



American Psychiatric Association

SYLLABUS BOOK

SYLLABUS AND SCIENTIFIC PROCEEDINGS

IN SUMMARY FORM

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AMERICAN PSYCHIATRIC ASSOCIATION

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The American Psychiatric Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The APA designates this live activity [The 166th Annual Meeting] for a maximum of 50 AMA PRA category 1 credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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

JOSEPHA A. CHEONG, M.D., Chairperson

JULIO LICINIO, M.D., 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.

EMBARGO: News reports or summaries of APA 2013 Annual Meeting presentations contained in these program materials may not be published or broadcast before the local time and date of presentation.

The information provided and views expressed by the presenters in this Syllabus are not necessarily those of the American Psychiatric Association, nor does the American Psychiatric Association warrant the accuracy of any information reported.

2013 Annual Meeting • San Francisco, CA

PURSUING WELLNESS ACROSS THE LIFESPAN



Dear Colleagues and Guests:

Welcome to the 166th Annual Meeting of the American Psychiatric Association in San Francisco, "The City by the Bay." "Pursuing Wellness across the Lifespan," is the theme of this year's meeting, which offers hundreds of sessions to learn the latest science, clinical advances, and promising practices from among the best in the field, as well as numerous networking and social opportunities.

The Opening Session will be on Saturday, May 18 from 4:30 – 5:30 p.m., and will be immediately followed by a special conversation between APA President Dilip Jeste, M.D., and Elyn Saks, J.D., Ph.D. Dr. Saks, who has schizophrenia, is an inspirational example of resilience in the face of a serious mental illness. She is the Orrin B. Evans Professor of Law, Psychology, and Psychiatry and Behavioral Sciences at the University of Southern California, a MacArthur Foundation Fellow, and author of the award-winning best-seller *The Center Cannot Hold: My Journey Through Madness*. The annual American Psychiatric Foundation Benefit will be on Saturday from 7:00 – 10:00p.m. (ticket required) at the City Club of San Francisco.

A special keynote address will be presented by President Bill Clinton on Sunday, May 19 from 5:30 – 6:30 p.m. The Convocation will be held on Monday from 5:30 – 6:30 p.m.

We are privileged to have among our presenters three Nobel Laureates: Elizabeth H. Blackburn, Ph.D., Nobel Prize winner in Physiology or Medicine (2009); Stanley B. Prusiner, M.D., Nobel Prize winner in Physiology or Medicine (1997); and Andrew V. Schally, Ph.D., M.D.hc, Nobel Prize winner in Physiology or Medicine (1977).

We are delighted to partner once again with the National Institute on Drug Abuse (NIDA) to feature a series of sessions highlighting advances in research and treatment of substance use disorders. Other topical tracks featured at the meeting include: addiction, child and adolescent psychiatry, forensic psychiatry, geriatric psychiatry, psychosomatic medicine, integrated care, and military mental health.

The much-anticipated DSM-5, the latest revision of the Diagnostic and Statistical Manual of Mental Disorders, will be released at the meeting. An extensive series of sessions will help attendees understand key changes in the DSM-5 and their implications for practice, focusing on topics such as substance use disorders, autism, major depression, military mental health, and the cultural considerations. In addition, a full-day Master Course: DSM-5: What you Need to Know, will be presented by DSM-5 Task Force chair David J. Kupfer, M.D., and Vice-Chair Darrel A. Regier, M.D., M.P.H. and members of the work groups on Saturday, May 18.

Meeting attendees can purchase the DSM-5 before it goes on sale to the public at the American Psychiatric Publishing (APP) bookstore in the Exhibit Hall. Attendees are also invited to meet the DSM-5 Task Force leaders at a special event at the APP bookstore on Saturday, May 18 from 4:00 to 5:00 p.m.

The always popular MindGames, APA's national Jeopardy-like competition for residents, will take place on Tuesday at 6:00.

Many thanks go out to the Scientific Program Committee for its outstanding work under the leadership of chair Josepha Cheong, M.D. and to the APA staff members who have worked to develop an outstanding program for the 2013 Annual Meeting. Of course, we hope you'll enjoy some of what San Francisco has to offer with its well-known landmarks and attractions such as Fisherman's Wharf, the Golden Gate Bridge, and cable cars, along with a multitude of cultural and culinary delights.

Outstanding educational and networking opportunities await you at our 166th Annual APA meeting. On behalf of APA and the Scientific Program Committee, welcome to the meeting and enjoy an informative, enlightening week!

Sincerely,

A handwritten signature in blue ink that reads "Dilip Jeste".

Dilip V. Jeste, M.D.

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ADVANCES IN MEDICINE**MAY 18, 2013****ADVANCES IN MEDICINE 1****PROTECTIVE VERSUS HARMFUL EFFECTS OF STRESS: BASIC MECHANISMS AND CLINICAL IMPLICATIONS***Speaker: Firdaus Dhabhar, Ph.D.**Chairs: Catherine C. Crone, M.D. and Baiju Gandhi, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Distinguish the newly appreciated protective effects of “good” short-term stress, versus the well-known harmful effects of “bad” long-term stress; 2) Understand mechanisms that mediate the effects of “good” versus “bad” stress on immune function; and 3) Appreciate the potential for behaviorally and/or biologically harnessing stress physiology to either maintain health or restore it in the case of disease.

SUMMARY:

Although stress has a “bad” reputation, it is important to appreciate that the stress response is one of nature’s fundamental survival systems. Without a fight-or-flight stress response, a lion has no chance of making a meal out of a gazelle, and the gazelle has no chance of escaping to graze another day. Therefore, we hypothesized that just as the stress response prepares the cardiovascular, musculoskeletal and neuroendocrine systems for fight or flight, it may also prepare the immune system for challenges (e.g. wounding or infection) that may be imposed by a stressor (e.g. predator or surgical procedure). This hypothesis was supported by studies showing that short-term stressors experienced at the time of immune activation can significantly enhance innate and adaptive immune responses. One mechanism mediating this immuno-enhancement involves a large-scale redistribution of immune cells within the body, i.e., during short term stress the body’s soldiers (e.g. immune cells) are first mobilized from the barracks (e.g. spleen) and into the boulevards (e.g. blood vessels), and then traffic onto potential battle stations (e.g. skin) that may be attacked (e.g. wounded) by the stressor (e.g. predator or surgeon). Additional mechanisms are thought to include increases in immune cell function, and changes in cytokine secretion. In contrast to adaptive short-term stressors, evolution has yet to catch up with harmful chronic/long-term stressors that have understandably been the major focus of research. Chronic stress can suppress/dysregulate immune function, shortens telomeres and accelerate senescence of immune (and perhaps other) cell types, and exacerbate many diseases of mind and body. Therefore, we also investigate mechanisms mediating the harmful effects of chronic stress. Our pre-clinical and highly-collaborative human subjects’ studies are designed to elucidate mechanisms that mediate these bi-directional effects of stress on immune function in the context of surgery and wound healing, vaccination, and cancer. We also investigate how some of these mechanisms may contribute to stress-related disorders like depression. We have proposed a Stress Spectrum model that begins to elucidate the transition from “good” to “bad” stress and proposes mechanisms that may mediate resilience versus

susceptibility to stress. Our goal is to design behavioral and/or biological interventions for manipulating physiology to optimally harness the body’s natural defenses to either maintain health or restore it in the case of disease.

MAY 19, 2013**ADVANCES IN MEDICINE 2****TOP 10 MEDICAL STORIES 2012: A COMPREHENSIVE AND PRACTICAL REVIEW OF WHAT WE NEED TO KNOW***Chairs: Catherine C. Crone, M.D., Josepha A. Cheong, M.D.**Speaker: Monique V. Yohanan, M.D., M.P.H.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Be familiar with recent publications from the Internal Medicine literature which are most likely to impact clinical practice; 2) Identify advances in Internal Medicine which are likely to be relevant to the care of people with psychiatric illness, with a focus on the identification and management of cardiovascular risk factors; and 3) Be aware of the evidence base and methodology of the selected publication.

SUMMARY:

People with psychiatric illness often have comorbid medical conditions. A familiarity with the current medical literature may assist psychiatrists in optimizing patient care. This symposium will focus on the 10 most important medical stories of 2012. The identification and management of cardiovascular risk factors will be highlighted, as will the current literature on the impact of diet and exercise on health outcomes. The final third of the session will be dedicated to a question and answer session in which topics of special interest to the audience will be discussed.

MAY 20, 2013**ADVANCES IN MEDICINE 3****MEDICAL MYSTERIES AND PRACTICAL MED PSYCH UPDATES: IS IT MEDICAL, PSYCHIATRIC, OR A LITTLE OF BOTH?***Chairs: Catherine C. Crone, M.D., Amanda J. Crosier, M.D.**Speakers: Jane Gagliardi, M.D., M.H.S., John Onate, M.D., Sarah Rivelli, M.D., Robert M. McCarron, D.O.***EDUCATIONAL OBJECTIVE:**

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

SUMMARY:

Psychiatrists often encounter clinical scenarios that may not have a clear explanation. The workshop faculty practice both internal medicine and psychiatry and will collaborate with the audience to review several case based “medical mysteries”. A relevant and concise update on several “Med Psych” topics will be discussed. Expect this session to be interactive and audience will be using the Audience Response System to participate in the session. Attendees should leave the session with a better understanding of the interplay between general medical conditions and abnormal or maladaptive behavior. They will also have an understanding of both common and less common psychiatric presentations that are frequently encountered in general medical conditions.

MAY 21, 2013

ADVANCES IN MEDICINE 4

ADVANCES IN SLEEP DISORDERS: WHAT'S NEW UNDER THE MOON?

Chair: Catherine C. Crone, M.D.

Speaker: Karl Doghramji, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the essential clinical features of selected sleep disorders including insomnia, narcolepsy, sleep apnea syndrome, circadian rhythm disorders, and the parasomnias; 2) Express the salient developments in these disorders over the past few years; and 3) Appreciate the impact that the management of these disorders has on the psychiatric complaints and conditions.

SUMMARY:

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

MAY 22, 2013

ADVANCES IN MEDICINE 5

ADVANCES IN MEDICINE: BIOMEDICAL MODELS FOR ASSESSING AND TREATING AUTISM

Chair: Robert Lee Hendren, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be

able to: 1) Review new research suggesting novel models for understanding the etiology of ASD and the implications of this for assessing and treating patients with autism; 2) Consider current pharmacologic and emerging “biomedical” treatments and their evidence for treating ASD; and 3) Discuss the implications of this “paradigm shift” for translational research, clinical assessment and integrated treatments.

SUMMARY:

Objective/Background: Current theories regarding the etiology of autism spectrum disorders (ASD) increasingly support an interactive gene-environment model. This presentation will review the evidence for the gene-environment model and describe potential mechanisms for the expression of this process. The relevance of this model for assessment and laboratory testing and how this is being translated into CAM\biomedical treatment studies will be discussed. **Method:** A review and integration of the evidence for the gene-environment interactive model for autism and potential mechanisms for its expression such as inflammatory and immune reactions, oxidative stress, fatty acid metabolism, and mitochondrial dysfunction will be presented. This will be followed by a review of potential testing for these processes such as genetic and laboratory testing, neuroimaging studies, and other measures and the indications for including these in a child psychiatry practice. Finally, a brief review of potential CAM\biomedical treatments for improving these processes and clinical outcomes as well as a review of more traditional treatments will be described. **Results:** Treatments and interventions based on the gene-environment etiology of ASD are growing in popularity although the number and quality of studies of the mechanisms for this expression and RCTs for treatments have limitations. While the evidence for CAM and biomedical treatments for autism are weak, there is an appeal to families often leading to a disconnect between them and their traditional practitioner. More accepted treatments also lack firm evidence but the evidence available will also be described. **Conclusions:** Practitioners are frequently asked about reports of novel models and mechanisms for the development of ASD and struggle with whether to order additional tests or suggest alternative treatments. This presentation will update and guide them to evidence based decisions about what to include in their practice and how to discuss these issues with the families of their patients. Approaches to work with families can lead to a more “integrative” practice that allows traditional and some non-traditional assessments and treatments.

ADVANCES IN RESEARCH**MAY 20, 2013****ADVANCES IN RESEARCH 1****ADVANCES IN RESEARCH***Chair: Herbert Pardes, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Recognize innovative techniques in the clinical psychiatric management of disorders of children; 2) Have an increased comprehensive knowledge of diagnostic and treatment phenomena of suicide; and 3) Identify novel approaches to the treatment of affective disorders.

SUMMARY:

This symposium is intended to present up to date findings on a number of clinical issues with a particular focus on innovation, new developments, etc. It includes foci on disorders of childhood, obsessive compulsive disorders, suicide, anxiety disorders, and depression. With regard to depression, there is a focus on novel methods for addressing depression on a population wide basis. There is also a presentation on new information regarding possible very rapid treatment innovations to reduce the amount of time before a patient gets relief. The focus on suicide takes cognizance of the differences in suicidal behavior with different age populations. The discussion will illustrate how these differences affect the psychiatrist's approach to the given patient and/or potential patient. At a time when the entire healthcare field is in such turbulence with the economy creating major problems, new techniques, new therapies, more efficient and economical ways of approaching these disorders while at the same time maintaining the highest quality are critical. It is our anticipation that the attendees of the conference should come away far better informed about current thinking and clinical approaches in several important areas in psychiatry.

NO. 1**INTEGRATED DEPRESSION CARE: CLOSING THE GAP BETWEEN WHAT WE KNOW AND WHAT WE DO***Speaker: Jurgen Unutzer, M.D., M.P.H.***SUMMARY:**

Fewer than 2 in 10 adults with depression see a psychiatrist and most depression treatment is provided in primary care. Data from primary care, public, and private psychiatric settings suggest that fewer than half of all patients treated for depression experience substantial improvements in their health. We will review an evidence-based, integrated approach in which consulting psychiatrists work closely with primary care providers to reach more people with effective treatment. This model

creates important new opportunities for psychiatrists and it can make a substantial impact on the health of populations in the era of patient centered medical homes and accountable care.

NO. 2**CHANGING CONCEPTIONS OF TOURETTE'S SYNDROME IN LIGHT OF EFFECTIVE BEHAVIORAL TREATMENT***Speaker: John T. Walkup, M.D.***SUMMARY:**

The mainstay of treatment for reducing tic severity has been medication management. However, recently, large studies (1,2) of a behavioral intervention for reducing tic severity have been completed and demonstrate the efficacy of a behavioral approach in reducing tic severity and impairment. The efficacy of behavioral treatments changes the approach to the patients with Tourette syndrome dramatically. As a result prevention is possible and early intervention is now preferred. Traditional advice for Tourette syndrome patients based on medication as the treatment of choice is now outdated and may actually cause harm. This presentation we will focus on the changing conceptualization of TS and outline how these conceptual changes will impact screening, prevention, early intervention and treatment.

NO. 3**TREATMENT STRATEGIES FOR MAJOR MOOD DISORDERS THAT ARE ROBUSTLY EFFECTIVE WITHIN 24 HOURS***Speaker: William Bunney, M.D.***SUMMARY:**

Currently available antidepressants require 2-10 weeks for patients to achieve a remission in depressive symptoms. During this time a significant risk for suicide has been reported. Bunney will review two treatment strategies for major depressive disorder (MDD) and bipolar disorder (BPD) which produce marked improvement in depressive symptoms within 24 hours in 40-70% of patients. He will also discuss a treatment which rapidly decreases severe suicidal ideation. The specific strategies to be reviewed are sleep deprivation therapy (SDT) and low-dose intravenous ketamine. Bunney will also discuss approaches to sustaining the clinical amelioration of symptoms over an extended period of time. He will present findings concerning the mechanism of action of SDT and low-dose ketamine which could lead to the development of novel pharmacological agents to rapidly treat depression.

NO. 4**PRACTICAL PROBLEMS IN DEALING WITH THE RECENTLY OR POTENTIALLY SUICIDAL TEEN-AGER**

Speaker: David Shaffer, M.D.

SUMMARY:

Suicide attempts are more common during adolescence than at any other period of life. In most but not all countries and cultures they are more common in girls than in boys. By contrast completed suicides are somewhat less common during this period than they will be as the youth turns into a young adult. At all ages death is more common in males than females. The mismatch in age and gender that results will take the clinician into an area of uncertainty that the presentation is designed to address.

NO. 5**OBSESSIVE-COMPULSIVE DISORDER: CUTTING-EDGE RESEARCH AND ITS PRACTICAL IMPLICATIONS**

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

SUMMARY:

Obsessive-compulsive disorder (OCD) is a disabling disorder, with a lifetime prevalence of 1.6%, an early age of onset, and a typically chronic course. To achieve excellent treatment outcomes, clinicians must correctly diagnose OCD and then tailor the treatment plan to the individual patient. This talk will focus on new research that clarifies what is (and is not) OCD, which strategies to consider when serotonin reuptake inhibitors (the only approved medications for OCD) do not work, and how and when to use psychotherapy. The goal is to provide clinicians with practical new knowledge that helps them achieve excellent outcomes for their patients with OCD.

ADVANCES IN SERIES**MAY 18, 2013****ADVANCES IN SERIES 1****ADVANCES IN BRIEF THERAPY***Chair: Mantosh Dewan, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of the session, the participant should be able to: 1) Recognize the most recent thinking in brief cognitive therapy; 2) Be familiar with the current techniques in time-limited dynamic therapy; and 3) Apply the principles of behavior therapy in the treatment of trauma.

SUMMARY:

Participants will learn the latest techniques in three of the most widely used brief therapies: cognitive therapy, behavioral therapy and psychodynamic therapy. Besides a clear enunciation of the principles and new techniques, each presentation will include video of experts doing their work. This will benefit those psychiatrists who do "pure" therapy in any of these schools, allow more eclectic therapists to more easily integrate selected techniques from any of these three therapies into their own work, and even help psychiatrists doing only "medication management" to use some of these techniques to build a better therapeutic alliance and improve adherence. There will also be adequate time for questions and answers.

NO. 1**COGNITIVE THERAPY***Speaker: Judith Beck, Ph.D.***SUMMARY:**

Cognitive Therapy (CT) has been demonstrated in over 1000 outcome trials to be effective for a wide range of psychiatric disorders, psychological problems, and medical conditions with psychological components. The basic cognitive model remains constant: the way individuals interpret their experience influences their reactions: emotional, behavioral, and physiological. CT uses techniques to produce changes in thinking, mood, and behavior, and follows a certain structure to engage patients, maintain the therapeutic alliance, and maximize efficiency in collecting data, identifying problems, formulating strategies for session, teaching skills, solving problems, and preparing patients for future challenges. To effectuate both remission and prevent relapse, CT focuses on modification of dysfunctional behavioral coping strategies and core beliefs. This dual emphasis on modification of core themes and skills training helps account for numerous studies indicating CT's efficacy.

NO. 2**EXPOSURE THERAPY FOR A RAPE SURVIVOR WITH PTSD***Speaker: Seth J. Gillihan, Ph.D.***SUMMARY:**

A large number of rigorously designed treatment outcome studies have demonstrated the efficacy of exposure therapy in the treatment of anxiety disorders, including posttraumatic stress disorder (PTSD). Based on these studies, multiple professional entities have concluded that exposure therapy is the treatment of choice for PTSD. This session will describe the components of exposure therapy for PTSD, using as an example prolonged exposure (PE) therapy for a survivor of rape. The session will focus on the clinical application of exposure therapy components, including imaginal and in vivo exposure. Video excerpts showing Dr. Edna Foa, the developer of PE, demonstrating how to deliver the interventions will supplement the presentation material.

NO. 3**TIME-LIMITED DYNAMIC PSYCHOTHERAPY: AN ATTACHMENT-BASED, EXPERIENTIAL, INTERPERSONAL APPROACH***Speaker: Hanna Levenson, Ph.D.***SUMMARY:**

Time-limited dynamic psychotherapy (TLDP) is a time-sensitive approach for clients with chronic, pervasive, dysfunctional ways of relating to others. By addressing the interpersonal and intrapsychic aspects of experience and understanding, its method of formulating and intervening makes it particularly well suited for the so-called difficult client seen in a brief or time-limited therapy. The brevity of the treatment promotes therapist pragmatism, flexibility, and accountability. Furthermore, time pressures help keep the therapist attuned to circumscribed goals with an active, directive stance. The focus is not on the reduction of symptoms per se (although such improvements are expected to occur) but rather on changing ingrained patterns of interpersonal and intrapersonal relatedness or personality style. In this presentation, the basic formulation and intervention strategies of TLDP will be presented along with a video of segments of a recreated therapy to illustrate.

MAY 19, 2013

ADVANCES IN SERIES 2**ADVANCES IN THE MANAGEMENT OF TRAUMATIC BRAIN INJURY***Chair: David B. Arciniegas, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of the session, the participant should be able to: 1) Identify pre-injury, injury-related, and post-injury factors that influence the development and persistence of postconcussive symptoms; 2) Recognize the contributions of context and process to cognitive dysfunction following mild traumatic brain injury; 3) Identify the effects of repetitive subconcussive impacts on short- and long-term cognitive performance; and 4) Recognize factors that influence effort and symptom reporting in the late period after mild traumatic brain injury.

SUMMARY:

Traumatic brain injury (TBI) is a worldwide public health problem with a broad range of mental health consequences. Approximately 1.5 million Americans experience traumatic brain injury each year, the vast majority of which are mild. In the moments following a TBI, postconcussive symptoms are nearly universal. These include alterations of consciousness, disturbances of attention, slow processing speed, impaired declarative memory, and executive dysfunction, and frequently are accompanied by emotional and behavioral disturbances as well as sensory and motor problems. Over the days to weeks after mild TBI, recovery usually proceeds rapidly and typically is complete. When early symptoms are unrecognized, misunderstood, and/or inadequately addressed, early postconcussive symptoms may become chronic and engender secondary psychological health and psychosocial consequences. Pre-injury health and psychosocial factors also influence the short- and long-term effects of TBI. Understanding and improving outcomes after TBI therefore requires consideration not only of the effects of external physical forces on the brain but also the person sustaining that injury and the events preceding and following it. The scope of such considerations is necessarily broad and their complete consideration is challenging, especially in the midst of a busy clinical practice. Accordingly, this session will provide participants with new and emerging perspectives on mild TBI. A heuristic with which to understand the influences of pre-injury, injury-related, and post-injury factors on postconcussive symptoms will be presented. The roles of context and process in the genesis of attention and memory impairments after TBI will be considered, and the long-term effects of repetitive subconcussive impacts will be described. Finally, factors that influence effort and symptom reporting after TBI are identified and their implications for clinical and forensic psychiatric practice are discussed.

NO. 1**ATTENTION AND MEMORY IMPAIRMENTS AFTER MILD TRAUMATIC BRAIN INJURY: NEW PERSPECTIVES ON AN OLD PROBLEM***Speaker: David B. Arciniegas, M.D.***SUMMARY:**

Attention and memory impairments are common in the early period after mild traumatic brain injury and may become chronic problems for some individuals. It is not uncommon for such attention and memory complaints to remain unexplained by conventional cognitive and neurodiagnostic findings. In some cases, factors other than neurotrauma contribute to, or account entirely for, complaints about attention and memory function. However, neurotrauma-induced abnormalities in context-specific information processing and processing resource allocation are opaque to detection by conventional cognitive and neurodiagnostics methods. This presentation will review findings from studies using the P50 evoked response to paired auditory stimuli and the functional magnetic resonance imaging-based N-back task that inform on the possible neurobiological bases of persistent attention and memory impairments after mild TBI.

NO. 2**EFFORT, EXAGGERATION, AND MALINGERING AFTER CONCUSSION: WHAT ARE WE MISSING?***Speaker: Jonathan M. Silver, M.D.***SUMMARY:**

Most individuals who experience a mild traumatic brain injury, or concussion, recover completely. However, a minority continue reporting symptoms well into the late period after concussion, the types and severities of which appear, on their face, inconsistent with the relatively mild severity of this type of traumatic brain injury. These symptoms are not infrequently ascribed to malingering, exaggeration, or poor effort on cognitive testing. This presentation will examine previously unconsidered factors that challenge the view of "symptom magnification" or "poor effort" as result of conscious processes. These complex and multi-determined behaviors entail a differential diagnosis that draws upon concepts and observations from social psychology and behavioral economics, and develops new perspectives with implications for research, evaluation, and treatment of persistent postconcussive symptoms.

NO. 3**THE EFFECTS OF REPETITIVE, SPORTS-RELATED HEAD IMPACTS ON COGNITION**

Speaker: Thomas W. McAllister, M.D.

SUMMARY:

Sports-related mild traumatic brain injury, or concussion, affects at least 1.6 million individuals annually in the United States, and are particularly common in contact sports such as football and ice hockey. Most individuals recover within 7 days after sports concussion, although recovery may be slower in a small percentage of individuals and there are growing concerns about the long-term effects of such injuries. Many more subconcussive head impacts occur than do concussions during contact sports, the forces associated with which may exceed thresholds commonly regarded as sufficient for concussive injury. The effects of repetitive head impacts are understudied but their potential short- and long-term consequences are subjects of growing concern to athletes, their families, and public policy-makers. This presentation will present findings from a study evaluating the effects of repetitive head impacts on cognition in college athletes.

ADVANCES IN SERIES 3**ADVANCES IN GERIATRIC PSYCHOPHARMACOLOGY**

Chair: Sandra A. Jacobson, M.D.

Discussant: Carl Salzman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session, the participant should be able to: 1) List and describe current recommendations regarding the use of antipsychotic medications in elderly patients with dementia; 2) Characterize current substance abuse patterns in elders, and list new treatments with a favorable risk/benefit ratio for this population; 3) Explain the concept of "molecular age," and describe how it relates to successful aging and potentially to psychopharmacological treatment; 4) Describe the mechanism by which lithium appears to exert neuroprotective effects; and 5) List new antidepressant therapies with a favorable risk/benefit ratio for elderly patients.

SUMMARY:

Controversy still rages over the issue of antipsychotic use in elders with dementia, particularly those residing in nursing homes. The psychiatric consultant may be left in the position of opposing the use of these drugs against the wishes of staff and family members, or supporting their use without good evidence. Is there a rationale for use of these drugs in individual

cases? Dr. George Grossberg, who has been at the forefront of this issue, will discuss recommendations and future directions. Abused substances among the current cohort of elders include mainly alcohol and tobacco. The benefits for elders of quitting smoking and problem drinking are clear, but what about new pharmacologic treatments? Are they safe? Do they work? Dr. David Oslin – an internationally recognized expert on substance abuse – will discuss these treatments, and also talk about emerging issues in the currently aging cohort, such as marijuana use. Converging evidence suggests that aging – whether accelerated or "successful" – takes place at the molecular level, and that individuals carrying specific risk alleles may "age" more rapidly, and develop frailty that has implications for psychopharmacologic practice. Dr. Etienne Sibille will talk about his group's work with elders carrying the SIRT5 risk allele and other genetic factors affecting aging processes. More than half a century after lithium's introduction to the pharmacopoeia for the treatment of mania, lithium now emerges with a new identity: as a neuroprotective agent that alters the processing of beta-amyloid and inhibits excessive tau phosphorylation. Dr. Ariel Gildengers will discuss the mechanism of cognitive decline in bipolar disorder and the potential for lithium to protect against this decline as well as the decline of Alzheimer's disease. In the last 5 years, 4 new antidepressants and repetitive transcranial magnetic stimulation (rTMS) have received FDA approval, and are now in clinical use for the treatment of depression. These therapies were released with little documentation as to efficacy and safety in the elderly population. What do we now know about these specific treatments in geriatrics? Dr. Abhilash Desai will present research data and recommendations from clinical experience to address this question.

NO. 1**THE USE OF ANTIPSYCHOTIC MEDICATIONS IN PATIENTS WITH DEMENTIA: FACTS AND CONTROVERSY**

Speaker: George T. Grossberg, M.D.

SUMMARY:

The Center for Medicare Services (CMS) has set the goal of a 15% reduction of neuroleptic use in Long Term Care for calendar year 2012, with further reductions planned. The US FDA has placed a "black-box warning" on the package insert of all neuroleptics, warning that they may increase mortality in elderly dementia patients. The NIH-CATIE Study examined the effectiveness of antipsychotics for the treatment of behavioral and psychological symptoms of dementia (BPSD) - in particular psychosis and agitation - and found only small benefits vs placebo. Further, the investigators warned of adverse events in this vulnerable population, which must be weighed against potential benefits. This presentation will focus on data relative to the use of conventional and atypical antipsychotics in the elderly, particularly those with dementia. Current recommendations and future directions will be discussed.

NO. 2**ADDICTION IN LATE LIFE: PHARMACOLOGICAL INTERVENTIONS**

Speaker: David Oslin, M.D.

SUMMARY:

There is a growing public and clinical awareness of addiction problems affecting older adults. These problems include not only the well-known issues of alcohol and nicotine addiction, but also the use of illicit drugs such as marijuana in the cohort now entering old age. In addition, misuse and overuse of prescription medications is an issue among older adults. While there are few treatment studies focused specifically on elders, we have clinical experience with treatments and interventions that are efficacious and safe in this population. This presentation will focus on specific pharmacologic treatments and their application to the geriatric population.

NO. 3**MOLECULAR BRAIN AGING: IMPLICATIONS FOR FUNCTIONAL DECLINE, DEPRESSION, AND PSYCHOPHARMACOLOGIC TREATMENT**

Speaker: Etienne Sibille, Ph.D.

SUMMARY:

Certain genes with age-dependent changes in expression significantly overlap those implicated in neuropsychiatric diseases involving mood, cognitive, and motor changes. We now know that molecular age – predicted by the gene expression profile of an individual – can deviate significantly from chronological age. For example, individuals carrying a particular variant in the putative longevity gene SIRT5 have a molecular age that is older than their chronological age. We hypothesize that individuals carrying these “risk” alleles will also show accelerated functional aging, while those with protective alleles will show “successful” aging. We found that elders carrying the SIRT5 risk allele have significantly more depressive symptoms, as measured by the CES-D. We continue to identify other genetic factors conferring risk or protection, some of which will be discussed at this session. The potential implications of our findings for psychopharmacological treatment of elders will be described.

NO. 4**THE NEUROPROTECTIVE EFFECTS OF LITHIUM**

Speaker: Ariel Gildengers, M.D.

SUMMARY:

Lithium has been a mainstay of treatment in BD. It has recognized neurotrophic and neuroprotective properties that may offset the neuroprogressive effects of BD and preserve cognitive function. Recently, there has been a strong interest

in lithium’s ability to inhibit glycogen synthase kinase-3 (GSK-3). GSK-3 plays an important role in Alzheimer’s disease (AD). Increased activity or overexpression of GSK-3 is associated with increase in tau hyperphosphorylation and alterations in amyloid-beta processing related to the formation of neurofibrillary tangles and plaques. Given lithium’s inhibitory effects on GSK-3, chronic lithium treatment may protect against tangles and plaques associated with AD. This presentation will review the mechanisms of cognitive dysfunction in BD and the potential for neuroprotective effects of lithium. Preliminary data from an ongoing study examining the effects of long term lithium treatment on amyloid deposition in older adults with BD will be presented.

NO. 5**ADVANCES IN ANTIDEPRESSANT TREATMENT**

Speaker: Abhilash Desai, M.D.

SUMMARY:

The last decade has seen the introduction of a number of new antidepressants as well as repetitive transcranial magnetic stimulation (rTMS) therapy. This presentation will briefly review unique characteristics of these new medications, geriatric data available to date, and the potential role of these drugs in the treatment of geriatric depression. This presentation will also briefly describe rTMS and its role in geriatric depression. The potential advantages and disadvantages of new antidepressant therapies compared to traditional therapies - SSRIs, SNRIs, and ECT - will be discussed.

MAY 20, 2013

ADVANCES IN SERIES 4**ADVANCES IN ADDICTION PSYCHOPHARMACOLOGY**

Chairs: Henry R. Kranzler, M.D., Domenic A. Ciraulo, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session, the participant should be able to: 1) Participants will demonstrate knowledge of the pharmacology of nicotine, alcohol, opioids, cannabinoids, benzodiazepines and other sedative-hypnotics, and cocaine and other stimulants; 2) Participants will demonstrate knowledge of medications that are approved by the US Food and Drug Administration for the treatment of nicotine, alcohol, and opioid dependence; and 3) Participants will demonstrate knowledge of medications being developed to treat nicotine, alcohol, opioid, cannabinoid, cocaine and other stimulant dependence.

SUMMARY:

This course will review the pharmacology of the six major classes of addictive substances: nicotine, alcohol, opioids, cocaine and other stimulants, benzodiazepines and sedative hypnotics, and cannabis. Drugs approved to treat each disorder will be discussed and medications being developed to treat these addictions will also be considered. Over the past two decades, approximately a dozen new medications or formulations have been approved by the U.S. Food and Drug Administration to treat alcohol, nicotine, or opioid dependence. Smoking cessation and opioid maintenance treatments have achieved the greatest success. This success is reflected in the large number of individuals treated with nicotine replacement, bupropion, and varenicline for smoking and methadone and buprenorphine for opioid dependence and the improved treatment outcomes and reduced costs that have resulted. Yet these medications are effective for only a fraction of the treatment-seeking population. Although three new medications were approved to treat alcohol dependence [i.e., oral naltrexone, long-acting injectable naltrexone (also approved to treat opioid dependence), and acamprosate], they have not been as widely prescribed as the prevalence of the disorder would seem to justify. Medications to treat other addictive disorders, including cocaine and other stimulant dependence and cannabis dependence, have not been shown consistently to be superior to placebo treatment. However, research has identified some promising candidates for the treatment of cocaine dependence, including the anticonvulsant topiramate, the analeptic modafinil, and immunologically-based treatments. Novel GABA agonists have been developed to reduce the risk of abuse/dependence on benzodiazepines, which are widely prescribed. In summary, there is a growing armamentarium of medications to treat addictive disorders. Further, greater understanding of the neuropharmacology and pharmacogenetics of addictive disorders promises to provide additional options and methods to target therapy for these highly prevalent, often serious, and costly disorders.

NO. 1**MEDICATIONS TO TREAT NICOTINE DEPENDENCE**

Speaker: Caryn Lerman, Ph.D.

SUMMARY:

This lecture will review the pharmacology and pharmacologic treatment of nicotine dependence. Treatments to be covered include nicotine replacement therapies, bupropion and varenicline. Paradigms for nicotine dependence medication development will be discussed, as will evidence supporting a pharmacogenetic approach to nicotine dependence treatment. Together, this evidence will provide a foundation to consider the future of nicotine dependence medications and treatment models.

NO. 2**MEDICATIONS TO TREAT OPIOID DEPENDENCE**

Speaker: John A. Renner Jr, M.D.

SUMMARY:

This lecture will discuss the pharmacology of medications approved to treat opioid dependence. It will cover agonists, partial agonists, and antagonists at the mu-opioid receptor. The presentation will also describe current efforts to enhance medication adherence through the use of novel depot formulations and the clinical implications of these approaches to treatment.

NO. 3**MEDICATIONS TO TREAT ALCOHOL DEPENDENCE**

Speaker: Henry R. Kranzler, M.D.

SUMMARY:

This lecture will discuss the pharmacology of alcohol, considering effects on multiple neurotransmitter systems. It will also review medications approved for treatment of alcohol dependence and others showing efficacy but which are not being developed for that indication. Efforts to use parenteral dosing, oral dosing on a targeted or as-needed basis, and pharmacogenetics to enhance treatment response will also be considered.

NO. 4**BENZODIAZEPINES AND SEDATIVE-HYPNOTICS**

Speaker: Domenic A. Ciraulo, M.D.

SUMMARY:

Drugs classified as sedative-hypnotics or anxiolytics are a pharmacologically diverse group of compounds. Those with abuse potential produce anti-anxiety effects that are on a continuum with their hypnotic actions. The liability for abuse is correlated with these actions, but also involves specific mood-elevating properties that are detected using standardized scales of drug-induced changes in mood states. There is not a classification scheme for these drugs that is either scientifically precise or universally accepted. This presentation will discuss benzodiazepines, selective GABAA1 (benzodiazepine1) receptor agonists, i.e. zaleplon and zolpidem, barbiturates, and other agents that are used less commonly clinically but are sometimes abused. The role for pharmacotherapy involves selecting therapeutic agents with the lowest abuse potential and management of abstinence syndromes and overdose.

NO. 5**MEDICATIONS TO TREAT COCAINE AND OTHER STIMULANT DEPENDENCE**

Speaker: Kyle Kampman, M.D.

SUMMARY:

This lecture will review the pharmacology of cocaine and other stimulants and the pharmacological treatment of dependence on these drugs. Medications that have been tested to treat cocaine dependence include antidepressants, anticonvulsants, analeptics, and immunotherapy. Recent findings that support the utility of some of these approaches to treat cocaine dependence will be reviewed, together with a more modest literature on the treatment of dependence on other stimulants.

NO. 6**MEDICATIONS TO TREAT CANNABIS USE DISORDERS**

Speaker: David Gorelick, M.D., Ph.D.

SUMMARY:

This lecture will review the pharmacology of cannabis and the development of pharmacological treatment for cannabis use disorders. Cannabinoid CB1 receptor antagonists/inverse agonist offered promise as treatment for cannabis intoxication and dependence, but clinical development was halted because of psychiatric side-effects. Other medications being studied include agonist substitutes such as Δ^9 -tetrahydrocannabinol (THC), the primary psychoactive constituent of cannabis, glutamate enhancers such as N-acetyl-cysteine, and a variety of antidepressants, anti-convulsants, and anti-anxiety agents. No medication has been promising in replicated controlled clinical trials. Growing understanding of the endogenous cannabinoid system offers the promise of new therapeutic targets.

MAY 21, 2013

ADVANCES IN SERIES 5**ADVANCES IN PTSD**

Chairs: Gary H. Wynn, M.D., David Benedek, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the overall construct of posttraumatic stress disorder with specific understanding of up-to-date information on biologic and psychological mechanisms underlying the disorder; 2) Elaborate on the most up to date pharmacologic treatments for PTSD and a well reasoned approach to the use of these pharmaceuticals in a clinical setting; and 3) Show understanding of the most up to date

non-pharmacologic treatments for PTSD to include psychotherapeutic and complementary and alternative modalities.

SUMMARY:

PTSD has garnered a great deal of attention over the course of the past decade. This attention has resulted in a significant increase in the amount of money and support for research into PTSD. While a boon to the understanding of this disorder, the influx in investment in PTSD resulted from the rapid increase in combat related cases due to the conflicts in Afghanistan and Iraq. These efforts along with more long standing efforts have advanced the understanding of PTSD in terms of etiology, epidemiology, diagnostics and treatment. Recent years have seen clinical trials in pharmacology and psychotherapy, neuroimaging and neurobiology studies, and a variety of investigations into treatment modalities and methods. This research has and continues to advance the field at a rapid rate. Clinical responsibilities often limit a practitioner's ability to stay abreast of the latest information regarding all aspects of such a varied a complex disorder, even for those specializing only in PTSD. This session will cover the range of PTSD research and various advances in understanding with an eye to clinically relevant material. Additionally this session will discuss the recent joint Department of Defense and Veterans Affairs Clinical Practice Guidelines in comparison to the APA Clinical Practice Guidelines.

NO. 1**EPIDEMIOLOGY OF PTSD**

Speaker: Gary H. Wynn, M.D.

SUMMARY:

This presentation will review the most recent findings and up to date understanding of the epidemiology of PTSD. The epidemiology presentation will focus on risk factors for the development of PTSD for the general population and for those who have experienced a traumatic event.

NO. 2**PSYCHOTHERAPY**

SPEAKER: DAVID BENEDEK, M.D.

SUMMARY:

A myriad of therapy options currently exist including prolonged exposure, cognitive behavioral therapy, eye movement desensitization and reprocessing and stress inoculation therapy to name a few. This presentation will focus on the recent advances in a number of the currently utilized psychotherapies. Therapy options not covered in this session are left out due to limited recent investigation rather than a lack of utility within the clinical setting.

NO. 3**PHARMACOTHERAPY**

Speaker: Gary H. Wynn, M.D.

SUMMARY:

Dr. Wynn and Dr. Benedek will discuss how the pharmacologic treatment of PTSD has been and remains the most controversial aspect of the overall management of PTSD. Despite the controversy there has been little research into medications to treat PTSD. A few medications have found investigators to champion them through the complexities of research while many others have only a small study or a few case reports backing up clinical practice. This session will review the current state of the evidence for a number of medications and classes of medications.

NO. 4**COMPLEMENTARY AND ALTERNATIVE MEDICINE**

Speaker: Gary H. Wynn, M.D.

