M, Susser E. Advancing paternal age and autism.Arch Gen Psychiatry. 2006 Sep;63(9):1026-32.

LECTURE 11—THE HEALING POWER OF ECT THE HEALING POWER OF ECT

Presenter: Kitty Dukakis, Larry Tye

EDUCATIONAL OBJECTIVES:

This presentation is designed to give participants a sense of one woman's experience with ECT, how that compares to benefits and risks afforded other patients, and how all that should influence a practitioner's decision on when and for whom to recommend the treatment.

SUMMARY:

There is no treatment in psychiatry more frightening than electroconvulsive therapy. There also is no treatment more effective than ECT.

This presentation seeks to separate scare from promise. In the process it offers guidance to practitioners on whether ECT can help patients battle depression and other disabling mental diseases. ECT stirs fears and hopes that intrigue everyone, but that mystify most. This talk is an exercise in demystification.

It does that in two voices, one personal, the other explanatory. The narrative is Kitty Dukakis's experience with ECT. Kitty knows about mental illness. For two decades she has suffered a depression that at times has marooned her in bed. She also knows about addictions. Her unlucky romance with diet pills started at age nineteen and lasted twenty-six years. Her drinking began later and persisted nearly as long. Such dependencies and disease would be tormenting for anyone; Kitty's were aggravated by her husband Michael's three terms as governor of Massachusetts, his 1988 run for president, and her high-profile roles in all of them.

The explanatory part comes from Larry Tye, a former medical writer at the *Boston Globe*. He explores the dramatic yet subterranean comeback of ECT, then zeroes in on what the treatment looks like today from the United States to the Indian subcontinent. He compares and contrasts Dukakis' experience with that of more than 100 other patients and scores of doctors he interviewed. And he reviews the mechanisms underlying electroshock, ones we know and others we guess at.

REFERENCES:

1. The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging, 2nd ed. Washington, D.C.: American Psychiatric Association, 2001.
2. Surgeon General of the United States. Mental Health: A Report of the Surgeon General. Washington, D.C.: U.S. Department of Health and Human Services, 1999.

LECTURE 12—WILLIAM C. MENNINGER MEMORIAL CONVOCATION LECTURE WILLIAM C. MENNINGER MEMORIAL LECTURE William C. Menninger Memorial Lecture

Presenter: John Nash

LECTURE 14—GLUTAMATE, THE PREFRONTAL CORTEX, AND SCHIZOPHRENIA: CAPTURING THE ANGEL IN "ANGEL DUST"

Distinguished Psychiatrist Lecture Series

Presenter: John H. Krystal, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation the participant should be able to understand the links between NMDA glutamate receptor dysfunction, abnormalities in the prefrontal cortex, cognitive disparities that underlie the disability associated with the diagnosis of schizophrenia and novel experimental treatment approaches.

SUMMARY:

Cognitive impairments associated with schizophrenia are disabling features of this disorder. This lecture will review research studies that may provide insights into the treatment of these cognitive impairments derived from studying the study of the NMDA glutamate receptor antagonist, ketamine. Two key impairments in prefrontal cortex function may emerge from reductions in NMDA receptor function: a more rapid decay of working memory and an inability to optimize PFC function in the service of cognition. This presentation will review the emerging treatment implications of these findings.

REFERENCES:

1. Krystal JH, Karper LP, Seibyl JP, et al.: Subanesthetic effects of the NMDA antagonist, ketamine, in humans: psychotomimetic, perceptual cognitive, and neuroendocrine effects. Arch Gen Psychiatry1994; 51:199-214.
2. Krystal JH, Dâ™Souza DC, Mathalon D, et al. NMDA receptor antagonist effects, cortical glutamatergic function, and schizophrenia: Toward a paradigm shift in medication development. Psychopharmacology 2003;169(3-4):215-33.

LECTURE 15—THAILAND'S RECENT EXPERIENCE: COMMUNITY MENTAL HEALTH AND DE-STIGMATIZATION

International Psychiatrist Lecture Series

Presenter: Apisamai Srirangson, M.D.

EDUCATIONAL OBJECTIVES:

1.) Participants will learn of the particular challenges that Thailand encounters in providing Mental Health services to its people and how social, cultural and economic factors affect these services. 2.) Participants will learn about Department of Mental Health's community mental health and de-stigmatization programs, current progress of these programs and future plans. 3.) Participants will take away an appreciation of the need to interpret 'best practices' in light of local culture in an economically sustainable model.