SUMMARY:

Despite a number of traditional treatment options of both psychotherapy and pharmacotherapy, PTSD remains a difficult and frequently treatment resistant disorder. Such treatment resistant has led to investigations of other treatment alternatives as well as research into other ways of providing the more traditional treatment options. This session will review these alternatives and options.

NO. 5**GUIDELINES**

Speaker: David Benedek, M.D.

SUMMARY:

The joint Department of Defense and Veterans Affairs Clinical Practice Guidelines for the management of traumatic stress disorder and acute stress reaction have notable differences from the Clinical Practice Guidelines from the American Psychiatric Association. This session will review and analyze a number of these differences.

MAY 19, 2013

CASE CONFERENCE 1**COPING WITH THE SUICIDE DEATH OF A PATIENT***Chair: Michael F. Myers, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Recognize how one might react to losing a patient to suicide; 2) Identify immediate and early ways of seeking assistance for oneself; 3) Reach out to grieving families and others with compassion and helpfulness; and 4) Recognize the centrality of postvention examination in advancing our knowledge of suicide and promoting resolution in the caregiver.

SUMMARY:

17 Suicides occur in clinical practice despite best efforts at risk assessment and treatment. It is estimated that fifty per cent of psychiatrists can expect to have at least one patient die by suicide, an experience that is considered an occupational hazard of treating mentally ill patients and may be one of the most difficult professional times in their careers. The presenter will give several brief case presentations of patients that he has lost to suicide spanning a forty year career. He will then highlight the following issues: 1) psychological reactions to patient suicide, including the myriad variables that characterize the physician-patient relationship; 2) self-care after losing a patient to suicide; 3) the clinician's roles and responsibilities after suicide, including outreach to survivors (family and significant others); 4) malpractice litigation after suicide – minimizing and dealing with lawsuits; and 5) postvention examination in the aftermath of suicide. Discussion with the presenter and attendees is an essential feature of this case conference (at least one third of the time will be protected). Those attending can expect to gain much new knowledge and become more comfortable with this very difficult dimension of professional life.

MAY 20, 2013

CASE CONFERENCE 2**WHEN PATIENTS CAN'T DECIDE: A CASE DISCUSSION OF GOOD CLINICAL PRACTICE, ETHICS, LAW, AND THE BOUNDARIES OF SELF-DETERMINATION***Chairs: Philip R. Muskin, M.A., M.D., Rachel Caravella, M.D.**Speakers: Rebecca Brendel, J.D., M.D., Laura Roberts, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Describe the evaluation of decision-making capacity and the management of a psychiatric patient once the decision about lack of capacity has been made; 2) Discuss the ethical issues surrounding the balance between self-determination and the physician's desire to "do no harm."; 3) Articulate the legal issues of the case, with a focus on involuntary psychiatric hospitalization and medical evaluation over objection; and 4) Discuss the psychiatrist's role as team liaison, patient advocate, and consultant in a case that activates a multitude of counter-transference reactions in many of the involved parties.

SUMMARY:

This case conference will discuss the challenges of treating a psychiatric patient on a medical unit who lacks decision-making capacity to refuse care in an urgent, but not emergent, situation. Sometimes, chronically psychotic patients refuse psychiatric treatment but what happens when their psychotic symptoms place them in mortal danger? As psychiatrists, we evaluate for psychiatric symptoms, assess for decision-making capacity, advocate for patients and recommend treatment. Yet, how do we proceed once the decision about capacity has been made? How do we balance the patient's right to self-determination with our role as physicians and our professional obligation to 'do no harm?' Rachel Caravella, MD will present that case of chronically psychotic woman who presented to the emergency department with severe anemia from vaginal hemorrhage who refused further treatment (including hysterectomy) after emergency medical stabilization was achieved. In this case, a psychiatric consultation was requested to manage her psychosis, determine capacity, and help decide on a treatment course. An ethics consultation, interdisciplinary team meeting, psychiatric hospitalization and appeal to the mental health court were ultimately used to the management of this case. Philip Muskin, MD will discuss the consultation-liaison psychiatrist's role in this patient's management, review determinants of decision-making capacity, and address the management of countertransference responses, with a focus on trainee / resident education. Laura Roberts, MD will address clinical and administrative/policy ethics issues arising in the case. She will discuss the role of ethics consultants and ethics committees in handling complex medical/psychiatric cases in which capacity to make a decision is in question. She will discuss the ethical principles in this case of a woman who clearly expressed the desire to live but whose decision was in opposition with that expressed wish. Rebecca Brendel, JD, MD will discuss the legal issues involved when a patient lacks decision-making capacity and when there is no surrogate decision-maker available for substituted judgment. She will address the legal issues surrounding involuntary hospitalization to treat psychosis once it has been identified as a potentially reversible, underlying cause for a patient's inability to make medical decisions. The role of the mental health court to request medical evaluations over objection in a mentally ill patient will be discussed.

CASE CONFERENCE 3**PSYCHODYNAMIC PSYCHOTHERAPY OF PATIENTS WITH GENDER UNCERTAINTY**

Chair: Glen O. Gabbard, M.D.

Speaker: Ken Masters, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify countertransference pitfalls in psychotherapy work with patients of ambiguous gender; 2) Recognize features of gender uncertainty through the patients' use of speech patterns; and 3) To Master the technique of facilitating self-exploration in the patient.

SUMMARY:

A case of a young adult will be presented to Dr. Gabbard. In this case the patient, a biological male, shares with the therapist his gender uncertainty. He also attempts to get his therapist to share his impressions of the patient's gender based on the sound of the patient's voice and his physical appearance. The therapist discusses his countertransference pulls to respond to the patient's pleas while also using technical strategies to facilitate self-discovery in the patient regarding his gender role and gender identity. Family and cultural matters will also be discussed.

CASE CONFERENCE 4**FEEDING AND EATING DISORDERS: NEW ISSUES FOR DSM-5**

Chair: Evelyn Attia, M.D.

Speakers: Rachel Bryant-Waugh, D.Phil., Anne E. Becker, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify individuals with Feeding and Eating Disorders using newly released DSM-5 criteria; 2) Discuss Avoidant-Restrictive Food Intake Disorder (ARFID) and newly clarified features of Anorexia Nervosa (AN); and 3) Recognize treatment options for individuals with Feeding and Eating Disorders as part of a case-based discussion.

SUMMARY:

Feeding and Eating Disorders can be challenging for clinicians to identify and treat. They are serious conditions with medical as well as psychiatric manifestations. Patients with these disorders may be reluctant to normalize eating behavior and weight, and may not self-disclose their symptoms to clinicians. The DSM-5 Eating Disorders Work Group has recommended several changes to the list of Feeding and Eating Disorders, including revisions to the diagnostic criteria

for Anorexia Nervosa (AN), and the introduction of Avoidant-Restrictive Food Intake Disorder (ARFID). The changes are intended to better categorize some individuals who had previously received a heterogeneous Eating Disorder Not Otherwise Specified (EDNOS) diagnosis. This case conference will include the presentation of an adolescent patient with a significant disturbance in eating behavior and secondary nutritional compromise. The differential diagnosis using DSM-5 diagnostic criteria will be discussed by clinical experts who have served on the DSM-5 Eating Disorders Work Group.

CASE CONFERENCE 5**PSYCHODYNAMIC APPROACHES TO THE DIFFICULT-TO-TREAT PATIENT**

Chair: Donald Rosen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate how one can introduce and work with transference material into the clinical work; 2) Identify an example of the clinical management of sadomasochistic enactments in this patient's treatment; and 3) Recognize an example of a psychodynamic perspective on working with Dissociative phenomenon during psychotherapy sessions.

SUMMARY:

This case conference will focus on a psychodynamic perspective regarding the clinical work with a patient with Depression, Dissociative Disorder, and PTSD. The patient, a middle aged female with long standing suicidal ideation, had six prior hospitalizations, ECT, and numerous medication trials. She had been in weekly therapy for 6 years. Despite attending her sessions regularly and taking medications as prescribed, her condition did not improve. She was referred for evaluation and treatment with the goals of clarifying the diagnosis, helping the therapist and patient review their work and plan their continued work, and to provide a psychodynamic formulation that would help the patient put her symptoms in a broader context. The treatment was to serve as a consultation to her therapist, with the plan for her to resume their work upon discharge. The patient presented as depressed, but insisting she didn't have any feelings, and never did. By the third session, the patient experienced dissociative and demonstrated self injurious behavior in the session. The presentation will focus on how this clinician engaged the patient's affects, dissociative states, and self injurious behavior from a psychodynamic perspective, and helped her develop a context and narrative for her experience, which she would then integrate into her outpatient therapy.

MAY 21, 2013

CASE CONFERENCE 6**YOUTH PSYCHIATRY: HELPING A PERSON WITH FIRST-EPIISODE SCHIZOPHRENIA TO ADULTHOOD***Chair: S. Charles Schulz, M.D.**Speakers: S. Charles Schulz, M.D., Andrew M. Chanen, M.B.B.S., Ph.D., Danielle Goerke, D.O.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Review the assessment of early stage schizophrenia when onset is in teenage years; 2) Discuss the overall approach to a very young patient from medication to family intervention, and psychosocial therapy; and 3) Engage in review of how to improve continuity of care from adolescence to young adulthood.

SUMMARY:

Many studies and meta-analyses have noted the better outcomes of early intervention for schizophrenia. Programs have emerged to reduce the duration of untreated psychosis (DUP). However, it is becoming challenging to address the issue of onset of psychosis in adolescence and how to maintain continuity of treatment to reduce the chance of relapse. One approach to this issue was initiated by Dr. Patrick McGorry who started the Youth Psychiatry Program. Such a program focuses on early recognition of schizophrenia—even in teenagers—and focuses on interventions for such young people. This is an important part of treatment, as there are specific challenges of medication dosing and management of side-effects. Dr. McGorry noted that even with a constructive initiation of treatment, there was substantial risk of relapse when such a young person changed teams. Therefore, this case conference will begin with a case presentation of a person with adolescent onset schizophrenia and their following course. To address the goals of this conference, Dr. Danielle Goerke will present a case of adolescent-onset schizophrenia with attention to evaluation, initiation of treatment, and inclusion of family psychoeducation. Further engagement in programs in the First Episode Program at the University of Minnesota as the patient grows older will be described. Regarding the issue of continuity of care, Dr. Andrew Chanen will describe the initiation of the Youth Psychiatry Program developed in Melbourne, Australia. He will focus on initial engagement and the methods of continuity of care. To address the challenging issue of initiating medication treatment in adolescents and young adults with schizophrenia, Dr. Charles Schulz will describe the background of initiating medication treatment with significant focus on the challenges adolescents face with side-effects. This will be followed by the management of psychosis in the early phases with discussion of adherence and non-response. In summary, DUP programs have been very constructive in identifying patients early in the course of schizophrenia.

Now there needs to be further attention on maintaining good outcome through a Youth Psychiatry approach and up-to-date psychosocial and medication treatment.

CASE CONFERENCE 7**CLINICAL CASE DISCUSSION OF A CORE FEATURE MODEL OF OCD: NEW PERSPECTIVES ON TREATMENT RESISTANCE***Chairs: Jane L. Eisen, M.D., Nicholas J. Sibrava, Ph.D.**Speakers: Steven Rasmussen, Nicholas J. Sibrava, Ph.D., Benjamin Greenberg, M.D., Ph.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Recognize the importance of understanding and assessing core underlying features of OCD, such as incompleteness and harm avoidance, and their influence on treatment; 2) Identify the clinical importance of the interaction between OCD and Obsessive Compulsive Personality Disorder (OCPD); and 3) Discuss innovative treatment options for severe OCD.

SUMMARY:

Obsessive-Compulsive Disorder (OCD) is a heterogenous disorder, both in its clinical presentation and its response to treatment, which can create significant challenges for clinicians. Ongoing research has sought to address this issue by identifying clinically meaningful subtypes such as hoarding, contamination, and symmetry, as well as comorbid Obsessive-Compulsive Personality Disorder (OCPD). More recent approaches have focused on the underlying motivation that drives the obsessions and need for compulsions. One such conceptualization that may provide important guidance to clinicians is a model of OCD that posits harm avoidance and incompleteness as key features. In this case conference, we will present a case of OCD with comorbid OCPD highlighting these core features, the associated clinical challenges, and a discussion of treatment approaches for refractory OCD. Panelists will comment on the case from the perspective of CBT, pharmacotherapy, neurosurgical, and neurostimulation approaches.

MAY 22, 2013

CASE CONFERENCE 8

TREATING DEPRESSION IN CANCER PATIENTS

Chair: Michelle Riba, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify depression in cancer patients;2) Learn principles of supportive-expressive group psychotherapy with cancer patients;3) Review outcome data on psychotherapy with cancer patients; and 4) Review risks and benefits of antidepressant medication with breast cancer patients.

SUMMARY:

This presentation will cover the phenomenology, prevalence, and neurobiology of depression in cancer survivors, along with possibilities to miss symptoms of depression as side effects of cancer treatment or the disease itself. Evidence regarding the effect of depression on cancer progression will be reviewed. Treatment, both Supportive-Expressive Group Psychotherapy, and psychopharmacology, and evidence of its effects, will be discussed with a clinical example. Special attention to interactions of certain SSRI antidepressants with tamoxifen metabolism and effects on disease progression will be reviewed.

COURSES

MAY 17, 2013

**PRE-CONFERENCE PRESENTATION
CLINICAL UPDATES IN PRIMARY CARE PSY-
CHIATRY: FOR PRIMARY CARE AND MENTAL
HEALTH PROVIDERS**

Directors: Robert M. McCarron, D.O., Lori Raney, M.D.

Faculty: Jürgen Unützer, M.D., M.P.H., Glen Xiong, M.D., Jaesu Han, M.D., Sarah Rivelli, M.D., Shannon Suo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review the core components of doing an initial psychiatric assessment in the busy primary care setting.;2) Discuss the most effective treatment strategies for depression, anxiety, bipolar disorder, and substance abuse disorders.;3) Provide an overview on how to approach the “difficult patient” encounter in the primary care setting.;4) Review the most recent developments in psychopharmacology and brief psychotherapies; and 5) Develop a framework in which common mental health conditions can be most effectively addressed in the primary care setting.

SUMMARY:

Well over half of all mental health delivery takes place in the primary care setting. Primary Care Providers (PCP's) often find it challenging to address psychiatric disorders due to a paucity of formal training in this area. PCP's may also find it difficult to address these often complex clinical matters within the confines of a busy practice. Many of our clinical faculty are dually trained and in both medicine and psychiatry and are experts in the area of collaborative care. The focus of this course is to provide the PCP with practical, clinical tools to more efficiently and effectively diagnose and address commonly encountered psychiatric disorders, within the primary care setting. Updates in psychopharmacology and brief psychotherapies will be reviewed for mental health care providers. Faculty will provide a concise, easy to use, step-wise approach on how to complete a primary care psychiatric assessment using the “AMPS” model. An overview on mood, anxiety and substance use disorders will be provided. Attendees will gain a better understanding about how to treat the “challenging patient encounter”, while using motivational interviewing and cognitive behavioral therapy. Faculty will discuss the collaborative care model, while providing a practical framework to deliver mental health care within the fast-paced primary care setting.

MAY 18, 2013

**COURSE 01
STREET DRUGS AND MENTAL DISORDERS:
OVERVIEW AND TREATMENT OF PATIENTS WITH
DUAL DIAGNOSIS**

Director: John Tsuang, M.D.

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) At the conclusion of this session, the participant should be able to understand the issues relating to the treatment of dual diagnosis patients.;2) Popular street drugs and club drugs will be discussed.;3) The available pharmacological agents for treatment of dual diagnosis patients will be covered.; and 4) Additionally, participants will learn the harm-reduction versus the abstinence model for dual diagnosis patients.

SUMMARY:

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

**COURSE 02
MENTALIZATION-BASED TREATMENT (MBT) FOR
BORDERLINE PERSONALITY DISORDER (BPD):
INTRODUCTION TO CLINICAL PRACTICE**

Directors: Anthony Bateman, M.D., Peter Fonagy, Ph.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

Mentalization is the process by which we implicitly and explicitly interpret the actions of ourselves and others as meaningful on the basis of intentional mental states (e.g., desires, needs, feelings, beliefs, & reasons). We mentalize interactively and emotionally when with others. Each person has the other person's mind in mind (as well as their own) leading to self-awareness and other awareness. We have to be able to continue to do this in the midst of emotional states but borderline personality disorder (BPD) is characterized by a loss of capacity to mentalize when emotionally charged attachment relationships are stimulated. The aim of MBT is to increase this capacity in order to ensure the development of better regulation of affective states and to increase interpersonal and social function. In this course we will consider and practice interventions which promote mentalizing contrasting them with those that are likely to reduce mentalizing. Participants will become aware of which of their current therapeutic interventions promote mentalizing. The most important aspect of MBT is the therapeutic stance. Video and role plays will be used to ensure participants recognize the stance and can use it in their everyday practice. Small group work will be used to practice basic mentalizing interventions described in the manual. In research trials MBT has been shown to be more effective than treatment as usual in the context of a partial hospital program both at the end of treatment and at 8 year follow-up. A trial of MBT in an out-patient setting has also been completed. This shows effectiveness when applied by non-specialist practitioners. Independent replication of effectiveness of MBT has been shown in cohort studies and additional randomized controlled trials are in progress. The course will therefore provide practitioners with information about an evidence-based treatment for BPD, present them with an understanding of mentalizing problems as a core component of BPD, equip them with clinical skills that promote mentalizing, and help them recognize non-mentalizing interventions.

COURSE 03 INTERPERSONAL PSYCHOTHERAPY (IPT)

Director: John C. Markowitz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the basic rationale and techniques of IPT; 2) Understand its application to the treatment of major depressive disorder and other conditions; and 3) Understand the basic research supporting its use and treatment indications

SUMMARY:

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

Axis I disorders such as bulimia. This course, now in its 20th consecutive year at the APA Annual Meeting, presents the theory, structure, and clinical techniques of IPT along with some of the research that supports its use. It is intended for therapists experienced in psychotherapy and treatment of depression who have not had previous exposure to IPT. Please note: the course will not provide certification in IPT, a process which requires ongoing training and supervision. Participants should read the IPT manual: Weissman MM, Markowitz JC, Klerman GL: *Comprehensive Guide to Interpersonal Psychotherapy*. New York: Basic Books, 2000; or Weissman MM, Markowitz JC, Klerman GL: *A Clinician's Quick Guide to Interpersonal Psychotherapy*. New York: Oxford University Press, 2007. They may also be interested in: Markowitz JC, Weissman MM: *Casebook of Interpersonal Psychotherapy*. New York: Oxford University Press, 2012.

COURSE 04 HEALTHY BRAIN AGING: EVIDENCE-BASED METHODS TO PRESERVE AND IMPROVE BRAIN FUNCTION

Directors: Abhilash Desai, M.D., George T. Grossberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe research clarifying different trajectories of cognitive health in older adults.; 2) Discuss evidence supporting modifiable factors associated with reduced risk of dementia in older adults.; and 3) Describe specific lifestyle modification strategies that promote cognitive health in older adults.

SUMMARY:

In the last decade, interest in staying sharp has taken central stage in the minds of middle aged and older adults. More and more adults are asking psychiatrists to give them advice regarding how to prevent memory loss and improve their cognitive functioning. Optimal cognitive and emotional function is vital to independence, productivity, and quality of life. In this light, psychiatrists need to be able to give their patients practical guidance in ways to revitalize their aging brain. This course will describe research indicating that cognitive decline is not inevitable with old age and a substantial number of older adults maintain high level of cognitive functioning even in their eighties and nineties. Research update on association of vascular risk factors such as hypertension, diabetes, high cholesterol, smoking and obesity with increased risk of Alzheimer's disease and protective effects of exercise, Mediterranean diet and social engagement will be discussed. Research indicating increased importance of sleep in cognitive health will be reviewed. Neuroplasticity-based simple and practical cognitive strategies along with ways to motivate patients to adopt a daily routine of physical activity, good sleep habits and healthy nutrition will be discussed.

COURSE 05**BASIC CONCEPTS IN ADMINISTRATIVE PSYCHIATRY**

Directors: Geetha Jayaram, M.B.A., M.D., John E. Wilkaitis, M.D., M.S.

Faculty: Mark Russakoff, M.D., Barry K. Herman, M.D., Robert Atkins, M.D., M.P.H., Shivkumar Hatti, M.B.A., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Participants should be able to demonstrate a working knowledge of the basic concepts for the theoretical, fiscal, and information technology concepts of administration in psychiatry; 2) Participants should be able to apply these concepts to psychiatric service systems; and 3) Further objectives will be to recognize gaps in services systems, use a collaborative service model, recognize future trends in health delivery systems

SUMMARY:

This is the first part of a two part series providing an overview of the theories, principles, concepts and developments relevant to administrative psychiatry. The course is designed for both novices and early career administrators. Dr. Jayaram will provide opening remarks and introduce faculty. This course consists of in- depth coverage of 5 broad topics: 1) Dr. Russakoff will review Administrative and Management Theories that have had the most applicability to psychiatric administration, including leadership and governance ; 2) Dr. Herman will discuss Professional issues relevant to psychiatric administrators, such as career development; skills and competencies required to manage psychiatric systems; alignment of personal and organizational goals; the realities of managing versus practicing; and ways to acquire business acumen ; 3) Dr. Atkins will discuss Integrated Care Management and teach professional and career issues relevant to clinical program issues; multidisciplinary service delivery; programs for special populations, medical and psychiatric care coordination; and principles of disease management; 4) Dr. Hatti will review budgeting and fiscal management, discuss types of budgets, balance sheets, funding, accounting and financial ratios; 5) Dr. Jayaram will present the Physician Advisor's role in managing aspects of Quality, Safety efforts and the Electronic health record. Case examples will be reviewed. Faculty members will have an open forum to discuss questions that remain unaddressed during the course in the final hour. Although Part A provides an overview of areas considered prerequisite for managing the medical-industrial complex, Part B next year will cover IT and health care trends, Patient Safety practices, Law and Ethics, Marketing and building your practice, and Human Resources Management to complete the series. The course is designed to answer the following questions: 'I am an M.D. - why don't people listen to me?' or 'Why should you take charge and not be frustrated with administrators?'

COURSE 06**MELATONIN AND LIGHT TREATMENT OF SEASONAL AFFECT DISORDER, SLEEP AND OTHER BODY CLOCK DISORDERS**

Director: Alfred Lewy, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) use the salivary dim light melatonin onset and sleep time to phase type circadian sleep and mood disorders as to whether they are phase advanced or phase delayed; 2) treat a patient with appropriately timed bright light exposure (evening or morning) and/or low-dose melatonin administration (morning or afternoon) using the patient's phase type; 3) monitor treatment response using the DLMO/mid-sleep interval, targeting 6 hours;

SUMMARY:

This course will enable practitioners to advise patients on how to use melatonin and bright light to treat circadian sleep and mood disorders. There are two categories for these disorders: phase advanced and phase delayed. The prototypical patient with SAD (seasonal affective disorder, or winter depression) is phase delayed; however, some are phase advanced (Lewy et al., PNAS, March 9, 2006). Shift work maladaptation, non-seasonal major depressive disorder (Emens, Lewy et al., Psychiatry Res., Aug. 15, 2009), and ADHD can also be individually phase typed and then treated with a phase-resetting agent at the appropriate time. Phase-advanced disorders are treated with evening bright light exposure and/or low-dose (~0.5 mg) morning melatonin administration. Phase-delayed disorders are treated with morning bright light and/or low-dose afternoon/evening melatonin administration. High doses of melatonin can be given at bedtime to help some people sleep. The best phase marker is the circadian rhythm of melatonin production, specifically, the time of rise in levels during the evening. In sighted people, samples are collected under dim light conditions. This can be done at home using saliva. Within a year or two, this test should become available to clinicians. The dim light melatonin onset (DLMO) occurs on average at about 8 or 9 p.m.; earlier DLMOs indicate a phase advance, later DLMOs indicate a phase delay. The circadian alignment between DLMO and the sleep/wake cycle is also important. Use of the DLMO for phase typing and guiding clinically appropriate phase resetting will be discussed in detail, focusing on SAD. A jet lag treatment algorithm will be presented that takes into account the direction and number of time zones crossed, for when to avoid and when to obtain sunlight exposure at destination and when to take low-dose melatonin before and after travel. Books instructing the use of light treatment will also be reviewed, as well as the most recent research findings.

COURSE 07 THE PSYCHIATRIST AS EXPERT WITNESS

Director: Phillip Resnick, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

Trial procedure and rules of evidence governing fact and expert witnesses will be reviewed briefly. The fallacy of the impartial expert witness will be discussed. Participants will learn that the adversary process seeks justice, sometimes at the expense of truth. The faculty will discuss pre-trial conferences and depositions. Participants will learn to cope with cross-examiners who attack credentials, witness bias, adequacy of examination, and the validity of the expert's reasoning. Issues of power and control in the witness cross-examiner relationship will be explored. Participants will learn how to answer questions about fees, pre-trial conferences and questions from textbooks. The use of jargon, humor, and sarcasm will be covered. Different styles of testimony and cross-examination techniques will be illustrated by 8 videotape segments from actual trials and mock trials. Participants will see examples of powerful and powerless testimony in response to the same questions. Mistakes commonly made by witnesses will be demonstrated. Slides of proper and improper courtroom clothing will be shown. Handouts include lists of suggestions for witnesses in depositions, 15 trick questions by attorneys, and over 50 suggestions for attorneys cross-examining psychiatrists.

COURSE 08 MANAGEMENT OF PSYCHIATRIC DISORDERS IN PREGNANT AND POSTPARTUM WOMEN

Directors: Shaila Misri, M.D., Diana Carter

Faculty: Deirdre Ryan, Shari Lusskin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Have an increased awareness about psychiatric disorders that occur in pregnancy and postpartum.;2) Have an improved ability to identify psychiatric disorders that occur in pregnancy and postpartum.; and 3) Have an improved ability to treat psychiatric disorders that occur in pregnancy and postpartum.

SUMMARY:

This course provides comprehensive current clinical guidelines and research updates in major depression, anxiety disorders (GAD, PD, OCD and PTSD) and eating disorders

in pregnancy and the postpartum. This course will also focus on mother-baby attachment issues; controversy and reality in perinatal pharmacotherapy; management of women with bipolar disorder and schizophrenia during pregnancy and the postpartum, with updates on pharmacotherapy; and non-pharmacological treatments including light therapy, psychotherapies, infant massage and alternative therapies in pregnancy/postpartum. This course is interactive. The audience is encouraged to bring forward their complex patients with management problems or case vignettes for discussion. Video clips will be used to facilitate discussion and encourage audience participation. The course is presented in depth and the handouts are specifically designed to update the audience on cutting edge knowledge in this subspecialty.

MAY 19, 2013

COURSE 14 OFFICE-BASED BUPRENORPHINE TREATMENT OF OPIOID DEPENDENCE

Directors: Petros Levounis, M.D., John A. Renner Jr, M.D.

Faculty: Andrew J. Saxon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the clinically relevant pharmacological characteristics of buprenorphine;2) List at least five factors to consider in determining if the patient is an appropriate candidate for office-based treatment with buprenorphine; and 3) Describe the resources needed to set up office-based treatment with buprenorphine for patients with opioid dependence.

SUMMARY:

Physicians who complete this course will be eligible to request a waiver to practice medication-assisted addiction therapy with buprenorphine for the treatment of opioid dependence.

The course will describe the resources needed to set up office-based treatment with buprenorphine for patients with opioid dependence and review:

- DSM-IV criteria for opiate dependence and the commonly accepted criteria for patients appropriate for office-based treatment of opiate dependence,
- HIPAA requirements and confidentiality rules related to the treatment of drug dependence, DEA requirements for record keeping related to the treatment of opiate dependence, and billing and common office procedures relating to the management of this condition,
- the epidemiology, symptoms, and current treatment of anxiety, common depressive disorders, ADHD, and how to distinguish independent disorders from substance induced psychiatric disorders, and
- common clinical events associated with addictive behavior.

ior. The practitioner will learn the importance of treatment contracts, clear treatment rules, appropriate enforcement of treatment rules, and the utilization of urine toxicology for the management of addictive disorders.

The course will also address special treatment populations, including adolescents, geriatric patients, pregnant addicts, HIV positive patients, and chronic pain patients.

Lastly, case topics will challenge participants to (1) identify if the patient meets DSM-IV criteria, (2) demonstrate understanding of psychiatric and medical co-morbidities and clarify the type of patients they are comfortable in managing, (3) review the buprenorphine induction process and identify common clinical problems, and (4) manage problem behaviors in existing patients.

COURSE 09 GOOD PSYCHIATRIC MANAGEMENT (GPM) FOR BORDERLINE PERSONALITY DISORDER (BPD): WHAT EVERY PSYCHIATRIST SHOULD KNOW

Director: John Gunderson, M.D.

Faculty: Paul Links, M.D., Brian Palmer, M.D., John Gunderson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explain the diagnosis to patients and families and establish reasonable expectations for change (psychoeducation).;2) Manage the problem of recurrent suicidality and self-harm while limiting personal burden and liability.;3) Expedite alliance-building via use of medications and homework.;

SUMMARY:

The course will describe an empirically validated treatment approach, Good Psychiatric Management (GPM) (McMain et al., AJP 2009). It emphasizes management strategies involving practicality, good sense, and flexibility. Listening, validation, judicious self-disclosures and admonishments create a positive relationship in which both a psychiatrist's concerns and limitations are explicit. Techniques and interventions that facilitate the patient's trust and willingness to become a proactive collaborator will be described. Guidelines for managing the common and usually most burdensome issues of managing suicidality and self-harm (e.g., intercession crises, threats as a call-for-help, excessive use of ER's or hospitals) will be reviewed. How and when psychiatrists can usefully integrate group, family, or other psychotherapies will be described.

COURSE 10 NEUROANATOMY OF EMOTIONS

Director: Ricardo Vela, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the functional neuroanatomical interrelationships of the hypothalamus, amygdala, septal nuclei, hippocampus, and anterior cingulate gyrus.;2) Identify the major limbic fiber pathways, their trajectories, and their specific targets.;3) Describe how each limbic structure contributes to the specific expression of emotions and attachment behavior.;4) Discuss neuroanatomical –emotional correlates in autism; and 5) Discuss neurodevelopmental abnormalities of migrating neurons in schizophrenia.

SUMMARY:

The rapid development of new brain imaging techniques has revolutionized psychiatric research. The human brain, the organ of psychiatry, had been largely neglected, in the face of intensive basic science research at the neurochemical/ synaptic level. Practitioners find themselves poorly equipped with knowledge about neuroanatomy and neurocircuitry to feel competent understanding this new level of analysis. Psychiatrists need to access new knowledge to allow them to understand emerging data from functional imaging research studies. This requires a fundamental background of underlying brain mechanisms involved in emotions, cognition and mental illness.

This course will describe the structure of limbic nuclei and their interconnections, as they relate to the basic mechanisms of emotions. Neuroanatomical illustrations of limbic nuclei, associated prefrontal and cerebellar structures and principal fiber systems will be presented. Drawing from classic neurobiological research studies and clinical case data, this course will show how each limbic structure, interacting with each other, contributes to the expression of emotions and attachment behavior. Three-dimensional relationships of limbic structures will be demonstrated through the use of a digital interactive brain atlas with animated illustrations. The relevance of neuroanatomical abnormalities in autism, PTSD, major depression and schizophrenia will be discussed in the context of limbic neuroanatomical structures.

COURSE 11 MOOD DISORDERS IN LATER LIFE

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

Faculty: Patricia A. Arean, Ph.D., Donald Davidoff, Ph.D., Brent Forester, M.D., M.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) The attendee will learn to implement an evidence-based approach to the diagnosis of mood disorders in older adults.;2) The attendee will learn to describe and discuss the characteristics of "normal cognitive aging", "major depressive disorder", and the "dementia syndrome of depression";3) The attendee will learn to apply an evidence-based approach to

using somatic therapies in the treatment of older adults with mood disorders, including treatment resistant mood disorders; and 4) The attendee will be able to discuss psychotherapy's evidence-based role in treating older adults with mood disorders and to describe special issues that arise in treating this population.

SUMMARY:

Unipolar and bipolar mood disorders are widespread and very disabling among older adults.

Clinicians who work with the elderly must therefore be able to detect, accurately diagnose, and effectively treat these conditions. The need for these skills is increasing as a result of our patients' increasing longevity, a growing recognition by older adults of the value of mental health treatment, and advances in diagnostic and treatment interventions that have increased treatment effectiveness. This course provides an interdisciplinary overview of late life mood disorders. The attendee will acquire an organized approach to assessment and a systematic and evidence-based approach to treatment planning incorporating both psychotherapeutic and somatic interventions. In addition, the attendee will learn to distinguish among the cognitive symptoms associated mood disorders, the cognitive changes associated with normal aging, and the cognitive impairments associated with dementia. The discussion of psychotherapy for older adults with mood disorders will review evidence-based approaches with particular emphasis on Cognitive Behavior Therapy, Interpersonal Therapy, and Problem-Solving Therapy. The discussion of somatic approaches will review interventions used with treatment resistant mood disorders and the syndrome of vascular depression. The faculty will lecture, using illustrative slides, and there will be ample time for interactive discussion. This course is designed primarily for general psychiatrists seeking greater understanding and expertise in treating older patients. For psychiatric residents, it will be an advanced introduction. For geriatric psychiatrists, it will provide a review and update. It will be of greatest practical value to attendees who already possess a basic familiarity with principles of pharmacotherapy and psychotherapy.

COURSE 12

YOGA OF THE EAST AND WEST EXPERIENTIAL PROGRAM FOR STRESS, ANXIETY, PTSD, MASS DISASTERS, STRESS-RELATED MEDICAL CONDITIONS, AND MORE

Director: Patricia L. Gerbarg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how Heart Rate Variability, sympathovagal balance, and cardiopulmonary resonance contribute to stress-resilience; 2) Experience Coherent Breathing for stress reduction and learn how it is used in the treatment of anxiety disorders, insomnia, PTSD, depression, and stress-related medical conditions.; 3) Experience Open Focus meditation for stress reduction, improved attention, and relief of physical and psychological distress; 4) Employ Coherent Breathing to

relieve personal stress and professional burnout.; 5) Acquire the tools to teach Coherent Breathing for stress relief to individual patients in their clinical practice.;

SUMMARY:

Participants will learn the theoretical background and applications of two powerful self-regulation strategies to improve their own well-being and the mental health of their patients. This Experiential Program program of non-religious practices will enable participants to experience Coherent Breathing, Resistance Breathing, Breath Moving, "Ha" Breath, and "Open Focus" meditation. Through rounds of breathing and meditation with gentle movements and interactive processes, participants will discover the benefits of mind/body practices.

Participants will learn how to teach Coherent Breathing to their patients. Evidence base and clinical guidelines for the safe and effective use of these techniques in clinical treatment of stress, anxiety, PTSD, insomnia, depression, ADD/ADHD, schizophrenia, inflammatory bowel syndrome, and other stress-related disorders will be addressed. The development of programs for children under stress and in school settings will be considered. A program using breath practices to alleviate stress and anxiety in children undergoing heart surgery, their parents, and the hospital staff will illustrate potential applications. Risks and contraindications will be described..

An in-depth case of posttraumatic stress disorder will illustrate the benefits of yoga breathing from the perspective of neuro-psychoanalytic theory. Clinical issues to consider when introducing mind/body practices in treatment are discussed.

Mind/body programs and studies in disaster relief are reviewed including the Southeast Asian tsunami, September 11th World Trade Center attacks, 2010 earthquake in Haiti, 2010 Horizon gulf oil spill, and for survivors of war and genocide in Rwanda and Sudan.

This course is suitable for novices and experienced practitioners.

COURSE 13

TREATMENT OF SCHIZOPHRENIA

Director: Phillip G. Janicak, M.D.

Faculty: Rajiv Tandon, M.D., Morris Goldman, M.D., Stephen R. Marder, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the psychopathological dimensions, recent DSM-5 diagnostic criteria and neurobiological underpinnings of schizophrenia.; 2) Describe the clinically relevant pharmacological aspects of first- and second-generation antipsychotics, as well as novel therapies.; 3) Better, understand the efficacy, safety and tolerability of antipsychotics when used for acute and chronic schizophrenia.; and 4) Describe recent approaches to integrating medication strategies with psychosocial and rehabilitation programs.

SUMMARY:

Treatment of schizophrenia and related psychotic disorders has rapidly evolved since the re-introduction of clozapine in 1989. There are now nine additional second-generation antipsychotics in various formulations (i.e., risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, iloperidone, paliperidone, asenapine, lurasidone). The relative effectiveness of these drugs when compared with each other (e.g., CAFÉ trial in first episode psychosis), as well as with first generation antipsychotics (e.g., the CATIE and CUtLASS trials), continues to be clarified. Increasingly, strategies to improve cognition, mood and negative symptoms, as well as safety and tolerability issues, are the focus of attention. The integration of cognitive therapeutic approaches, psychosocial interventions and rehabilitation programs with medication is also critical to improving long-term outcomes (e.g., recovery). Our increased understanding of the neurobiology and psychopathology of schizophrenia will guide the development of future more effective agents for acute and maintenance strategies.

COURSE 15 ESSENTIALS OF ASSESSING AND TREATING ADHD IN ADULTS AND CHILDREN

Director: Thomas E. Brown, Ph.D.

Faculty: Jefferson Prince, M.D., Anthony Rostain, M.A., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the wide range of executive function impairments characteristic of ADHD in adults, adolescents and children.;2) Explain current research-based understandings of pathophysiology of ADHD.;3) Assess and diagnose ADHD in adults, adolescents and children using updated instruments and methods;4) Select appropriate medications and psychosocial interventions for treatment of ADHD and various comorbidities; and 5) Implement and monitor effectiveness of multi-modal treatment plans for patients with ADHD and various comorbidities

SUMMARY:

Understanding of ADHD has changed considerably over recent years. Rather than being seen as a disruptive behavior disorder, ADHD is now recognized as a complex syndrome of developmental impairments of the management system of the brain, its executive functions. This basic course describes this new model of ADHD as it is manifest across the lifespan from childhood through adolescence and also into adulthood. Content will include 1) typical symptom profiles for different age groups; 2) measures and procedures for assessment; 3) comorbidities often seen with ADHD; 4) research-based guidelines for pharmacotherapy of ADHD alone and in combination with typical comorbidities; 5) strategies for designing and implementing multi-modal treatment programs for adults, adolescents and children with ADHD.

COURSE 16

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

Directors: Lori Raney, M.D., Jürgen Unützer, M.D., M.P.H.

Faculty: Anna Ratzliff, M.D., Ph.D., John Kern, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Make the case for integrated behavioral health services in primary care, including the evidence for collaborative care;2) Describe the roles for a primary care consulting psychiatrist in an integrated care team;3) List models of care used to provide primary care services in mental health settings;4) Apply a systematic approach to target health behavior change and medical illness in a mental health setting.; and 5) Discuss principles of integrated behavioral health care

SUMMARY:

We need to leverage the limited psychiatric resources in this country to cover the mental health needs of the larger population. Collaborative Care has an evidence base that can help us accomplish this. It represents a significant departure from traditional psychiatric care, which focuses primarily on face to face evaluations. Moving from traditional office-based practice to “consultant specialists” who can be effective on a population level will require psychiatrists to develop a new skill set. Preparing for this new role will require training, financing and leadership to be successful. This course will offer a set of skills for psychiatrists interested in working in these collaborative settings, covering the spectrum of treating mental illness in primary care to emerging models of treating physical health problems in mental health settings.

MAY 20, 2013

COURSE 17 PRACTICAL ASSESSMENT AND TREATMENT OF BEHAVIOR DISTURBANCE FOR THOSE WITH MODERATE TO SEVERE DEMENTIA

Director: Maureen Nash, M.D.

Faculty: Sarah Foidel, O.T., Maria Shindler, M.S.N., R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe different types of behavior disturbance and how they may present in differing types of dementia;2) Describe when and how to use various types of behavioral interventions to prevent and treat behavior disturbance in those with dementia;3) Will have a framework for understanding and treating those with behavior disturbance due to advanced dementia;4) Discuss the risks, benefits and alternatives to pharmacological treatment of behavior disturbance in

those with advanced dementia; and 5) Discuss the challenges of interpreting evidence to treat behavior disturbance in those with dementia.

SUMMARY:

This course is designed for psychiatrists, primary care providers and advanced practice nurses who desire to learn to assess and manage behavioral disturbances in those who have moderate or severe dementia. The course will review assessment, nonpharmacological management, pharmacological strategies and discussion of quality of life issues. Management for both inpatient and outpatient situations will be covered; however, emphasis will be on the most difficult situations—typically inpatients on adult or geriatric psychiatric units. The first part will be an overview of the topic and determining the proper diagnosis. Determining the type of dementia is emphasized for proper management. There will also be a subsection reviewing delirium as it relates to behavior disturbance in those with dementia. Next there will be discussions of practical nonpharmacological interventions and in-depth discussion of the pharmacological management of behavioral disturbances in dementia. Cases of Alzheimer's, Lewy Body, Frontal Temporal Lobe Dementia and other dementias will be used to highlight aspects of diagnosis and successful management of the behavioral disturbances unique to each disease. Audience participation will be encouraged.

COURSE 18 EXPLORING TECHNOLOGIES IN PSYCHIATRY

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

Faculty: Carlyle Chan, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

Managing information and technology has become a critical component of the practice of psychiatry and medicine. Finding ways to make technology work both as a means of communication and as a way of keeping up-to-date on current changes in the field is an important goal. The process of being connected means developing a new understanding about what technology can best facilitate the various levels of communication that are important. Whether it is collaborating with a colleague over the Internet, using a teleconferencing system to visit a remote patient, participating in a social network about a career resource, using a smartphone or tablet to connect via email, obtaining critical drug information at the point of care, or evaluating the impact of various treatments in healthcare management, there are many ways and reasons to connect. This course will explore many of the ways that clinicians can connect to colleagues and to needed information

and even to patients. Keeping up with the technology requires a basic review of the hardware as well as the software that drives the connections. The goal of this course is to explore the most current technologies and how they can assist the busy clinician in managing the rapidly changing world of communication and information. It will explore the evolving role of tablets and smartphones and how these leading edge technologies have changed our relationship to information and their widespread adoption by psychiatrists and healthcare professionals. It will also describe the evolution of mobile and cloud technology. A review of social media, new trends and how physicians can manage their online identity in the changing online world is critical. Other topics include teleconferencing, educational technologies and resources for lifelong learning, electronic medical records, privacy and security. This course is not intended for novices. It will get the experienced computer user up to speed on cutting edge technologies and trends that will impact the profession over the next decade. It will also explore ways to participate in the creation of content to become part of the future.

COURSE 19 ECT PRACTICE UPDATE FOR THE GENERAL PSYCHIATRIST

Directors: Charles H. Kellner, M.D., Laurie McCormick, M.D.

Faculty: Charles H. Kellner, M.D., Donald Eknoyan, M.D., Andrew Krystal, M.D., M.S., Vaughn McCall, M.D., M.S.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

Target Audience: General psychiatrists and other health care providers who are involved in providing ECT or referring patients for ECT. This course is intended for those who wish to update their knowledge of ECT, but is not intended as a "hands on" course to learn the technique of ECT. Many subjects will be covered including the history of ECT, indications for treatment, use of ECT in special patient populations, anesthesia options, potential side effects from ECT and concurrent use of psychotropic and non-psychotropic medications. Emphasis will be placed on newer ideas such as ultra-brief pulse right unilateral ECT, different forms of electrode placement and other techniques which may impact cognition. There will be special mention of neuroimaging and basic science studies

that point to possible explanations for the mechanism underlying ECT's therapeutic action. A video of an actual ECT procedure will be shown and a presentation on how to perform an ECT consult will be given. The five faculty of this course are intimately involved with both research and the administration of ECT on a regular basis. Any practitioner who has involvement with ECT, either in administration of the procedure or in the referral of patients for ECT, should consider attending this course.

COURSE 20

ADVANCES IN NEUROPSYCHIATRY: THE NEUROPSYCHIATRY OF EMOTION AND ITS DISORDERS

Director: C. Edward Coffey, M.D.

Faculty: Robert Robinson, M.D., Matthew Menza, M.D., W. Curt LaFrance Jr, M.D., M.P.H., M. Justin Coffey, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) At the conclusion of this course, the participants should be able to: Demonstrate knowledge of the neurobiology of emotion; 2) Demonstrate knowledge of the pathophysiology of mood disorders; and 3) Demonstrate knowledge of the evidenced-based management of mood disorders in patients with stroke, Parkinson's Disease, epilepsy, and Alzheimer's Disease.

SUMMARY:

Disturbances in emotional behavior are common in patients with many neurological illnesses. These mood disturbances may have important implications for the clinical presentation, management, and prognosis of the neurological illness. In addition, the recognition and treatment of these mood disturbances may themselves be impacted by the underlying neurological illness.

This course will discuss the evidenced-based management of mood disorders in patients with common neurologic illnesses such as stroke, Parkinson's disease, epilepsy, and Alzheimer's disease. We will also review the implications of these comorbid conditions for our understanding of brain-behavior relations in general, with particular reference to the neurobiology of emotional behavior.

COURSE 21

PATIENT SAFETY AND QUALITY IMPROVEMENT IN THE PRACTICE OF PSYCHIATRY

Director: Avram H. Mack, M.D.

Faculty: Melissa Arbuckle, M.D., Ph.D., Vince Bradley Watts, M.D., M.P.H., Robert J. Ursano, M.D., Robert J. Ursano, M.D., Lloyd Sederer, M.D., Harold Pincus

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) apply quality improvement methods to a psychiatric practice; 2) recognize important concepts of the patient safety culture; 3) describe the function of a root cause analysis and other methods of elucidating the basis of errors; 4) define the concept of "error"; and 5) describe the meaning of "patient safety" used in general medical settings as distinct from the term "safety" as used in psychiatric practice

SUMMARY:

This course will review the worldwide movement to improve patient safety in medical care. It begins with a review of key general themes in patient safety including (1) the Epidemiology of Error and Safety, (2) The Culture of Safety, (3) Human Factors/Human Factors Engineering, (4). Safety Enhancing Technology, (5). Communication, (6). Safety through Systems-Based Care, (7) Methods and Tools to Prevent Safety Events, (8) Methods and Tools for Evaluating Safety Events, and (9) Quality Improvement. This is followed by a review of specific problems in psychiatric practice and ways in which a patient safety approach might be applied to them including suicide, Violence and Aggression, Elopement, Diagnostic Errors in Psychiatry, Falls, and working towards safe care with patients and families. It is intended to be a comprehensive review of the patient safety movement and its relationship to psychiatry.

COURSE 22

EMERGENCY PSYCHIATRY: PRACTICAL TIPS FROM THE EXPERTS

Directors: Seth Powsner, M.D., Kimberly Nordstrom, J.D., M.D.

Faculty: Scott Zeller, M.D., Avrim Fishkind, M.D., Jon S. Berlin, M.D., Leslie Zun, M.B.A., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Assess, manage and treat an agitated patient.; 2) Assess the patient for acute precipitants of psychiatric crisis, including causative or contributing medical conditions.; and 3) Perform a comprehensive suicide/homicide risk assessment.

SUMMARY:

Psychiatric emergencies occur in and out of the hospital setting and all psychiatrists must know how to handle these crisis situations. During this course, leaders in emergency psychiatry will share their knowledge and skills focusing on the approach to agitation, risk assessment, and other practical topics in emergency psychiatry. This revision of our successful seminar from last year (Emergency Psychiatry: From Theory to Practice), will focus on a practical, how-to approach to psychiatric emergencies using lecture, group discussion and role-play formats.

COURSE 23 ADVANCED ASSESSMENT AND TREATMENT OF ADHD

Director: Thomas E. Brown, Ph.D.

Faculty: Anthony Rostain, M.A., M.D., Jefferson Prince, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand current research on nature and pathophysiology of ADHD as developmentally impaired executive function.;2) Explain emerging models of comorbidity of ADHD with other psychiatric disorders;3) Adequately assess more complicated cases of ADHD in children and adults;4) Plan modification of medication treatments to deal with psychiatric or medical complications of ADHD in adults and children; and 5) Develop effective treatment plans to effectively address complicated ADHD across the life cycle

SUMMARY:

This advanced course is designed for clinicians who have completed basic professional education in assessment and treatment of ADHD and have mastered basic concepts and skills for treatment of ADHD. It will review clinical implications of relevant research on the nature and pathophysiology of ADHD. The course will also introduce a new model for understanding ADHD in relation to other disorders with which it is often comorbid. Emphasis will be on treatment of adults, adolescents and children whose ADHD is complicated by learning disorders, mood disorders, substance abuse, OCD, anxiety disorders, sleep problems and Asperger's disorder. Discussion of case materials will illustrate ways in which ADHD can be complicated by psychiatric comorbidity and by diverse interacting psychosocial factors.

COURSE 24 ADHD IN ADULTS: FROM CLINICAL RESEARCH TO PRACTICE

Directors: Craig Surman, M.D., Paul Hammerness, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To recognize ADHD as a disorder broadly impacting control of mental activity and behavior;2) To implement assessment strategies for adults with ADHD; and 3) To appreciate the evidence-basis, and limits of that basis, for ADHD interventions;4) To learn principles for choosing among treatment strategies for ADHD in adults

SUMMARY:

Purpose: In the last decade the body of research on Attention Deficit Hyperactivity Disorder in adulthood has grown dramatically. Consumers frequently present to clinicians with the condition, but most practicing clinicians have not had formal training in its management. This course will catch participants

up on the extent, including limits, of the science of ADHD, and train participants in evidence-informed approaches to identifying and managing ADHD in clinical practice.

Course Format: The faculty are practicing clinicians who have contributed to over 50 studies of ADHD in the past decade, including studies of the association between ADHD and sleep and eating disorders, novel pharmacotherapies, and a cognitive-behavioral therapy technique published in the Journal of the American Medical Association. Up-to-date scientific findings will serve as context for practical, step-by-step training in the art of in-office clinical decision making. Attendees will participate in a virtual patient encounter, learn to identify ADHD symptoms, and principles for applying medication and non-medication treatments.

Learning Goals: Participants will learn 1) when ADHD is and is not a clinically significant diagnosis; 2) efficient methods for assessing ADHD symptoms and impairment; 3) what ADHD symptoms respond, and which do not, to pharmacologic therapies; 4) step-by-step instruction on personalizing treatment for ADHD patients, including optimal pharmacologic and non-pharmacologic supports; 4) evidence based-cognitive behavioral therapy strategies; 5) principles for managing common complex presentations, including patients with non-attention executive function deficits, mood disorders, anxiety disorders, and substance abuse disorders

Summary: This course offers participants practical and effective techniques to appropriately diagnose and treat ADHD in adults, developed from extensive recent research and clinical experience.

COURSE 25 RISK ASSESSMENT FOR VIOLENCE

Director: Phillip Resnick, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

This course is designed to provide a practical map through the marshy minefield of uncertainty in risk assessment for violence. Recent research on the validity of psychiatric predictions of violence will be presented. The demographics of violence and the specific incidence of violence in different psychiatric diagnoses will be reviewed. Dangerousness will be discussed in persons with psychosis, mania, depression, and substance abuse. Special attention will be given to persons with paranoid delusions, command hallucinations, premenstrual tension, and homosexual panic. Personality traits associated with violence will be discussed. Childhood antecedents of adult violence will be covered. Advice will be

given on taking a history from potentially dangerous patients and countertransference feelings. Instruction will be given in the elucidation of violent threats, sexual assaults, and “perceived intentionality.”

COURSE 26

AUTISM SPECTRUM DISORDERS: DIAGNOSTIC CLASSIFICATION, NEUROBIOLOGY, BIOPSYCHOSOCIAL INTERVENTIONS, AND PHARMACOLOGIC MANAGEMENT

Directors: Alice Raymay Mao, M.D., Kimberly Stigler, M.D.

Faculty: Julie Chilton, M.D., James Sutcliffe, Ph.D., Matthew N. Brams, M.D., Jennifer Yen, M.D., Stephanie Hamarman, M.D., Karen Pierce, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: At the conclusion of this session, the participant should be able to: 1) Have up-to-date information on neuroimaging, genetics, and psychopharmacology research, diagnostic procedures and educational/psychotherapeutic and behavioral interventions; 2) Review clinical translational research; and 3) Integrate psychopharmacologic, behavioral and educational interventions for individuals with ASD through the lifespan.

SUMMARY:

This course fills an educational gap by providing a practical and useful synthesis of the most recent research on the etiology, assessment and treatment of autism spectrum disorders from leading psychiatrists in the field. This master course is designed for psychiatrists, and other mental health professional that are providing care for individuals with autism spectrum disorders. Attendees will receive updates on neuroimaging, genetics and psychopharmacology research, diagnostic procedures and educational/ psychotherapeutic and behavioral interventions. Clinicians are frequently asked to evaluate children with speech and language delays, abnormal behaviors and social interaction problems. Although they may be able to recognize diagnostic symptoms of autism, they are uncertain about how to proceed with the diagnostic evaluation and development of treatment plans. Many are practicing in solo or group practices rather than multidisciplinary settings, where the child with autism spectrum disorder could be evaluated more comprehensively. In addition, the rapid expansion of basic science research in autism has provided additional information that may have important clinical implications. The purpose of this course is to provide a review of advances in genetic and neuroimaging research, behavioral/ educational interventions and pharmacological

interventions for children with autism. Increased awareness of the multiple domains that diagnosis and treatment can encompass will help the child and adolescent psychiatrist to develop a realistic plan for helping their patient with ASD to achieve optimum functioning and adaptive life skills.

Obstacles to achieving appropriate care because of parental denial, lack of information and limited financial resources will be identified. The importance of providing support to the parents or caretakers of children with autism in order to help them navigate through often conflicting and confusing treatment recommendations will be discussed. This autism course will review clinical translational research and then help the clinician to integrate psychopharmacologic, behavioral and educational interventions for individuals with ASD through the lifespan.

COURSE 27

SLEEP MEDICINE: A REVIEW AND UPDATE FOR PSYCHIATRISTS

Director: Thomas D. Hurwitz, M.D.

Faculty: Max Hirshkowitz, Ph.D., Imran S. Khawaja, M.B.B.S., R. Robert Auger, M.D., Elliott Lee, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) At the conclusion of this session, the participant should be able to recognize the major categories of sleep disorders that can affect patients in their practices; 2) At the conclusion of this session, the participant should be able to determine which patients should be referred to a board certified sleep physician; 3) At the conclusion of this session, the participant should be able to help patients with obstructive sleep apnea pursue treatment; 4) At the conclusion of this session, the participant should be able to determine if patients experience excessive daytime sleepiness; and 5) At the conclusion of this session, the participant should be able to facilitate use of CBT principles to treat insomnia

SUMMARY:

This course will be introduced by a review of the basic anatomical and neurophysiological aspects of sleep-wake regulation to set the stage for a review and update of the major sleep disorders. Each topic will be presented with descriptions based upon the current International Classification of Sleep Disorders Second Edition (ICSD-2), most recent epidemiological data, underlying pathophysiology, and therapeutic interventions. Relevant comorbidities with psychiatric disorders will be addressed. The topics addressed will include insomnia (primary, comorbidities, and restless legs syndrome), hypersomnia (narcolepsy and idiopathic hypersomnia), sleep-related breathing disorders (obstructive and central sleep apnea), circadian rhythm sleep disorders (delayed and advanced sleep phase types, shift work sleep disorder, and jet lag), as

well as parasomnias (sleepwalking, sleep terrors, sleep-related eating disorder, and REM sleep behavior disorder).

COURSE 28
**PSYCHODYNAMIC PSYCHOPHARMACOLOGY:
 PRACTICAL PSYCHODYNAMICS TO IMPROVE
 PHARMACOLOGIC OUTCOMES WITH TREAT-
 MENT-RESISTANT PATIENTS**

Director: David Mintz, M.D.

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Cite and understand the evidence base which connects meaning and medication; 2) Diagnose common dynamics that interfere with healthy use of medications; and 3) Use practical psychodynamic interventions to ameliorate pharmacologic treatment resistance

SUMMARY:

Despite significant advances in neuroscience and psychopharmacology, pharmacologic treatment resistance remains all-too-common. Common treatment algorithms for treatment resistant conditions generally focus specifically on particular sequences of medications, in adequate dosages. The presenters suggest that psychological and interpersonal dynamics often play a key role in pharmacologic treatment resistance, and that neglect of these factors is one reason that treatment resistance remains so problematic. When treatment resistance derives from the level of meaning, it is likely that it can only be adequately addressed at the level of meaning. In this course, we will first look at the evidence base that emphasizes how meaning factors impact pharmacological treatment outcomes, either causing or overcoming hindrances to the healthy and effective use of psychiatric medications. Then, we will explore common dynamics leading to pharmacologic treatment resistance. This includes not only dynamics that lead patients to resist medications, but also those in which patient surrender unhelpfully in ways that diminish their capacities, leading to entrenched illness. Then we will consider technical principles for diagnosing dynamic interferences with pharmacologic treatment, and for intervening in ways that can transform treatment resistance into treatment response. The course is intended to be interactive, and will conclude with a discussion of cases, preferably those offered by the course participants.

COURSE 29
NEURODEGENERATIVE DISORDERS PRESENTING AS PSYCHIATRIC DISORDERS IN THE MENTAL HEALTH SETTING

Directors: Ted Huey, M.D., Chiadi Onyike, M.D., M.H.S.

Faculty: Adam Boxer, M.D., Ph.D., Stephanie Cosen-

tino, Ph.D., Mary De May, M.D., Jill S. Goldman, M.S., Bruce L. Miller, M.D., Katherine Rankin, Ph.D., Howard J. Rosen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify behavioral, emotional, and cognitive syndromes that suggest an underlying neurodegenerative disorder in patients presenting for psychiatric evaluation; 2) Appropriately evaluate and refer these patients including interpretation of neuropsychological and genetic testing and imaging; 3) Treat neuropsychiatric symptoms in patients with neurodegenerative disorders, especially patients with frontotemporal lobar degeneration (FTLD);

SUMMARY:

Some neurodegenerative disorders, notably frontotemporal lobar degeneration (FTLD) but other neurodegenerative disorders as well, often manifest as changes in behavior, cognition, personality, and language. These patients usually initially present to a mental health setting and it often takes several years for the patients to be correctly diagnosed. In this course we will discuss ways to identify, evaluate, and treat these patients. In addition, research on patients with neurodegenerative disorders can elucidate the neuroanatomical bases of many common psychiatric symptoms and syndromes.

COURSE FOR DBS
UNDERSTANDING, USING, AND IMPLEMENTING DSM-5 IN CLINICAL AND RESEARCH SETTINGS

Directors: Donald Black, M.D., Jon Grant, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the history, development, and use of the DSM.; 2) Identify the changes in DSM-5 from DSM-IV-TR and explain their rationale.; and 3) Use the new criteria in clinical settings, in research, and for administrative purposes.

SUMMARY:

In development since 1999, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is a landmark publication that sets an international standard for psychiatric diagnosis and classification. DSM-5 follows a tradition set by its predecessors, beginning with the first edition (DSM-I) that appeared in 1952. The manual is a compendium of officially recognized psychiatric diagnoses and specifies the criteria that must be present. The course reviews the history of psychiatric classification and diagnosis; the development of the DSM from DSM-I to the present; and the importance of the DSM to the field. The lengthy process that led to DSM-5 will be described, including the development of the Task Force to oversee the process, the naming of the 13 work groups and their members, the review process to ensure scientific integrity and clinical usefulness, the field trials, and the formal approval process. DSM-5 will be compared with its immediate predecessor DSM-IV-TR. The many changes will be highlighted and the rationale behind them explained including the

reorganization of the chapters (the “metastructure”), the creation of new diagnoses and categories, the consolidation of some diagnoses, and the deletion of others. The demise of the multi-axial diagnosis will be reviewed. The changes include an emphasis on dimensional ratings, gender, and cultural issues. Controversies accompanying the development of DSM-5 will be explored. Persons attending this course will understand the use of DSM-5 in clinical and research settings, and for administrative purposes.

COURSE 30 MOTIVATIONAL INTERVIEWING FOR ROUTINE PSYCHIATRIC PRACTICE

Director: Steven Cole, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) At the conclusion of this session, the participant should be able to; 2) Describe the 3 questions and 5 skills of Brief Action Planning (B.A.P.); 3) Explain how B.A.P. aligns with the “Spirit of Motivational Interviewing (MI)”; 4) Discuss 13 advanced communication and MI skills for persistent unhealthy behavior (PUB); 5) Use B.A.P. and 21 skills of Comprehensive Motivational Interventions (CMI) in routine clinical practice; and 6) Teach B.A.P. to trainees, team members, or colleagues.;

SUMMARY:

Motivational Interviewing (MI) is defined as a “collaborative, patient-centered form of guiding to elicit and strengthen motivation for change.” There are over 15 books on MI, over 1000 publications and 200 clinical trials, 1500 trainers in 43 languages, and dozens of international, federal, state, and foundation research and dissemination grants. Four meta-analyses demonstrate effectiveness across multiple areas of behavior including substance abuse, smoking, obesity, and medication non-adherence as well as improved outcomes in physical illnesses, including mortality. MI has been shown to contribute to improved outcomes when combined with cognitive-behavioral and other psychotherapies. New data reinforces its relevance for psychiatrists: life-expectancy of patients with severe mental illness is 32 years less than age and sex-matched controls and the risk of death from cardiovascular disease is 2-3x higher in mental patients than controls. Despite this evidence and its compelling relevance, most psychiatrists have little appreciation of the principles and practice of MI. Using interactive lectures, high-definition annotated video demonstrations, and role-play, this course offers the opportunity to learn core concepts of MI and practice basic and advanced MI skills. The course introduces participants to an innovative motivational tool, “Brief Action Planning (BAP),” developed by the course director (who is a member of MINT: Motivational Interviewing Network of Trainers). Research on BAP was presented at the First International Conference on MI (2008) and the Institute of Psychiatric Services (2009). The BAP Checklist was published by the AMA, by the Patient-Centered Primary Care Collaborative, by Bates’ Guide to the Physical Exam, and by the Commonwealth Fund. BAP has been

disseminated by programs of the CDC, HRSA, the VA, the Indian Health Service, and the Robert Wood Johnson Foundation. Participants will learn how to utilize the 3 core questions and 5 associated skills of BAP in a manner consistent with the “spirit of motivational interviewing.” These 8 skills comprise a set of basic competencies of “Comprehensive Motivational Interventions (CMI),” appropriate for all patients at all levels of readiness for change. In a stepped-care approach to change, for those patients with persistent unhealthy behaviors (“PUB”), attendees will also have the opportunity to observe and practice 13 higher-order evidence-based interventions from the repertoire of MI and Dr. Cole’s textbook on medical communication: *The Medical Interview: The Three Function Approach*. These 13 additional skills represent the skill set of “advanced” CMI. Though designed as an introductory course, the material will also be useful to practitioners with intermediate or advanced experience in MI (or other behavior change skills) because they will learn how to utilize BAP in routine care for improved clinical outcomes and/or for training others.

COURSE 31 CAN’T WORK OR WON’T WORK? PSYCHIATRIC DISABILITY EVALUATIONS

Director: Liza Gold, M.D.

Faculty: Marilyn Price, C.M., M.D., Donna Vanderpool, J.D., M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Evaluate the relationship between psychiatric disorders, impairment, and disability; 2) Identify psychiatric and nonpsychiatric factors relevant in disability evaluations; 3) Become familiar with a “work capacity” model to develop a disability case formulation and answer most frequently asked questions in a disability evaluation; 4) Improve competence in writing disability reports; and 5) Understand potential liability associated with performing disability evaluations and develop related risk management skills

SUMMARY:

Our multidisciplinary faculty will review the complex relationship between psychiatric impairment and work disability in competitive employment contexts utilizing case examples and interactive discussion. Legal or administrative disability decisions may depend on psychiatric opinions and may have profound implications for the evaluatee’s psychological, social, financial, and employment status. The presence of a psychiatric diagnosis does not automatically imply functional impairments, and functional impairment does not necessarily result in work disability. Our faculty will review the most common diagnoses associated with disability claims in competitive employment contexts. Comprehensive disability evaluations should also consider personal, social, economic, and workplace factors or circumstances that may influence a disability claim or status. We will discuss what information is needed to provide opinions regarding impairments and associated dysfunction, and the correlation of impairments and dysfunction with specific

job requirements and work skills. We will present an innovative “work capacity” model that facilitates the development of case formulations. We will review the most frequently asked questions psychiatric disability examinations are asked to answer, including causation, motivation, and malingering. We also discuss how to conduct a disability evaluation and write a disability report. Finally, we will discuss and review relevant ethical issues, including those that arise when psychiatrists provide disability evaluations and documentation for their own patients, HIPAA issues, legal liability in the provision of disability evaluations, and risk management of these important practical aspects of disability evaluations.

COURSE 32 EVALUATION AND TREATMENT OF SEXUAL DISORDERS

Director: Waguih Ishak, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

The course is designed to meet the needs of psychiatrists who are interested in acquiring current knowledge about the evaluation and treatment of sexual disorders in everyday psychiatric practice. The participants will acquire knowledge and skills in taking an adequate sexual history and diagnostic formulation. The epidemiology, diagnostic criteria, and treatment of different sexual disorders will be presented including the impact of current psychiatric and non psychiatric medications on sexual functioning. Treatment of medication-induced sexual dysfunction (especially the management of SSRI-induced sexual dysfunction) as well as sexual disorders secondary to medical conditions will be presented. Treatment interventions for sexual disorders will be discussed including psychotherapeutic and pharmacological treatments. Clinical application of presented material will be provided using real-world case examples brought by the presenter and participants. Methods of teaching will include lectures, clinical vignettes and group discussions.

COURSE 33 BRIEF BEHAVIORAL INTERVENTIONS FOR INTEGRATED CARE CONSULTING PSYCHIATRISTS

Directors: Anna Ratzliff, M.D., Ph.D., Kari Stephens, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List fundamental principles of 2 evidence-based

brief behavioral interventions in primary care integrated behavioral health programs: Modular anxiety treatment and Behavioral Activation for depression;2) Integrate brief behavioral interventions into treatment plans for primary care settings.; and 3) Support the use of brief behavioral skills during consultation with behavioral health care managers.

SUMMARY:

Many patients are currently being treated for depression and anxiety by integrated care teams in primary care settings. There is an increasing demand for psychiatrists that can work as consulting psychiatrists in integrated primary care teams. An important part of this role is to support the integration and delivery of evidence based brief behavioral interventions delivered by the primary care team. This course is designed to present the fundamentals of two brief behavioral interventions. Modular anxiety treatment (MAT) and Behavioral Activation (BA) will be reviewed with time to practice a skill from each of these interventions. Additionally, there will be a focus on how the consulting psychiatrist can support the delivery of these interventions in primary care settings.

COURSE 34 RATIONAL OPIOID PRESCRIBING AND PRESCRIPTION DRUG ABUSE

Director: Scott Fishman, M.D.

Faculty: Robert M. McCarron, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the recent statistics indicating a public health problem of prescription drug abuse;2) Recognize how the goals of pain treatment contrast with outcomes of addiction;3) Differentiate substance dependence, misuse, tolerance, addiction, and non-adherence; and 4) Identify the main components of a risk management approach to pain care

SUMMARY:

The United States is suffering from an epidemic of prescription drug abuse as well as a public health crisis of undertreated pain. The White House Office of the National Drug Control Policy has stated that education is a key pillar in improving prescription drug abuse and the Institute of Medicine has reported that 100 million Americans suffer from chronic pain at a direct and indirect cost of approximately 600 million dollars per year. This course will focus on rational use of controlled substances for pain management while reviewing the public health problems of prescription drug abuse and under-treated pain. Lectures will address risk management approaches, legal issues involved in treating pain and in using controlled substances, as well as issues related to mental illness and opioid use. Particular attention will be given to functional outcomes associated with analgesic treatment regimens, appropriate vigilance for addiction, substance dependence, misuse, tolerance, and non-adherence as well as appropriate mental health screening in cases in which controlled substances are prescribed.

COURSE 35

THE DETECTION OF MALINGERED MENTAL ILLNESS

Director: Phillip Resnick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate skill in detecting deception.;2) Identify factors that distinguish genuine from faked hallucinations.; and 3) Detect malingered psychosis.

SUMMARY:

This course is designed to give psychiatrists practical advice about the detection of malingering and lying. Faculty will summarize recent research and describe approaches to suspected malingering in criminal defendants. Characteristics of true hallucinations will be contrasted with simulated hallucinations. Dr. Resnick will discuss faked amnesia, mental retardation, and the reluctance of psychiatrists to diagnose malingering. The limitations of the clinical interview and psychological testing in detecting malingering will be covered. The session will delineate 10 clues to malingered psychosis, and five signs of malingered insanity defenses.

Videotapes of three defendants describing hallucinations will enable participants to assess their skills in distinguishing between true and feigned mental disease. Participants will also have a written exercise to assess a plaintiff alleging PTSD. Handouts will cover malingered mutism, and feigned posttraumatic stress disorder in combat veterans.

MAY 21, 2013

COURSE 36

BRAIN STIMULATION IN PSYCHIATRY

Directors: Linda Carpenter, M.D., Ziad Nahas, M.D., M.S.

Faculty: John P. O'Reardon, M.D., Mustafa Husain, M.D., Darin D. Dougherty, M.D., M.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) recognize the different brain stimulation modalities currently applied for psychiatric treatments;2) recognize the principals behind their applications; and 3) recognize where each stand with respect to clinical investigations or clinical practice

SUMMARY:

This 4 -hour course describes the various brain stimulation techniques and how they are playing in role in the therapeutic arsenal. It addresses a growing interest in therapeutic use of somatic intervention in neuropsychiatric conditions. Originally limited to electroconvulsive therapy (ECT), now many new

modalities have shown potential benefit for treatment resistant conditions like depression, hallucinations and OCD. These modalities can be generally grouped by their property of rely on an induced seizure or not to affect a therapeutic change. Of course ECT has been available for decades but more recently the US FDA approved Vagus Nerve Stimulation (VNS) Therapy for depression and a number of other therapies are in various stages in their pivotal studies and regulatory approvals (like Transcranial Magnetic Stimulation (TMS) and Deep Brain Stimulation (DBS)).

- The course describes the backdrop of functional neuroanatomy of major neuropsychiatric conditions and principals of electrical neuromodulations. (30 minutes)
- The faculty will then details Sub-Convulsive Therapies [TMS and deep TMS, VNS, DBS, Epidural Cortical Stimulation (EpCS), Focal Electrically Administered Seizure Therapy (FEAST) and transcranial Direct Current Stimulation (tDCS)] by focusing on data form clinical studies in mood disorders, as well as anxiety disorders, schizophrenia, obesity, Alzheimer disease and migraine headaches). Each modality will also be described in terms of its postulated mechanisms of actions and clinical set up. (2.5 hours)
- The faculty will also details Convulsive Therapies (ECT [briefly since well covered in other symposia and workshops], Magnetic Seizure Therapy (MST) and Focal Electrically Administered Seizure Therapy (FEAST). (45 min)

COURSE 37

THE EXPERT WITNESS IN PSYCHIATRIC MALPRACTICE CASES

Director: Phillip Resnick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) The participant should be able to identify practical pitfalls of being an expert witness.;2) Write better malpractice opinion reports.; and 3) Be a more effective expert witness in depositions.

SUMMARY:

This course will focus on practical aspects of serving as a psychiatric expert witness in malpractice litigation. It will also be useful to psychiatrists who are being sued. The workshop will cover the initial contact with the attorney, data collection, case analysis, report writing and preparation for discovery depositions. Instruction will be given in identifying the correct standard of care, use of the defendant psychiatrist's perspective, and avoidance of the hindsight bias. Dr. Resnick will draw case examples from his experience of evaluating more than 150 malpractice cases.

Principles of writing malpractice reports will be explicated. The differences in plaintiff and defense expert reports will be explored. For example, defense reports are only expected to address deviations from the standard of care identified by plaintiff's experts. In preparing for expert witness depositions, participants will be advised about what to remove from their file, the importance of not volunteering anything, and that nothing is "off the record." Handouts will include suggestions

for discovery depositions. Each participant will write an opinion about an actual inpatient suicide malpractice case. Participants will defend their opinions in mock cross-examination.

COURSE 38
A PSYCHODYNAMIC APPROACH TO TREATMENT-RESISTANT MOOD DISORDERS: BREAKING THROUGH TREATMENT RESISTANCE BY FOCUSING ON COMORBIDITY AND AXIS II

Director: Eric Plakun, M.D.

Faculty: Edward Shapiro, M.D., David Mintz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe recent research evidence suggesting that psychosocial factors play a major role in the cause and more effective treatment of treatment resistant mood disorders.;2) Explain the contribution to treatment resistance of personality pathology, including primitive defenses like projective identification.;3) Define the psychopharmacologic treatment approach called “psychodynamic psychopharmacology” and explain its role in treatment resistance.; and 4) Utilize specific psychodynamic principles to improve outcomes in patients with treatment resistant mood disorders

SUMMARY:

Although algorithms help psychiatrists select biological treatments for patients with treatment resistant mood disorders, the subset with prominent Axis II pathology often fails to respond to medications alone. These treatments frequently become chronic crisis management, with risk of suicide. This course describes a comprehensive approach to this subset of treatment resistant patients derived from a longitudinal study of patients in extended treatment at the Austen Riggs Center. The course offers an overview of psychoanalytic object relations theory that sets the stage for understanding primitive defenses and their impact on treatment resistance. Ten psychodynamic principles extracted from study of successful treatments are presented and illustrated with case examples. These include listening beneath symptoms for therapeutic stories, putting unavailable affects into words, attending to transference-countertransference paradigms contributing to treatment resistance, and attending to the meaning of medications [an approach known as “psychodynamic psychopharmacology”]. This psychodynamic treatment approach guides interpretation in psychotherapy, but also guides adjunctive family work, helps integrate the psychopharmacologic approach and maximizes medication compliance. Ample opportunity will be offered for course participants to discuss their own cases, as well as the case material offered by the presenters. The course is designed to help practitioners improve outcomes with these patients.

COURSE 39
NEUROPSYCHIATRIC MASQUERADES: MEDICAL AND NEUROLOGICAL DISORDERS THAT

PRESENT WITH PSYCHIATRIC SYMPTOMS

Director: Jose Maldonado, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the incidence, epidemiology and clinical features of the most common Endocrine disorders masquerading as psychiatric illness.;2) Understand the incidence, epidemiology and clinical features of the most common Metabolic disorders masquerading as psychiatric illness.;3) Understand the incidence, epidemiology and clinical features of the most common Infectious disorders masquerading as psychiatric illness.;4) Understand the incidence, epidemiology and clinical features of the most common Autoimmune disorders masquerading as psychiatric illness; and 5) Understand the incidence, epidemiology and clinical features of the most common CNS disorders masquerading as psychiatric illness

SUMMARY:

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

COURSE 40
MINDFULNESS-BASED COGNITIVE THERAPY FOR THE TREATMENT OF MAJOR DEPRESSIVE DISORDER

Director: Stuart J. Eisendrath, M.D.

Faculty: Maura McLane, M.S., Erin P. Gillung, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Participants will learn the basic aspects of mindfulness meditation and its application to psychotherapeutic interventions for major depression.;2) Participants will learn about the theoretical and therapeutic differences between mindfulness-based cognitive therapy (MBCT) and traditional cognitive behavior therapy (CBT).;3) Participants will better understand existent research and literature supporting MBCT broadening therapeutic implications.;4) Participants will learn about MBCT contribution to the field of neuroscience and the understanding of depression through a biophysical model.; and 5) Participants will engage in experiential meditation exercises and learn how these techniques can be applied in

psychotherapeutic settings.

SUMMARY:

Mindfulness-Based Cognitive Therapy (MBCT) is a relatively new form of psychotherapy that blends mindfulness meditation with elements of traditional cognitive behavioral therapy (CBT). The course will describe the initial development of MBCT as a preventive therapy against depression relapse. Several randomized controlled trials have demonstrated its effectiveness in reducing relapse with efficacy rivaling maintenance antidepressants. MBCT is appealing to patients as it promotes self-efficacy and emotion regulation. MBCT has also been extended as a therapy for active depression, particularly as an augmentation strategy for medication-resistant patients. Although its psychological mechanisms are not completely clear, MBCT appears to reduce rumination, enhance self compassion, decrease experiential avoidance, and increase mindfulness. In addition, because of studies demonstrating mindfulness meditation's effects on brain function, MBCT may have direct impact on neural pathways involved in depression. The course will examine the research literature supporting MBCT's broadening use and theoretical psychological and neural mechanisms.

As noted above, this course will have an experiential component, allowing participants to become directly familiar with several features of MBCT training. This component will be interactive and focus on mindfulness meditation techniques and their application for the depressed patient. This first-hand knowledge will give participants the opportunity to learn how MBCT teaches individuals to gain a metacognitive perspective on their thoughts, feelings and sensations. The course will contrast MBCT's approach with traditional cognitive behavioral techniques.

MAY 22, 2013

**COURSE 41
EVIDENCE-BASED GROUP AND INDIVIDUAL
PSYCHOSOCIAL TREATMENTS FOR ADULT
ADHD: THEORY AND PRACTICE**

Director: Anthony Rostain, M.A., M.D.

Faculty: J. Russell Ramsay, Ph.D., Mary Solanto, Ph.D., Susan Sprich, Ph.D., Alexandra Philipsen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Cite major findings from the published literature on psychosocial interventions for adult patients with Attention-Deficit Hyperactivity Disorder (ADHD).;2) Describe similarities and differences among 2 group interventions and 2 individual-focused interventions all of which are reasonably effective for treating adults with ADHD.; and 3) Apply individual and group treatment approaches to the clinical practice setting.

SUMMARY:

In recent years, psychosocial interventions for adult ADHD have been shown to reduce core symptoms of the disorder

and to improve functional status (see references). This course will present four evidence-based treatment approaches (individual and group administered) that can easily be applied to clinical practice settings. Course faculty members, all authors of manualized interventions, will present the rationale, background and basic principles underlying their approaches. In addition to didactic presentations, attendees will be able to participate in two concurrent, two-hour small-group sessions in which they will learn many of the specific techniques employed by each intervention. The course will include question and answer periods during which participants can discuss case examples from their practices.

MAY 20, 2013**FOCUS LIVE 1***Speaker: Michael E. Thase, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) This FOCUS LIVE session will assist clinicians in testing their knowledge and in staying current regarding clinical and diagnostic aspects of major depression and dysthymic disorders as well as their treatment; 2) Participants will answer board-type questions designed to increase their knowledge and help them identify areas where they might benefit from further study; and 3) Participants will understand treatment strategies and evidence and relate multiple choice question based learning to their own patient care;

SUMMARY:

Major depressive disorder (MDD) has the highest lifetime prevalence rate of any psychiatric disorder and is expected to be the second leading cause of disability worldwide by the year 2020. It is a significant risk factor for suicide, especially in adolescents, young adults, and the elderly. It is an important risk factor for poor treatment response in patients with cardiovascular disease. Recent neurobiological discoveries have advanced our understanding of MDD. Clinicians in practice face the challenge of recognizing and treating this disabling condition. Board-type multiple choice questions will cover areas such as the phenomenology and treatment of MDD and dysthymic disorder; efficacy and tolerability of currently available treatments; results of studies such as the NIMH-sponsored clinical treatment trial, STAR-D; evidence for combination or augmentation medication therapies; psychosocial therapies, alternative treatments and combination pharmacotherapy/ psychotherapy; and side effects associated with medication treatment. In FOCUS LIVE sessions an expert clinician will lead a lively multiple choice question-based discussion. Participants test their knowledge with an interactive Audience Response System, which instantly presents the audience responses as a histogram on the screen. Questions in this session will cover major depressive disorder, including diagnosis, treatment, and new developments.

FOCUS LIVE 2*Speaker: Anthony Rostain, M.A., M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Assist clinicians in testing their knowledge and in staying current regarding clinical and diagnostic aspects of child and adolescent psychiatry; 2) Answer board-type questions designed to increase their knowledge and help them identify areas where they might benefit from further study; and 3) Understand treatment strategies and evidence and relate multiple choice question based learning to their general knowledge of the topic and to their own patient care.

SUMMARY:

This multiple choice question and answer presentation focuses on information that is important to practicing general psychiatrists, including diagnosis, treatment, and new developments in Child and Adolescent Psychiatry. The session features the opportunity for participants to test their knowledge on specific features of diagnosis, epidemiology, psychosocial and pharmacological treatments regarding disorders affecting children and adolescents. Attendees will have the opportunity to ask questions and to increase their knowledge of current treatment. Questions will be presented on topics in child and adolescent psychiatry as ADHD, pediatric mood and anxiety disorders, autistic disorders, psychopharmacologic management, treatment recommendations, and side effects of medications. In FOCUS LIVE! sessions, expert clinicians lead lively multiple choice question-based discussions. Participants will test their knowledge with an interactive audience response system, which instantly presents the audience responses as a histogram on the screen, allowing private comparison to other clinicians in the audience. Questions will cover existing knowledge regarding disorders of children and adolescents that may persist into adulthood.