SUMMARY:

Thailand faces many of the same mental health challenges as other countries in the developing world but has taken a more active role in confronting them. The nation of 60 million is served by less than 400 psychiatrists in 17 specialized facilities. Cultural and traditional beliefs in harmonious living and family provide a strong support system inside the home but can promote embarrassment concerning the mental health of a family member and can delay access to professional help.

Thailand has created a special agency to address these needs. The Department of Mental Health is responsible for the promotion of mental health in addition to the treatment and rehabilitation of patients with mental illness. Although community mental health has been a priority for years, Thailand is in the process of instituting a

new improved national community mental health project; trying to implement best practices for community mental health in a culturally appropriate and economically sustainable model. This model focuses on social and community issues in addition to treatment. It also aims to enlist political and public support to reduce the stigma of mental illness and decrease the discrimination that patients and their families experience. Thailand has had significant success with an ongoing national de-stigmatization campaign, developing advocacy and empowering affected portions of the population. This presentation will review the recent history and progress of current mental health initiatives and will demonstrate the progress of the community mental health project and the importance of the de-stigmatization campaign as part of this effort.

REFERENCES:

1. Murthy, et. al: The world health report 2001 - Mental Health: New Understanding, New Hope. Geneva Switzerland, World health Organization,.
2. Norman Sartorius and Hugh Schulce:Reducing the Stigma of Mental Illness:A Report From a Global Programme of the World Psychiatric Association:Cambridge University Press,2005.

LECTURE 16—THE FUTURE OF PSYCHIATRY: INTERNATIONAL PERSPECTIVES
International Psychiatrist Lecture Series

Presenter: Norman Heinz Sartorius, M.D.

SUMMARY:

The future of psychiatry will reflect developments in the wider society and in medicine in addition to changes that science and experience will make necessary in psychiatry itself.

The lecture will discuss the context of changes of psychiatry and challenges before our discipline and suggest avenues of action that will make psychiatry useful to those suffering from mental illness and to medicine and society in general.

REFERENCES:

1. Sartorius, N. Fighting for Mental Health, Cambridge University Press, 2002.
2. Sartorius, N: Metnal Health Policies for the 21st Centruy: A personal view. Integrated Psychiatry 1987; 5(3):151-154.

LECTURE 17—THE NEUROBIOLOGY OF FREE WILL IN ADDICTIVE DISORDERS
National Institute on Drug Abuse

Presenter: Nora Volkow, M.D.

EDUCATIONAL OBJECTIVES:

(1) To give participants a fundamental knowledge of the complex biological and environmental factors that underlie vulnerability to drug abuse and addiction. (2) To teach participants about changes in the brain dopaminergic system that distinguish drug use or drug intoxication from addiction. (3) To help participants appreciate the complex interaction of the multiple brain circuits involved in addiction.

SUMMARY:

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

REFERENCES:

1. Volkow ND, Fowler JS, Wang G-J. The addicted human brain viewed in the light of imaging studies: brain circuits and treatment strategies. Neuropharmacology 47: 3-13, 2004.
2. Kalivas PW, Volkow ND. The neural basis of addiction: a pathology of motivation and choice. Am J Psychiatry 162: 1403-1413, 2005.

LECTURE 18—NEW NEURONS IN THE ADULT BRAIN
Frontiers of Science Lecture Series

Presenter: Fred H. Gage, Ph.D.

EDUCATIONAL OBJECTIVES:

My objective is to educate the audience on the recent developments in research on neurogenesis in the adult mammalian brain

SUMMARY:

Most neurons in the adult central nervous system (CNS) are terminally differentiated and are not replaced when they die. Evidence now exists that small populations of neurons are formed in the adult olfactory bulb and hippocampus. In the adult hippocampus, newly born neurons originate from putative stem cells that exist in the subgranular zone of the dentate gyrus. Progeny of these putative stem cells differentiate into neurons in the granular layer within a month of the cellsâ€™ birth, and this late neurogenesis continues throughout the adult life of all mammals. Stem cells can be harvested from a variety of brain and spinal cord regions, genetically modified, and transplanted back to the brain and spinal cord where they can differentiate into mature glia and neurons depending on the local environment. In addition, environmental stimulation can differentially affect the proliferation, migration, and differentiation of these cells in vivo. These environmentally induced changes in the structural organization of the hippocampus, result in changes in electrophysiological responses in the hippocampus, as well as in hippocampal related behaviors. We are studying the cellular, molecular, as well as environmental influences that regulate neurogenesis in the adult brain and spinal cord. We have recently identified several proteins that regulate proliferation, survival and differentiation of these adult derived stem cells. The functional and practical significance of these findings will be discussed in light of their implications for alternative or expanded views of structural plasticity in the adult brain.

REFERENCES:

1. . Muotri, A.R. and Gage, F.H. Generation of neuronal variability and complexity. Nature, 44: 1087-1093, 2006.
2. . Lie, D.C., Song, H., Colamarino, S.A., Ming, G. and Gage, F.H. Neurogenesis in the adult brain: new strategies for central nervous system diseases. Annu. Rev. Pharmacol. Toxicol. 44: 399-421, 2004.

LECTURE 19—THE THREE STAGES OF SCHIZOPHRENIA: CAN EARLY DETECTION AND INTERVENTION CHANGE ILLNESS COURSE AND PREVENT DISABILITY?
APA's Adolf Meyer Award Lecture

Presenter: Jeffrey A. Lieberman, M.D.

EDUCATIONAL OBJECTIVES:

1. understand the progressive nature of schizophrenia as a neurodegenerative disorder and the prospect of preventive interventions.
2. define the stages of schizophrenia in terms of patient episodes of active symptoms using diagnostic criteria.
3. appreciate why a "one size fits all" treatment approach of antipsychotic drugs is not optimal.

SUMMARY:

The hallmark of schizophrenia first recognized by Kraepelin was the "clinical deterioration" that emerged in its clinical course. This phenomenon was attributed to progression of the illness and thought to reflect neurodegeneration. However, the absence of supportive histopathologic evidence and the emergence of genetics and developmental neurobiology gave rise to the predominance of neurodevelopmental theories of schizophrenia. But recent longitudinal neuroimaging studies have characterized the progressive nature of the illness by demonstrating region specific reductions in gray matter volume. These findings have revived the question of whether schizophrenia is a neurodegenerative disorder and the prospect of preventive interventions.

The phenomenon of clinical deterioration frames the natural history of schizophrenia into three clinical stages. The first is the premorbid stage in which the clinical manifestations of the illness have been not been fully expressed and patients cannot yet be diagnosed. The second is the onset/progressive stage in which the symptoms of schizophrenia are expressed gradually or iteratively till they eventually meet diagnostic criteria. Third is the chronic/residual stage in which patients have experienced sustained or multiple episodes of active symptoms and clinical deterioration after which they remain residually symptomatic and functionally disabled.

Distinct pathophysiological processes underlie each clinical stage in a manner that is comparable to congestive heart failure, type II diabetes and hypertensive cardiovascular disease. The different pathophysiological mechanisms provide different targets and require different therapeutic approaches. Thus the "one size fits all" treatment approaches based on antipsychotic commonly employed are not optimal for this model of the disease.

REFERENCES:

1. Lieberman JA, Tollefson GD, Charles C, Zipursky R, Sharma T, Kahn RS, Keefe RS, Green AI, Gur RE, McEvoy J, Perkins D, Hamer RM, Gu H, Tohen M: Antipsychotic drug effects on brain morphology in first-episode psychosis. Arch Gen Psychiatry 2005; 62(4).
2. Lieberman JA, Perkins D, Belger A, Chakos M, Jarskog F, Boteva K, Gilmore J: The early stages of schizophrenia: Speculations on pathogenesis, pathophysiology and therapeutic approaches. Biological Psychiatry 2001; 50(11):884-897.

LECTURE 20—HOMOSEXUALITY AND IGNORANCE
APA's John Fryer Award Lecture

Presenter: Lawrence Hartmann, M.D.

EDUCATIONAL OBJECTIVES:

This lecture and discussion will try to help consider the history of homosexualities, the history of psychiatry and homosexualities, and the interaction of ignorance and prejudice in much of this history.

SUMMARY:

We will consider the long cross-species and international history of homosexualities, with documentation at least since Gilgamesh and the Iliad ; go on to the history of psychiatry and homosexualities in the 19th and 20th Centuries; go on to many kinds of research, knowledge, and ignorance in the mid 20th Century; go on to the considerations and achievements of the 1973 APA decision to remove homosexuality form our diagnosticd manual; go on to the many interactions of these issues with scientific, social, legal, govermental issues since 1973. Much ignorance remains, as does much prejudice. The change from sin to crime to illness to difference is a major conceptual shift.