MAY 18, 2013

FORUM 01

THE PATH TO LIFETIME ACHIEVEMENT: THE ROLE OF APA IN CAREER SUCCESS STORIES*Chair: Lama Bazzi, M.D.**Speakers: John M. Oldham, M.D., Steve Koh, M.B.A., M.D., Molly McVoy, M.D., Debra Pinals, M.D., Carol A. Bernstein, M.D., Alik Widge, M.D., Ph.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Appreciate the benefits American Psychiatric Association (APA) membership for all stages of attendees' careers with focus on Members in Training (MITs) and Early Career Psychiatrists (ECPs); 2) Understand how the APA can help assist in developing your career; 3) Practical advice from APA leaders in the field; and 4) Explore APA networking and unique mentorship opportunities.

SUMMARY:

The American Psychiatric Association Leadership Fellowship is submitting to present a panel of expert psychiatrists to discuss the path to career development for MITs and ECPs. The goal of this symposium is to help members see the immense benefits of remaining active in the APA throughout their career. We hope to help target the population of membership that become inactive in the organization early in their career as MITs and ECPs. This symposium will provide leaders in the field who can discuss how the APA has effected and enriched their career. These leaders were selected to allow a wide range of expertise including individuals from the fields of academic psychiatry, organized psychiatry, and private practice. Two separate panels have been constructed based on the stages of the leaders' careers. Our aim is to allow participants a developmental understanding of how the APA can play an enriching and positive role in one's career at different stages. The Early Career Psychiatrists are young leaders and active APA members. The second panel we named Established Career Psychiatrists are notable, respected leaders in the field of psychiatry. The Early Career Psychiatrists will discuss the transition from MITs to ECPs, addressing the challenges of establishing one's career, and the role their involvement in the APA has played in facilitating their evolution. The panel will consist of Steve Koh MD, MPH, MBA, Molly McVoy MD, and Alik Widge MD, MPH. Their experiences with mentorship, the establishment of clinics and research grants, as well as the advice they received that they consider invaluable will be the focus. The heterogeneous interests of our ECPs allows for a unique and diverse perspective that should appeal to a wide variety of audiences. Our panel of Established Career Psychiatrists will discuss the steps they took to lay down the foundations for their respective careers. This panel will consist of Carol Bernstein MD, John Oldham MD, and Debra Pinals MD. Established Career Psychiatrists will describe

their unique paths, including triumphs and challenges faced in route to achieving their successes. The focus will be on the role the APA played in their careers and how they utilized the APA to realize their goals. Again, the different leadership styles, rich experiences, and unique concepts of success will illicit interest and participant interaction. All the panel members will make PowerPoint presentations, and each speaker will be limited to 20 minutes. No questions will be taken during the presentations, and participants of the symposium will be encouraged to write down questions for the allotted Q&A time. A 45-minute question and answer session will ensue, moderated by members of the APL fellowship. Questions will be focused on queries pertaining to the learning objectives enumerated above. Participants will be encouraged to ask specific questions about how to maximize their membership in the APA for their career development.

MAY 19, 2013

FORUM 02

EMERGENCY ROOM EVALUATION OF PERSONS WITH INTELLECTUAL DISABILITY AND PSYCHIATRIC DISORDER: ACROSS THE LIFESPAN*Chair: Robert Pary, M.D.**Speakers: Janice L. Forster, M.D., Jarrett Barnhill, M.D., Jeffrey I. Bennett, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Discuss who among persons with intellectual disability (ID) presents in crisis in the emergency room; 2) Describe how to modify one's standard psychiatric evaluation depending upon the level of ID; and 3) Recognize which individuals with ID would likely benefit from inpatient psychiatric admission, medical admission crisis bed, or ER release.

SUMMARY:

Psychiatrists who do crisis evaluations of persons with intellectual disability and possible intellectual disability often find it frustrating. Part of the problem seems to be their standard psychiatric interview often does not help in determining whether the person is suffering from behavior problem, a psychiatric disorder, a medical problem, or perhaps mainly a problem in person's environment. This workshop shares the experience of clinicians whose focus has been working with persons with psychiatric disorders and intellectual disability. The workshop will provide clinical vignettes and techniques to assess individuals with intellectual disability across the life span. Particular attention will address which individuals who present with self-injury and/or aggression require inpatient (psychiatric or medical) admission versus an outpatient modification of challenging behavior support plan.

FORUM 03**NIDA ADDICTION PERFORMANCE PROJECT**

Chair: Nora D. Volkow, M.D.

Speakers: Steven L. Batki, M.D., Roger D. Weiss, M.D. (will need to add actors at a later date)

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify and more successfully treat or refer drug-addicted patients; 2) Explore the role of individual biases and beliefs about people who abuse drugs and how these beliefs affect individual physician screening and treatment of patients; and 3) Use empathy, knowledge, and supporting tools to improve communication skills and confidence in conducting Screening, Brief Intervention, and Referral to Treatment (SBIRT).

SUMMARY:

The Addiction Performance Project is a unique event featuring professional, award-winning actors performing a dramatic reading from Eugene O'Neill's Pulitzer Prize-winning play, *Long Day's Journey into Night*. The play's key themes are used as a catalyst to discuss the experience of addiction from patient, caregiver, and societal perspectives. It is followed by reactions to the performance from a panel of experts and a facilitator-guided audience discussion. NIDA's Addiction Performance Project was developed to offer physicians and other health care providers the opportunity to explore the challenges of working with addicted patients and their families, to discuss how to break down the stigma associated with addiction, and to promote a healthy dialogue about addiction. To learn more about the Addiction Performance Project, visit <http://drugabuse.gov/nidamed/APP>.

MAY 20, 2013

FORUM 04**TREATMENT OF THE PREGNANT WOMAN AND HER CHILD: AN AMERICAN JOURNAL OF PSYCHIATRY FORUM**

Chairs: Robert Freedman, M.D., Monifa Seawell, M.D.

Speakers: Veerle Bergink, M.D., Ph.D., Randal Ross, M.D., Harita Raja, M.D., Katherine Wisner, M.D., M.S., Mallay Occhiogrosso, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Participants will receive current information on the effects of prenatal antidepressant treatment on fetal growth and development; 2) Participants will receive current information on the therapeutic efficacy of preventive treatment of bipolar disorder and postpartum psychoses in mothers at risk;

and 3) Participants will be informed of new research directions in perinatal mother and child mental health.

SUMMARY:

Recent articles in the *American Journal of Psychiatry* provide new scientific and clinical guidance for treatment decisions during pregnancy. Effects on both the mother and the unborn child mandate careful balancing of risk and benefit. The authors of four articles will present their findings, their clinical implications, and updates on their current investigations. Katherine L. Wisner, M.D., has meticulously characterized the effects of depression itself and medication treatment on the growth and development of the fetus. She finds independent effects of each, but little evidence that antidepressants cause additional harm to the fetus. Mallay Occhiogrosso, M.D., has made similar findings about newborn pulmonary hypertension, once thought to be an adverse effect of SSRI treatment during pregnancy. Her extensive epidemiologic investigations reveal that the effect is small and as likely to be caused by depression itself. Veerle Bergink, M.D., will present a study of the approach preferred by her clinic for pregnant women with a history of bipolar mood disorder or postpartum psychosis. Her clinic's prophylactic treatment diminishes some but not all risk for subsequent illness during or after pregnancy. Randal G. Ross, M.D., has developed a physiological indicator of the newborn's brain development. With this technique, he finds that antidepressant treatment frequently prevents the otherwise deleterious effect of a maternal anxiety disorder and that the nutrient choline may prevent the development of pathological brain dysfunction associated with later mental disorders in the child. Harita B. Raja, M.D., a Resident at Georgetown University, will begin the symposium with a case presentation. She is the author of a review article on treatment of maternal depression in the *Residents' Journal*, an online publication of the *American Journal of Psychiatry*.

References:

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FORUM 05

WORLD PREMIER OF THE DOCUMENTARY, HIDDEN PICTURES: THE UNDEREXPOSED WORLD OF GLOBAL MENTAL HEALTH

Chair: Delaney Ruston, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the difficulties faced by persons with mental illness in various countries around the world; 2) Understand the effect of mental illness on family members of affected persons; and 3) Identify strategies to promote public advocacy and to counter the stigma of mental illness.

SUMMARY:

Physician and Documentary filmmaker Delaney Ruston grew up under the shadow of her dad's illness, schizophrenia. While reconnecting with him after years of estrangement, (as seen in the PBS documentary *Unlisted*) Ruston became interested in the experiences of other families around the globe. How are people accepted or rejected? What is mental health care like? Given that the WHO estimates that 400 million people worldwide have a mental illness, why do we rarely hear about their lives? Ruston takes us on her journey to answer these questions, uncovering personal stories in India, China, South Africa, France, and the US. What emerges are scenes of profound frustration, moments of true compassion, and haunting insights. The journey ends by exploring the force of change that individuals are bringing about, including actress Glenn Close's movement to fight stigma. *Hidden Pictures* is the first feature documentary on global mental health. Artistically crafted, with unforgettable characters, this powerful film will bring needed dialogue to a vastly neglected field. Join us for this historic world premier screening. The film *Hidden Pictures* is 1 hour in length and will be viewed then discussed with the audience.

MAY 21, 2013

FORUM 06

PSYCHIATRIC RESIDENTS AND THE CREATIVE PROCESS

Chair: Michael F. Myers, M.D.

Speakers: Daniel Roman, M.D., Kiyoko R. Ogoke, M.D., Mohamed A. Sherif, M.D., M.Sc., Kendra Campbell, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize how much the creative process varies from one resident to another; 2) Integrate the pivotal worth of creativity into one's developmental process as a resident (for resident attendees); and 3) Highlight and encourage creativity in psychiatric residents (for training directors.)

SUMMARY:

Doctors who choose psychiatry as their specialty have always been distinguished by their attraction to clinical complexity, intellectual challenge, and the unknown – all hallmarks of the creative personality. In this workshop, four residents will make 12 minute presentations in which they will discuss projects that they have embarked upon during their residency that have not only given them a creative outlet but have also informed and enriched their daily work and study as residents. Dr Kendra Campbell will discuss her journey as a psychiatric resident via her online blog and her weekly submissions to Medscape/WebMD. She will share her reflections on how writing has been both a cathartic outlet as well as a means for sharing her experiences with residency with the entire international community. Dr Kiyoko Ogoke will discuss her writing. She recently published her article "Teaching Psychodynamic Psychotherapy to Competency" in *AJP Residents' Journal* and has also been working on her book "Long and Winding Road: A Personal Memoir" which describes her struggle as a psychiatry resident. Dr. Mohamed Sherif is doing a combined psychiatry residency / Ph.D. program. His research in the field of computational neuroscience involves building mathematical and computer models of brain regions to combine data obtained from different experimental techniques. He has recently published an article in the *American Journal of Psychiatry Residents' journal* titled "The role of computational neuroscience in psychiatry". His work is focused on computer and animal models of schizophrenia. Dr Daniel Roman will discuss his endeavors as Director of the SUNY Downstate Film Forum. As a widespread and influential art medium, film is a good way of understanding how society perceives mental illness and psychiatry over time and in different societies. Screening documentaries and feature films and discussing them stimulates thinking about emotions, psychiatric illness, treatment and the stigma associated with them from a novel and more creative perspective. More than one third of the time will be protected for attendees to engage with the speakers in brisk discussion.

FORUM 07**HUMANITARIAN CHALLENGES IN PSYCHIATRY: A MODEL OF FORENSICS, ETHICS, AND ADVOCACY**

Chairs: Rama Rao Gogineni, M.D., Andres J. Pumariega, M.D.

Speakers: Paul S. Appelbaum, M.D., Steven Moffic, M.D., Abraham L. Halpern, M.D., Pedro Ruiz, M.D., John H. Halpern, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about the importance of humanitarianism and the role that psychiatry can play in the promotion of humanism in the national and international settings; 2) Understand and apply forensic psychiatry to patients' rights and humane treatment of imprisoned and captured individuals; 3) Learn ways of enhancing ethical treatment of mentally ill and disadvantaged; and 4) Enhance advocacy for the humane treatment of children, women, older or underserved and discriminated against population.

SUMMARY:

In medicine, and especially in medical school education, there is growing interest in and emphasis on professionalism, humanism, and clinical bioethics. Persons living with mental disabilities often face substantial obstacles to improving their mental health and participating fully in their communities and societies. They have been subject to discrimination, stigmatization, and other indignities, including involuntary confinement without fair process in some parts of the world, inability to access needed care and treatment, and the erection of social and economic barriers that limit their opportunities. The impact of these persistent human rights violations exacerbates the burden of mental disabilities throughout the population and may preclude persons with mental and intellectual disabilities from successfully seeking and obtaining mental health services. Ethics and respect for human rights should be the guiding principles of medical interventions and public policies. Violence and injustice against children, adolescents, the elderly and against disadvantaged persons with mentally illness need to be addressed, in the clinical context as well as in the social sphere. Physicians, especially psychiatrists and other mental health care professionals should be sensitive and skilled in preventing, identifying, diagnosing and treating cases of abuse and negligence in any patient, in any institution, and in any country. Abraham L. Halpern, M.D., Professor Emeritus at New York Medical College, an internationally renowned leader in psychiatry, and a forensic psychiatrist received APA's Human Rights Award in 2000 for his tireless advocacy of the rights of the persons with mental illness. Dr. Halpern has been a member of the UN Alliance of NGOs on Crime Prevention and Criminal Justice, representing both the International Council of Prison Medical Services and the World Psychiatric Association, and is a Board member of

Friends of Falun Gong, USA. Dr. Halpern is also a very strong opponent of the death penalty and has written extensively on the subject of physician participation in executions. Forensic psychiatry's contribution to human rights developed with the evolution in medico-legal understanding and appreciation of the relationship between mental illness and criminality; the evolution of tests to define legal insanity; the new methodologies for the treatment of mental conditions that provide alternatives to custodial care; and the changes in public attitudes and perceptions about mental conditions in general. Psychiatrists are expected to provide expert knowledge on matters such as readiness for parole, predictions of recidivism, commitment legislation applicable to released offenders, and the phenomenon of the revolving door for the mentally ill in prisons and hospitals. Abraham L. Halpern, M.D. will receive 2nd Annual Humanitarian of the year Award from the American Association for Social Psychiatry.

FORUM 08**THE INTEGRATION OF BEHAVIORAL HEALTH AND PRIMARY CARE: THE EVOLVING ROLE OF PSYCHIATRY IN THE ERA OF HEALTH CARE REFORM**

Chair: Lori Raney, M.D.

Speakers: Jurgen Unutzer, M.D., M.P.H., Wayne Jay Katon, M.D., Benjamin Druss, M.D., Roger Kathol, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the major models of collaborative care and the evidence base supporting wide-spread implementation; 2) Understand funding limitations and proposed models for financing collaborative care in the era of healthcare reform; 3) Appreciate the value added by psychiatrists participating on healthcare teams and the need to continue the dialogue with our primary care partners; and 4) Comprehend the role collaboration with primary care plays in reducing the 25 year mortality gap in the SMI population.

SUMMARY:

The integration of primary health and behavioral health has a robust evidence base and the dissemination and adoption of this practice has progressed rapidly. The idea that bringing together the diverse cultures of primary care and behavioral health to better treat mental illnesses in primary care and improve the health status of those with mental illnesses in public mental health settings both intrigues and excites professionals in both disciplines. In primary care settings the development and implementation of the IMPACT and TEAMCare models have proven that collaborative care models, which introduce new members to the health care team: a consultant psychiatrist and a care manager, can improve outcomes in the treatment of mental illness, are cost effective to implement and can reduce overall healthcare expenditures. In public mental health settings an emerging data base shows connecting

our most vulnerable patients with serious mental illnesses to much needed resources in primary care can lead to effective treatment of chronic illnesses associated with cardiovascular disease. Receiving this care can lead to the reduction in morbidity and mortality responsible for the 25 year mortality gap. The major stumbling blocks to the full scale dissemination of these models include the soloed funding for mental health and primary care dollars, same day billing of a primary care and behavioral health visits, carved out mental health funding, and lack of coding and reimbursement models to pay for the collaboration and consultative portions of care are some of the barriers to widespread dissemination and implementation of these models of care. While the inseparable nature of mental health and primary care is recognized by psychiatrists by virtue of their medical training, funding mechanisms will have to be developed to more fully engage them in this work. Models of funding are currently being tested nation-wide, funded by innovation projects provided in the Affordable Care Act, legislated changes in state Medicaid reimburse structures, private foundations and other resources to bridge the gap to more sustainable funding is implemented. The value added to a healthcare system when psychiatric and behavioral health resources are included is well proven and healthcare teams held accountable for outcomes, cost containment and patient satisfaction (the "Triple Aim"), will seek our expertise to design systems of care to meet these goals. Psychiatrists need to be prepared for these changes to assist in well-informed and meaningful ways. This Forum brings together a cadre of experts who have led this revolution and includes Wayne Katon, MD, a pioneer in collaboration with primary care and lead author of the TEAMCare study, Jürgen Unützer, M.D., lead author of the IMPACT study, Ben Druss, M.D. whose research involves improving the health and health status of persons with SMI, and Roger Kathol, M.D., who studies funding mechanisms for care sustainability.

FORUM 09

A RESIDENT'S GUIDE TO BORDERLINE PERSONALITY DISORDER FROM THE EXPERTS: PART 1

Chairs: John Gunderson, M.D., Brian Palmer, M.D.

Speakers: Perry Hoffman, Ph.D., Kenneth R. Silk, M.D., John M. Oldham, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Diagnose BPD and understand its relationship to other disorders; 2) Structure an effective psychotherapy for BPD; 3) Thoughtfully choose psychopharmacologic approaches that fit within a formulation of a patient's problems; 4) Effectively integrate family work into a treatment plan; and 5) Establish a concrete plan for integrating BPD into their further psychiatric training.

SUMMARY:

This is a repeat of two workshops held in New Orleans in 2010 and Philadelphia in 2012. Those resident-only workshops were very successful. Even though part II was held at a different time from the Part I in 2010, attendance was even greater for the Part II; similar interest was seen in 2012. We thus are submitting two workshops here in the same manner in which we submitted the prior presentations. Patients with BPD represent approximately 20% of both inpatient and outpatient clinical practice, and their effective treatment requires specific knowledge, skills, and attitudes that will be addressed in this workshop. This workshop is designed for and limited to residents, fellows, and medical students who, in training, often struggle with the treatment of these patients. In a highly interactive format, trainees will learn from and along with experts in the field of borderline personality disorder (BPD) to deepen their understanding of the disorder and its treatment. Alternating brief presentations of salient points with participant discussions will allow participants to increase their knowledge and skill and to synthesize and apply the content as presented in the workshop. The workshop will be presented in two sessions (Part I and Part II). The workshop moves from an overview of BPD to essentials of psychotherapy and psychopharmacology, family therapy, and residency training objectives. Specifically, participants will review the diagnosis of BPD and its relationship with other disorders in order to build a basis for case formulation. Following this, the workshop examines core features of effective psychotherapy as well as features of treatments likely to make patients worse. Strategies and common pitfalls in psychopharmacologic treatment for BPD are examined, with case material from both experts and participants. Principles of family involvement follow, including data supporting the idea that families can and should learn effective ways of decreasing reactivity and increasing effective validation. Finally, objectives for residency education will help participants bring content from the workshop and integrate it with their current training. Participants are encouraged to attend both parts, though we will, in Part II, review material from Part I, so if necessary either session could be attended independently.

FORUM 10

A RESIDENT'S GUIDE TO BORDERLINE PERSONALITY DISORDER FROM THE EXPERTS: PART 2

Chairs: John Gunderson, M.D., Brian Palmer, M.D.

Speakers: John M. Oldham, M.D., Kenneth R. Silk, M.D., Perry Hoffman, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Diagnose BPD and understand its relationship to other disorders; 2) Structure an effective psychotherapy for BPD; 3) Thoughtfully choose psychopharmacologic approaches that fit within a formulation of a patient's problems; 4) Effectively integrate family work into a treatment plan; and 5) Establish a concrete plan for integrating BPD into their further psychiatric training.

SUMMARY:

This is a repeat of two workshops held in New Orleans in 2010 and Philadelphia in 2012. Those resident-only workshops were very successful. Even though part II was held at a different time from the Part I in 2010, attendance was even greater for the Part II; similar interest was seen in 2012. We thus are submitting two workshops here in the same manner in which we submitted the prior presentations. Patients with BPD represent approximately 20% of both inpatient and outpatient clinical practice, and their effective treatment requires specific knowledge, skills, and attitudes that will be addressed in this workshop. This workshop is designed for and limited to residents, fellows, and medical students who, in training, often struggle with the treatment of these patients. In a highly interactive format, trainees will learn from and along with experts in the field of borderline personality disorder (BPD) to deepen their understanding of the disorder and its treatment. Alternating brief presentations of salient points with participant discussions will allow participants to increase their knowledge and skill and to synthesize and apply the content as presented in the workshop. The workshop will be presented in two sessions (Part I and Part II). The workshop moves from an overview of BPD to essentials of psychotherapy and psychopharmacology, family therapy, and residency training objectives. Specifically, participants will review the diagnosis of BPD and its relationship with other disorders in order to build a basis for case formulation. Following this, the workshop examines core features of effective psychotherapy as well as features of treatments likely to make patients worse. Strategies and common pitfalls in psychopharmacologic treatment for BPD are examined, with case material from both experts and participants. Principles of family involvement follow, including data supporting the idea that families can and should learn effective ways of decreasing reactivity and increasing effective validation. Finally, objectives for residency education will help participants bring content from the workshop and integrate it with their current training. Participants are encouraged to attend both parts, though we will, in Part II, review material from Part I, so if necessary either session could be attended independently.

MAY 22, 2013

FORUM 11

REDUCING LONG-TERM CONSEQUENCES FROM ATYPICAL ANTIPSYCHOTIC USE IN COLLEGE STUDENTS

Chairs: Daniel Kirsch, M.D., Michelle Riba, M.D., M.S.

Speakers: Vicki L. Ellingrod, Pharm.D., Daniel Eisenberg, Ph.D., John F. Greden, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the role of folic acid in the potential development of metabolic complications seen with atypical antipsychotic use; 2) Discuss the implications of these risks in the college aged population using atypical antipsychotics and provide research findings to date; and 3) Outline innovative interventions and highlight the importance of standard monitoring plans to attenuate development of metabolic syndrome and cardiovascular disease in the at risk college population.

SUMMARY:

Although much attention has been given to atypical antipsychotic (AAP) consequences in schizophrenia* *metabolic risks are rising in other primary mental health disorders due to expanding AAP use. Perhaps the most concerning on these populations are college aged adults who sometimes garner a lifetime of exposure to AAPs, despite a thorough knowledge concerning the extent of these risks. While monitoring guidelines currently exists for patients who require an AAP, the stark reality is that these guidelines are not being followed. Research has shown that a diet low in folic acid combined with its pharmacogenetically regulated metabolism may increase the risk of metabolic complications seen with atypical antipsychotic (AAP) use. However this information as well is not being used in the clinically setting. Thus, with the expansion of AAP use beyond the "traditional" diagnosis of schizophrenia we have a new generation of AAP users who may suffer long term consequences of up to 30 years of life lost due to premature cardiovascular disease. Thus, understanding ways to attenuate this risks using clinical monitoring, dietary education and interventions, and personalized medicine approaching need to be identified and put into practice.

LECTURES

MAY 18, 2013

**LECTURE 01
MOLECULES OF TEMPERAMENT, MOOD AND
EMOTION: ANIMAL MODELS AND HUMAN
STUDIES**

Speaker: Huda Akil, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to:

1) Identify what genome wide analyses of human brains have taught us about the neurobiology of mood disorders—the range and degree of dysregulation across many brain regions and families of molecules; 2) Understand the importance of temperament in vulnerability and resilience to mood disorders. This has implications for treatment strategies and more personalized medicine. Therefore, the talk will describe animal models for difference in temperament and the associated phenotypes at the behavioral and neuromolecular levels; and 3) The importance of specific “neuroplasticity” in mood disorders and the role of a particular family of growth factors, the FGF family, as a developmental organizer, a “switch” that sets into motion a cascade of events in early development that modifies the structure and function of the hippocampus and leads differences in vulnerability and resilience, in part via epigenetic mechanisms.

ABSTRACT:

“Mood” is an ephemeral concept. Yet disruptions of mood, such as Major Depression and Bipolar Disorder, are highly prevalent and devastating lifelong disorders that remain difficult to understand scientifically or treat medically. This lecture describes a multidisciplinary approach using animal models, human post mortem brains, genetics and genomics, which is leading to new insights into the neurobiology of mood and the role of temperament in defining vulnerability and resilience to mood disorders. It describes new molecules that have been identified as potential biomarkers and treatment targets. Finally it focuses on the critical role of early development in determining emotional reactivity and describes the role of epigenetic mechanisms in altering vulnerability or resilience to affective disorders.

**LECTURE 02
THE TEACHING NOVEL: THE SPINOZA PROBLEM**

Speaker: Irvin D. Yalom, M.D.

Lecture Chairs: Edmond H.T. Pi, M.D., Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify benefits of the use of narrative in psychotherapy training; 2) Describe how the narratives discussed in Dr. Yalom’s textbooks on group therapy and existential therapy reinforce some aspect of therapy theory or techniques; 3) Identify the therapy ideas in Dr. Yalom’s four novels and most recent work “The Spinoza Problem.”;

SUMMARY:

For decades I have used narrative as a tool for teaching psychotherapy. My textbooks on group therapy and existential therapy are full of short narratives that teach some aspect of therapy theory or technique. Following that I’ve written four novels meant to teach important therapy ideas and techniques. I’ll review the therapy ideas in each of these and concentrate on my most recent novel: *The Spinoza Problem*. Irvin D. Yalom, M.D., is an emeritus professor of psychiatry at Stanford University and a psychiatrist in private practice in San Francisco. He is the author of many books, including *Love’s Executioner*, *Theory and Practice in Group Psychotherapy*, and *When Nietzsche Wept*. He lives with his wife in Palo Alto, California.

**LECTURE 3
LESSONS LEARNED FROM 30 YEARS OF A RESEARCH CAREER**

Speaker: Glorisa Canino, Ph.D.

Lecture Chairs: Daniel B. Martinez, M.D., Jose De La Gandara, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the need to include culture and context in the diagnosis of child psychiatric disorders. Evidence will be provided from several child epidemiological studies; 2) Discuss findings related to how risk and prevalence of child psychiatric disorders and impairment in functioning vary by specific disorder; 3) Identify the present prevalence and risk factors associated with a culture bound syndrome called “ataques de nervios” among Puerto Rican children and adolescents; 4) Understand reasons to include policy makers, patients, and other stakeholders in research study; and 5) Understand the need to develop study aims that are relevant to community and may translate into either treatment or policy changes.

SUMMARY:

An important goal of both the Diagnostic Statistical Manual, Fourth and Fifth Edition (DSM-5) of the American Psychiatric Association and the International Statistical Classification of Diseases and Related Health Problems, 10th edition (ICD-10) (WHO) is to provide descriptions of valid diagnostic constructs that can be applied across age, gender, ethnicities and cultures or contexts]. Consistent with this goal, the DSM 5 has included in its text the importance of considering culture, age and gender for each diagnostic category which is in-

tended to guide the clinician on variations of the disorder that may be attributable to the individual's culture, sex or developmental stage. However, how well this goal has been achieved by both clinicians and researchers is a matter of controversy. Both risk and protective factors associated with psychiatric disorders are often highly correlated, and studies have not consistently disentangled whether the low or high prevalence rates of certain specific disorders in poor or minority samples are due to differences in poverty or neighborhood characteristics or other risk factors, rather than to cultural differences that may be associated with protective factors. Prevalence rates can also be affected by cultural factors related to the degree to which psychiatric symptoms are considered impairing and or are differentially tolerated in various cultures and across age groups. Furthermore, the nature of a child's environment is different from those of adults and varies according to the child's developmental age. In early childhood, the child's environment is largely controlled by parents, so that child/caregiver's relationships and family environment are important components of the context in which the young child functions. As the child ages, school becomes an important context at this is where the child spends most of his/her days. As adolescence approaches both peers and the community at large become much more salient.

In this presentation the author will discuss evidence from several child psychiatric studies carried out by her research team over the last 30 years that attest to the need of considering culture, developmental age and context for diagnosing children and adolescents of Latino origin. Evidence will be provided by specific psychiatric disorder of how both prevalence and risk factors may vary (or not) according to culture, age and contextual difference across ethnic groups. Furthermore, the presentation will emphasize the need to consider comorbidity of psychiatric and physical disorders such as asthma in determining risk and prognosis of both of these conditions among Puerto Rican children and adolescents. Finally, recent evidence will be presented on the importance of pairing genetic and behavioral researchers to carry out epigenetic studies of asthma and psychiatric disorders with Latino populations in the near future.

LECTURE 04 CNS DRUG DISCOVERY AND DEVELOPMENT 2013: PROBLEMS, PROMISES, AND PARTNERING

Speaker: Robert H. Lenox, M.D.

Lecture Chairs: Josepha A. Cheong, M.D., Edmond H.T. Pi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the problems facing the pharmaceutical industry in 2013 for the development of new drugs for the treatment of psychiatric and neurological disorders; 2) Recognize the challenges and promise that the neurosciences offer for the discovery of new targets and novel drugs for the treatment and prevention of neuropsychiatric diseases; and 3)

Describe new strategies the pharmaceutical industry is using with biotech companies, academia and the NIH to change and enhance the drug discovery process, optimize clinical development & productivity.

SUMMARY:

The discovery and clinical development of new drugs for the treatment of both psychiatric and neurological disorders has been struggling over the past 50 years since the major breakthroughs in the last century that resulted in the introduction of the first anxiolytics, antidepressants, neuroleptics, and treatments for Parkinson's disease. The pharmaceutical industry has been facing significant challenges in productivity and cost within their drug discovery and clinical development paradigms due to the lack of understanding of the pathophysiology of many of the diseases, especially in psychiatry, and the relative lack of clinically-validated preclinical animal models; despite the remarkable advances that are being made in both the basic and clinical neurosciences. Discovery of pathways modulating the neuronal biology of survival/differentiation, inflammation, protein processing, axonal repair, and synaptogenesis are defining novel approaches to neurodegenerative diseases including Alzheimer's and MS.

Progress in functional brain imaging is providing new insights into neuropsychiatric disorders including pain, and recent studies in autism are offering the promise of modifying the disease process and phenotype of developmental brain disorders in childhood, and may augur similar opportunities for altering disease progression in schizophrenia. New strategies for drug discovery and clinical development are shifting risk of failure to earlier phases of the drug development process with the incorporation of novel translational biomarkers. Public-private partnering ventures by Pharma including universities, the NIH and MRC, promise more efficient screening for clinical proof of concept using repurposing strategies, as well as designing new 'crowdsourcing' approaches for more rapid and novel drug development in an open-access environment; addressing the thorny issues directly related to cost, proprietary, and regulatory constraints within the standard pharmaceutical drug discovery paradigms.

LECTURE 5 SCIENCE TO PRACTICE: ROLE OF THE LEADERSHIP IN NARROWING THE GAP

Speaker: Sy Atezaz Saeed, M.D., M.S.

Lecture Chair: Barry K. Herman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize that medical knowledge is growing at a pace faster than ever; 2) Recognize that today there remain significant gaps between science and practice; and 3) Describe the role of leadership in creating and sustaining health service environments that increase the likelihood of desired health outcomes.

SUMMARY:

It's been well documented that health care does not reliably transfer what we know from science into practice. As a result, Americans do not always receive the care suggested by the scientific evidence. Serious and widespread quality problems exist throughout our healthcare in both small and large communities. They occur in all parts of the country and with approximately the same frequency in both managed care and non-managed systems of care. Despite the best intentions of a dedicated and skilled healthcare workforce, our system often leads to poor clinical outcomes. As research and technology rapidly advance, this gap between science and practice appears to be widening. Failure to follow best evidence has been described to result in issues of underuse, overuse, and misuse of treatments. There is an increasing public concern about the lack of access to appropriate treatment, pervasiveness of unsafe practices, and wasteful uses of precious health care resources. Physicians and other clinical providers are under increasing pressure to demonstrate competence and satisfactory patient outcomes. Leadership has a critical role in creating and sustaining the environment that supports health services for individuals and populations that increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Evidence-based treatment guidelines; effective use of information technologies; measurement-based care; knowledge and skills management; and care coordination are amongst the approaches identified as ways to bridge this gap. For these approaches to be successful, we need systems that help structure the care delivery environment so that providing safe, timely, effective, efficient, patient-centered, and equitable care, as identified by the Institute of Medicine, becomes routine. This requires system-level tools that put the recommendations for evidence-based care into the care itself without adding undue burden on providers.

MAY 19, 2013

**LECTURE 6
THE BAD MOTHER IN AMERICAN PSYCHIATRY:
WHERE SHE CAME FROM, WHERE SHE WENT,
WHY HER STORY MATTERS**

Speaker: Anne Harrington, Ph.D.

Lecture Chair: Liza Gold, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Have a better understanding of the complex forces that shape psychiatric thinking and practice in the American context; and 2) Reflect on the larger ethical implications of different theoretical commitments.

SUMMARY:

For some fifty years - and within living memory for many still today - American psychiatry was deeply preoccupied with the effects of defective mothering on mental health. A parade of different kinds of bad mothers were blamed as responsible for everything from mental breakdown on the battlefield to homosexuality to autism to schizophrenia (arguably, this last was the most pernicious mother of all).

Today, memories of that whole era make many people wince. Most everyone today is convinced, for example, that schizophrenia is a brain disorder, best treated with medication; and that parents of people with schizophrenia need support instead of blame. The psychiatric profession today is appalled by the burden and pain that was once inflicted by telling families, and especially mothers, that they had literally driven their children crazy.

That all said, there is a lot that remains imperfectly understood about where all these bad mothers originally came from, why they maintained such a hold on the thinking of American psychiatry for so long, and especially why they have (mostly) gone away. This lecture will aim to illuminate some of these issues. The story of the bad mother in psychiatry - and especially the story of the so-called schizophrenogenic mother - forces us to confront themes and events in psychiatry's recent history that are still emotionally raw. We have not yet learned to tell this story well, but in this lecture I will propose some reasons why it is worth trying to do so.

**LECTURE 7
BENEFICIAL EFFECTS OF NOVEL ANTAGONISTS
OF GHRH IN DIFFERENT MODELS OF ALZHEIMER'S
DISEASE**

Speaker: Andrew V. Schally, M.D., Ph.D.

Lecture Chair: Julio Licinio, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize different models of Alzheimer's disease; 2) Identify Beneficial effects of Growth Hormone Releasing Hormone (GHRH) antagonist (MIA-690) in models of Alzheimer's disease; and 3) Discuss the merit of further studies with GHRH analogs in the models of Alzheimer's disease.

SUMMARY:

Alzheimer's disease is the most frequent debilitating disorder of the central nervous system, afflicting millions of people all over the world. Neuroendocrine mechanisms appear to play an important role in this insidiously developing degenerative disease. In the present study, the effects of a recently developed growth hormone releasing hormone (GHRH) antagonist (MIA-690) were evaluated in vivo observing the behavior of genetically modified 5XFAD strain, "Alzheimer's" mice in Morris water maze (MWM). The effects of the antagonist were also evaluated in vitro using cell cultures of HCN-2 human

cortical cell lines treated with amyloidbeta (1-42). In vivo, the indices of cognitive performance (latency, cumulative index etc.) were followed up for 6 months. In vitro, the formation of reactive oxygen species, markers of inflammatory and neuro-hormonal signaling were measured by fluorescent detection, PCRs, and ELISAs in tissue culture supernatants. Accumulation of amyloid-beta rafts and tau-filaments in necropsied brain samples was verified with the help of ELISA. In the MWM experiments, MIA-690 attenuated the progress of cognitive decline, prolonged survival and inhibited the aggregation of pathologic proteins. In cell cultures, the analog showed strong anti-oxidative and neuro-protective properties and inhibited the GHRH-growth hormone (GH)-insulin like growth factor (IGF) axis. The beneficial in vivo and proteomic findings were supported by concordant PCR results. Our data strongly suggest the merit of further studies with GHRH analogs in the models of Alzheimer's and elementary clinical trials.

LECTURE 8 WHAT WE CAN LEARN FROM ALCOHOLICS ANONYMOUS ABOUT ADDICTION TREATMENT, SPIRITUALLY-ORIENTED RECOVERY, AND SOCIAL NEUROSCIENCE

Speaker: Marc Galanter, M.D.

Lecture Chairs: Charles S. Aist, Ph.D., John Raymond Peteet, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss employing AA in clinical practice; 2) Understanding how AA supports the psychology of addiction recovery; and 3) Recognize how AA relates to recent findings in social and cognitive neuroscience.

SUMMARY:

Alcoholics Anonymous, with over 2 million members worldwide, and over 100,000 weekly meetings, is a valuable cost-free resource for continuing support of its members' abstinence. Even for those who participate for a limited time, a positive outcome is found to be proportional to one's level of attendance. It is useful for clinicians to understand the psychology of engagement in AA as reviewed here, as this can help them achieve successful referral. This also sheds light on aspects of long-term recovery from addiction that can be subsumed under spiritual renewal. Members' involvement is initially typically fostered by social support and mutuality in a setting where norms for communication are sustained by a preponderance of established members. Response to the spiritual nature of the fellowship, involving a personal transformation, usually comes later. Our studies on induction to religious sects, and our recent findings on long-term recovering young AA members, physicians in recovery, and drug addicts in NA, will be used to illustrate the points made. Video illustrations on sobriety and spiritual response in AA will also be shown. In order to clarify the biological substrate of the AA experience, recent findings from cognitive and social

neuroscience will be reviewed. They shed light on brain sites, primarily in the prefrontal cortex, with extension to limbic sites associated with social responsivity, with the integration of stimuli presented in the AA setting taking place in hippocampal sites.

LECTURE 9 ERB AND LXRB IN CNS

Speaker: Jan-Ake Gustafsson, M.D., Ph.D.

Lecture Chair: Julio Licinio, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of nuclear receptors; 2) Demonstrate knowledge of ERbeta in the CNS; and 3) Demonstrate knowledge of the LXRbeta in the CNS.

SUMMARY:

LRB and LXRB are later discovered members of the nuclear receptor gene family. Both were discovered in 1995 and both are important in the development of the CNS and in the maintenance of specific populations of neurons in adults. ER β is involved in the survival of GABAergic interneurons, serotonergic neurons of the Dorsal Raphe (DR) and the activity of microglia, while the motor neurons of the spinal cord, the dopaminergic neurons of the Substantia Nigra (SN) and the neurons of the prefrontal cortex depend on the presence of the LXR β . Thus ERB is involved in depression, anxiety and neuroinflammation while LXR β is involved in Amyotrophic lateral sclerosis and Parkinson's disease. The functions of ERB have been revealed with the use of knockout mice and the use of selective ERB agonist (LY3201) provided by Lilly. At present there is no specific a LXR β agonist available so we have worked with LXR β -1-mice and an agonist which acts on both LXR β and LXR α . Male but not female LXR β -1-mice develop motor neuron disease as they age. The first symptoms occur when mice are 6 months of age and begin to perform poorly on the rotor rod. The disease progresses to paralysis when mice are one year old and is accompanied by loss of motor neurons in the spinal cord and loss of dopaminergic neurons in the SN. Administration of the LXR agonist, GW3965, protected mice against the MPTP-induced loss of dopaminergic neurons in WT mice. ER β but not ER α is the ER in the serotonergic neurons of the DR. These are the neurons involved in fear, anxiety and depression. In overiectomized WT mice and in ER β -1-mice, there is a marked reduction in the number of tryptophan hydroxylase-positive neurons and this decrease in WT mice can be prevented by administration of LY3201. Thus LXR agonists may have beneficial effects in treatment to PD and ER β agonists in treatment of depression. Both receptors may be targets for treatment of neurodegeneration by modulating the cytotoxic functions of microglia.

LECTURE 10 PRION BIOLOGY: NEW INTERFACE BETWEEN PSYCHIATRY AND NEUROLOGY

Speaker: Stanley B. Prusiner, M.D.

Lecture Chairs: John M Oldham, M.D., M.S., Iqbal Ahmed, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize and diagnose the frontotemporal dementias (FTDs); 2) Learn about the pathogenesis of FTDs and the evidence that these illnesses are caused by prions; and 3) Understand the data that argues that the FTDs sit at an interface between psychiatry and neurology.