REFERENCES:

1. Cabaj R, Stein T,eds :Textbook Of Homosexualih, Washington, D.C., American Psychiatric Press, 1996.
2. Drescher J, Lingiardi V,eds : Journal of Gay and Lesbian Psychotherapy, vol 7 # 1 : The mental Health Professions and Homosexuality: International Perspectives, New York, Haworth Press, 2003.

LECTURE 21—THE CREATING BRAIN: THE NEUROSCIENCE OF GENIUS
APA'S Judd Marmor Award Lecture

Presenter: Nancy C. Andreasen, M.D.

EDUCATIONAL OBJECTIVES:

To explore the definition of creativity
To discuss the relationship between creativity and mental illness

SUMMARY:

The capacity to be creative_to produce new concepts, ideas, inventions, objects, or art_is perhaps the most important attribute of the human brain. We know very little, however, about the nature of creativity or its neural basis. Some important questions include: how should we define creativity? How is it related (or unrelated) to high intelligence? What psychological processes or environmental circumstance cause creative insights to occur? What is happening at the neural level during moments of creativity? How is it related to healthy or illness, and especially mental illness? How can creativity be enhanced or nurtured, or can it? This presentation will review introspective accounts from highly creative individuals. It will also review existing data from neuroimaging on the neural basis of creativity and its relationship to unconscious processes. And it will review evidence concerning familial transmission of creativity and its relationship to mental illnesses.

REFERENCES:

1. Andreasen NC (1987): Creativity and mental illness: prevalence rates in writers and their first-degree relatives. Am J Psychiatry; 144(10):1288-1292.
2. Andreasen NC (1987): The Creating Brain: The Neuroscience of Genius. Washington, DC: The Dana Press.

LECTURE 22—LECTURES PRESENTER: WILLIAM T. CARPENTER A PARADIGM SHIFT FOR SCHIZOPHRENIA DISCOVERY
Distinguished Psychiatrist Lecture Series

Presenter: William T. Carpenter, Jr., M.D.

SUMMARY:

Schizophrenia as a disease entity has influenced most work in the field. Limitations of this paradigm are severe. An alternative paradigm based on domains of pathology is more robust and can help address shortcomings in etiological, pathological, and therapeutic discovery. Domains of pathology are the basis for deconstructing

psychotic syndromes and understanding the porous boundaries between disease classes.

REFERENCES:

1. Carpenter WT. The schizophrenia paradigm: A hundred-year challenge [Editorial]. The Journal of Nervous and Mental Disease 2006: 194(9):639-643.
2. Kirkpatrick B, Buchanan RW, Ross DE and Carpenter WT. A separate disease within the syndrome of schizophrenia. Archives of General Psychiatry 2001: 58:165-171.

LECTURE 23—PSYCHOSIS ON THE STREETS: AN ETHNOGRAPHY OF CHICAGO'S NETHERWORLD
Frontiers of Science Lecture Series

Presenter: Tanya Luhrmann, Ph.D.

SUMMARY:

The presentation describes the social and cultural world of homeless psychotic women in one neighborhood in Chicago. It argues that cultural and social factors may inhibit the women's willingness to accept help. Those social and cultural factors may also make the illness worse. The history of the way schizophrenia has been conceptualized in American psychiatry has led us to be hesitant to explore the role of social causation in schizophrenia. But there is now good evidence for social impact on the course, outcome and even origin of schizophrenia, most notably in the better prognosis for schizophrenia in developing countries and in the higher rates of schizophrenia for dark-skinned immigrants to England and the Netherlands. The presentation proposes the experience of social defeat during homelessness may impact illness experience. It uses original ethnographic research to argue that the social defeat is a common feature of the social context in which many people diagnosed with schizophrenia in America live today.

REFERENCES:

1. Luhrmann TM Social defeat Culture, Medicine and Psychiatry, in press.
2. Harrison G et.al. Increased incidence of psychotic disorders in migrants from the Caribbean to the United Kingdom. Psychol Med. 1997; 27: 799-806.

LECTURE 24—KEYS TO EFFECTIVE MENTORING FOR ALL IN PSYCHIATRY
Distinguished Psychiatrist Lecture Series

Presenter: Leah Dickstein, M.D.

EDUCATIONAL OBJECTIVES:

Attendees will learn the specific keys to functioning as effective mentors including: understanding the mentee's goals, guiding them to plan steps to successes and teaching them the skills needed to gain professional independence and begin mentoring others, while continuing to receive mentoring from others for specific needs.

SUMMARY:

Too often those seen as the best potential mentors are the busiest professionals, unable to assume yet more responsibilities to guide those less experienced professionally who are earnestly seeking senior advisors, coaches, i.e., mentors.

However, all levels of professionals, across the spectrum of professional knowledge and experiences, learning the foundation blocks, i.e., effective keys to good mentoring, can understand, adopt, adapt, and apply them to guide increasing numbers of mentees seeking professional assistance.

Asking the right questions too learn another's current visions, goals, knowledge and skills, guiding them to set priorities, gain additional needed knowledge & skills through selected experiences and to reach out to others too to network professionally in their fields of interest locally, nationally, internationally whether on-line or at professional meetings.

Maintaining professional communication with mentees whether on-line, in person or by phone, mentors must ensure mentees become aware of what they are learning so they can also begin advising others as they become more independent professionals, are major keys to success.

Attendees will gain insights into the mutual professional benefits of mentees maturing into mentors, even to their senior mentors, who, over specific issues, can become mentees themselves. Aver time these professional exchanges add to career successes and professional satisfactions.

Finally, academic and all institutional administrators must ensure mentors receive appropriate credit and time to carry out these most valued roles.

REFERENCES:

1. Advisor, Teacher, Role Model, Friend (book) Natioal Academy of Sciences & Engineering, Institute of Medicine, National Academy Press Washsington DC 1997.
2. The Lexan Ceiling Leah J Dickstein, M.D.,M.A. Psychiatric News col. 1991 Dec.

PRESIDENTIAL SYMPOSIA

1. THE ROLE OF ETHICS IN WORLD PSYCHIATRY

APA Council on Global Psychiatry

Chairperson: Pedro Ruiz, M.D.
Co-Chairperson: Darrel A. Regier, M.D.
Discussant: Alan A. Stone, M.D.

1. **Conflicts of Interests in Psychiatric Practice and Research**
   Mario Maj, M.D.
2. **TBD**
   Sam Tyano, M.D.
3. **Ethics in the Mediterranean Countries**
   Juan J. Lopes-Ibor, Jr., M.D.
4. **From Ethical Mantras to Living Ethics in Psychiatry**
   Julio Arboleda Flores, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this symposium, the participants will 1) be able to learn about the role of ethics in worldwide psychiatry, 2) assess the best enforceable ways of implementing internationsl ethical standards, and 3) identify which ones are the most relevant ethical standards across the world.

SUMMARY:

Ethical standards in Psychiatry has been increasingly focused upon and improved during the last several decades. The World Psychiatric Association (WPA) has put forward several "declarations" (Madrid) focusing on this very important topic in the field. Despite these efforts one must question the cpaacity of existing international institutions, organization and/or associations to enforce ethical standards worldwide. In most instances, ethical violations in the field of psychiatry are not looked at, rationalized, minimally enforced or negiated along political lines. Yet, as the globalization process intensifies all over the world, respect for ethical standards in the profession and field becomes more relevant and essential.

In this symposium a series of world leaders in the field of psychiatry will examine this issue, discuss it and debate it. The aim is to bring clarity, relevance and enforcable methods that are effective and consistantly applicable. At times, international organizations weakens from an ethical standards and ethical image point of view. This unfortunate situation makes it imperative that out efforts to substain appropriate methods and models to substain appropriate ethical standards across the world in an ongoing basis.

REFERENCES:

1. Maj M: Conflicts of interests in psychiatric research and practice. Die Psychiatrie 2005; 2: 138-140.
2. López-Ibor Jr., J.J.y M.D. Crespo Hervás: A West Mediterranean Perspective. En: ETHICS, CULTURE AND PSYCHIATRY. INTERNATIONSL PERSPECTIVES. A Okasha, J. Arboleda-Florez, N. Sartorius (Eds.). American Psychiatric Press, Inc. Washington, D.D., 2000.
3. The Declaration of Madrid. http://www.wpanet.org/generalinfo/ethic1.html.