SUMMARY:

Over the past three decades, there has been a steady accumulation of evidence that each neurodegenerative disease is caused by a particular protein that becomes a prion. As with the prion diseases caused by the aberrant prion protein (PrP^{Sc}), amyloid deposits in other neurodegenerative disorders were found to have the same protein as that identified by molecular genetic studies of patients with inherited neurodegeneration. Mammalian prions composed of PrP, A β , tau, α -synuclein, SOD1 or huntingtin proteins all cause distinct neurodegenerative diseases. In each of these disorders, the respective mammalian proteins adopt a β -sheet-rich conformation that readily oligomerizes and becomes self-propagating. The oligomeric states of mammalian prions are thought to be the toxic forms, and assembly into larger polymers such as amyloid fibrils seems to be a common mechanism for minimizing toxicity. The role of the tau protein in the pathogenesis of AD was resolved when mutations in the tau gene were found to cause heritable tauopathies including familial frontotemporal dementia (FTD), inherited progressive supranuclear palsy (PSP) and Pick's disease but not familial AD. Aggregates formed from truncated recombinant tau were shown to enter cells and seed the polymerization of endogenous tau into additional aggregates. Such self-propagating tau aggregates were also detected in the brains of Tg mice expressing wild-type human tau that were inoculated with brain homogenates prepared from Tg mice expressing mutant tau. Tau prions are likely to cause all the tauopathies including the sporadic and familial FTDs, PSP, Pick's disease and chronic traumatic encephalopathy (CTE). Some athletes participating in contact sports develop FTD after repeated traumatic brain injury (TBI). In boxers, this illness has been called punch-drunk syndrome as well as dementia pugilistica; in football players, a similar progressive neuropsychiatric disorder with numerous neurofibrillary tangles in the frontal lobes is called CTE. Recent reports of military personnel, who were diagnosed with post-traumatic stress disorder (PTSD) and committed suicide, argue that concussions from shock waves from roadside bombs can initiate a tau prion-mediated process indistinguishable from that in football players with CTE. To date, there is not a single medication that halts or even slows a neurodegenerative disease caused by prions. This may indicate that unique

pathogenic mechanisms feature in each of the prion diseases.

LECTURE 11 BRAIN HEALTH AND ALZHEIMER'S PREVENTION

Speaker: Gary W. Small, M.D.

Lecture Chair: Brent Forester, M.D., M.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate Knowledge of the connection between healthy lifestyle habits and lower risk for Alzheimer's disease; 2) Discuss potential mechanisms for nutrition, physical exercise, mental stimulation, and stress management for improving brain health and lowering Alzheimer's risk; 3) Identify practical strategies to help people develop and maintain healthy behavior habits.

SUMMARY:

Age is the greatest single risk factor for developing Alzheimer's disease, and more than five million Americans and 34 million people worldwide suffer from this condition, which impairs an individual's ability to live independently. Genetics account for only part of the risk for developing Alzheimer's disease; thus, non-genetic factors likely contribute to disease risk. A recent NIH consensus panel couldn't draw firm conclusions between decreasing risk factors for Alzheimer's disease and slowing cognitive decline. However, the panel did conclude that many studies of healthy lifestyle habits – including diet, physical activity, and cognitive engagement – are providing new insights into the prevention of cognitive decline and Alzheimer's disease. Additional studies to supplement these findings are needed, but since these lifestyle choices help us feel better right away and appear to help prevent several diseases that increase Alzheimer's risk, the question is: Why wait years for results of definitive studies? Moreover, physical exercise and healthy diet, two of the key strategies of an Alzheimer's prevention program, are proven ways to prevent diabetes. Since diabetes is a major risk factor for developing Alzheimer's disease, anything that prevents diabetes should also prevent Alzheimer's disease. The goal of Alzheimer's prevention strategies is to help people stave off the onset of dementia symptoms for as long as possible. A 25% reduction in modifiable risk factors could potentially prevent as many as 500,000 cases of Alzheimer's disease in the United States and three million cases worldwide. This lecture will review the scientific evidence suggesting that healthy lifestyle habits can improve and maintain brain health and possibly forestall symptoms of Alzheimer's disease. It also will provide practical strategies to help people begin to develop brain healthy habits for preventing cognitive decline.

LECTURE 12 THE PSYCHIATRIC REPORT: INQUIRIES AND PRAXIS

Speakers: Alec Buchanan, M.D., Ph.D., and Michael Norko, M.D., M.A.R.

Lecture Chair:

EDUCATIONAL OBJECTIVES:

At the conclusion of the session, the participant should be able to 1) identify areas in which research and scholarship has informed the practice of psychiatric report writing 2) outline areas in forensic practice in which further scholarly development is needed 3) discuss how the principle of respecting the evaluatee can inform the writing of the psychiatric report.

SUMMARY:

The written report is a focal point for many of the skills of forensic psychiatric practice. It requires the author to assemble and organize data, interpret the results of an evaluation and, in most cases, offer an opinion in response to legal questions. The last 30 years have seen substantial development in principles and practice of forensic report writing. The lecture will review some of these developments in areas that include writing a narrative, forensic ethics, coercion within the justice system, and the implications of limitations on data in forming forensic opinions. The lecture will identify unanswered questions in these areas and suggest opportunities for empirical study and theoretical development. Two conceptual frameworks for the application of professional ethics in forensic report writing will be described.

LECTURE 13 KEYNOTE SPEECH BY PRESIDENT BILL CLINTON

Speaker: President Bill Clinton

SUMMARY:

President Bill Clinton, founder of the William J. Clinton Foundation and 42nd president of the United States, will deliver the keynote lecture at the APA annual meeting in San Francisco on Monday, May 20. The lecture will be held in Hall D at the Moscone Convention Center from 5:30 p.m. to 6:30 p.m.

MAY 20, 2013

LECTURE 14 TELOMERES AND TELOMERASE: THEIR RELATION TO STRESS AND HUMAN DISEASE

Speaker: Elizabeth H. Blackburn

Lecture Chairs: Dilip Jeste, M.D., Kelli Harding, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Biological science principles underlying telomere structure and function; 2) How telomerase acts to maintain telomeres; and 3) Clinical studies that correlate telomere length in humans to stress and various human syndromes.

SUMMARY:

Telomeres are the protective tips that stabilize the ends of chromosomes. Telomeres contain specialized, simple repetitive DNA sequences that, together with their specifically-bound proteins, protect chromosome ends from damage and thus stabilize the genetic information. As cells divide, unless a process of telomere elongation intervenes, telomeres suffer progressive attrition, causing the cells eventually to die or malfunction. This telomere shortening process can be counteracted by the ribonucleoprotein enzyme telomerase in eukaryotic cells. Telomerase is a unique reverse transcriptase found at highly regulated levels in various human cell types. Telomerase replenishes telomeres by adding telomeric DNA to them, thereby slowing, preventing or even reversing telomere shortening. In humans, in normal cells throughout human life, telomerase generally appears to be insufficient, because telomeres often erode down, even in some stem cell types. Increased telomere shortness has been linked to chronic psychological stress and to the major diseases that increase with aging. Through many clinical studies, telomere shortness has emerged as a potential marker for stress and its effects, which include the biological aging that limits human "healthspan". An important challenge is applying the growing knowledge of telomeres and telomerase to improvements in health and clinically.

LECTURE 15 PSYCHIATRY, THE AMA, AND MEDICINE: THE NEXT CHAPTER

Speaker: Jeremy A. Lazarus, M.D.

Lecture Chairs: Carolyn Robinowitz, M.D., Barton J. Blinder, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the impact of the Affordable Care Act on physicians, especially psychiatrists and other medical specialties and subspecialties now and in the decades to come; 2) Understand current workforce challenges, especially as they relate to medical specialties and subspecialties; 3) Understand the outlook for the future of medical specialties such as psychiatry and how payment and delivery reforms envisioned in the ACA and private sector will impact those specialties; 4) Understand AMA advocacy efforts on scope of practice and truth in advertising issues, and how they affect psychiatry; and 5) Understand the role played by psychiatrists in the AMA and how they advance organized medicine.

SUMMARY:

As physicians, psychiatrists are constantly learning and

striving for more – better outcomes, better tools, improved systems, and more focused frameworks. With more integration into primary care, psychiatrists can learn from each other and other physicians. Psychiatrists are also sensitive to their patients overall health and wellness and need tools and guidance to help patients improve their physical wellness and reduce the life expectancy disparities between the general patient population and the psychiatric patient population. The AMA is working to improve outcomes and set the standards for the next generation of team approaches to care as part of its new strategic focus and Dr. Lazarus will discuss this, as well as the impact of the Affordable Care Act on psychiatrists and physicians in general and the AMA's efforts to shape health system reform going forward.

LECTURE 16 ADVANCING DRUG DEVELOPMENT IN SCHIZOPHRENIA: A FOCUS ON IMPROVING

Speakers: Stephen R. Marder, M.D., Robert Buchanan, M.D., Daniel C Javitt, M.D., Ph.D., Donald C. Goff, M.D.

Lecture Chair: Darrel A. Regier, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the factors related to poor functioning and disability in schizophrenia; 2) Evaluate the most promising molecular targets for developing drugs to improve cognition and negative symptoms in schizophrenia; and 3) Describe the most promising pharmacological agents that are being developed for cognition.

SUMMARY:

Although dozens of pharmacological agents have been developed for treating schizophrenia during the past 60 years, a substantial number of individuals with schizophrenia remain disabled. The available drugs are effective at easing the burden of psychotic symptoms, such as hallucinations and delusions, but they have very little effect on the ability of these individuals to function in their communities. Since negative symptoms and cognitive impairments are strongly related to community functioning, it is plausible that drugs that improve these symptom domains will, in turn, improve functioning. The four presentations in this session will focus on the progress that has been made during the past decade in changing the direction of drug development in schizophrenia. Dr. Marder will provide an overview of an initiative from the National Institute of Mental Health that addressed important issues in drug development in these areas including regulatory hurdles, the selection of promising targets, the development of methods for measuring cognition and negative symptoms in clinical trials, and approaches to study design. Dr. Javitt will present data indicating that drugs that promote glutamatergic function can improve cognition and negative symptoms, and will also discuss more recently developed non-invasive brain stimulation approaches. Dr. Buchanan will provide an overview of studies of drugs that engage cholinergic targets, particularly nicotinic agents. Dr. Goff will describe progress in two new

areas of drug development: matching treatments to patients using genetic predictors of response and combining cognitive-enhancing agents with non-pharmacological treatments.

LECTURE 17 SUBSTANCE USE DISORDERS: NEW SCIENTIFIC FINDINGS AND THERAPEUTIC OPPORTUNITIES

Speaker: Nora D. Volkow, M.D.

Lecture Chairs: Annette Matthews, M.D., Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the complex biological and environmental factors that underlie vulnerability to drug abuse and addiction; 2) Recognize the changes in brain function that distinguish the normal brain from the addicted brain; 3) Discuss pharmacological and immunological strategies that have shown promise in treating addiction and in preventing relapse to drug use.

SUMMARY:

Recent scientific advances have increased our understanding of the biological (genetic and epigenetic), developmental and environmental factors and their interactions that are involved in drug abuse and addiction. This presentation will highlight recent findings on the consequences of acute and chronic drug exposure on epigenetic modifications, gene expression and cell function; brain circuit disruption in addiction; and factors involved in genetic vulnerability and resilience for drug abuse. In the coming years key addiction research challenges and opportunities will include discovery of genes that are involved in vulnerability and resilience for drug abuse, genes that affect brain development and function and how they interact with the environment to either protect or increase drug abuse vulnerability. Emphasis will also be placed on translational research employing state-of-the-art imaging tools as biomarkers to predict effectiveness of drug abuse prevention interventions and to assess and monitor promising addiction treatment strategies. Progress in the development of targeted pharmacotherapies, medication combinations, and immunotherapeutic approaches for addiction treatment will also be summarized.

LECTURE 18 STRESS-INDUCED DOPAMINE RELEASE IN PSYCHOSIS RELATED DISORDERS AND CANNABIS USE

Speaker: Romina Mizrahi, M.D., Ph.D.

Lecture Chair: Anthony F. Lehman, M.D., M.S.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be

able to: 1) To understand the effects of stress on dopamine function in the brain; 2) To understand the effects of stress on dopamine function in the brain of those with psychosis related disorders; and 3) To understand the effects of stress and dopamine in cannabis use.

SUMMARY:

Schizophrenia is a complex disorder, caused by both genetic and environmental factors and their interactions. Research on pathogenesis has mostly focused on neurotransmitter systems in the brain, particularly dopamine (DA). The environmental factor mostly focuses on either psychosocial stress or drug exposure, specifically cannabis. However, there is limited evidence on their interaction. Using the ability of endogenous DA to compete with [¹¹C]-(+)-PHNO binding, as measured with positron emission tomography (PET), we investigated DA response to psychosocial stress in-vivo in healthy volunteers (HV), clinical high risk (CHR) for schizophrenia and antipsychotic naïve patients with schizophrenia, (SCZ) in both cannabis users and nonusers. Here we show that a validated laboratory psychosocial stress task elicited increased release of DA in Schizophrenia (SCZ) and CHR in the associative striatum (AST), but not in HV. Cannabis resulted in a blunting of the stress induced DA response. Possible discussions of these findings will be presented.

LECTURE 19

ADVANCES IN AUTISM: FROM GENES TO THERAPY

Speaker: Daniel H. Geschwind, M.D., Ph.D.

Chair: Dilip V. Jeste, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize autism has genetic causes; 2) Discuss how to test for these genetic causes; and 3) Identify how we use this information to develop treatments.

SUMMARY:

Autism is a common, complex neurodevelopmental syndrome that causes significant morbidity because few effective treatments are available. Since there is a significant genetic component to autism, we and others have used modern genetic methods, including whole-exome sequencing to identify genetic causes of autism, as a first step in defining its etiology. Many genes have been identified, but none account for more than 1% of ASD, which has led us to conceive of autism more as “the autisms” than as a unitary disease. From this perspective, autism is best conceived as a group of disorders caused by developmental disconnection of specific brain circuits involving the frontal lobes and other interconnected regions. Recent translational advances based on these genetic findings have begun to expose potential mechanisms of the autisms, and harbor great potential for development of new treatments. This includes valid mouse models and in vitro models based on human neural stem cells, which provide exciting possibilities for drug development and screening.

One of the big challenges now is to understand how specific genetic perturbations effect brain development and function, leading to the specific clinical features of ASD.

LECTURE 20

TRAINING AND MENTORING PUBLIC PSYCHIATRISTS: AN ONGOING COLLABORATIVE LEARNING PROCESS

Speaker: Jules Ranz, M.D.

Lecture Chair: Frederick G. Guggenheim, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the past and present roles of fellowship training in public psychiatry, and possible future developments; 2) Discuss the importance to public psychiatrists of assuming leadership roles; and 3) Explain how these developments may lead to enhancements in systems based training of psychiatrists at the residency level.

SUMMARY:

Formal fellowship training in community psychiatry first appeared in the mid 1960s in the wake of the Kennedy Community Mental Health Centers (CMHC) Act. Over the ensuing 45 years the existence and focus of such programs has served as a mirror to trends in public and community psychiatry. None of the original programs survived more than a decade probably because of a shift in NIMH priorities to biologic psychiatry. Furthermore, the expectation that CMHCS would be run by psychiatrists never materialized and marginalization of psychiatrists in CMHCS was the rule during the 1970s. In 1981 Columbia University initiated a public psychiatry fellowship (PPF). The training model brings together faculty, fellows, alumni and field placement agencies in a long-term collaborative learning process. Responding to the onslaughts of crack, HIV/Aids and homelessness, in 1984 the American Association of Community Psychiatry (AAP) was created to provide a forum for community psychiatrists to deal with these challenges. AAP began promoting leadership roles for community psychiatrists and the PPF faculty conducted surveys demonstrating the positive effect on the careers of public psychiatrists of assuming program and agency medical director roles. The 90s saw the development of evidence-based practices (EBP), the concept of recovery and attempts to deal with burgeoning health care costs. By 2000 it became apparent that psychiatrists were spending more time in organizational settings than in private practice. To better prepare psychiatrists to work in these evolving organizations, 14 public and community psychiatry fellowships were created in the past seven years. Most of these are modeled on the Columbia program and focus on leadership training geared towards implementing EBP and recovery. Moving forward, the Affordable Care Act will accelerate the trend towards psychiatrists working in organizational settings. All these developments have led to an increased need for systems-based training for psychiatrists at both residency and fellowship levels. This presentation discusses current and future models for this training.

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LECTURE 21 WILLIAM C. MENNINGER MEMORIAL CONVOCATION LECTURE

Speaker: Baroness Susan Greenfield, D.Phil., C.B.E.

SUMMARY:

Baroness Greenfield will be giving a positive and uplifting lecture. She is also presenting Lecture 26: "Are Digital Technologies Impacting on Wellness of the Young Mind?"

MAY 21, 2013

LECTURE 22 SHIFTING PARADIGMS FOR THERAPEUTIC DISCOVERY

Speaker: William T. Carpenter, M.D.

Lecture Chairs: David Kupfer, M.D., Mary Brady, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify strategies for intervention; 2) Recognize therapeutic targets; and 3) Understand deconstruction of psychotic disorders.

SUMMARY:

Schizophrenia is a disorder most often treated as a disease entity in research, teaching and clinical practice. However, as a construct it is a clinical syndrome with substantial between patient heterogeneity at all levels of a biopsychosocial medical model. Failing to establish schizophrenia as a single disease entity challenges the field to either identify diseases within the syndrome or to deconstruct the syndrome into psychopathology domains. The former has resulted in deficit schizophrenia as a putative disease entity, but has not resolved heterogeneity

for the majority of the schizophrenia construct. Deconstructing into pathology domains is a paradigm shift that has gained momentum by providing more specific targets for investigation and has identified unmet therapeutic needs. A second paradigm shift points to the future of therapeutics of psychotic disorders with implications for primary and secondary prevention. Early risk factors induce brain changes during developmental years that result in a vulnerability for presently defined disorders. Vulnerable individuals may progress to one of a number of more severe disorders, or this progression may be prevented by resiliency factors or by therapeutic intervention. Acquiring new knowledge with vulnerability platforms as the target is substantially different from knowledge development on presently defined disorders. Conceptualizing disorder development as pleiotropic and progressing in stages creates new opportunities for discovery. Given the prolonged stagnation in therapeutic advances for psychotic disorders, this new paradigm for therapeutic intervention offers the best opportunity to make a substantial difference in the life course of persons vulnerable to schizophrenia and related psychotic disorders.

LECTURE 23 THE CRITICAL ROLE OF FAMILY SUPPORT IN PROMOTING RISK & WELL-BEING FOR LGBT CHILDREN & YOUTH

Speaker: Caitlin Ryan, Ph.D.

Lecture Chairs: Anand Pandya, M.D., Mary E. Barber, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the impact of family acceptance and rejection of an adolescent's LGBT identity on their health & mental health; 2) Describe specific family behaviors that increase health risks for LGBT adolescents and family behaviors that protect against risk and promote the youth's well-being; 3) Identify one to three specific change(s) in assessment and care of adolescent patients related to sexual orientation and gender identity to decrease risk and promote well-being.

SUMMARY:

Historically, approaches to providing services and care for lesbian, gay, bisexual and transgender (LGBT) youth focused on generating peer support, rather than helping families support their LGBT children. Little was known about how families adjusted and responded to their LGBT children, and how their reactions affected their children's health and well-being despite a significant drop in the age of coming out, compared with earlier generations of LGBT individuals who came out in adulthood. This presentation will focus on a body of work undertaken over a nearly 40-year career in LGBT health and mental health which led to the development of the Family Acceptance Project (FAP) – a research, education, intervention and policy initiative at SF State University to decrease risk and promote well-being among LGBT children and adolescents in the context of their families, culture and faith backgrounds.

Research from the Family Acceptance Project includes the first major study of the critical role of families in contributing to risk and well-being for their LGBT children. FAP studies have shown that family acceptance helps promote well-being and helps protect against risk, while family rejection is related to serious health and mental health concerns in young adulthood, including depression, suicidal behavior, substance abuse and sexual health risks. This research is being applied to develop an evidence-based family intervention approach for use in multiple practice settings to help ethnically and religiously diverse families to decrease rejection and increase support for LGBT children and adolescents to decrease health and mental health risks, including homelessness and placement in foster care, to promote well-being and to strengthen families. This presentation will discuss key findings, approaches to engaging families in care, the development of multi-cultural family education resources ("Best Practices" for suicide prevention) and implications for public policy.

LECTURE 24 DECONSTRUCTING SCHIZOPHRENIA AND THE HIDDEN LIFE OF GENES

Speaker: David L. Braff, M.D.

Lecture Chair: Darrel A. Regier, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Will learn about subtyping schizophrenia and the DSM-V's new classification of schizophrenia; 2) Will be able to understand the significance of endophenotypes in understanding schizophrenia; and 3) Will have a balanced knowledge of the time course of genomic based "personalized medicine" treatments (medications and psychosocial) for schizophrenia.

SUMMARY:

Our understanding of Schizophrenia is being impacted by a dramatic revolution in our understanding of mammalian neurobiology and genomics. But our ability to integrate this new knowledge into a coherent understanding of the etiological and treatment implications of schizophrenia is still profoundly difficult.

In the past, schizophrenia was understood as largely familial and developmentally determined. Then, enthusiasm grew for psychopharmacological treatments based on single neurotransmitters - single loci understandings of the neurobiology of schizophrenia, such as the "dopamine overactivity hypothesis".

Now, psychiatry is undergoing a dramatic challenge: how do we apply our rapidly advancing understanding of mammalian neurobiology and human genomics to our understanding of and treatment of "circuit-based" psychiatric disorders such as schizophrenia? In the future, with our ability to sequence the genome of patients, we will need integrative knowledge and tools specifying which biological and psychosocial treatments work, for which patients they work, and how we can help patients in the years it will take to apply advanced genomic and

personalized medicine concepts to the relatively phenotypically "fuzzy" disorders which plague the brains and then the lives of our patients and their families.

This presentation will focus on the use of biomarkers and endophenotypes to "deconstruct" schizophrenia in a novel, non-reductionistic framework. This includes understanding how social as well as biologic factors impact schizophrenia and its neurocognitive and neurophysiological biomarker deficits. The discussion will also include how we can integrate both new "small molecules" (e.g. D-cycloserine) and psychosocial (sensory training) treatments with their brain changing actions into a dynamic framework in the service of improving the outcomes of our patients.

LECTURE 25 SUICIDAL BEHAVIOR: SHOULD IT BE A SEPARATE DIAGNOSIS?

Speaker: Maria A. Oquendo, M.D.

Lecture Chairs: Michael F. Myers, M.D., Amresh K. Shrivastava, M.D., M.R.C.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List pragmatic reasons for considering suicidal behavior as a diagnosis; 2) Recognize biological, epidemiological and phenomenological support for a separate disorder; and 3) Identify epidemiology of suicidal behavior.

SUMMARY:

Although there are about 1 million suicides a year and anywhere between 25 and 50 suicide attempts for each suicide death, preventive strategies have so far done little to decrease the morbidity and mortality associated with suicidal behavior. Further, suicidal behavior is associated or comorbid with a wide range of psychiatric diagnoses. A pragmatic problem has been the ease with which crucial information about history of suicidal behavior is lost in medical communications. Often times, discharge summaries lack information about this key element and there is no way for clinicians to code it in diagnostic summaries of the case. Interestingly, suicidal behavior meets the criteria for diagnostic validity set forth by Robins and Guze, and it does so as well as most conditions we treat. It is clinically well described; research has identified postmortem and in vivo laboratory biomarkers; it can be subjected to a strict differential diagnosis; follow-up studies confirm its presence at higher rates in those with a past diagnosis; and it is familial. From both theoretical and practical perspectives, making such a diagnosis available to clinicians makes sense and more importantly, has the potential to save lives.

LECTURE 26 ARE DIGITAL TECHNOLOGIES IMPACTING ON WELLNESS OF THE YOUNG MIND?

Speaker: Baroness Susan Greenfield, D.Phil.

Lecture Chairs: Josepha A. Cheong, M.D., Catherine C. Crone, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how digital technology might impact on the young mind; 2) Identify specific issues and challenges; and 3) Gain insights into possible solutions.

SUMMARY:

A recent survey of US teenagers showed that over half those aged 13 to 17 spend more than 30 hours a week, outside school, using screen technologies. Given the plasticity of the human brain, not surprisingly, adaption to a cyber-environment will lead to positives in enhanced performance in a variety of skills continuously rehearsed. However, we need urgently to gain a much fuller picture. Time spent in front of a screen is time not spent doing other things. We need to understand the full impact of the current cyber culture on the emotional and cognitive profile of the 21st century mind. We can look at three broad areas. First, what is the impact of social networking sites on interpersonal skills and personal identity? If a young brain with the evolutionary mandate to adapt to the environment is establishing relationships through the more sanitized medium of a screen, the skills that are so essential for empathy may not be acquired as naturally, as well or as quickly as in the past. Secondly, on video games, neuropsychological studies suggest that frequent and continued playing might lead to enhanced recklessness and low-grade aggression. In addition, data indicate reduced attention spans and even possible addiction. Moreover, significant chemical and even structural changes are being reported in the brains of obsessive gamers. Thirdly, on search engines, can the internet actually improve or impair cognitive skills and learning? We need to understand much more about the impact of search engines on comprehension skills and need to differentiate information from knowledge. Like Climate Change, this transformational scenario of 'Mind Change' is complex, unprecedented and controversial. However, unlike climate change, the end point is not one of just damage limitation but rather of ensuring that we deliver to the next generation an environment that can for the first time enable the realization en masse of each individual's full potential.

LECTURE 27 NEW INSIGHT INTO THE NEUROBIOLOGY OF DEPRESSION

Speaker: Eric J. Nestler, M.D., Ph.D.

Lecture Chair: Dilip Jeste, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the neurobiology of depression in humans; 2) Identify animal models of depression; and 3) Recognize the molecular mechanisms underlying depression-like behavior in animal models.

SUMMARY:

Depression is a common, chronic, and debilitating syndrome. Only about half of depressed patients show a complete remission to available treatments, which underscores the need for more effective agents. The mechanisms that precipitate depression, such as stress in some patients, are incompletely understood. Unraveling the pathophysiology of depression represents a unique challenge. In addition to the heterogeneity of depressive syndromes and their diverse etiologies, symptoms like guilt and suicidality are impossible to recapitulate in animal models. Nevertheless, other symptoms can be accurately modeled, which, along with growing clinical data, are beginning to provide new insight into the neurobiology of depression. Recent studies, which combine behavioral, molecular, and electrophysiological techniques, reveal that certain aspects of depression result from maladaptive stress-induced changes in reward circuits of the brain. We are currently investigating the detailed molecular mechanisms underlying these changes. One major focus is stress-induced changes in gene expression, which are mediated via epigenetic mechanisms, that is, changes at the level of chromatin remodeling. We have identified such mechanisms that mediate susceptibility to stress in some individual animals and other mechanisms that instead mediate resilience to stress in other individuals. This work provides new insight into the molecular mechanisms by which chronic stress produces lasting changes in brain to cause depression-like symptoms. The findings also suggest novel leads for the development of new antidepressant treatments, including mimicking coping mechanisms mounted by resilient individuals.

LECTURE 28 EVOLUTIONARY EXPLORATIONS OF THE HUMAN GENOME

Speaker: Robert K Moyzis, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the results of recent molecular genetic studies suggesting that our culture may have had a profound and ongoing effect on shaping our DNA. We define this as the "encultured genome;" 2) Identify the major neurotransmitter gene sites (dopamine, serotonin, norepinephrine, glutamate, and GABA) with evidence for recent (<10,000 years) adaptive selection; and 3) Recognize the implications of these results for understanding the relationship between genes and culture, and the underlying genetic basis of human behavioral variability.

SUMMARY:

There is a general consensus in the scientific community regarding the evolutionary pathway to humans, but controversies abound regarding the recent evolution of humans. While it is often assumed that humans have stopped evolving due to our rapid cultural development, recent molecular genetic analysis suggests the opposite: that our culture may have had a profound and ongoing effect on shaping our DNA. We define

this as the “encultured genome”. The evolutionary payoff of an individual’s behavior in complex human societies will depend strongly on the reaction of others to that behavior. The pace of this evolutionary change has accelerated, as populations have expanded and migrated to diverse geographical locations. This genetic transient state of many human genes, resulting in both an ancestral allele and a recently selected allele, likely underlies some aspects of human behavioral variability. Using data from the HapMap, 1000 Genomes, and Beijing Genes-Brain-Behavior (BGBB) Projects, clear evidence of recent adaptive selection at 44 out of the 108 major neurotransmitter gene sites (dopamine, serotonin, norepinephrine, glutamate, and GABA) has been uncovered ($p < 5 \times 10^{-10}$), with most selection events occurring during the last 10,000 years. These recently selected neurotransmitter alleles are preferentially associated with normal human variability, as measured by 300 physiological and behavioral variables obtained for the BGBB Project. The impact of one of these alleles, the DRD4 7R variant, was directly tested. The frequency of this allele was increased 66% in individuals >90 years old ($p = 3.5 \times 10^{-9}$), and a DRD4 7R genotype was strongly associated with increased levels of physical activity. DRD4 knockout mice displayed a 7-9.7% decrease in lifespan, reduced spontaneous locomotion, and no lifespan increase when reared in an enriched environment. The implications of these results for understanding the relationship between genes and culture will be discussed.

LECTURE 29 WHAT IS A 21ST CENTURY NEUROBIOLOGICAL-EMPOWERED PSYCHIATRIST? LESSONS FROM CRIME SCENE INVESTIGATORS

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

Lecture Chairs: Philip R. Muskin, M.A., M.D., Sheila Hafter-Gray, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the role of genetics and genotyping in the diagnosis and treatment of psychiatric disorders and the convergence of environmental stress upon genes via epigenetic mechanisms; 2) Explain “symptoms and circuits” by showing how modern neuroimaging techniques are uncovering the neuronal basis of symptom endophenotypes that cut across numerous psychiatric conditions; and 3) Demonstrate how a 21st century neurobiologically empowered psychiatrist puts this all together to make a diagnosis and to select and combine treatments.

SUMMARY:

Classically, a psychiatrist makes a diagnosis from an interview alone without diagnostic tests, and then chooses a treatment from published guidelines derived from evidence-based medicine from studies of populations of patients. Currently, treatments are linked to a specific diagnosis but not to the unique characteristics of the individual patient. Now all of this is changing. Increasingly available are genomic tests which

promise to link specific patients to markers that suggest greater or lesser likelihood of responding to or tolerating a given drug. Thus, “population based medicine” defining the median patient dictating treatment for all, is giving way to personalized medicine and customization of both symptom profiles and treatments to the individual. Also, translational neuroscientists are rapidly making available results from structural and functional neuroimaging techniques that correlate with symptom endophenotypes but not necessarily with DSM diagnoses. Endophenotypes are symptoms linked to inefficient information processing in specific brain circuits that are present transdiagnostically as a dimension of psychopathology that cut across many psychiatric disorders. Examples include impulsivity, compulsivity, mood, anxiety, motivation and many more. Thus, the 21st century neurobiologically empowered psychiatrist is poised to become a “disease scene investigator” analogous to crime scene investigators celebrated in the popular media and who investigate individual unique crimes and not the median crime. That is, practicing psychiatrists may soon be investigating the “scene of the disease,” namely, the brain, with neuroimaging and pharmacogenomics, to determine the linkage of specific symptoms to specific malfunctioning brain circuits regulated by unique genes and neurotransmitters that predict what treatments to select for best results for that individual. Sherlock Holmes, watch out.

LECTURE 30 POLICY TO PRACTICE: CHALLENGES FOR EFFECTIVE MENTAL HEALTH CARE

Speaker: John O. Gaston, M.D.

Lecture Chairs: Michele Reid, M.D., Stephen A. McLeod-Bryant, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the influence of policy development on mental health care; 2) Discuss the role and importance of education and training in achieving competent and effective care; and 3) Understand the potential impact of organizational participation and leadership on mental health care.

SUMMARY:

The relationship of policy development in mental health care to the desired clinical outcomes on the surface appears relatively straight forward. Often, however, this may not be the case. A variety of factors influence how and/or whether policy is developed. The process of implementing a ‘good idea’ so that it translates into a positive clinical outcome is convoluted. Through the prism of his career and experience as an educator, clinician, and organizational leader in Psychiatry, Dr. Gaston will explore the challenges and opportunities this matrix presents for the development of competent and effective mental health care for African Americans

MASTER COURSES

MAY 18, 2013

MASTER COURSE 01 TREATING THE LGBT PATIENT

Director: Petros Levounis, M.D.

*Faculty: Jack Drescher, M.D., Mary E. Barber, M.D.,
Jennifer C. Pizer, Esq.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List three unique problems LGBT people face in their everyday lives when compared with heterosexual individuals.;2) Discuss problems that are common to all LGBT individuals, such as the anxiety of being in the closet (hiding one's identity) or coming out (embracing one's identity).; and 3) Diagnose common psychiatric disorders within the context of an LGBT individual's everyday life.

SUMMARY:

'Treating the LGBT Patient' provides the general psychiatrist with the essential tools needed for LGBT affirmative treatment. The course is organized in four sections, which cover basic concerns that affect LGBT populations, including coming out, heterosexist attitudes, the 'don't ask, don't tell' mentality, legal issues, gay parenting, and sexual identity in patient-therapist relationships. During the course, we will also present a number of case studies with different DSM diagnoses, illuminating the impact of LGBT identity and illustrating a way of working with each presented patient. While 'Treating the LGBT Patient' is a useful general overview and roadmap for the clinician new to treating LGBT patients, it also provides new pearls of wisdom and insights for psychiatrists, residents, medical students, nurses, and clinical social workers who are already familiar with working with the LGBT community. By introducing a diverse range of people, diagnoses, and presenting problems, it serves as a valuable introductory course for all mental health professionals when assessing and treating the mental health concerns of lesbian, gay, bisexual, and transgender patients.

MASTER COURSE 02 UPDATE ON PEDIATRIC PSYCHOPHARMACOLOGY

Director: Christopher Kratochvil, M.D.

*Faculty: John T. Walkup, M.D., Karen D. Wagner, M.D.,
Ph.D., Christopher J. McDougale, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of current clinical guidelines for the use of pharmacotherapy in pediatric psychiatric disorders.;2) Demonstrate knowledge of practical clinical use

of psychopharmacology and management of adverse events.; and 3) Demonstrate knowledge of recent research on pharmacotherapy in common psychiatric disorders of childhood.

SUMMARY:

Objective: The primary objective of this course is to provide practical information to clinicians on the use of psychotropic medications in the treatment of children and adolescents in their practices. Methods: This course will provide an overview and discussion of recent data in pediatric psychopharmacology, with a focus on mood disorders, attention-deficit/hyperactivity disorder, anxiety disorders, and autism spectrum disorders. The role of pharmacotherapy in the treatment of these disorders will be addressed, as will practical clinical aspects of using psychotropic medications in the treatment of children and adolescents. Management of adverse effects will be reviewed as well. Awareness of recent research data will help to facilitate an understanding of the basis for current clinical guidelines for the treatment of these psychiatric disorders. Clinically relevant research will be reviewed, within the context of clinical treatment. Conclusion: Awareness of recent research and practice parameters on the use of pediatric psychopharmacology, and the application of this information to clinical practice, can inform and positively impact patient care.

MASTER COURSE 07 DSM-5: WHAT YOU NEED TO KNOW

*Directors: David Kupfer, M.D., Darrel A. Regier, M.D.,
M.P.H.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List the primary significant changes in the classification of and diagnostic criteria for mental disorders from DSM-IV to DSM-5.;2) Discuss some of the major clinical modifications that might be needed to implement the major changes in DSM-5; and 3) Describe some of the important research implications resulting from changes in DSM-5

SUMMARY:

Release of DSM-5 marks the first major revision to the classification of and diagnostic criteria for mental disorders since DSM-IV was released in 1994. The focus of this master course is to educate clinicians and researchers on the major changes from DSM-IV to DSM-5, including diagnosis-specific changes (e.g., criteria revisions) as well as broader, manual-wide changes (e.g., revised chapter ordering, use of dimensional assessments, integration of neuroscience and developmental material across the manual). The primary emphasis is on ensuring clinicians understand how these changes might impact patient care and knowing what modification might be necessary to implement these revisions in their practice. Presentations will also address potential scientific implications and assist researchers in understanding how DSM-5 might impact the study of mental disorders. The session will be led by the DSM-5 Task Force chair and vice-chair, Drs. David J. Kupfer and Darrel A. Regier, respectively, and will be supplemented by presentations from chairs or members of the 13

DSM-5 Work Groups, who will be on hand to provide explicit explanations regarding changes in their respective diagnostic classes and to offer specific guidance about implementation in clinical care and research.

MAY 19, 2013

MASTER COURSE 03 SEX, DRUGS, AND SOCIAL MEDIA: PROFESSIONALISM AND ETHICS PUT TO THE TEST

Director: Glen O. Gabbard, M.D.

Faculty: Gabrielle Hobday, M.D., Holly Crisp-Han, M.D., Valdesha Ball, M.D., Laura Roberts, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the major professionalism and ethics issues regarding the use of the electronic media; 2) Identify the major problematic boundary issues inherent in dual relationships; and 3) Recognize the “hidden” professionalism themes in the areas of gender, sexuality, race, culture and religion

SUMMARY:

Making ethics and professionalism clinically relevant and practical has been a perennial problem in the education of psychiatrists and other mental health professionals. In this course we take some of the major clinical dilemmas encountered in practice and bring them to life with vivid clinical examples and film clips. To be sure we engage the learners, we will use the Audience Response System to pose questions that grow out of the details of the clinical problems we present. The audience can then receive instant feedback on how their responses compare to those of their colleagues. The major areas that will be covered include the problems of maintaining professional boundaries, dual relationships, intercolleague relationships, the complicated issues surrounding race, culture, gender, sexuality and religion in the clinical setting and the brave new world of electronic media, i.e., email, texting, social media. The course will end with an interactive dialogue with the audience based on complex clinical dilemma in the areas of professionalism and ethics.

MASTER COURSE 04 PRACTICAL COGNITIVE BEHAVIOR THERAPY

Director: Jesse H. Wright, M.D., Ph.D.

Faculty: Donna Sudak, M.D., Robert M. Goisman, M.D., Judith Beck, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe core CBT theories that offer practical guidance for psychiatric treatment; 2) Use basic cognitive and behavioral methods for depression; and 3) Use basic cogni-

tive and behavioral methods for anxiety disorders

SUMMARY:

Cognitive-behavior therapy (CBT) is a highly pragmatic, problem-oriented treatment that is used widely in psychiatric practice. Clinicians who employ CBT work on modifying maladaptive cognitions and behaviors in an effort to reduce symptoms and improve coping skills. This course is designed to help clinicians learn the fundamentals of CBT, including the basic cognitive-behavioral model, the collaborative empirical relationship, methods of structuring and educating, techniques for changing dysfunctional automatic thoughts and schemas, behavioral interventions for anxiety and depression, and strategies of improving medication adherence. Teaching methods include didactic presentations, video illustrations, role plays, and interactive learning exercises.

MAY 21, 2013

MASTER COURSE 06 2013 PSYCHIATRY REVIEW

Directors: Arden D. Dingle, M.D., Robert Boland, M.D.

Faculty: Richard Balon, M.D., Sandra M. DeJong, M.D., M.Sc., Natalie Lester, M.D., M.P.H., Avram H. Mack, M.D., Vishal Madaan, M.D., Anthony Rostain, M.A., M.D., Mark Servis, M.D., Marcy Verduin, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

Essential psychiatric and neurology topics will be reviewed and discussed using multiple-choice questions (MCQ). After a brief introduction covering the basic structure and format of MCQs typically used in psychiatric examinations, participants will review and answer MCQs using an audience response system. After viewing a summary of the audience responses, faculty members will lead and facilitate a review and discussion of the topic covered by the MCQs. The questions will be grouped by topic and will cover a number of core subjects in psychiatry and neurology. The clinical topics are depression, bipolar disorders; psychotic disorders; substance abuse; cognitive disorders/geriatric psychiatry; anxiety disorders; personality disorders; child and adolescent psychiatry; forensic psychiatry and ethics; somatoform disorders, impulse control disorders, and paraphilias; and neurology. Audience members will use an audience response system to respond to the multiple choice format before correct answers and full explanations and references will be covered.

**MASTER COURSE 08
UPDATE ON THE MANUAL OF CLINICAL PSY-
CHOPHARMACOLOGY**

Directors: Charles DeBattista, M.D., Alan F. Schatzberg, M.D.

Faculty: Antonio Hardan, Rona Hu, M.D., Charles Nemeroff, M.D., Ph.D., Terence A. Ketter, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

Psychopharmacology remains a mainstay of psychiatric treatment. This Master Course reviews recent advances in the treatment of a number of common disorders and provides an update on material in the Manual of Clinical Psychopharmacology that is in its 7th edition and that is edited by the Course Co-Directors. The course is designed for practitioners of intermediate and advanced skill levels. The speakers and topics to be covered include: Charles B. Nemeroff, M.D., Ph.D. Treatment of Anxiety Disorders Alan F. Schatzberg, M.D. Medication Management and Pharmacogenetics in Depression Charles DeBattista, DMD, M.D.-Electro-stimulatory Devices in Depression Antonio Hardan, M.D. Treatment of Autistic Disorders Rona Hu, M.D. Treatment of Schizophrenia Terry Ketter, M.D. Recent Advances in Bipolar Disorder. In addition to formal presentations, case examples will be employed and there will be questions and answers periods.

MAY 18, 2013

MEDIA WORKSHOP 1

DEPARTURES: PERSONAL TRANSFORMATION THROUGH AN ENCOUNTER WITH DEATH

Chair: Francis Lu, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize both the universal process of grief and the specific cultural processing of grief in Japan; 2) Understand how an awareness of and acceptance of death can lead to personal transformation; 3) Utilize film as a method of instruction for patients and trainees concerning the existential issue of death;

SUMMARY:

“Departures” (2008) is a Japanese film that was a surprise Academy Award winner for Best Foreign Language Film. Set in a contemporary rural village in Japan, it traces the profound transformation of a young unemployed cello player and his young bride as he accidentally becomes an apprentice of an older master who practices “encoffinment,” an undertaking trade involving the precise, graceful ritual cleansing and dressing of the deceased in front of relatives just prior to cremation. While initially he is repulsed by his work, the master’s steadfast perseverance and compassion for the family members gradually engages him to participate. When his wife finds out, she is shocked and leaves him, but later returns when she discovers that she is pregnant. The ultimate challenge happens when he is called upon to care for his dead father, who he has not seen for many years. Imbued with a Japanese Buddhist aesthetic sensibility of the beauty in the transience of life in the tradition of such great films as Kurosawa’s “Ikiru” and Ozu’s “Tokyo Story,” this film explores the mystery of how an acceptance of death leads to personal transformation. A Roger Ebert Great Movie.

MEDIA WORKSHOP 2

THE HOLDING ENVIRONMENT: PHOTOGRAPHS OF PSYCHOTHERAPY ROOMS

Chair: Jose Ribas, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about the importance of how to set a therapy room from different theoretical backgrounds;2) Familiarize yourself with Winnicott’s concept of holding environment and implications in current practice;3) Become aware how visual arts and documentaries enhance training in residency programs;

SUMMARY:

Within medicine today, patients receive care in doctors’ offices, clinics and hospitals. Typically these rooms are staid, predictable and interchangeable. An examination room in a North Carolina hospital or clinic probably appears quite similar to an examination room in a hospital or clinic in New York, South Dakota or Texas. Where this model departs is in Psychiatry, where the room itself plays an important role, as it becomes the physical “holding environment” where the therapist conveys to the patient that he or she is safe to explore those areas within him/herself that are threatening or causing distress. As a Psychiatry resident on the verge of setting up my own practice, I photographed 28 therapeutic spaces and interviewed 12 of these providers about why they configured their space in the way they did. It was informative and rich to see the range of spaces, from the more traditional “blank slate” position, trying to keep the space as neutral as possible to invite all kinds of fantasies and projections from the patient, to the rooms where therapists intentionally made their space very personal.

MEDIA WORKSHOP 3

“HEALTHY MINDS” PUBLIC TELEVISION SERIES: MILITARY MENTAL WELLNESS

Chair: Jeffrey A. Borenstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Gain a new perspective of service members who have experienced the invisible injuries of war and how their return home affects them and their families;2) Gain insight into the perspective of the former Chairman of the Joint Chiefs of Staff’s view of the mental health impact of war, including depression, PTSD, and suicide;3) Go behind the scenes of the production of this public television series with host, Jeffrey Borenstein, M.D.;

SUMMARY:

The public television series, Healthy Minds, hosted by Jeffrey Borenstein, M.D. aims to educate the public about psychiatric conditions, reduce stigma, and encourage people not to suffer in silence but to seek treatment. Three episodes in the current season are presented. The episodes focus on mental health issues that service members and their families face when they return home. Admiral Mike Mullen, US Navy (RET), who served as the Chairman of the Joint Chiefs of Staff and his wife Deborah candidly discuss the invisible injuries of war, including depression, post-traumatic stress, and suicide. Col. David Sutherland US Army (RET) shares his own personal experiences. In addition, a wounded warrior and his wife share their life experiences they refer to as “our battle after the war.” Journalist Rita Cosby shares how she gained insight into her father’s battle with post-traumatic stress. Dr. Borenstein will share his behind the scenes experience as host of Healthy Minds.

MAY 19, 2013

MEDIA WORKSHOP 4

“VOICES”

Speakers: Hiroshi Hara, Ph.D., Karthik Sivashanker, M.D.

Chairs: Gary Tsai, M.D., Rachel Lapidus, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Better understand the challenges of living with severe mental illness, both from the perspective of the patient and family members; 2) Better empathize with severely mentally ill clients; 3) Better recognize systemic areas of improvement that can be made to mental health systems; 4) Better recognize how advocacy can play an important role in patient care from a policy and systems-based perspective;

SUMMARY:

“One of the greatest diseases is to be nobody to anybody.”
- Mother Teresa

Over 13 million Americans suffer from severe mental illness, which include diseases such as schizophrenia and bipolar disorder. In the 1950s, inhumane treatment in mental asylums, the advent of promising new medications, and increasing budgetary concerns led to the widespread deinstitutionalization and release of over half a million people from psychiatric hospitals around the United States. The hope was that mental health clinics would be able to provide support and care for these vulnerable individuals. However, community resources were vastly insufficient to meet the needs of this population. While some have benefited from this cultural shift in care, others have slipped through the cracks. As mental health budgets continue to be targeted for cuts, these individuals are increasingly marginalized and neglected. *Voices* is a feature length documentary film that focuses on these individuals who live in the shadow of society, and provides a unique and honest glimpse into their lives. Some have been living on the streets for decades, others are now housed, but all are connected by their struggles, and successes, with mental illness. By shining a light on their experiences, we aspire to give them a voice and to humanize their experiences so that they are defined not by their disability or homelessness, but by their unique and compelling stories. More information at: <http://voicesdocumentary.com/index.html>

MEDIA WORKSHOP 5

THE IMPACT OF ILLNESS ON THE FAMILY: A VIEWING AND DISCUSSION OF “A SISTER’S CALL”

Speakers: Rebecca Schaper, Kyle Tekiela

Chair: Gregory W. Dalack, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Experience, in this unique film, the lifetime trajectory and significant impact of chronic mental illness on the affected individual and his family; 2) Appreciate that a committed support system, including family members, can work together to overcome conflict and estrangement to achieve recovery; 3) Recognize the courage necessary to confront difficult life experiences, and the importance of working together to overcome them; 4) Affirm the critical importance of confronting ignorance and stigma about mental illness so that proper diagnosis and engagement in treatment can occur;

SUMMARY:

“A Sister’s Call” is an incredibly moving documentary told by co-director Rebecca Schaper, describing the impact of severe paranoid schizophrenia on the life of her brother Call and their family. Like any family’s story, layers of complexity are revealed. Struggles with mental illness among other family members are countenanced and overcome, even as Call re-appears and works towards recovery after being missing for 20 years. Through this compelling narrative, we witness the effects of severe mental illness and the challenges inherent in working to heal old wounds and achieve recovery. In the course of this journey, we learn that the impact of mental illness runs deep, exacerbated by the negative effects of shame, ignorance and stigma in delaying access to necessary treatment and support. Finally, we come to appreciate the strength and resilience of a remarkable family, committed to helping each other, even as they struggle to help Call. The producers, Rebecca Schaper and Kyle Tekiela, will participate in a panel discussion after the film. A trailer for the film may be viewed at: http://www.asisterscall.com/A_Sisters_Call/A_Sisters_Call.html

MEDIA WORKSHOP 6

WE WERE HERE: A DOCUMENTARY ABOUT SURVIVING THE AIDS EPIDEMIC IN SAN FRANCISCO

Speaker: Bill Weber, B.A.

Chairs: Richard R. Pleak, M.D., Jose Vito, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Attendees will recognize the profound personal and community issues raised by the AIDS epidemic; 2) Attendees will understand “The San Francisco Model”, overcoming the obstacles of HIV/AIDS in the United States; 3) Attendees will learn the political and sexual complexities, the emotional toll, and the role of women – particularly lesbians – in caring for and fighting for gay men with HIV/AIDS;

SUMMARY:

The 2011 film “We Were Here” will be screened, followed by a discussion including one of the filmmakers and one of the film’s interviewees. “We Were Here” documents what was called the “Gay Plague” in the early 1980s, which started with reports of a “gay cancer” in San Francisco in 1981. It illuminates the profound personal and community issues raised by the AIDS epidemic as well as the broad political and social upheavals it unleashed. It offers a cathartic validation for the generation that suffered through, and responded to, the onset of AIDS. It provides insight into what society could, and should, offer its citizens in the way of medical care, social services, and community support. The film focuses on 5 individuals who lived in San Francisco prior to the epidemic. Their lives changed in unimaginable ways when their city changed from a hotbed of sexual freedom and social experimentation into the epicenter of a terrible sexually transmitted plague. From their different vantage points as caregivers, activists, researchers, as friends and lovers of the afflicted, and as people with AIDS themselves, the interviewees share stories which are not only intensely personal, but which also illuminate the much larger themes of that era: the political and sexual complexities, the terrible emotional toll, the role of women – particularly lesbians – in caring for and fighting for their gay brothers. Early in the epidemic, San Francisco’s compassionate, multifaceted, and creative response to AIDS became known as “The San Francisco Model”. The city’s activist and progressive infrastructure that evolved out of the 1960’s, combined with San Francisco’s highly politicized gay community centered around the Castro Street neighborhood, helped overcome the obstacles of a nation both homophobic and lacking in universal healthcare. In its suffering, San Francisco mirrors the experience of so many American cities during those years. In its response, The San Francisco Model remains a standard to aspire to in seeking a healthier, more just, more humane society. 2013 marks 32 years since AIDS descended. Like an unrelenting hurricane, the epidemic roiled San Francisco for two decades and only began granting some reprieve with medical advancements in the late 90s. The death years of AIDS left the City ravaged and exhausted, yet, as in most of the developed world, the worst seems past. Though thousands are still living with HIV, and new infections continue at an alarming rate, the relentless suffering of the 80s and 90s has given way to a kind of calm, and, understandably, a degree of willful forgetfulness. “We Were Here” utilizes San Francisco’s experience with AIDS to open up an overdue conversation both about the history of the epidemic, and the lessons to be learned from it.

MAY 20, 2013

MEDIA WORKSHOP 7

SAYING GOODBYE: A STIMULUS VIDEO DOCUMENTARY OF ATTACHMENT AND LOSS AT THE END OF LIFE

Chair: Geraldine Fox, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe common psychological stages and challenges of old age and end-of-life decisions; 2) Reflect on ways to provide empathy and support when caring for elderly and dying patients, as well as their families; 3) Reflect on our individual experiences of aging and loss in our own families and cultures, and how these experiences and beliefs may inform our professional reactions;

SUMMARY:

End-of-life presents a complex series of decisions and emotional challenges to the individual, family, and health professional, including end-of-life decisions, differentiation of depression from an informed decision about treatment termination, and collaborative decision-making. Psychiatrists need to develop empathic skill in working with families who are dealing with losing a loved one. The use of carefully chosen stimulus video clips provides one method of engaging participants in discussion about complex issues, fostering empathic connection, and encouraging higher-order learning. At this Media Workshop, Dr. Fox will share a personal 40-minute stimulus video of her father, entitled “Saying Goodbye.” Just as attachment is a bidirectional process creating bonds between loved ones, so “Saying Goodbye” portrays the mutually painful yet loving acceptance of impending loss (Bowlby). In this short video journal of events from the fall of 2009, Dr. Fox’s father shared his decision-making process with his daughter as he concluded that it was time for his life to end. The process of family coming to terms with his decision is also shown. Attendees will be encouraged to discuss the issues raised by these video clips in relation to common clinical situations encountered in our practices, and the ways in which our personal experiences with loss may impact our professional roles as physicians. Note: This video has been constructed as a curriculum resource with an accompanying teacher’s manual. The manual will be available for reference for interested participants who may be educators or consultants to hospice or palliative care organizations. Quick Guide to “Saying Goodbye”: Submenu clip titles and length of each clip (15 clips, four parts, 38 minutes total) Saying Goodbye (:32): Introduction PART 1-Prologue (Si, age 89 and age 95) #1 (:54): “Super Dad” Si #2 (3:18): “Why keep on living?” PART 2- August-October 2009 (Si, age 97) #3 (:35): “Not too many more birthdays” wish #4 (2:18): “like lambs to the slaughter” #5 (2:02): what are their care options? #6 (1:55): difficult to add, gets angry at self #7 (4:26): “promise you’ll stick around?” #8 (3:45): “You’ve been the love of my life” #9

(2:01): agonizing at airport

PART 3-November 2009 (Si, age 97)-Three weeks later #10 (1:24): "The time has come" #11 (2:05): "I don't want all this crap to keep me alive" #12 (4:35): a comforting lie for Cele #13 (:45): "I want you to go on living" PART 4-Epilogue (November-December 2009) #14 (2:37): "My Song" #15 (3:25): "Where's Si?" Credits (1:05)

MEDIA WORKSHOP 8

A CASE OF XENOGLOSSY AND THE NATURE OF CONSCIOUSNESS

Speakers: Jonathan Lieff, M.D., William M. Harvey, Ph.D., R.Ph., Narendranath Reddy, M.B.B.S., M.D., G. Venkataraman, Ph.D.

Chair: Samuel H. Sandweiss, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To broaden our understanding about consciousness; 2) To broaden our understanding about the importance of spiritual issues in our patient's lives; 3) To increase awareness about the importance of cross cultural factors in understanding our patients; 4) To increase awareness about how alignment of values and behavior reduces anxiety and depression and broadens consciousness;

SUMMARY:

Is consciousness an outgrowth of the physical brain -- or is it something more fundamental, perhaps the primary substance of reality? This centrally important and relevant question in science today is addressed by the following case. In June – July, 1983, in San Diego, CA, I observed and videotaped remarkable phenomena in the course of treating a 32-year-old female Caucasian patient who suffered from a severe headache disorder. Having dropped out of high school and without having had prior knowledge of Sanskrit, my patient spontaneously began to speak Sanskrit fluently, write it down phonetically, and translate it into English. Two Sanskrit scholars verified that most of the words were clearly Sanskrit, some were distortions that closely resembled Sanskrit words, and a very few were English. They felt that it would be impossible for the patient to have learned this language simply to impress a psychiatrist – let alone be able to express such spiritually sophisticated ideas expressed in the notes. This case provides compelling information about the possibility that consciousness extends beyond our physical brain and personal life experience, as my patient communicated complicated information she had no plausible way of knowing otherwise. Although these phenomena cannot be explained by Western scientific concepts, similar accounts have been described in yogic literature and the Sanskrit notes clearly declare the primacy of consciousness consistent with Vedantic teachings. Dr. Jon Lieff, a pioneer in geriatric psychiatry, past-president of the American Association for Geriatric Psychiatry (AAGP),

consulting editor of the American Journal of Geriatric Psychiatry for 10 years, will discuss the case in light of current findings about extraordinary mental states including accidental savants with increased cognitive and artistic capabilities, experimentally stimulated out of body experiences, near death experiences, psychedelic experiences, meditation and spiritual experiences. Can this case be explained as related to these phenomena? Dr. William Harvey will discuss some relationships between spirituality and psychology and the experience of "I". I have created a 45 min video describing this case, including showing raw footage of the patient speaking Sanskrit, describing her experience and the meaning of the notes -- and including discussions with a student of Sanskrit about the validity and meaning of the notes. The video touches on the path of expanding consciousness described in Eastern traditions including the importance of values and community on the spiritual journey.

MEDIA WORKSHOP 9

SHAME AND THE SEX ADDICT: MANAGING SEXUAL COMPULSIONS IN THE TIME OF DSM-5

Speaker: Keith Hermanstynne, M.D., M.P.H.

Chairs: Petros Levounis, M.D., Tauheed Zaman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Assess individuals with sexual compulsions; recognize diverse clinical presentations; and diagnose sex addiction; 2) Identify three dysfunctional dynamics among patients with sex addiction; 3) Discuss common elements shared by sex addiction, other behavioral addictions, and substance use disorders; 4) Apply Motivational Interviewing approaches to the management of sex addiction;

SUMMARY:

"Shame" (2011, 101 minutes) raised many eyebrows when it debuted at the Toronto International Film Festival due to its graphic but masterful depiction of sex addiction. Brandon (Michael Fassbender) is a 30-something, stylish New York yuppie who balances a successful profession with a personal life fueled by compulsive sexual behavior. A visit from his younger sister Sissy (Cary Mulligan), lost and self-destructive in her own right, disrupts this balance and sends both characters spiraling out of control. Featuring career-defining performances by both leads, "Shame" explores the intersection of intimacy, isolation, heartbreak, and addiction in the modern world through an unusual lens. Recently, both the American Psychiatric Association and the American Society of Addiction Medicine have accepted behavioral addictions under the umbrella of more traditional addictions, namely substance dependence. Behavioral addictions will likely gain new prominence under the DSM-5 as well. Given this context, the discussants will use "Shame" as a detailed case study to examine the cultural and scientific contexts of sex addiction, the difficulties of defining compulsive behaviors in the DSM, and the clinical approach to the assessment and management

of sexual compulsions. We will discuss the psychodynamic underpinnings of the relationships vividly depicted in the film, and broaden these to an understanding of the conflicts and experiences common to many other types of addiction. Finally, we will develop a bio-psycho-social formulation based on our case study, discuss a potential treatment plan, and provide resources to clinicians who treat patients with such disorders in their everyday psychiatric practice. The workshop is open to all clinicians who would like to study the assessment and management of sex addiction and its similarities to other addictions, but is particularly targeted towards members in training and early career psychiatrists.

MAY 21, 2013

MEDIA WORKSHOP 10

DOCUMENTARY FILM TITLED “UNLISTED: A STORY OF SCHIZOPHRENIA”

Speakers: Igor Galynker, M.D., Ph.D., Ira D. Glick, M.D., Delaney Ruston, M.D.

Chair: Michael S. Ascher, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand that the family as a system is affected by schizophrenia;2) Recognize that families of individuals who suffer from mental illness experience a myriad of emotions: anger, frustration, hopelessness, sadness, fear, anxiety, shame, and loss;3) Understand that family-oriented patient care includes communicating with families, helping them to understand and cope with mental illness, and considering family members as members of the treatment team;4) Identify resources in the community that can help families build a knowledge base, which can be a tool for families to assist their loved ones and themselves;5) Appreciate that research has shown over the last 40 years that family psychoeducation reduces relapse rates and improves function in all areas of severe mental illness;

SUMMARY:

Unlisted is a moving first person account of a physician's troubled relationship with her father who suffers from schizophrenia. Delaney Ruston, a Seattle general physician, went into hiding to protect herself from her dad's erratic behavior and episodes of paranoia. After more than a decade of separation she decides to reconnect. Dr. Ruston documents her reconciliation with her father in a film that exposes the pain that mental illness inflicts on families. As she works to overcome the obstacles to getting her dad appropriate treatment, the film exposes the failings of the American mental health system as experienced by the families trying to navigate it. The film is a soul-searching examination into the nature of responsibility of parents and children, of physicians and patients, of society and citizens towards those afflicted with severe mental illness. Following the screening of the film, a panel discussion will be

held with thought leaders in the field of family psychiatry.

MEDIA WORKSHOP 11

TEACHING CULTURAL COMPETENCY: IDENTIFYING AND CHANGING STEREOTYPES USING FILM WITH EMPHASIS ON GENDER IDENTITY DISORDER

Speakers: Dennis K. Lin, M.D., Asad Kirmani, M.D., Jack Pula, M.D.

Chairs: Prameet Singh, M.D., David Roane, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Acquire a better understanding of Gender Identity Disorder and the proposed classification changes in the DSM-5 and the standards of care;2) Become familiar with some of the barriers that trainees may have in working with transgender patients arising from lack of knowledge as well as preexisting beliefs and attitudes;3) Learn to use film to begin to modify attitudes and behavior in any area where bias and stigma affect the delivery of mental health care;

SUMMARY:

Amongst the six core competencies taught throughout medical education, professionalism is perhaps the hardest to codify. The ACGME includes under professionalism, the ability to consider and work with patients of diverse cultures, ethnicity and sexual orientation. Despite the increased acceptance of gays and lesbians in our culture and society, there remain biases and stereotypes that influence the care that such patients receive in the medical system. Transgendered patients are even more marginalized and Gender Identity Disorder is often ignored or swept under the rug. Encountering such patients strikes discomfort in most clinicians, who may be only partially aware of their attitudes and the effect these have on the treatment relationship. Even as a specialty, Psychiatry continues to grapple with this cohort of patients and the DSM 5 task force has debated whether Gender Identity Disorder should be revised, renamed, or eliminated as a pathological entity. This leads to further perplexity on the part of our trainees who most often remain unaware of their own attitudes and biases, particularly when working with transgendered patients. This workshop describes a program we developed to raise residents self-awareness about their own attitudes towards transgendered patients. A documentary film, entitled “Curing Gender”, produced and directed by a psychiatry resident, was screened at two residency programs. The documentary includes depictions of several transgendered individuals and interviews with experts in both transgender and cultural aspects of gender. The film screening was followed by a discussion lead by a moderator with knowledge in this area. After the discussion, participating residents completed a three part reflective statement that enquired about their existing beliefs, and changes in attitude and behaviors following the program. The workshop will begin with a brief overview of the nosol-

ogy of Gender Identity Disorder, and some of the proposed changes in both DSM5 and in the standards of care of transgendered individuals. It will include a screening of scenes from the film, a review of some of our residents' reactions to the film and a discussion led by the film director that will allow participants to reflect on their own beliefs about transgender.

MEDIA WORKSHOP 12

LEAVING PLEASANTVILLE: EXPLORING THE MOVIE "PLEASANTVILLE" AS A WAY TO IDENTIFY AND TREAT OBSESSIVE CHARACTER STRUCTURES

Speakers: Joseph Insler, M.D., Nina Tioleco, M.D.

Chair: Eric Yarbrough, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize obsessional defenses and relational patterns in patients; 2) Understand how obsessional people function and recognize its effects on their professional and personal lives; 3) Understand how to treat the obsessional patient in both psychotherapy and with psychopharmacology; 4) Develop better treatment plans and goals for obsessional patients;

SUMMARY:

The obsessional patient has been a subject of analytic writing since the time of Freud. While they tend to be highly successful and organized, the obsessional character can have long-term relational patterns that can cause frustration and barriers to intimacy. They tend to take their obsessional defenses, which work well in their professional lives, and apply them to their personal relationships. Because of their rules and pattern-driven lives, they create cages for themselves. These cages have no real walls and their doors are always open. Our jobs as psychiatrists and therapists are to show the obsessional patient out of their cages and create a free space for them to experience life without all the rules. The movie Pleasantville represents an entire town of obsessional characters. Through the addition of two outsiders, the metaphorical therapists, the people in Pleasantville start to change in a way that adds richness and depth to their lives. This workshop will show participants how to take this information and apply it to those patients who suffer from the cages of their obsessional defenses. By the end of the workshop, participants will be more skilled at identifying and treating obsessional characters.

MAY 22, 2013

MEDIA WORKSHOP 13

HOW TO BE AN ETHICAL THERAPIST: LESSONS NOT LEARNED FROM HOLLYWOOD MOVIES

Chair: Mark Komrad, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To consider the role that movies have in educating the public about who therapists are and what they do; 2) To view movies clips that represent some common lessons from movies about therapist behaviors in sessions, and to critique the ethics of those examples; 3) To appreciate how movie portrayals affect patient expectations of what will happen in treatment, and how to work with those common perceptions and misperceptions;

SUMMARY:

If one were to learn about the ethics of psychiatric treatment and the behavior of psychiatrists strictly from Hollywood movies (the only teaching resource for most of the public), what conclusions would be drawn? The depictions of psychiatrists and their clinical conduct in contemporary blockbuster movies is largely at variance with typical clinical reality. Movies are rife with boundary violations, exploitation, dual-relationships, pathological paternalism, and all other manner of ethical mischief on the part of psychiatrists and related professionals. This workshop will review just what the public is learning about us from the movies, what we may be learning about ourselves, and how art meets reality in the construal of what are appropriate ethical norms in psychiatric treatment. Come watch some remarkable movie excerpts, and be afraid....be very afraid!

MEDIA WORKSHOP 14

A MOVIE ON TWO DISEASES, ADHD AND PARKINSON'S, AND THEIR IMPACTS ON GROWTH, DEVELOPMENT, INTERPERSONAL RELATIONSHIPS, SEX, LOVE, MEDS, AND OTHER DRUGS

Speaker: Lawrence Richards, M.D.

Chair: Lawrence Richards, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Comprehend the overt and the unstated, the conscious and the unconscious, and the details and the dynamics of the lives of the two main characters in this motion picture story; 2) Enable continuing education presentations and discussions between presenters and attendees regarding ADHD and Parkinson's Disease. An Audience Response System augments this greatly; 3) Discuss on forms of Parkinson's Disease, including the differential diagnosis of tremor, and

discussions about the history and forms of ADHD;4) Understand the process of the treatment of ADHD and Parkinson's Disease will be described, including the 'gap' between the extent of knowledge before, during, and after the making of the movie;5) Be appraised of the major advances in neurosurgery for Parkinson's, including use of iMRI in the implantation of stimulative electrodes for treatment with Deep Brain Stimulation;

SUMMARY:

The story primarily occurs in 1990s Pittsburgh and eastern Ohio areas. While trying to persuade her physician to use Pfizer products Gyllenhaal's Jamie, a smooth-talking pharmaceutical rep, meets Hathaway's Maggie, a once aspiring artist with early onset Parkinson's Disease. The attraction is instant. While he and his Pfizer supervisor work on a transfer from Ohio to Illinois, Jake and Maggie's fling develops into an actual relationship, because as Maggie puts it: "God, you have latent humanity after all." On the comic side, Jamie battles a rival rep, switches from Sertraline to Viagra which results in considerable popularity at doctors' offices, and gains a roommate in his financially successful but socially inept brother. On the dramatic side, he gets a glimpse of Maggie's world, which involves her organized geriatric medication buying trips to Canada- and the intermittent loss of motor skills. Her humanity forms a therapeutic working through for him, which in turn causes him to value her more over time. Maggie is traumatized by knowing her diagnosis and how miserable her life could become, so she seeks refuge in intense, often sexual, mini-relationships while avoiding any true commitment which would force her to face the major losses she expects to befall her as her CNS deteriorates. Jamie's life has been a role of the loser who never could make it to med school and follow in his father's footsteps because his ADHD blocked graduating from college. Jamie is the eldest in a sibship of 3, with his sister an M.D. and his little brother a millionaire from his software company IPO. ADD apparently also interfered with Jamie ever taking anything seriously, and eventually he found refuge in sex as he was excellent there - even in grade school he realized girls thought him to be genuinely likable. Both Maggie and Jamie use sex as an adjustment to their personal pain; for one, sex is his forte of success and for the other it's her distraction from worry and despair. The movie has some early farcical "big pharma" scenes, but both lead characters clearly show the psychopathology and the efforts at adjusting and overcoming. It is their truly loving one another that temporarily causes his going "a little nuts" over his efforts to save her, which not only ruins their joy together, but triggers her decision, ostensibly, that they should break up, as she doesn't want to drag him down. She, while heroic in some way, is seen sobbing over her loss, as she resumes her old adjustment patterns, which includes waitressing and helping the elderly get to Canada to buy their meds cheaper, which she needs also. He quietly, confusedly, leaves her, has some despondency, but adjusts and wins the Pfizer promotion to Chicago territory because of his success detailing Viagra. While packing in his apt, he finds their old mutually made video, plays it, achieves insight, works it through, is able to perceive a plan, and can now go into action.

PRESIDENTIAL SYMPOSIUM 1**ENVISIONING A NEW PSYCHIATRY: RADICAL PERSPECTIVES**

Discussants: Helena Hansen, M.D., Ph.D., Sami Timimi, M.D.

Chairs: Carl I. Cohen, M.D., Kenneth Thompson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how globalization, environmental changes, and economic disparities affect mental well-being.;2) Understand the limitations of the biomedical/ technological paradigm with respect to treatment outcomes, nosology, and its ability to integrate broader social transformations.;3) Recognize the importance of the consumer's role in care with respect to empowerment and self-determination, and in the use of modalities within and outside of traditional psychiatry.;4) Identify ways in which a new psychiatry paradigm can help in understanding how to further liberation at the individual and social level.;

SUMMARY:

Pinel's unchaining of the 18th century Parisian insane in the aftermath of the French Revolution has been an historical metaphor for the emancipatory underpinnings of psychiatry that links it to medicine and science as well as to sociopolitical circumstances. This symposium rests on two foundational points: (1) The project of psychiatry includes the promotion of emancipation; (2) Psychiatry's principal object, the mind (psychological sphere), is inherently biological and social. Viewed from this perspective, psychiatry has a necessary role in understanding how to further liberation at the individual and social levels. For several decades, psychiatry has pursued a narrow technological approach, focusing on specific disorders within a biomedical paradigm. This has produced important achievements. However, it has not reduced the prevalence of mental disorders nor appreciably improved long term outcomes. At the same time, there have been enormous social, economic, political, and environmental upheavals throughout the globe that have had a marked impact on psychological well-being. Psychiatry is well-positioned to explore the subjective ramifications of living in various social formations and the psychological impact of domination, alienation, or of being in a particular class, gender, or ethnic group. The prevailing biomedical/technology paradigm has been ill-equipped to address these pressing concerns. There is ample evidence that the current paradigm has reached its limits and is in crisis, and that a new paradigm is needed. This session's underlying theme is that a new psychiatry must assist people to be "free from" the effects of internal biological forces that contribute to mental illness but also from social circumstances that can hinder psychological development or produce psychological distress. Moreover, consistent with the presidential theme, we envision an evidenced based "positive psychiatry" that can assist persons to be "free to" flourish and lead self-directed

lives. This session builds on a project of the Radical Caucus of Members of the APA in the USA and the Critical Psychiatry Network in the UK, and that was initially published in 2008 (Liberatory Psychiatry, Cambridge Press). The presentations will address the following: (1) The impact of globalization on mental health, particularly on social bonds; (2) The socio-economic factors that shape mental illness and distress; (3) How environmental changes such as global warming and pollution are affecting mental well-being; (4) A critique of the biomedical /technological paradigm that will explore how mental health problems reach beyond the brain and involve social, cultural and psychological dimensions; (5) The importance of the consumer's role in care with respect to empowerment and self-determination, and in the use of modalities within and outside of traditional psychiatry. Presenters will offer their visions of how a new psychiatric paradigm can address these concerns.

NO 1**GLOBALIZATION AND MENTAL HEALTH: THE WEIGHT OF THE WORLD, THE SIZE OF THE SKY**

Speaker: Jean Furtos, M.D.

SUMMARY:

It is now well accepted that the health and well-being of people are dependent on their social circumstances. In France, the term "psychosocial" captures the indissoluble interaction between what belongs to the subject and what belongs to social life, i.e., the social bonds of life. In this sense, the increasing globalization of the economic and cultural system is producing pronounced psychosocial effects all over the planet. Globalization is reconfiguring social bonds-- at times tearing them asunder, often generating profound anxiety and insecurity. Globalization affects the very notions of the future and the meaning of life. This presentation will specify the current pathologies of social bonds and their mechanisms, the necessity of reinterpreting psychiatric distress, and the need for further research on the emerging ecology of social bonds. It will also describe the possible antidote of a reinvigorated global solidarity and the role that psychiatrists might play in this effort.

NO 2**RE-ENGAGING RESEARCH AROUND THE SOCIAL AND ECONOMIC PRODUCTION OF MENTAL HEALTH: TOWARD A COMPREHENSIVE MODEL OF MENTAL ILLNESS**

Speaker: Sandro Galea, M.D.

SUMMARY:

It is well-established that macrosocial/economic factors affect the commonest mental disorders. Modern epidemiological methods can isolate specific effects and identify targets for interventions. Manipulation of large-scale social/economic

factors may improve mental health far more, and more cost-effectively, than do personalized genetic/molecular interventions. However, the prevailing research focus has been on the genetic/molecular drivers. Although useful, it has resulted in the neglect of research that considers how social/ economic factors shape mental health. We argue for a comprehensive research agenda that re-engages the social /economic production of mental health and how these forces influence downstream molecular mechanisms to produce mental illness. We will use empirical examples to illustrate the limitations of a narrowly defined, individual-based approach to improving mental illness and the potential of an approach that targets large-scale social /economic forces.

NO 3

BEYOND THE TECHNOLOGICAL PARADIGM: A POSITIVE PATH FOR PSYCHIATRY

Speaker: Pat Bracken, M.D., Ph.D.

SUMMARY:

Since it's origins in the asylums of the 19th century, psychiatry has been guided by a technological paradigm. Through this mental health issues 'show up' as technical problems to be classified, modelled and fixed. The non-technical aspects of our work (relationships, meanings and values) are not ignored but they are of secondary importance only. There is accumulating empirical evidence that this ordering of priorities is simply wrong. Increasingly, the non-technical aspects of mental health care are being revealed as of primary import. A post-technological psychiatry would not abandon current understandings and interventions but would position these as secondary to a more fundamental ethical and hermeneutic discourse. This would allow for the development of a psychiatry that was more genuinely scientific and transparent. It would also be a psychiatry that could work more positively with the growing international movement of consumers and survivors.

NO 4

ECO-PSYCHIATRY: WHY WE NEED TO KEEP THE ENVIRONMENT IN MIND

Speaker: Steven Moffic, M.D.

SUMMARY:

Evidence that ecological challenges are becoming more mainstream is reflected in the central conflict in the revival of the television series "Dallas". Many of the psychological issues related to ecology are embedded in the plot: the quest for wealth that still exists in oil; the uncertainty in exploring alternative energy sources; and the need for some psychological intervention.

Nevertheless, ecological challenges have important psychological and psychiatric ramifications. This presentation will describe how the environment can impact individuals and patients, using global warming, noise pollution, and designing

therapeutic settings as examples. In addition, the powerful psychological processes that are diverting our attention from the environment will be examined, such as the denial of danger, narcissistic needs, and rationalization.

This presentation will use a variety of educational processes - including multi-media - to indicate the potential role of psychiatrists.

NO 5

ALTERNATIVE, COMPLIMENTARY, OR TRADITIONAL: A RADICAL PSYCHIATRY APPROACH FROM THE C/S/X PERSPECTIVE

Speaker: Keris J. Myrick, M.B.A., M.S.

SUMMARY:

The C/SX movement "nothing about us without us" approach requires a radical revisioning of psychiatry inclusive of patient choice, empowerment and self-determination in how,when and where wellness is achieved.A radical psychiatry approach must include an acceptance that oppressed people must move from silence to speech in an act of talking back that is healing and a means of moving us from object to subject through our liberated voice. This voice imbues psychiatry with our understanding of Dx in terms of social context and the achievement of wellness through modalities within and without traditional psychiatry. The use of alternative "treatment" to achieve wellness, recovery and internal locus of control for ones well-being is well documented.Soteria Communities, self-help support groups, peer services, peer run crises respite and Open Dialogue are examples of approaches that fit along the continuum of alternative, complimentary and traditional psychiatric treatment.

PRESIDENTIAL SYMPOSIA

MAY 18, 2013

PRESIDENTIAL SYMPOSIUM 2

FORENSIC PSYCHIATRY FOR THE GENERAL PSYCHIATRIST: A PRACTICAL GUIDE FOR LEGALLY-SOUND ASSESSMENTS AND TREATMENT

Chair: Charles Scott, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify risk factors for violence in paranoid patients.;2) Recognize five motives regarding homicidal actions of a parent toward their child.;3) Identify clinical and legal issues relevant to a psychiatrist's "duty to protect";4) Assess capacities in individuals who may have challenges with personal treatment decision making.;5) Recognize malingered PTSD symptom presentations.;

SUMMARY:

Forensic psychiatry focuses on mental health issues that interface with the law. This fascinating field, however, is not an esoteric isolated subspecialty. As our mental health and legal systems became increasingly and inextricably intertwined, mental health providers need to maintain an updated understanding of important fundamental principles that govern their assessments and treatment. This symposium reviews six key topic areas relevant to both general psychiatric practitioners and forensic psychiatrists. Practical guides in the assessment and treatment of psychiatric patients will be reviewed. Key issues address include violence risk assessment in paranoid patients, assessment of parents who murder their children, review and update on a psychiatrist's "duty to protect," assessment of decision making capacities in psychiatric patients, legal issues related to recovered memories, and evaluation of malingered PTSD.

NO 1**PARANOIA AND VIOLENCE**

Speaker: Phillip Resnick, M.D.

SUMMARY:

Paranoid delusions are more likely to result in serious violence than any other type of delusion. Of all persons found not guilty by reason of insanity for murder in the United States, 80% killed in response to a paranoid delusion. Paranoid delusions are seen in over 50% of persons with schizophrenia, 44% of persons with psychotic depression, and 31% of persons with dementia. This presentation will identify the risk factors for violence in paranoid patients. Four motives for paranoid violence will be described: self defense; defense of manhood; defense of children; and defense of the world. Case examples will be used to illustrate each of these motives. Over 96% of paranoid persons engage in safety behaviors each month. These include avoidance of dangerous activities, increased protection of self, decrease of their visibility to be less vulnerable, and to enhance their vigilance. Assessing violence risk and distinguishing making a threat vs. posing a threat are reviewed.

NO 2**CHILD MURDER BY PARENTS**

Speaker: Phillip Resnick, M.D.

SUMMARY:

No conduct puzzles the average person more than a mother killing her own child. This presentation will offer a classification of parents who kill their children (filicide). Parents who kill their children usually act on one of the following five motives: (1) Altruistic - These parents kill their children in an extended suicide or in a delusional belief that their children are better off in heaven. Andrea Yates' drowning of her five children is an example. (2) Acutely psychotic – These parents

kill in an acute psychosis with no comprehensible motive. (3) Unwanted child – These parents believe that their children are somehow standing in their way. (4) Child maltreatment – These parents engage in fatal "battered child syndrome" behavior. (5) Spouse revenge – These parents want to bring suffering to their partner.

Mothers who kill their newborn child tend to be younger, unmarried, and are much less likely to be psychotic or depressed than parents who kill older children.

NO 3**TARASOFF: THE ORIGIN AND EVOLUTION OF THE DUTY TO PROTECT**

Speaker: Debra Pinals, M.D.

SUMMARY:

In *Tarasoff v. Regents of the University of California* (1976), the Supreme Court of California issued a landmark legal decision that changed the face of psychiatric care by establishing a duty to protect third parties at risk of harm by a patient after such risk of harm becomes known to a psychotherapist. The case stemmed from a situation in which a patient had expressed to his therapist that he had thoughts of killing a young woman, Tatiana Tarasoff, and later carried out his plan. A lawsuit emerged, leading to the Court's decision. Since that time, most states have established statutes that delineate clinician duties relevant to the protection of third parties who may be at risk. At the same time cases have continued to unfold leading to litigation and court rulings that have extended applicable scenarios to include a duty to protect the public at large from harm at the hands of a psychiatric patient.

NO 4**CAPACITY TO MAKE TREATMENT DECISIONS**

Speaker: Debra Pinals, M.D.

SUMMARY:

In the United States, all adults are presumed competent unless a court has adjudicated them as incompetent or incapacitated to make decisions for themselves. In those instances, typically a guardian would be assigned to take over the decision-making function of the individual. Outside of court processes, a physician can also verify in a medical record that a patient has lost capacity, which would allow a health care proxy or other type of substitute decision-maker to render treatment decisions on behalf of the incapacitated individual. Given the importance of clinical capacity determinations, it important to have a basic understanding of the assessment of individuals who may have challenges with personal decision-making. Capacity determinations include assessments of the individual's ability to 1) make a choice, 2) factually understand the information relevant to the decision, 3) rationally manipulate the information, and 4) appreciate the nature of one's situation.