2. WOMEN LEADERS IN THE APA AND BEYOND

APA Committee on Women

Chairperson: Pedro Ruiz, M.D.
Co-Chairperson: Donna M. Norris, M.D.
Discussant: Altha J. Stewart, M.D., Mary Jane England, M.D.

5. **Women Leaders of the APA and Beyond: The Contribution of International Medical Graduates**
   Geetha Jayaram, M.D.
6. **Women in Leadership: Issues and Challenges**
   Ann Marie T. Sullivan, M.D.
7. **No Crystal Stair**
   Annelle B. Primm, M.D.
8. **Getting to the Inner Circle - The Long Hard Trail**
   Jo-Ellyn M. Ryall, M.D.
9. **Lessons in Leadership: Mentoring Our Future Women Leaders**
   Patricia Isbell Ordorica, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this cymposium, members of the audience will be able to appreciate important factors in th professional development of a diverse group of women leaders in the American Psychiatric Association and other national medical and educational organizations. Highlights of these presentations will be the personal stories of these outstanding women.

SUMMARY:

During my introduction, I will address the important role of women in organized medicine, especially in psychiatry. I will also discuss the priorities and emphasis that I see for women psychiatrists within the American Psychiatric Association structure. Hopefully, this discussion will help to embrace the role of women in the American Psychiatric Association.

REFERENCES:

1. Journal Article: Davidhizar,R et al: Gender Differences in Leadership in the Health Professions. Frederick:March 2000 Vol.18, Iss.3.pp.18 -25.
2. Brown D, Keith V: In and Out of Our Right Mind: The Mental Health of Black Women, New York, NY Columbia University Press, 2004.
3. None.
4. Robinson-Walker C: Women and Leadership in Healthcare: The Journey to Authenticity and Power. San Francisco, Jossey-Bass, 1999.

3. Review of Geriatric Psychiatry—Current Issues

Chairperson: Christopher C. Colenda, M.D.
Co-Chairperson: Pedro RuizColenda, M.D.

10. **Late Life Addiction: Rapidly Changing Needs**
    David W. Oslin, M.D.
11. **Health Services Research in Geriatric Psychiatry**
    Mark Snowden, M.D.
12. **Diversity Issues in Geriatric Psychiatry**
    Warachal E. Faision, M.D.
13. **Ethical Issues in Geriatric Psychiatry Research**
    Scott Y. Kim, M.D.

EDUCATIONAL OBJECTIVE:

Demonstrate a basic knowledge of the major components that distinguish geriatric psychiatry from general psychiatry; Identify 3 current trends in the field of geriatric psychiatry; Recognize the unique treatment differences of older adults.

SUMMARY:

This session will contain an overview of the field of geriatric psychiatry. The intended audience for this program is general psychiatrists interested in late life mental illness as well as for those clinicians who are finding their patient population is aging. Special emphasis will be placed on current topics and trends in the field of geriatric psychiatry including health services research, teaching and training issues, diversity, bio-ethical concerns, and late life addictions research and interventions.

With one in five individuals over age 65 suffering from mental disorders, and the number of older adults with psychiatric disorders expected to double in the next 30 years, psychiatrists treating late life mental disorders will become even more critical to the paradigm of quality health care.

REFERENCES:

1. Bartels S, Unutzer J: Special issue on mental health services research. Am J of Geriatric Psychiatry;2003 Sep-Oct;11(5).
2. Mintzer J, Hendrie H, Faison W. Geriatrics: Minority and Sociocultural Issues. In Benjamin J Sadock and Virginia Sadock (Eds). Kaplan & Sadock's Comprehensive Textbook of Psychiatry, Baltimore, MD, Lippincott Williams & Wilkins, 2004.
3. Kim SYH, Appelbaum PS, Jeste DV, Olin JT. Proxy and Surrogate Consent in Geriatric Neuropsychiatric Research: Update and Recommendations. Am J Psychiatry 2004; 161(5):797-806.

4. CURRENT RESEARCH ADVANCES: APA/NIMH/ NIDA/NIAAA/NAMI PERSPECTIVES

APA Council on Global Psychiatry

12. Current Research Advances: APA/NIMH/NIDA/NIAAA/ NAMI Perspectives

Discussant: Nora D. Volkow, M.D., *NIDA, 6001 Executive Blvd Room 5274, Bethesda, MD, 20892-0001*Discussant: Thomas R. Insel, *NIMH, 6001 Executive Boulevard, Bethesda, MD, 20892*Co-*Chair:* Darrel A. Regier, M.D., *American Psychiatric Association, 1000 Wilson Blvd., Suite 1825, Arlington, VA, 22209Chairperson:* Pedro Ruiz, M.D., *University of Texas Health Sci. Center, Department of Psychiatry, 1300 Moursund St, Houston, TX, 77030-3406 Presenter:* Pedro Ruiz, M.D.