NO 5**RECOVERED MEMORIES AND MALPRACTICE**

Speaker: Charles Scott, M.D.

SUMMARY:

A therapist's use of techniques designed to retrieve "recovered memories" remains a controversial area in the field. The reality of recovered memories has triggered a near epic academic battle between two "memory" camps. Recovered memory proponents cite literature indicating that over 50% of women have experienced amnesia for a forced sexual experience that occurred prior to age 18. Research indicates that adults can have false memories for events that have never occurred, particularly when suggestive techniques are used when questioning an individual. Nationally prominent legal cases in the United States will be presented that highlight issues related to the admissibility of recovered memory testimony in criminal trials, medical malpractice lawsuits related to alleged iatrogenic causation of Dissociative Identity Disorder, and medical malpractice lawsuits related to harm to third parties.

NO 6**EVALUATING MALINGERED PTSD**

Speaker: Charles Scott, M.D.

SUMMARY:

The U.S. Department of Veterans Affairs (VA) provides disability benefits to service members determined to have service-connected medical or mental conditions. Benefits are potentially wide ranging and may include cash benefits, free medical care, rehabilitation and employment services, as well as educational and health insurance benefits for family members. Although a PTSD diagnosis may present in all types of disability evaluations, PTSD is the most prevalent compensable mental disorder within the U.S. Department of Veterans Affairs disability system with significant associated financial costs. . A significant number of service members clearly have a legitimate service connected disability; however, there is also evidence that a significant number may malingering their symptoms. This presentation reviews clinical indicators of malingered PTSD and various psychological testing strategies to assess feigning of PTSD symptoms.

PRESIDENTIAL SYMPOSIUM 3**PSYCHOTHERAPY: EXPANSE, EDUCATION, AND EFFICACY**

Chair: Salman Akhtar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Enumerate the new methods of psychotherapy education.;2) Identify the chief characteristics of cognitive behavior therapy.;3) Cite the evidence for cost-effectiveness of psychotherapy.;

SUMMARY:

This symposium will address the important place of psychotherapy in the profession of psychiatry. By elucidating the centrality of 'talking cures', this symposium will seek to redress the schism that has regrettably developed between the so-called biological orientation of the field and its fundamental psychological focus. Attention will be paid to psychodynamic paradigms as well as to the newly-emergent and widely accepted cognitive behavioral models of psychotherapy. New and advanced ways of teaching psychotherapy will be highlighted and empirical evidence for the efficacy and cost-effectiveness of psychotherapy will be demonstrated.

NO 1**COGNITIVE BEHAVIOR THERAPY IN PSYCHIATRIC PRACTICE**

Speaker: Jesse H. Wright, M.D., Ph.D.

SUMMARY:

There are many challenges for psychiatrists who want to incorporate evidence-based psychotherapy into their clinical practices. These challenges include receiving adequate training in therapies such as CBT and finding ways to perform therapy in sessions that are briefer than the traditional "50-minute hour." This presentation details: 1) educational methods and resources for effective learning of CBT; 2) the impact of education on treatment efficacy; 3) methods of using CBT in brief sessions; and 4) technologies that can enhance CBT and improve the efficiency of treatment.

NO 2**OBJECTIVES, FORMULATION, AND VIDEOTAPE: PSYCHOTHERAPY TRAINING TODAY**

Speaker: Deborah L. Cabaniss, M.D.

SUMMARY:

DBT, IPT, CBT, psychodynamic psychotherapy – today there are a multitude of psychotherapies for us to learn, use, and teach. Doing this requires us to use new methods to give our

students the psychotherapy skills that they will need in their work with patients. Dr. Cabaniss will discuss new ways of thinking about psychotherapy education in the 21st century.

NO 3

STUDIES ON THE COST-EFFECTIVENESS OF PSYCHOTHERAPY

Speaker: Susan G. Lazar, M.D.

SUMMARY:

This presentation will review the growing body of evidence that psychotherapy is cost-effective for many conditions, reduces disability, morbidity, mortality, provides at times a reduction of medical and surgical costs, and is not overused or abused by those not truly in need. For schizophrenia, borderline personality disorder, depression, medical patients with concomitant psychiatric illness and patients with more chronic anxiety, depression or personality disorders requiring extended and intensive psychotherapy, the majority of the studies available document the cost-effectiveness of the psychotherapeutic treatments studied.

NO 4

THE UNFORTUNATE MARGINALIZATION OF PSYCHOTHERAPY IN THE PRACTICE AND TRAINING OF PSYCHIATRY

Speaker: Salman Akhtar, M.D.

SUMMARY:

Dr. Akhtar will give a 10-minute introductory talk in which he will discuss . He will emphasize the importance of keeping psychotherapy within the confines of psychiatry and not relegating it to other mental health professionals. Following this, he will introduce the three speakers and their topics. After each speaker, he will summarize their main points in a 5-minute précis. At the end of the third speaker's talk, he will raise some questions and then invite a discussion between the panelists first, and then from the floor.

MAY 19, 2013

PRESIDENTIAL SYMPOSIUM 4

MEETING THE EDUCATIONAL NEEDS OF RESIDENTS AND EARLY CAREER PSYCHIATRISTS

Discussant: John M. Oldham, M.D.

Chairs: Cesar A. Alfonso, M.D., Silvia W. Olarte, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify basic principles of psychodynamic psychotherapy and learn clear methods and different approaches for

teaching psychodynamic psychotherapy to trainees and early career psychiatrists;2) Become aware of educational outreach initiatives using telemedicine videoconferencing to enhance psychodynamic psychotherapy clinical supervision in underserved or remote areas with scarce resources;3) Consider a new educational paradigm where residents would learn cognitive behavioral psychotherapy skills before mastering psychodynamic psychotherapy skills;4) Understand how to integrate psychodynamic teaching into child and adolescent psychiatry clinical settings;5) Learn how group process experiences as an educational tool can complement individual psychodynamic psychotherapy supervision for trainees;

SUMMARY:

Teaching psychodynamic psychotherapy to busy residents is a challenging endeavor but can be effectively accomplished using different methods in a variety of settings. Experienced educators in leadership positions will illustrate how to integrate psychodynamic principles in psychiatric education. A psychiatric resident will give a trainee's perspective and the APA Immediate Past President will serve as the symposium's discussant. The first presenter, Dr. Deborah Cabaniss, Director of Psychotherapy Training at Columbia University, will describe the importance of using clarity to teach complexity. Clear language, topics, and readings help residents to understand what psychodynamic psychotherapy is and to feel that they can conduct it with their patients. She will discuss methods for teaching psychodynamic psychotherapy, including approaches for teaching both technique and formulation. The second presenter, Dr. Jeff Katzman, Vice Chair for Education at the University of New Mexico, will describe educational outreach initiatives with a focus on creating opportunities for training in psychodynamic psychotherapy in areas with limited resources. He will describe pilot programs aimed at the development of a national supervision program in psychodynamic psychotherapy. The third presenter, Dr. Joanna Chambers, Director of Residency Training at Indiana University, will challenge the conventional practice of teaching psychodynamic principles to residents before cognitive behavioral therapy principles. She will discuss the possible benefits and complications of reversing this order. The fourth presenter, Dr. Debra Katz, Vice Chair for Education at the University of Kentucky, will focus on teaching psychodynamic principles to child and adolescent psychiatry residents. Through a series of brief vignettes, Dr. Katz will illustrate ways to help residents broaden their psychodynamic understanding of patients and to make psychodynamically informed interventions. The fifth presenter, Dr. Heather Furuhar-Graff, a PGY2 psychiatric resident at the Institute of Living, will offer her perspective on how group process can offer formative experiences in psychodynamic education. Each presentation will offer practical ideas for integrating psychodynamic teaching into real-world clinical and educational settings. There will be ample time for audience questions and discussion. This symposium is sponsored by the American Academy of Psychoanalysis and Dynamic Psychiatry, an allied organization of the APA.

NO 1**USING CLARITY TO TEACH COMPLEXITY**

Speaker: Deborah L. Cabaniss, M.D.

SUMMARY:

Clear language, topics, and readings help residents to understand what psychodynamic psychotherapy is and to feel that they can conduct it with patients. Too often, psychotherapy is taught using language and readings that were originally written for advanced practitioners. This material often confuses and alienates the early learner. On the contrary, clear, operationalized materials that not only transparently teach concepts, but also do so in a way that feels experience near to today's trainees and early career psychiatrists, engages and excites them about psychodynamic psychotherapy. These principles are essential when teaching both technique and formulation. Dr. Cabaniss, who is Director of Psychotherapy Training at Columbia and who has written a widely used textbook, will discuss her methods for teaching in this way in each of these areas. She will also introduce new ideas about teaching psychodynamic formulation from her book on this topic, which will be published in 2013.

NO 2**EDUCATIONAL OUTREACH IN PSYCHODYNAMIC PSYCHOTHERAPY TRAINING**

Speaker: Jeffrey Katzman, M.D.

SUMMARY:

This presentation will describe endeavors to create opportunities for training in psychodynamic psychotherapy in areas with limited resources. The presentation will share a unique telesupervision program developed at the University of New Mexico, where supervisors from around the nation are connected to a weekly case conference with residents in Albuquerque. The impact of these case conferences on resident recruitment, training, and faculty development will be shared. The presentation will then move into potential applications for a national program linking residents at programs outside of major urban centers. Initial experiences with this format on a national level will be shared with the group including methodologies for program development, and barriers to creating a national case conference. The program will conclude with a discussion of potential applications of this technology to other areas of psychiatric education.

NO 3**THE PSYCHIATRY RESIDENCY PSYCHOTHERAPY CURRICULUM: DOES ORDER MATTER?**

Speaker: Joanna E. Chambers, M.D.

SUMMARY:

Traditionally, psychiatry residencies have taught psychotherapy by introducing psychodynamic principles before cognitive behavioral therapy principles. The reasons for this are both historical as psychoanalytic thought predates CBT as well as practical as it takes longer to learn psychodynamic concepts. Our program reversed the order of the curriculum such that after a brief introduction to general concepts in psychotherapy, the residents were taught cognitive behavioral theory in their PGY2 year and psychodynamic psychotherapy in their PGY3 year. CBT would be an easier transition for the resident into learning about the relationship with the patient, and would in turn lead to a natural curiosity regarding psychodynamics. This section will discuss how residents and faculty experienced the change, as well as benefits and complications of reversing the conventional order.

NO 4**TEACHING PSYCHODYNAMICS IN CHILD PSYCHIATRY**

Speaker: Debra A. Katz, M.D.

SUMMARY:

Child psychiatry provides a natural setting to teach residents about psychodynamic concepts. Residents may struggle with how to think about their interactions with families, the influence of development on the clinical presentation of the child, and the multiple transferences that get evoked. Helping residents understand psychodynamic concepts such as the idea that symptoms have meaning, that behavior has symbolic significance or the importance of unconscious conflicts allows them to think about patients in new ways. Increased psychodynamic understanding also fosters interest in psychotherapy. Psychopharmacology clinics provide unique teaching opportunities. Issues that are commonly discussed in this setting include the role and identity of a psychiatrist, the meaning of medication, what can be learned from close observation of the child and family, how to place the child's struggles developmentally, and, ultimately, how to expand this knowledge into a psychodynamic formulation.

NO 5**GROUP DYNAMICS OF TRAINING RESIDENTS**

Speaker: Heather Forouhar Graff, M.D.

SUMMARY:

Group processes occur whether or not they are examined. The learning that occurs in groups is experiential as well as intellectual. The current state of residencies is virtually devoid of individual psychotherapy as part of training. Because of this, understanding transference and countertransference may only be achieved through the examined group process. Experiencing concepts of role, authority and boundaries lends itself to a deeper understanding that will ultimately better prepare trainees to be competent psychiatrists and leaders. A stronger therapeutic alliance is fostered by sincere shared empathetic experience. Tolerating intense affect is made possible with the containment that can only be offered by a group of peers and an engaged leader. There exists significant doubt in some leaders of psychiatry as to whether the current state of training is providing the skills necessary for future psychiatrists to understand their patients with the depth that previous generations had.

PRESIDENTIAL SYMPOSIUM 5**RECOGNIZING AND ADDRESSING DISTINCTIVE NEEDS AMONG DIVERSE PATIENTS WITH ADDICTIONS: ADOLESCENTS, WOMEN, VETERANS, AND SENIORS**

Chairs: Larissa Mooney, M.D., Laurence Westreich, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify common diagnostic and clinical management issues in adolescents with co-occurring ADHD and substance use disorders; 2) Recognize gender differences in prevalence of substance use disorders, the telescoping course of addiction in women, and women-focused approaches to treatment.; 3) Diagnose prominent mental health and substance use issues in veterans returning from overseas war zones and identify treatment resources available for their treatment.; 4) Define strategies for minimizing the risk of opioid misuse in older adults and the elderly with chronic pain.;

SUMMARY:

Some of the most serious public health concerns in the United States stem from the social, personal, and economic burdens associated with alcohol use and drug use disorders involving illicit and prescription drugs. Similar burdens are associated with mental health disorders such as depression, posttraumatic stress disorder and schizophrenia. Substance use disorders are the third leading cause of mortality in the United States and have a significant negative impact on socio-economic and family dysfunction as well as loss of quality of life. As a health professional in psychiatry, how does this impact your practice? Research shows that: 1) six out of ten people with a substance use disorder also suffer from another form of mental illness, and 2) almost 50% of individuals diagnosed with schizophrenia or bipolar disorder have co-occur-

ring substance use disorders. Given the prevalence and the severe impact of comorbidity on both individuals and the community, it is imperative that all health practitioners, particularly those in psychiatry, should routinely incorporate screening, assessment, diagnosis and treatment of co-occurring mental health and substance use disorders in their clinical practices. This session will provide an overview of the prevalence of addiction, common complications, and appropriate treatment interventions for populations typically encountered in clinical practice in which substance use disorders are routinely under-recognized: adolescents, women, veterans, and the elderly. Diagnostic challenges and unique treatment needs among these special populations will be reviewed.

NO 1**CHRONIC PAIN AND PRESCRIPTION OPIOID ABUSE IN OLDER AGE**

Speaker: Maria A. Sullivan, M.D., Ph.D.

SUMMARY:

This presentation will focus on the clinical challenges inherent in chronic pain management for older patients, particularly with long-term opioid therapy. Treatment approaches that balance treating chronic pain against minimizing risks for opioid abuse, misuse, and diversion are greatly needed. Particular vulnerabilities of older adults to addiction will be considered. Specifically, we will explore the prevalence and patterns of use of prescription opioids in older adults, including the effects of these substances on morbidity and mortality. Strategies for screening this patient population, including risk factor stratification and the use of opioid screening tools, will be discussed. We will offer recommendations for prescribing as well as for monitoring aberrant behaviors and other signs of opioid misuse. Treatment intervention strategies will be discussed, and areas for future research suggested.

NO 2**EVALUATION AND MANAGEMENT OF ADOLESCENTS WITH ADHD AND CO-OCCURRING SUBSTANCE USE DISORDERS**

Speaker: John J. Mariani, M.D.

SUMMARY:

Attention deficit/hyperactivity disorder (ADHD) is the most common psychiatric disorder in children and adolescents with ADHD are at increased risk for co-occurring substance use disorders. Adolescents with substance use disorders and co-occurring ADHD, as well as other psychiatric disorders, are overrepresented in clinical populations, and are typically among the most challenging patients to treat. The most commonly used medication treatments for ADHD are psychostimulants, and the use of these medications in patients with substance use disorders is complex. Common diagnostic and clinical management issues in treating adolescents with

co-occurring ADHD and substance use disorders will be discussed, with special attention focused on the complex issues that arise when prescribing controlled substance (stimulants) to adolescents with substance use disorders.

NO 3

TREATMENT OF WOMEN WITH ADDICTION THROUGHOUT THE LIFESPAN

Speaker: Shelly Greenfield, M.D., M.P.H.

SUMMARY:

The prevalence of substance use disorders has increased in women since the mid-20th century with women initiating their use at earlier ages than in prior decades and currently at the same rates as men. However women experience an accelerated course of addiction to many substances. The phenomenon in which women progress more rapidly from first use to the onset of dependence and first treatment compared to men has been labeled “telescoping.” This telescoping course of addiction women has implications for screening, early detection, and treatment. Diagnosis and treatment approaches to women with addiction and other co-occurring substance use disorders will be reviewed as will the use of women-focused treatment for women with addiction.

NO 4

UNIQUE ASPECTS OF SUBSTANCE USE DISORDERS IN U.S. VETERANS RETURNING FROM IRAQ AND AFGHANISTAN

Speaker: Kevin A. Sevarino, M.D., Ph.D.

SUMMARY:

In the decade following Sept. 11, 2001 2.33 million American military personnel were deployed to Iraq, Afghanistan or both. Over half were under 30 years old. The Iran (OIF) and Afghanistan (OEF) conflicts are unique in several ways. Multiple deployment rates far exceed those of previous wars. Survival of battlefield injuries (>90%) has never been higher, resulting in many veterans returning with extensive physical injuries, including traumatic brain injury (TBI). Rates of PTSD and/or depression may exceed 25%. Finally, no U.S. war has seen greater service by women or National Guard and Reserve forces. The elevated risk of substance use disorders (SUDs) in: 1) U.S. veterans, 2) those with mental health diagnoses, 3) those with TBI, and 4) those with concurrent PTSD and chronic pain, places OIF and OEF veterans at marked risk to suffer these diseases.

PRESIDENTIAL SYMPOSIUM 6

THE CONTRIBUTIONS OF IMGs TO PSYCHIATRY IN THE U.S.

Discussant: Silvia W. Olarte, M.D.

Chairs: Henry A. Nasrallah, M.D., Nyapati R. Rao, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the role of international medical graduates in the U.S. psychiatry workforce.;2) Discuss the contributions of international medical graduates to psychiatric education and training in the U.S.;3) Review the research and scholarship achievements of the U.S. international medical graduates.;4) Describe the academic and professional leadership roles by international medical graduates in the U.S.;

SUMMARY:

The presidential symposium reviews the major contributions made by International Medical Graduates (IMGs) to American psychiatry as well as some challenges they face in their career paths. IMGs are physicians who graduated from medical schools located outside of the USA, Canada and Puerto Rico. They comprise 25% of APA members, 30% of all U.S. psychiatrists, and nearly 1/3 of all residents in psychiatry. They are an extremely diverse group: IMGs speak more than 135 native languages, and in 2010, they graduated from 1078 medical schools spread over 148 countries. IMGs have made significant contributions to psychiatry in the U.S. In addition to their clinical services for a large proportion of the U.S. population, often in underserved regions, IMGs are active in academic activities as well. They have made widely recognized contributions to discovering new knowledge and teaching or training medical students or psychiatric residents. Many IMGs have ascended to prominent professional or academic leadership roles such as medical directors, department chairs, medical school deans or presidents of major organizations such as the American Psychiatric Association, the American College of Psychiatrists, the Society of Biological Psychiatry and others. In this presidential symposium, the faculty speakers, most of whom are IMGs, will address the various contributions of IMGs in the U.S. as follows: Dr. Rao will discuss the role of IMGs in the psychiatric workforce. Dr. Ruiz will discuss the educational and training involvement of IMGs. Dr. Nasrallah will describe the significant research contributions to psychiatry. Finally, Dr. Buckley will describe the leadership positions of psychiatry IMGs in the U.S.

Following the presentations, a panel of distinguished psychiatrists will provide additional insights and perspectives about psychiatry IMGs in the U.S. These include: Dr. Hagop Akiskal, Dr. Emmanuel Cassimatis, Dr. Silvia Olarte, and Dr. Bela Sood. An interactive Q/A session with the audience will complete the symposium.

NO 1**IMGs CONTRIBUTIONS TO PSYCHIATRIC WORKFORCE**

Speaker: Nyapati R. Rao, M.D., M.S.

SUMMARY:

Psychiatry, like the rest of medicine is experiencing a major shortage of its physician workforce due to decreasing supply in face of increasing demand. Historically, psychiatry depends heavily on IMGs who have contributed to the care of the underserved (safety-net) and its sustainability (gap-filling). The availability of IMGs has kept the supply of psychiatrists sufficient to keep the field viable. In an attempt to correct physician shortages, the output of US medical schools is being raised without a concomitant increase in GME positions, which may result in IMGs being forced out of GME. Recent changes to the Match and IMGs ongoing struggles with immigration may only hasten the process of reduction in their presence. The consequences of this happening will be far reaching on the profession in terms of its identity, its workforce composition, its clinical outcomes and its care of vulnerable populations.

NO 2**THE EDUCATIONAL CONTRIBUTIONS OF IMG PSYCHIATRISTS**

Speaker: Pedro Ruiz, M.D.

SUMMARY:

The educational contributions of International Medical Graduate (IMG) Psychiatrists have been progressively increasing in the United States, as well as in other countries across the world.

In the year 1997, the number of American psychiatric residents in the U.S. was 55.9%. The number of IMG psychiatric residents was 41.2%. A few years later in 2000, the number of U.S. born psychiatric residents decreased to 52.2%, while the number of IMG psychiatric residents increased to 47.8%.

In 1995 the number of U.S. physicians in the United States was 646,000 or 100%; however, the number of U.S. medical graduate physicians was 492,200 or 76.2%, while the number of IMG physicians was 153,800 or 23.8%. 63% of IMG psychiatrists are Board Certified by the ABPN, while 83% of the U.S. medical graduate psychiatrists were Board Certified by the ABPN. In this presentation, the role of IMG will be presented and discussed, and future recommendations will be addressed.

NO 3**THE RESEARCH AND SCHOLARSHIP EXCELLENCE OF IMG PSYCHIATRISTS IN THE UNITED STATES**

Speaker: Henry A. Nasrallah, M.D.

SUMMARY:

Psychiatrists who are IMGs have substantially enriched the academic caliber of USA psychiatry over the past century. The first IMG president of the APA, Adolph Meyer (1927-28) was a shining & transformational icon of psychiatric excellence & innovation. Other IMGs have made major contributions to advancing research & scholarly work in the field of psychiatry according to the following metrics:

- funding by NIH agencies to generate new knowledge
- publishing extensively in peer-reviewed journals
- serving as editor-in-chief of major psychiatric journals
- authoring or editing books
- serving on NIH study sections
- mentoring young investigators at medical schools or the NIH
- serving as peer reviewers for various scientific journals
- serving on the NIMH Council
- consulting with industry and conducting FDA clinical trials to develop psychotropic medications
- presenting data at meetings
- establishing major psychiatric societies
- participating in evidence-based practice guidelines

NO 4**ACADEMIC AND PROFESSIONAL LEADERSHIP BY IMG PSYCHIATRISTS IN THE UNITED STATES**

Speaker: Peter F. Buckley, M.D.

SUMMARY:

With large numbers of International Medical Graduates (IMGs) practicing in the United States, the continued ascent of IMGs to leadership roles can be anticipated. IMGs represent 18% of the academic workforce, with opportunities thereupon to serve as academic leaders. This trajectory is confirmed by the presence and professional visibility of IMGs in many academic and professional leadership roles, including our esteemed APA president. IMGs face the same challenges as leaders and are called upon to articulate a vision, inspire faculty and staff and develop the leadership capabilities of others. The extent to which the unique challenges that IMGs may face early in their career could shape (and potentially enhance) their aptitude for leadership roles in academia is worthy of consideration. This presentation will juxtapose these considerations in the context of national perspectives on leadership development and data on the role of IMGs in academic leadership.

MAY 20, 2013

PRESIDENTIAL SYMPOSIUM 7**ETHICAL WAVES OF THE SILVER TSUNAMI:
FOCUS ON CAPACITY, DECISION MAKING, AND
END-OF-LIFE ISSUES***Chairs: Laura B. Dunn, M.D., Maria I. Lapid, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Understand the concept of decision-making capacity and identify the core components of capacity.;2) Describe the assessment of decision-making capacity in several specific situations, including altered mental status and the capacity to make everyday decisions.;3) Discuss clinical approaches to ethical issues at the end of life.;

SUMMARY:

The demographic shift occurring in the U.S. and in most developed countries-frequently referred to as the Silver Tsunami-will bring with it numerous ethical challenges. Among older adults with varied medical, neurological, and psychiatric conditions, there will be growing evidence of decision-making impairments. Physicians will need to be knowledgeable about what decision-making capacity is, how to assess it, and what to do when patients have impaired capacity. This symposium will provide an in-depth review of the science of decision-making capacity, as well as discuss ethical issues in hospitalized patients and patients at the end of life. The first presenter, Dr. Appelbaum, will review the core characteristics of capacity, including the concepts of specific capacity, task specificity, and temporal specificity. The four elements of capacity will then be described, i.e., the abilities to understand, appreciate, reason, and evidence a choice, along with approaches to their assessment. The second presenter, Dr. Glezer, will focus on substitute decision making (SDM) and the assessment of capacity in patients with altered mental status. Recommendations will also be provided regarding the best ways to engage a surrogate decision maker if a patient does lack capacity. The third presenter, Dr. Shim, will discuss the common problem of consultation requests to "evaluate for capacity"--when the underlying reason for the consultation is actually a difficult medical or ethical dilemma. Using a case presentation, Dr. Shim will explore the ethical conflicts that arise in considering cases involving treatment refusal. The fourth presenter, Dr. Karlawish, will describe the concept of the capacity to make everyday decisions, a capacity that runs through a host of instrumental activities of daily living such as managing money and meal preparation. Questions of everyday decisionmaking capacity often are at issue when discharge planning becomes difficult. Dr. Karlawish will present the results of the ACED, or Assessment of the Capacity for Everyday Decisionmaking, an instrument to assess this capacity. The final presenter, Dr. Lapid, will discuss ethical issues in the context of end of life care, using a case that illustrates the complex issues of respecting patients' wishes while striving to provide quality of life for dying patients and their families.

NO 1**AN APPROACH TO ASSESSING CAPACITY TO
CONSENT***Speaker: Paul S. Appelbaum, M.D.***SUMMARY:**

Requiring capacity to consent to treatment is meant to insure that elderly patients can make meaningful treatment choices. This is in keeping with the assumption that patients are best able to determine what is in their interests. When patients are unable to identify their preferences or to select courses of action most consistent with those preferences, this assumption breaks down. This presentation will review the core characteristics of capacity, including the concepts of specific capacity, task specificity, and temporal specificity. The four elements of capacity will then be described, i.e., the abilities to understand, appreciate, reason, and evidence a choice, along with approaches to their assessment. Issues to be addressed include: who should perform the assessment, preparatory steps, informing patients of the purpose of the assessment, use of adjunctive sources of information (which may be of particular importance with elderly patients), and efforts to maximize performance.

NO 2**ALTERED MENTAL STATUS IN THE OLDER HOSPITALIZED PATIENT: ASSESSING CAPACITY AND
ENGAGING SUBSTITUTE DECISION MAKERS***Speaker: Anna Glezer, M.D.***SUMMARY:**

The issue of substitute decision making (SDM) is particularly salient to the geriatric population, as older adults are often admitted with altered mental status, challenging clinicians with ascertaining their elderly patient's ability to make medical decisions. Key to such an evaluation is to assess whether a patient has a health care proxy (HCP). A pilot study was conducted to examine how often providers documented mental status evaluation prior to informed consent for lumbar puncture, whether the patient's capacity was evaluated, and whether HCPs were documented. Findings demonstrated that although assessment of mental status was documented prior to procedures, assessment of capacity and existence of a HCP were infrequently documented. This presentation will focus in particular on the assessment of capacity in the context of altered mental status. Recommendations will also be provided regarding the best ways to engage a surrogate decision maker if a patient does lack capacity.

NO 3

“EVALUATE FOR CAPACITY”: IDENTIFYING AND ADDRESSING UNDERLYING ETHICAL DILEMMAS IN THE CAPACITY ASSESSMENT REQUEST

Speaker: Jewel Shim, M.D.

SUMMARY:

Psychiatrists frequently receive consultation requests for a stated reason of capacity assessment. However, further inquiry into the basis for such requests often uncovers underlying difficult medical and ethical dilemmas. Often, the requesting service has not identified these issues and may need the PM psychiatrist's help in developing an approach to handling these. This and related issues will be illustrated using an actual consultation request. The following case will be presented and discussed: An elderly male with multiple medical comorbidities and global treatment non-adherence presents repeatedly to the ED with complaints of chest pain, but then refuses work-up or admission. The consultation request read, "Assess for capacity" and "conserve this patient." This presentation will explore the ethical conflicts that arise in considering cases involving treatment refusal.

NO 4

THE CAPACITY TO LIVE INDEPENDENTLY (AKA THE CAPACITY TO BE DISCHARGED HOME)

Speaker: Jason Karlawish, M.D.

SUMMARY:

Progress in both theoretical and empirical understandings of capacity and its assessment have broadened the scope of decisions subjected to measurement. The field has moved beyond the stereotypical ethically charged decisions of treatment refusal and research enrollment, to also engage other decisions. Capacity is increasingly becoming one of the ways we can measure brain function in an ecologically valid framework. This talk will present the concept of the capacity to make everyday decisions, a capacity that runs through a host of instrumental activities of daily living such as managing money and meal preparation. Among patients who have impairments in these functional abilities, do they still retain the capacity to decide how they want to manage them? The answer to this question is at the heart of often contentious cases of discharge planning, as well as elder abuse and neglect. The talk will present the results of the ACED, or Assessment of the Capacity for Everyday Decisionmaking,

NO 5

ETHICAL ISSUES IN END-OF-LIFE CARE: A GERIATRIC PSYCHIATRY PERSPECTIVE

Speaker: Maria I. Lapid, M.D.

SUMMARY:

End of life decision making often involves complex issues, such as considerations of medical futility, and withholding or withdrawal of life-sustaining therapies. The ultimate goal is to provide care that relieves suffering, promotes comfort and dignity, respects patients' wishes, and provides quality of life for dying patients and their families. Critical to end of life decisions are patients' preferences, family involvement, and input from interdisciplinary care providers. These considerations can lead to ethical tensions. Psychiatrists have much to contribute to promoting high-quality end of life care. A case study of an elderly male with premonitory anxiety and depression who developed medical, psychiatric, and psychosocial complications following a life-extending treatment will be used to highlight some of the ethical issues encountered at the end of life, review the relevant ethical principles involved, and discuss useful clinical approaches to navigating these ethical dilemmas.

PRESIDENTIAL SYMPOSIUM 8**THE PSYCHIATRIST'S ROLE IN TREATING THE PATIENT WITH CANCER**

Chair: Donald L. Rosenstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the theoretical and practical issues related to depression and suicide screening in the oncology setting.;2) Identify the benefits of collaborative, inter-disciplinary depression care for patients with cancer.;3) Describe the major psychiatric syndromes experienced by cancer survivors and key psychopharmacological considerations in their treatment.;4) Appreciate the importance of a patient-centered perspective in the provision of cancer care.;

SUMMARY:

Approximately 15 million Americans are cancer survivors, many of whom experience substantial psychosocial suffering related to their cancer and its treatment. Over the past few years, several influential organizations (Institute of Medicine; Commission on Cancer, American Cancer Society; Livestrong Foundation) have called for systematic psychosocial distress screening and the provision of (or referral for) mental health treatment for patients with cancer. As the number of patients with cancer grows and mental health care becomes expected or mandated, the role of psychiatrists in caring for cancer patients will assume increasing importance. This symposium, sponsored by the Academy of Psychosomatic Medicine, will provide a critical update on psycho-oncology for the practicing psychiatrist. Dr. Walker will discuss depression and suicide screening in the outpatient cancer setting. Dr. Sharpe will report research findings from a collaborative care intervention for depressed cancer patients. Dr. Rosenstein will review psychosocial aspects of cancer survivorship care. Finally, Dr. Katon will share a personal account of his own cancer journey.

NO 1**SCREENING FOR DEPRESSION IN PATIENTS WITH CANCER**

Speaker: Jane Walker, M.Sc.

SUMMARY:

Dr. Walker will review depression screening in cancer patients from a clinical perspective. She will describe the practicalities of screening, including the pros and cons of including a suicidal thoughts item, based on her clinical practice and her research. She will report on the successes and challenges of running a large depression screening service on multiple geographical sites and present new data on the prevalence of major depression in cancer subgroups based on analysis of more than 100,000 patient appointments.

NO 2**INTEGRATED CARE FOR PATIENTS WITH CANCER AND DEPRESSION: HOW DO YOU DO IT AND DOES IT WORK?**

Speaker: Michael Sharpe, M.A., M.D.

SUMMARY:

Dr. Sharpe will describe a collaborative care approach (delivered by cancer nurses who are supervised by psychiatrists) to the management of depressive disorder in patients attending cancer clinics whose depression has been identified by screening: 'Depression Care for People with Cancer' (DCPC). He will present the results of his two recently completed clinical trials which have compared DCPC with care as usual: one in patients with a good cancer prognosis (cancer survivors) and one in patients with a poor cancer prognosis (lung cancer). Both trials have found substantially better outcomes for depression with DCPC than with usual care. Finally, practical issues in the implementation of DCPC will be discussed.

NO 3**PSYCHOSOCIAL ASPECTS OF CANCER SURVIVORSHIP**

Speaker: Donald L. Rosenstein, M.D.

SUMMARY:

Dr. Rosenstein will provide an update on recent developments in cancer survivorship care that are relevant to psychiatric practitioners. He will describe the major psychosocial challenges facing cancer survivors as well as several different models of survivorship care. Particular attention will be paid to the variety of roles that psychiatrists play in caring for cancer survivors and their caregivers. Dr. Rosenstein will highlight important psychopharmacological considerations in caring for cancer survivors. He will also review recent requirements and

expectations of cancer centers with respect to the identification of and response to the mental health needs of cancer patients.

NO 4**A PHYSICIAN'S PERSONAL EXPERIENCE WITH CANCER**

Speaker: Wayne Jay Katon, M.D.

SUMMARY:

Dr. Katon will describe his personal experience with cancer from initial signs and symptoms, to diagnostic workup, to initial diagnosis, to treatment and finally survivorship. This lecture will describe emotional and family issues, experience with interacting with friends and work colleagues, and emotional experience with his physicians and medical system. The talk will also focus on how the diagnosis with cancer changes one's priorities in terms of work, family, friends and how to approach the future. The unique issues of being a physician and having a diagnosis and treatment for cancer will be discussed. Dr. Katon will describe going through chemotherapy, having a potentially life threatening side effect and his interaction with his physicians and medical system regarding this experience. He will describe his rehabilitation from treatment, regaining his health and existential issues that arise as he moves into the future including how much to continue work and new meaning in his work.

PRESIDENTIAL SYMPOSIUM 9**MEDICAL STUDENT RECRUITMENT FOR PSYCHIATRY RESIDENCY: A GLOBAL PERSPECTIVE**

Chairs: Dinesh Bhugra, M.D., Ph.D., Michelle Riba, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand factors which stop medical students from choosing psychiatry; 2) Identify what can be done to attract medical students; 3) Recognize and have an awareness of the differences in recruitment methods;

SUMMARY:

It has been noted that there is a chronic worldwide shortage of psychiatrists, which has impaired the delivery of first class mental health care across different cultures. At the same time there is a marked mental health gap, showing the high burden of mental health, neurological and substance misuse disorders worldwide, with an estimated treatment gap of 75% between health need and resources. In 2005, 11.48% of disability adjusted life-years (DALYs) were due to these disorders, yet only 3.76% of the worldwide healthcare budget was being spent on mental health services. The mental health gap is serious not only in low and middle income (LAMI) countries but also in industrialized countries. In addition, there

are variations in numbers of students selecting psychiatry as a career choice. Interest in psychiatry among medical schools has been static and in some countries has been going down. Different countries use different curricula and there are variations in numbers of students selecting psychiatry as a career choice. The reasons are both external and internal. In this session we aim to explore differences and reasons noted in five different countries, what we can learn from each others' experiences and what measures need to be taken at local and international levels to deal with these discrepancies. Teaching, clinical experience and exposure to patients all are said to play a role. This session will explore these factors in depth and suggestions will be made for improving recruitment and retention into psychiatry. After this session, the attendees will have learnt different factors and different strategies which may well need to be culturally informed and specific.

NO 1

MANAGING RECRUITMENT IN MEDICINE AND PSYCHIATRY IN THE NETHERLANDS

Speaker: Rutger J. Van Der Gaag, M.D., Ph.D.

SUMMARY:

Medicine has shown a remarkable shift to feminization in the past three decades. In the Netherlands two thirds are currently women. This has advantages and presents some inconveniences. Recruitment is not an issue in terms of numbers, but more of quality. The recruitment programs in secondary school and the specific recruitment programs for psychiatry in the freshman years focus on quality and seek to attract socially gifted students that are interested by the fascinating advances in research both from a neurobiological and social environment's perspective. Heads of departments go to secondary schools and spend evenings interesting students for the introductory internships. Then through bachelor and master degree theses they appear to be successful in creating an influx in psychiatry that has nothing to envy to other medical specialties.

NO 2

MEDICAL STUDENT RECRUITMENT IN PSYCHIATRY: THE INDIAN EXPERIENCE

Speaker: Vihang N. Vahia, M.D.

SUMMARY:

Medical education in India is supervised by the Medical Council of India. The curriculum mandates between two weeks to four weeks of clinical placement for bedside learning of mental illness and 10 hours of class room lectures, usually in the 3rd of Medical Education. After medical graduation, each student is required to appear for a qualifying examination to pursue post graduation at the state level or the national level seat allocation where Psychiatry is an option. The demand for pursuing post graduate studies is far in excess of the opportunities. The applicants are compelled to accept the

subject allotted to them, based on their rank at the entrance examinations, irrespective of their choice or aptitude. Stigma and abstractness of the subject are considered a deterrent by some students. Implementation of Mental Health Act in India makes Psychiatry a non-lucrative and hence not a very sought after branch of medicine. This session attempts to answer the sequel of this reality by

NO 3

MEDICAL STUDENTS' INTEREST IN PSYCHIATRY IN THE UNITED KINGDOM

Speaker: Dinesh Bhugra, M.D., Ph.D.

SUMMARY:

Recruitment into psychiatry has been a major concern for over 30 years. Factors influencing the choice of subject include external factors related to teaching of the subject and clinical experience, and personal factors such as the ability to deal with openness and ambiguity. We studied factors prior to entering medical school, experiences in medical school and postgraduate factors. Potential psychiatrists fall into three major groups: those who decide prior to joining medical school; those who decide during medical school, and those who decide after qualification. Each group is influenced by a varying set of factors. Some of these findings will be discussed according to our 19 country quantitative cross sectional study looking at medical school recruitment. Final year students from medical schools were recruited. Their intent to do psychiatry was measured by using a number of questionnaires which measure attitudes towards psychiatry and personality traits. Among 2198 students who part

NO 4

RECRUITMENT INTO PSYCHIATRY: CURRENT STATUS AND FUTURE CHALLENGES IN JAPAN

Speaker: Shigeto Yamawaki, M.D., Ph.D.

SUMMARY:

In Japan the higher public consciousness of mental health in recent years and decreasing of the stigma around psychosis have made more patients visit psychiatry out-patient clinics and consultation-liaison(C-L) in hospital. This circumstance and especially increasing female psychiatrists resulted in the increase of the number of psychiatrists by 1.49 times in 2010 from 1994, one of top increased rates in all specialties. Nonetheless we have many issues by a psychiatrist shortage. The possible factors include; psychiatrists concentrated in large cities; increase of private clinic psychiatrists; lack of psychiatrists for C-L and emergency psychiatry; shortage of female returners after their childcare leave; and most seriously decreasing research-oriented young psychiatrists. We must develop more attractive undergraduate education programs of psychiatry practice and research, and better working conditions for psychiatrists in general hospitals and university academia and female returners.

NO 5

RECRUITMENT OF U.S. MEDICAL STUDENTS TO PSYCHIATRY: SOCIETAL NEED, MULTIPLE CHALLENGES*Speaker: Joan Anzia, M.D.***SUMMARY:**

Medical students' choice of specialty in the U.S. has some unique characteristics; currently there are more residency positions in psychiatry than the number of American medical students who choose this field. U.S. medical students may apply to any specialty training program, but there are some specialties that are in very high demand and offer limited training spots relative to the number of interested students (i.e., dermatology, orthopedic surgery, anesthesia etc.) U.S. medical students applying to psychiatry programs began declining in the 1970s, the percentage decreased by half between 1988 and 1998. Suggested reasons for the decline include: stigma related to mental illness, lower prestige of the profession, beliefs and attitudes about efficacy and length of psychiatric treatments. This presentation will review research findings on current needs for psychiatrists in the U.S., obstacles to recruitment, and the impact of undergraduate medical student education in psychiatry.