SUMMARY:

As a consequences of the research efforts made during the "decade of the brain", major advances have taken place in all areas and aspects of research; particularly, in the neurosciences field. This impact and outcomes have taken place not only in the United States but across the world as well. Unique areas of major advances have been imaging, psychopharmacology, neuropharmacology, genetics and biological psychiatry at large. Transactional research has also benefited from these research efforts and advances. It is imperative, however, that organized medicine (American Psychiatric Association) and patients and advocacy groups also participate in the formation, clinical implementation, educational integration and policy formulation with respect to the current and future research outcomes.

In this symposium, the Directors of the three Federal Research Institutes (NIMH, NIDA, and NIAAA) will present their views of where their research programs are moving toward in the future and its implications to the field of psychiatry. A response from organized medicine (APA) and Advocacy (NAMI) will hopefully lead to an integration of these research efforts with respect to its influence and applications to ongoing psychiatric care.

5. HEALTH INEQUALITIES FOR PERSONS WITH MENTAL HEALTH PROBLEMS AND DEVELOPMENTAL DISABILITIES

Co-Chairpersons: Sheila Hollins, M.D.
Discussants: SidneyWeissman, M.D., Greg Richardson, M.D.
Royal College of Psychiatrists

14. Training in Health Care Delivery Systems in the United Kingdom
Dinesh Bughra, Ph.D.

15. The Role of Organized Medicine and Psychiatry in the United Kingdom
Sue Bailey, M.D.

16. The Provision of Care for Special Populations in the United Kingdom
Helen EJ Miller, M.B.

17. Health Care Delivery Systems in the United States
Roger Peele, M.D.

18. The Role of the Professional Society (Organized Psychiatry) in Addressing Healthcare in the U.S.
James H. Scully, Jr., M.D.

19. The Provision of Care for Persons with Intellectual Disabilities in the United States
Stephen Ruedrich, M.D.

EDUCATIONAL OBJECTIVES:

1.) Become familiar with the health care systems of USA and England; 2.) Become familiar with the Role of Organized Medicine in the USA and England; 3.) To learn about Intellectual Disabilities in the USA and England.

SUMMARY:

The United States and United Kingdom confront similar concerns in providing health care to persons with mental disorders and intellectual disabilities. The American Psychiatric Association and Royal College of Psychiatrists are the lead organizations to accomplish these tasks with uniquely different health care delivery systems. Experts from both countries will review how their respective country provides these services and steps that are being taken to ensure quality of care within the systems.

REFERENCES:

1. Bhugra D, Malik A, Brown N (eds): Workplace Based Assessments in Psychiatry. London, Gaskell Press, 2007.
2. Bhugra D: The new curriculum for psychiatric training. Advances in Psychiatric Treatment 2006; 12: 393-396.
3. Blasinsky M, Goldman HH, Unutzer J: Project IMPACT: A report on barriers and facilitators to sustainability. Adm Policy Mental Health. 2006 Nov: 33[6]:718-29.
4. Goldman HH, Frank RG, Burnam MA, et al: Behavioral health insurance parity for federal employees, N Engl J Med. 2006 Mar 30; 354(13):1378-86.

6. FOCUSING ON EUROPEAN PSYCHIATRY

APA Council on Global Psychiatry

Chairperson: Pedro Ruiz, M.D.
Co-Chairperson: Cyril Hoschl, M.D.
Discussant: Norman Sartorius, M.D.

20. Psychiatry in Europe: The German Perspective
Wolfgan Gaebel, M.D.

21. European Psychiatry: Between Neurosciences and Medical Humanities
Michael Musalek, M.D.

22. Historical Background and Furure Perspectives in the Development of Psychiatric Services in Central Europe
Livia Vavrusova, M.D.

23. Brain Activity in Delusions
Juan J. Lopez-Ibor, Jr., M.D.

24. Mental ;Health Concept in Europe: Limits of Psychiatry
Cyril Hoschl, M.D.

EDUCATIONAL OBJECTIVES:

It is expected that at the end of this Presidential symposium, the participants will 1) be able to learn about new pxychiatric initiatives taking place in Europe, 2) develop clinical projects of relevance in Europe and the United States, and 3) learn from the educational and training programs that exist in Europe and the United States.

SUMMARY:

Since the creation of the European Union as a regional set of institution/countries pursing a common goal, including psychiatry as a profession and field, strong collaborative efforts have emerged among the psychiatric societies from the countries that are part of the European Union. In many ways, the European College of Psychiatry symbolizes these very relevant and importnat efforts. On a parallel basis, now-a-days the globalization process has intensified all over the world. As a result of these two processes, a major emphasis on international collaboration has evolved and intensified. With this concept in mind, the idea of an APA Presidential symposium focusing on Europe evolved. This is the first time that such a project is implemented. The idea is to develop mechanisms of collaboration between both continents with the goal in mind of achieving better patient care, investigational collaboration and educational exchanges. We hope that this effort will be found productive and that it will be sustained for years to come.

REFERENCES:

1. European Commission (2005) Green Paper. Improving the mental health of the population: Towards a strategy on mental health for the European Union. European Communities Publication. COM (2005) 484.
2. Gaebel W, Zielasek J, Müller U (2007) Psychiatry in Germany. International Psychiatry (in press).
3. Sass, LA, and Parnas, J. Schizophrenia, consciousness, and the self. Schizophr Bull, 2003; 29(3):427-44.
4. Schneider K: Clinical, Psychopathology, Grune and Stratton, New York, 1959.
5. Hoschl C.: "Green Paper and Limits of Psychiatry as a Medical Discipline."

7. Globalization and Mental Health: Role of Spanish-Speaking Psychiatry

Chairperson: Renato D. Alarcon, M.D.
Co-Chairperson: Cesar Nella Mejias, M.D.
Discussant: Manuel Trujillo, M.D.

25. Globalization and its Discontents: The Spanish-Speaking Perspective
Renato D. Alarcon, M.D.

26. Psychiatry in Ibero-America: Historical Perspective
Pedro Ruiz, M.D.

27. Globalization and Psychiatry in Latin America: A Role for Professional Prudence
Fernando Lolas, M.D.

28. A Global Psychiatry for a Globalized World
Jose Lazaro

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the impact of globalization on the mental health of nations across the world, and the contributions of the three main components of Spanish-speaking psychiatry to its understanding and management.

SUMMARY:

This symposium examines the realities, controversies, benefits and disadvantages of the current globalization process, while responding to the challenges that such process presents to a "globalized psychiatry". In turn, the role of the three most relevant components of Spanish-speaking psychiatry (Latin American, Spanish, and USA-based Hispanic) is discussed, with emphasis on demographic, clinical, ethical and socio-cultural aspects. The valuable integration of psychiatry into scientific medicine has strengthened an "evidence-based" discipline, somehow in detriment of the traditional clinical values of psychopathology. In this context, it seems historically pertinent for Spanish-speaking psychiatry to vindicate the "narrative- and value-based" aspects of the practice of the profession, as the globalized world still includes dissimilar and co-existing cultures, each with its own array of value systems. A true global psychiatry (able to integrate biological, brain-based facts with patients' and practitioners' personal values) in a globalized world, (able to integrate different ways of understanding facts and diverse value systems) is suggested as a defining objective of and role for the Spanish-speaking psychiatry, on the basis of its solid humanistic trajectory and scientific achievements.

REFERENCES:

1. Kraidy M: Hybridity, or a cultural logic of globalization. Philadelphia, Temple University Press, 2005.
2. Ruiz P: "La Psiquiatria en las Minorias Etnicas: El Ejemplo de los Estados Unidos" . In J. Vallejo Ruiloba, C. Leal Cercos (eds.): "Tratado de Psiquiatria", Volume II. Madrid, Spain, Editorial Ars Medica, 2005, pp. 2273-2280.
3. Lolas, F, Quezada, A., Rodriguez, E. (editors) Investigación en Salud. Dimensión ética. Santiago de Chile, CIEB, 2006.
4. Sadler JZ: Values and psychiatric diagnosis, Oxford, Oxford University Press, 2005.

SYLLABUS INDEX

F

G

H

I

J

K

L

M

N

O

S

Z