PRESIDENTIAL SYMPOSIUM 10**DSM-5 AND RESIDENCY TRAINING: OPPORTUNITIES AND CHALLENGES***Chair: Richard F. Summers, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Demonstrate awareness of significant changes in DSM5.;2) Recognize the key opportunities and challenges in teaching DSM5 in psychiatry residency.;3) Plan for teaching of DSM5 in their home institutions.;

SUMMARY:

The focus of this panel will be on how to teach DSM5 in residency training programs. Every adult and child training director will need to include DSM5 in the coming year, and the panel will provide ideas, recommendations and resources for the audience to accomplish this important task effectively.

Panelists will address the major changes in DSM5, the history of previous DSM rollouts, the department chair's perspective, as well as the training director and residents' perspectives. Didactics, bedside teaching, faculty development, adult learning, and integration with medical student teaching will be discussed. There will be ample opportunity for audience discussion.

NO 1

DSM-5: NEW OPPORTUNITIES AND CHALLENGES FOR TEACHING AND TRAINING*Speaker: David Kupfer, M.D.***SUMMARY:**

The development of the DSM-5 over the past decade has sought to review the major scientific and methodological advances made in the last two decades. The organizational chapter structure has been reorganized to facilitate both clinical practice and teaching to improve our assessment skills and appreciate the new knowledge not available for specific disorders. More specifically, we anticipate that we will have a structure that contains "receptors" for new biological, neurocognitive, and environmental risk factors as they emerge to guide future research and clinical practice. Of particular relevance for the DSM-5 and its role in residency education, the emphasis in the manual on the medical psychiatric interface is highly warranted. In addition to the content of information to be used, both didactically and practically, increased attention is being given to the new communication technology that makes it possible for the emergence of electronic versions and various types of "apps."

NO 2

DSM AND THE IMPERATIVES AND OPPORTUNITIES FOR CHANGE IN ACADEMIC ORGANIZATIONS*Speaker: Laura Roberts, M.D.***SUMMARY:**

This presentation will review and discuss issues from the Department Chair's perspective related to cultural and organizational issues, faculty development, and system revisions.

NO 3

A DSM-5 "TO-DO" LIST FOR ADULT RESIDENCY TRAINING DIRECTORS*Speaker: Sheldon Benjamin, M.D.***SUMMARY:**

Training residents in the use of DSM-5 will need to be part of an integrated plan that includes training of faculty, revision of medical student psychiatry courses, and balancing the syndromic approach of the DSM with the emerging neuroscientific understanding of components of DSM syndromes. Ideally, academic departments will plan for the transition as a whole. During the transition period, program directors will need to seek opportunities for insertion of DSM-5 terminology into the day to day routine of psychiatric care on teaching services and seek ways of making the conversion an educationally compelling experience.

NO 4**DSM-5 AND CHILD PSYCHIATRY TRAINING:
WHAT'S THE PLAN?**

Speaker: Arden D. Dingle, M.D.

SUMMARY:

This presentation will review and discuss issues related to implementing and using the DSM V in child and adolescent psychiatry residency program. There will be an emphasis on the opportunities presented for faculty development, modeling and development of lifelong learning skills as well as utilizing diagnostic systems in clinical care to enhance and support educational and clinical goals

NO 5**RESIDENTS' PERSPECTIVES ON DSM-5 AND
RESIDENCY TRAINING**

Speaker: Neisha D'Souza, M.D.

SUMMARY:

The publication of the DSM-5 will have a significant impact on resident physicians during their training. There will be variation in the amount of formal training residents receive on the use of the new manual, requiring residents to educate themselves as they work to improve patient care and perform well on exams that assess cognitive expertise. As resident physicians are less indoctrinated with the DSM-IV, it may be easier for them to integrate DSM-5 revisions into practice. In some instances, residents may be more familiar with the DSM-5 than faculty, offering a unique opportunity to contribute to learning on clinical sites. In this session, participants are invited to explore how resident physicians will manage anticipated changes within their training.

Objectives:

1. Identify ways in which residents may educate themselves on the DSM-5.
2. Recognize key opportunities for residents to contribute to learning on clinical sites.

MAY 21, 2013

PRESIDENTIAL SYMPOSIUM 11**POSITIVE PSYCHIATRY: FROM BIOLOGY TO INTERVENTIONS**

Chair: Dilip Jeste, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the contributions of positive psychologi-

cal traits such as resilience, optimism, and wisdom to overall health.;2) Understand the neurobiology of resilience, empathy, and compassion.;3) Use strategies to promote well-being such as optimizing stress.;

SUMMARY:

The role of psychiatry extends beyond diagnosis and treatment of mental illnesses. There is growing evidence that positive psychological traits such as resilience, optimism, wisdom, and social engagement are associated with significant positive health outcomes that include better overall functioning, reduced susceptibility to cardiovascular, metabolic, and other physical diseases and depression, and even greater longevity. Recent investigations have sought to understand neurobiology of resilience, optimism, compassion, and other positive traits. By strengthening the development of positive traits through psychotherapeutic, behavioral, psychosocial, and eventually biological, interventions, Positive Psychiatry has the potential to improve health outcomes and reduce morbidity as well as mortality in people with mental as well as physical illnesses. Thus the Positive Psychiatry of future is likely to be at the center of overall healthcare.

NO 1**POSITIVE PSYCHIATRY AND WISDOM**

Speaker: Dilip Jeste, M.D.

SUMMARY:

Our studies of several thousand community-dwelling seniors have shown the value of positive traits in middle-aged and older people. We found that, contrary to the usual stereotypes of aging, older age was associated with higher self-rated successful aging and better psychosocial functioning, despite worsening physical health and some cognitive decline. Resilience and depression seemed to have effects on successful aging with magnitudes comparable to that of physical health. Even in people with long-standing schizophrenia, psychosocial functioning tended to improve with aging. Wisdom may be an important contributor to improved psychosocial functioning in older age. Components of wisdom common to different definitions include social decision making, emotional regulation, insight, pro-social behaviors such as empathy and altruism, decisiveness, and tolerance of divergent value systems.

NO 2**BIOLOGY OF RESILIENCE**

Speaker: Eric J. Nestler, M.D., Ph.D.

SUMMARY:

Increasing attention is being given to the phenomenon of resilience, the fact that most people, when exposed even to extraordinary levels of stress and trauma, manage to maintain normal psychological and physical functioning and avoid serious mental illness. Recent work in laboratory animals has

provided early insight into the biological basis of resilience. This work has established that resilience—the ability to avoid deleterious behavioral changes in response to chronic stress—is mediated not only by the absence of key molecular abnormalities which occur in susceptible animals to impair their coping ability, but also by the presence of distinct molecular adaptations which occur uniquely in resilient individuals to help promote normal behavioral function.

NO 3

THE NEUROCIRCUITRY UNDERLYING OPTIMISM AND EMPATHY

Speaker: Lisa T. Eyler, Ph.D.

SUMMARY:

Optimism, or expecting that good things will happen in the future, has been linked to better mental and physical health, social connectedness, and well-being. Emotional resilience, or the ability to recover from adversity and avoid deleterious long-term effects, also leads to better health and well-being. Optimism facilitates resilience, suggesting overlapping neural mechanisms. Neural systems underlying these positive traits are just beginning to be explored. I will present data from neuroimaging studies of the anatomical and functional correlates of optimism and resilience as measured by questionnaires such as the Life Orientation Test-Revised and the Connor-Davidson Resilience Scale. Further developmental studies and investigations of how these traits interact with altered neural processing due to brain disorders are needed.

NO 4

EMPATHY AND ALTRUISM: BIOLOGY AND PATHOLOGY

Speaker: Bruce L. Miller, M.D.

SUMMARY:

Human societies value empathy and altruism, behaviors that require the intact function of specific neural circuits. The neurodegenerative condition FTD is reliably associated with profound decreases in empathy and altruism, while in mild AD these abilities are maintained or even enhanced. Furthermore, FTD patients are far less likely than AD patients to elicit compassion or empathy from others. FTD begins in fronto-insular and anterior temporal lobe circuits that appear to be critical for the generation of empathy and altruism, while AD attacks posterior-temporal-parietal and hippocampal networks involved with memory, language and spatial cognition. Activity in the fronto-insular salience network turns off the posterior default mode network. Understanding these reciprocal circuits is not only important for the diagnosis and treatment of FTD and AD, but is also critical for understanding the brain basis for social values that are needed to maintain a compassionate and altruistic society.

PRESIDENTIAL SYMPOSIUM 12

PSYCHIATRISTS WHO WRITE FOR THE GENERAL PUBLIC: EXPLORING OUR ROLE AS EDUCATORS, PROMOTORS, AND DISSENTERS

Chair: Richard A. Friedman, M.D.

SUMMARY:

Psychiatrists Who Write for the General Public: Exploring Our Role as Educators, Promoters and Dissenters: Psychiatrists who write for the lay press have the capacity to communicate with a very large audience and have an opportunity to educate the general public about our field. Psychiatrist-writers are in a unique position to tell the public about what we do, how we think, and where the field of psychiatry is heading. This is a critically important role; if we do not define ourselves before the public, others will do it for us. The titles for the presentations: 1. The Promise and Peril of Writing About Psychiatry for the General Public; 2. The Huffington Post is not the AJP; 3. The "Dos" and "Don'ts" of Writing About Psychiatry for a General Audience

NO 1

THE PROMISE AND PERIL OF WRITING ABOUT PSYCHIATRY FOR THE GENERAL PUBLIC

Speaker: Richard A. Friedman, M.D.

SUMMARY:

Psychiatrists who write for the lay press have the capacity to communicate with a very large audience and have an opportunity to educate the general public about our field. Psychiatrist-writers are in a unique position to tell the public about what we do, how we think, and where the field of psychiatry is heading. This is a critically important role; if we do not define ourselves before the public, others will do it for us.

NO 2

THE HUFFINGTON POST IS NOT THE AMERICAN JOURNAL OF PSYCHIATRY

Speaker: Lloyd Sederer, M.D.

SUMMARY:

Online publications are now the primary means by which the general, educated public seek and obtain information. Yet online contributors range from the ridiculous to the remarkable, and there are more of the former than the latter. Psychiatric and mental health professionals can either educate the public well, or let others fill their minds. The Huffington Post, for example, has twice the page hits of the NYT online so there are great opportunities to reach substantial numbers of people. But effective online writing is very different from what professional journals require. It is not better nor worse, just different. I will discuss what works for online publications if that is where - and to whom - you want to communicate.

NO 3**THE “DOS” AND “DON'TS” OF WRITING ABOUT PSYCHIATRY FOR A GENERAL AUDIENCE**

Speaker: Norman Rosenthal, M.D.

SUMMARY:

Psychiatrists are used to talking to patients. In that sense they are well-equipped to write for patients. I will flag some tips for making such writing compelling and accessible

NO 4**THE DESIGNATED DISSENTER**

Speaker: Sally Satel, M.D.

SUMMARY:

The challenge of questioning elements of your own profession without giving aid and comfort to the wholesale critics of psychiatry.

MAY 18, 2013

SCIENTIFIC AND CLINICAL REPORT 01**SUBSTANCE ABUSE: TREATMENT AND RECOVERY****SCR01-1****PHYSICIANS IN RECOVERY WHO ARE MEMBERS OF ALCOHOLICS ANONYMOUS: CORRELATES OF SUSTAINED REMISSION FROM SUBSTANCE DEPENDENCE***Speaker: Marc Galanter, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Identify patterns of prior substance use among currently abstinent physician AA members; 2) Identify reasons why AA attendance is widely used in physician recovery programs; 3) Apply an understanding of the characteristics of physician AA members to better treat addicted patients

SUMMARY:

We undertook a study of physicians who were long-term, abstinent members of AA. Research to date on AA has generally been limited to subjects followed after referral from addiction treatment, but many such patients do not attend AA with regularity or remain affiliated. With regard to physicians in recovery, only those who have been monitored in physician health programs have been evaluated, even though many physicians join AA independent of monitoring programs. Studies on the experience of long-term community-based samples, such as physician AA members, can therefore augment our understanding of the way AA helps to stabilize abstinence, and the role of cognitive and social support elements play in successful AA membership. We therefore investigated certain aspects of the nature of long-term AA membership in a sample of physicians in recovery (N=144) at a conference of doctors in AA. The respondent sample was 81% male and 83% employed, with a mean age of 58 years; 31% had no history of involvement in physician health programs; their principal problems were alcohol only (46%), drugs alone (6%), or both drug and alcohol abuse (48%). Most (58%) had received outpatient substance abuse treatment, and half (50%) had been hospitalized for this problem. They reported a mean current period of sobriety of 140 months. The respondents scored an average of one standard deviation higher on the Brief Symptom Inventory for both depression and anxiety compared to a normative population, and the majority (66%) had received treatment for general psychological problems other than substance abuse. Given studies showing that AA recruits' affective status generally improves with engagement into AA; these respondents may have been materially distressed upon entry. Because AA members, particularly long-term members, emphasize the importance of their "spiritual experience," we evaluated aspects of this experience among

the respondents. Those who reported "having a spiritual awakening" were more likely than the others to "experience God's presence" on most days (81% vs. 19%); importantly, they were less likely to report craving for alcohol (21% vs. 41%) than those who did not. Such findings may help explain why these respondents strongly endorsed AA principles and successfully adhered to the AA norm of abstinence: These orientations may be reinforced by relief of their anxiety and/or depression secondary to membership. They also clarify how AA membership is associated with long-term abstinence among certain recovering physicians, and shed light on the emphasis that physician health programs place on AA attendance.

SCR01-2**DISSEMINATING EVIDENCE-BASED MODELS FOR SUBSTANCE USE AND DEPRESSION IN COMMUNITY HEALTH CENTERS***Speaker: Mark Valenti***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Discuss new team roles, including the consulting psychiatrist, for evidence-based collaborative care models in primary care settings; 2) Describe workflows and processes for integrating behavioral healthcare into primary care settings; 3) Discuss how to design screening and brief intervention models for primary care settings based on consumer feedback

SUMMARY:

With AHRQ-funding, the Pittsburgh Regional Health Initiative (PRHI) in partnership with the Institute for Clinical Systems Improvement (ICSI), the Wisconsin Collaborative for Healthcare Quality (WCHQ), the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL), and the Network for Regional Healthcare Improvement (NRHI), developed a consortium, Partners in Integrated Care (PIC), to build on their local integrated care successes and disseminate an evidence-based, primary care delivery model based on: Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) for depression; plus Screening, Brief Intervention, and Referral to Treatment (SBIRT) for unhealthy substance use. Toolkits for recruiting health centers, engaging stakeholders, training, HIT, and primary care support have been developed for local and national implementation. 40 primary care offices are implementing the model across MN, WI, and PA, and the Massachusetts Health Quality Partners (MHQP) has been engaged to disseminate PIC to MA. In Pennsylvania, PRHI recruited 13 primary care sites (10 FQHC sites) and provided training, coaching, and adaptive leadership support to break-through organizational and implementation issues. PRHI also convened stakeholders, with the goal of advancing regional payment policy. This conference program will provide an overview of the PIC initiative, and will explain how to implement the IMPACT+SBIRT model in community health centers. It will focus on the role of the consulting psychiatrist in collaborative

care teams that use a stepped-care, target-to-treat approach. The program will conclude with an interactive activity to facilitate the audience's thinking in how to engage and train psychiatrists in collaborative care models for behavioral health conditions in medical settings.

SCR01-3

RESIDENTIAL VERSUS OUTPATIENT SUBSTANCE ABUSE TREATMENT FOR OLDER ADULTS WITH CO-OCCURRING PSYCHIATRIC CONDITIONS AND CHEMICAL DEPENDENCY

Speaker: Bentson McFarland, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the frequent co-occurrence of psychiatric conditions with chemical dependency among older people; 2) Discuss advantages and disadvantages of outpatient versus residential treatment for older people with co-occurring substance abuse and psychiatric disorders; 3) Identify differential impact of residential versus outpatient substance abuse treatment for older people who have dual diagnoses of chemical dependency and psychiatric disorders

SUMMARY:

Background: Addictive disorders are chronic conditions for many older adults. Indeed, people ages 50 and over comprise the fastest growing group of publicly funded substance abuse treatment program users. Psychiatric conditions (such as major depressive disorder) often co-occur with chemical dependency among older people. Each year in the United States there are over 40,000 admissions to publicly funded substance abuse treatment agencies of older individuals with so-called "dual diagnosis". Chemical dependency treatment for this population is provided almost entirely in (non-hospital) residential or outpatient programs. There has also been substantial growth in the percentage of residential (versus outpatient) care for older patients with chemical dependency. Yet concerns have been raised about the comparative effectiveness of these two treatment regimens. This project used national data to compare residential versus outpatient care for this population. **Methods:** Data on 85,849 discharges (40% over age 55, 36% female, 64% white, 38% with poly-substance use, 35% with alcohol use only, 30% residential) for patients ages 50 and older with co-occurring substance abuse and psychiatric conditions were obtained from the 2006 through 2008 Treatment Episode Data Set which collects information from the vast majority of publicly funded chemical dependency programs in the United States. The dependent variable was optimal discharge (program completion or transfer to another facility) versus other than optimal discharge (left against advice, terminated by program, incarcerated, or died). Data on availability of residential (versus outpatient) care from the National Survey of Substance Abuse Treatment Services were used as instrumental variables to adjust for endogeneity (e.g., the assignment of more impaired individuals to residential care). Discharge data

were linked with service availability measures via geographic area. Logistic regression models were constructed. **Results:** There were substantial differences between residential versus outpatient on patient characteristics such as homelessness (26% residential versus 9% outpatient) and prior substance abuse treatment (78% residential versus 66% outpatient). Most discharges were optimal (79% for residential and 57% for outpatient). In simple logistic regression models adjusted for patient characteristics, residential treatment was a powerful predictor of optimal discharge (odds ratio of 3.3). In two stage residual inclusion models adjusting for endogeneity as well as patient characteristics, residential treatment remained a strong predictor of optimal discharge (odds ratio of 1.7). **Conclusions:** Preliminary findings suggest residential treatment may be advantageous for this population. More detailed analyses including multi-level models will be presented.

SCIENTIFIC AND CLINICAL REPORT 2

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

SCR02-1

COMPARISON OF CURRENT ADHD SYMPTOM SEVERITY WITH RETROSPECTIVE CHILDHOOD ADHD SYMPTOM SEVERITY IN EUTHYMIC BIPOLAR PATIENTS

Speaker: Biswadip Chatterjee, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To correlate the childhood ADHD symptoms and their severity with the current adult ADHD symptoms severity in euthymic Bipolar Disorder patients; 2) To assess the effect of childhood ADHD symptom and current ADHD symptom severity on various aspect of bipolar illness and disability; 3) Assess the feasibility and need to assess presence of ADHD symptoms in cases of BPAD-I patients

SUMMARY:

Background: Both DSM-IV criteria and Wender-Utah criteria for adult ADHD require that, the criteria for childhood ADHD must be fulfilled. However, recall of childhood history is often inaccurate and biased. **Aim:** To compare current ADHD symptom severity with retrospective childhood ADHD symptom severity in euthymic bipolar patients. **Method:** Patients diagnosed as BPAD-I by SCID-CV were assessed for remission by Hamilton Depression Rating Scale (HDRS) and Young Mania Rating Scale (YMRS). Screening for adult ADHD was done using Adult ADHD Self-Report Scale-v1.1 (ASRS V1.1) and symptom severity assessed using Weinder-Reimherr Attention Deficit Disorder Scale (WRAADDS). Retrospective childhood ADHD assessment was done using Wenders Utah Rating Scale (WURS). Dysfunction was measured using Sheehan Disability Scale (SDS) and Global functioning was measured using Global Assessment of Functioning (GAF)

Scale. Result: As compared to the retrospective recall of the severity of childhood ADHD symptoms, the current ADHD symptom severity correlate more with the clinical course, severity and dysfunction among euthymic bipolar patients. Further details will be discussed during the presentation. Conclusion: The role of the childhood ADHD diagnosis for the diagnosis of adult ADHD need to be further evaluated. Adult ADHD symptom severity seems to be more relevant as a factor affecting BPAD course and severity.

SCR02-2

ELEVATED BACKGROUND NOISE IN PATIENTS WITH ADHD: A NEURONAL CORRELATE FOR INATTENTION

Speaker: Emanuel Bubl, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Why the eye is so useful in finding a diagnostic marker in psychiatry; 2) Identify the potential neural correlate of inattention; 3) Why there is a need for an objectively measurable surrogate marker in psychiatry

SUMMARY:

Background Inattention and distractibility belong among the core symptoms of attention-deficit/hyperactivity disorder (ADHD); still a neuronal correlate is largely unknown. An elevated noise ratio has been proposed as underlining pathophysiological correlate. Methods 20 patients with the diagnosis of attention deficit disorders and 20 matched healthy subjects were studied. The pattern electroretinogram (PERG) derived noise was obtained in patients with ADHD and a matched control group. The PERG is an electrophysiological measurement for the activity of the retinal ganglion cells. PERGs were recorded in steady state mode in response to checkerboard stimuli at 12 reversals/s. Results Patients with attention deficit disorder displayed significantly elevated noise. The signal correlated highly with the psychometric measures for ADHD especially for inattention.

Conclusions Here we report the novel finding of altered visual signal processing in patients with ADHD at a very early neuronal level. The data provide evidence that elevated background noise is associated with inattention and might turn out as neuronal correlate for inattention in ADHD.

SCR02-3

RISK FACTORS ASSOCIATED WITH ATTENTION-DEFICIT/HYPERACTIVITY DISORDER AMONG ADULTS WITH SERIOUS MENTAL ILLNESS

Speaker: Sebastien C. Fromont, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Examine the prevalence of adulthood ADHD among smokers with serious mental illness; 2) Identify elevated risk factors among adults with ADHD and serious mental illness; 3) Examine the impact of adulthood ADHD on functioning among patients with serious mental illness

SUMMARY:

Context: Adult attention-deficit hyperactivity disorder (ADHD) has an estimated prevalence of 5% and is characterized by deficiencies in self-regulation and self-motivation. Adults with ADHD are at increased risk for co-occurring psychiatric (anxiety and depression) and substance use disorders. Objective: The increased risk and harm to functioning of adult ADHD was examined among patients with serious mental illness.

Sample: Participants (N=693, 50% male, 45% Caucasian, age M=39, 49% income < \$10,000) were recruited from five acute inpatient psychiatry units in the San Francisco area. All were current tobacco users, recruited for a study on smoking among the seriously mentally ill. Using the eMINI computerized diagnostic interview, primary psychiatric disorders were unipolar depression (57%), bipolar depression (46%), drug (49%) and alcohol use (42%) disorders, post-traumatic stress disorder (42%), and psychotic disorders (40%). Additionally, 39% were found to meet DSM-IV criteria for adult ADHD. Results: Relative to participants without ADHD, those who were ADHD+ reported more severe depression, worse interpersonal functioning, greater tendencies for self-harm, greater emotional lability, and more substance use problems on the CESD, BASIS-24, and SF12 measures (all $p < .001$), but did not differ on symptoms of psychosis. They were more likely to abuse alcohol (51% vs. 35%), stimulants (32% vs. 19%), and opiates (18% vs. 8%) ($p < .003$), but not marijuana (46% overall). Those who were ADHD+ reported experiencing greater discrimination due to mental illness (2.7 vs. 2.3 on 4-pt scale) and had lower subjective social standing in their communities (4.4 vs. 5.2 on 10-pt scale) and in the US (3.9 vs. 4.8) more broadly (all $p < .003$). Measures of physical health functioning did not differ by ADHD status nor did employment or marital status. Conclusions: Over a third of hospitalized smokers with serious mental illness met criteria for adult ADHD. ADHD in adulthood was associated with worse mental health functioning, greater problems with substance use, lower social standing, and greater discrimination. Given the elevations in risk, attention to ADHD in psychiatric care is warranted. Funding #R01 MH083684, #K05 DA016752, and #P50 DA09253 Sebastien C. Fromont, MD1, Stephen Hall, MD1, Thomas Bonas, PhD2, Sharon M. Hall, PhD1, Judith J. Prochaska,

PhD, MPH3

1Department of Psychiatry, University of California, San Francisco

2Alta Bates Summit Medical Center, Herrick, Berkeley, California

3Stanford Prevention Research Center, Department of Medicine, Stanford University

SCIENTIFIC AND CLINICAL REPORT 3

INTEGRATION: COLLABORATIVE MENTAL HEALTH AND MEDICAL CARE

SCR03-1

CADET: CLINICAL AND COST-EFFECTIVENESS OF COLLABORATIVE CARE FOR DEPRESSION IN UNITED KINGDOM PRIMARY CARE, A CLUSTER RANDOMIZED CONTROLLED TRIAL

Speaker: David A. Richards, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the strength of the international evidence for collaborative care; 2) Identify the effective clinical protocol for collaborative care; 3) Understand the health economic arguments for the cost effectiveness and affordability of collaborative care

SUMMARY:

Background: Collaborative care for depression is effective in the US but effects are uncertain internationally. Objective: is collaborative care is more clinically and cost effective than usual care in the management of patients with moderate to severe depression in UK primary care? Design: multi-center, cluster randomized controlled trial with two parallel group arms. Setting: Three primary care areas in Bristol, Waltham Forrest and Greater Manchester, UK Participants: patients in primary care, aged 16 and over who met ICD-10 criteria for a depressive episode Collaborative care: six to 12 face to face or telephone contacts over a period of 14 weeks by case managers including education about depression; medication management; behavioral activation; and relapse prevention instructions, supervised by psychiatrists, psychologists and other specialist professional mental health practitioners. Control: general practitioner care according to each GP's normal clinical practice, including treatment by antidepressants and referral for other treatments Outcomes: depression severity (PHQ9) at 4 and 12 months; quality of life, health utility and costs. Results: 581 participants recruited from 49 primary care practices 276 in collaborative care, 305 usual care, Participants in collaborative care had a mean reduction in depression score 1.33 PHQ9 points greater (95% CI 0.35 to 2.31, $p = 0.009$) compared to usual care (effect size = 0.26, 95% CI 0.07 to 0.46). Odds ratios for PHQ9 scores below depression

threshold (PHQ<10) were 1.31 (95% CI 1.08 to 1.58, $p=0.006$) at four months and 1.39 (95% CI 1.15 to 1.67, $p=0.001$) at 12 months in favor of collaborative care. Odds ratios for PHQ9 reductions of 50% or more were 1.34 (95% CI 1.11 to 1.62, $p=0.003$) at four months and 1.34 (95% CI 1.11 to 1.61, $p=0.002$ at 12 months). The collaborative care group had smaller other healthcare costs at 12 months (-\$332.23, 95% CI: -\$910.36, \$226.63); overall costs including collaborative care were more expensive (\$194.74.60, 95% CI: -\$407.64, \$752.63). Depending on scenario, cost per QALY was either \$9,678, with an expectation that in 80% of cases collaborative care would be cost-effective against a payer willingness to pay threshold of \$47,363 per QALY or \$35,371 with an expectation of being cost-effective in 56% of cases. Discussion: collaborative care in the UK has modest but persistent positive effects and is cost effective within the affordability threshold set by NICE. Our effect size is almost exactly the same as that reported in US trials, suggesting that the benefits of collaborative care transfer between different health systems. Junior mental health workers in the NHS could treat large numbers of depressed people in primary care with a comparatively small investment. Further trials of collaborative care for depression, in the UK or internationally, are no longer required since the effect size of collaborative care is now well established beyond the US.

SCR03-2

PRIMARY CARE AND MENTAL HEALTH INTEGRATION: OVERCOMING THE CLASH OF CUSTOM AND CULTURE

Speaker: Robert C. Joseph, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize some of the customs of mental health care and primary care and specify some of the advantages and disadvantages of each; 2) Identify specific examples of cultural differences at your institution which may interfere with the integration of medical and mental health care; 3) Identify elements of traditional mental health training that currently perpetuate the divide between medicine and psychiatry and might be modified to facilitate collaboration

SUMMARY:

The integration of mental health care into primary health care is increasingly supported by scientific literature and by policy makers. The prevalence of mental illness in primary care populations, the awareness of the co-morbidity between medical and mental illness, the bidirectional negative influence of each on outcomes of the other and the inaccessibility of conventional behavioral health care has made "integration" one of the darlings of health care reform. The traditional tension between the isolated silos of mental health and primary care clinics is being challenged by efforts to integrate providers, medical records, finances and real estate. The literature is replete with demonstration programs which have proven the

viability and effectiveness of taking care of a variety of mental disorders in primary care while improving outcomes and reducing health care costs. Integration can exist on a spectrum from geographically separated services with facilitated referral and communication to full service co-location. The evidence for integrated care is most robust for the model of “collaborative care” reported by Kato and others. Despite the robust evidence in support of such models and the growing support of policy makers many barriers exist which inhibit implementation of reform. Barriers to effective integration include the separation of administrative leadership, financing, reimbursements, third party payers and location as well as the traditional differences in mission and responsibilities. A less appreciated barrier is the differences in the culture of primary care and behavioral health. This presentation will elucidate a series of cultural differences which have traditionally separated the practice of medicine from behavioral health and which need to be addressed for effective integration to take place. Such barriers include subtle differences in mission and methodology that can lead to tension between providers of different disciplines. Many of these barriers are reinforced by traditional training in our respective disciplines.

deepen the discussion to prepare a Therapeutic Project. This entailed, mostly in medical consultation, seeking drug treatment. To illustrate cases that required professional psychiatry or psychology adherence did not occur, and linking to other devices on the network of mental health that could benefit the user. Thus there is a need for the presence of a specific look for composing the discussions in each case. Thus, in October 2011, has established itself within the Theme Team NASF Nuclei were divided in: Mental Health, Rehabilitation and Health of the Elderly, and Women’s Health and Children. In these nuclei are present in the specific professional NASF for each topic to be discussed at meetings. This provided further consideration of cases and drafting Therapeutic Project involving conduct not only medical but, addressing aspects of daily life, family, psychological and social factors having the possibility to expand to look at each case and thus make a more qualified. Although there was no time to assess the results of this new work proposal, but it is necessary to always be attentive staff NASF cases and the demands of the FH teams for the changes to take aim at generating improved functionality in the shares of primary health care

SCR03-3

MENTAL HEALTH IN PRIMARY CARE: NEW PERSPECTIVES ON THE CENTER SUPPORT FOR FAMILY HEALTH SOUTHEAST OF SAO PAULO, BRAZIL

Speaker: Ligia Florio, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the role of psychologist, psychiatrist, social worker, occupational therapist working on Mental health in primary care;2) Evaluate the Family Health Strategy cases with the teams, develop projects and do some therapeutic actions with therapeutic groups with units and staff;3) Focus on Specialist Orientation Network, a group of mental health in primary care;4) Challenge-dealing with people and with the human misery.

SUMMARY:

The Centers Support for Family Health (NASF) were created by the Ministry of Health through Ordinance GM n 154, January 24, 2008 in order to offer support to the Family Health Strategy, with the aim of expanding its solvability. Initially the work process was defined by the participation of a couple of members of staff NASF (double reference) Meetings. In 2009, there was an addition to this team NASF two new UBSs adding 6 more Family Health Teams (SF) totaling 19 teams. Thus, there was a need for change in the organization of the work process. It was decided that the team would remain united NASF during activities and UBS in a double reference were kept. The case discussions between the pairs and teams SF remained at the level of common knowledge, as there was necessarily the specific professional looking to broaden and

SCR03-4

INTEGRATING COLLABORATIVE CARE: GENERAL HOSPITAL COST PERSPECTIVES FROM A TRANSITIONAL COLLABORATIVE CARE PROGRAM, THE MED PSYCH CENTER APPROACH

Speaker: Carsten Leue, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize that transitional integrated care is easy to realize in multi-conditional comorbidity; 2) Furthermore, the participant will recognize that the MedPsych Centre approach reduces healthcare cost substantially; 3) Moreover, the participant will identify that all partners of integrated care - physicians and mental healthcare providers (patients and community included!) will profit

SUMMARY:

Objective: Collaborative care services providing care at the interface of medical and psychiatric comorbidity in the general hospital are still widely organized by using specific disease management models. Previous work suggests that psychosomatic care may gain in effectiveness by merging different disease related approaches to joined collaborative care solutions. However, evidence regarding (cost-) effectiveness is scarce and divergent.

Method: A ‘transitional’ form of merged collaborative care, the Medical Psychiatric Center (MPC) was created between a tertiary care University Medical Center (hereafter: UMC) and a primary care Community Mental Health Center (hereafter: CMHC) with a view to treat somatic and psychiatric multimorbidity initially inside and, if acceptable, subsequently outside the hospital, bridging the gap to General Practitioners. A record linkage study was conducted, linking cost data of

hospital medical service use, length of stay (LOS) and 'transitional' mental health care interventions in patients referred to the MPC over a two-year period. Analyses quantified pre-post cost changes around MPC referral. Results: Referral rates were highest for somatoform disorders (28%), anxiety disorders (34%) and mood disorders (44%) in different comorbid somatic conditions. Comparisons revealed lower costs of medical service use ($p < 0.001$) and LOS ($p < 0.01$) after referral to the MPC. Conversely, cost of 'transitional' psychiatric interventions was higher after MPC referral ($p < 0.001$) as was cost of psychological interventions ($p < 0.001$). Overall, total costs were lower after MPC referral (- €34.5; 95%CI - €143.3 to - €25.8; p -value < 0.001) and could not be explained by general cost developments in the hospital over the period of investigation. Thus, the hospital related annual cost saving was approximately 1000, - Euro per patient. Conclusion: A novel 'transitional' collaborative care approach towards treatment of common somatoform or affective disorders in different somatic conditions, guiding patients from inside the hospital to accept primary mental health care, is acceptable and cost-effective.

SCIENTIFIC AND CLINICAL REPORT 4

PANIC DISORDER

SCR04-1

DETERMINATION OF LONG-TERM OUTCOME AND DURATION BEFORE RELAPSE FOR PATIENTS WITH PANIC DISORDERS

Speaker: Olga A. Abdukhadov, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Determine the long term outcome and duration before relapse for patients with panic disorders; 2) Determine the long term outcome of patients with panic disorder treated with SSRIs alone or in combination with CBT; 3) Determine the probability that patients remained asymptomatic every six months for up to 3 years

SUMMARY:

To determine long term outcome and duration before relapse for Olga Abdukhadov ,Eric D. Peselow,Waguih Ishak Introduction The short -term treatment of panic disorder with antidepressants alone or with benzodiazepines has been well established. However the effect of long-term continuation treatment with these medications need to be further elucidated. It is the purpose of this paper to evaluate the effect of education in the long-term treatment of panic disorder. Method: Treatment of panic disorders involves numerous strategies, medication management, CBT, combination of both. Short-term outcome of treatment fairly established, but long-term needs to be evaluated in more details. In our study, total of 184 patients had been seen since 2003 in a community outpatient clinic, where evaluated for a panic disorder. The scale used to diagnose panic disorder was the SCID. These

patients met criteria for DSM-4 panic disorder. Patients were treated with varied SSRIs. About 30% of patients had Cognitive Behavioral Therapy in addition to SSRI treatment. These patients then were followed for up to 36 months to evaluate whether they maintained the response or relapsed. Relapse was defined as having again met the criteria for DSM-4 panic disorder, whereas clinical response was defined as a total elimination of full-blown panic attacks. Results: Of 184 patients, 66 relapsed within the 3-year period. The probability of remaining well for 6 months was 87.5%, 77.7% for 12 months, 73.9% for 18 months, 69.6% for 24 months, 66.1% for 30 months, and 64.0% for 36 months. Of these 184 patients, 55 were on CBT and medication management, whereas 129 were on medication management only. Out of the 55 patients who were on combined treatment, 20 relapsed; the probability of remaining well was 63.7%. Out of the 129 patients who were on medication management only, 46 relapsed; the probability of remaining well was 64.4%. Conclusion: We researched literature and thirty-one studies were identified, out of which only 5 studies of four patient populations (279 patients) met the criteria that make a long-term outcome study useful in providing information about differential treatment efficacy. The quality of the studies was analyzed and methodological problems were found among the majority of the studies; these problems included lack of clarity of diagnosis, lack of clarity in the treatment administered, and inadequately tracked non-study treatments during the study and follow-up periods. The uniqueness of our study is that it is naturalistic. Also, in this study, patients were followed for up to 36 months. As a result, our study showed that there is no significant difference in the treatment outcome between patients on medication management only or on combined treatment medication plus CBT. Evidence from our study identified that a majority of patients are responsive to treatment. Many patients remained well, and some of the patients continue to experience symptoms and/or require on

SCR04-2

PANIC DISORDER: EFFECTS OF COMORBID PSYCHIATRIC DISORDERS ON TREATMENT RESPONSE

Speaker: Ramakrishna R. Veluri, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify underlying comorbid disorders and their treatment can relieve suffering and restore function; 2) Recognizing the treatable comorbidities will enhance the treatment response in patients with both panic disorder and comorbidities to medication and/or therapy; 3) Diagnose and treat the underlying comorbidity will make the panic disorder and comorbidities less treat resistant during longitudinal course.

SUMMARY:

Introduction: Panic disorders not stand alone and it is known that panic disorder associated with various psychiatric comorbidities. As such having these comorbidities not compromises the responsiveness of panic disorder. Literature showed the incidence of psychiatric comorbidities with panic disorders and but did not specify the impact of comorbid disorders on clinical response and course of panic disorder. Objective: To determine how the comorbid psychiatric disorders will influence the treatment responsiveness in patients suffering from panic disorder and to review the various effects of comorbid disorders on the longitudinal course of panic disorder. Methods: In this study we used to Structured Clinical Interview for DSM IV (SCID) along with Panic Inventory and diagnosed 304 patients with panic disorder and also used similar SCID to identify other comorbid psychiatric disorders. 240 of 304 patients had at least one comorbid disorder in addition to panic disorder. Clinical or treatment response defined as complete alleviation of full blown panic attack with in 8 week period of treatment, which is either Selective Serotonin Receptor Inhibitors (SSRIs) or SSRIs along with the Benzodiazepines. Results: During our study, 240 of 304 (78.9%) had at least one comorbid disorder and 90(44%) of them had one comorbid disorder and in turn 58(64.4%) of them had Major Depression, 18 (20%) had Generalized Anxiety Disorder, 7 (7.7%) had Social Anxiety and Obsessive Compulsive Disorder (OCD) each. 80(33.3%) of 240 had two comorbid disorders, 60 (25%) patients had three comorbid disorders and 10 (4%) had four comorbid disorders. As we know by now 64 patients with panic disorder had no other psychiatric comorbid disorders and during the 8 week course of treatment with SSRIs and/or combination with Benzodiazepines, 48(75%) patients showed clinical response, whereas only 126 (52.5%) did responded to the above treatment during the course of same 8 weeks course. This difference is clinically and statistically significant. Conclusion: Our study suggested that having comorbid psychiatric disorders in addition to panic disorder make the panic disorder patients less responsive to current pharmacotherapy. We searched literature since 1996 until today and found very few studies regarding impact of comorbid disorders and also one study arguably reported similar outcomes for patients with both disorders and those with panic disorder uncomplicated by comorbid psychiatric illnesses as panic disorder and depression share similar neuro and psychopathological mechanisms. We emphasized here the importance of conducting more randomized and multi central trials to find better strategies of treatment of panic disorder with comorbid psychiatric disorders. References: 1.Gorman JM, Coplan JD. Comorbidity of depression and panic disorder; J Clin Psychiatry. 1996;57 Suppl 10:34-41. 2.Möller HJ. Anxiety associated with comorbid depression. J Clin Psychiatry. 2002;63

SCR04-3**CARDIOVASCULAR RISKS AFTER ESCITALOPRAM TREATMENT IN PATIENTS WITH PANIC DISORDER**

Speaker: Jung-Yoon Heo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize increased risk of cardiovascular disease after SSRIs treatment in patients with panic disorder. The levels of total cholesterol, high-density lipoprotein cholesterol, and low-density lipoprotein cholesterol were significantly increased in the PD patients after escitalopram treatment, whereas the body mass index and weight, blood pressure were unchanged.

SUMMARY:

Background: Panic disorder (PD) has been suggested to have increased cardiovascular risks. Recent prospective cohort studies showed that patients with PD had a nearly 2-fold increased risk for cardiovascular disease, when compared with normal controls. In addition, there have been a few reports that some SSRIs may increase cholesterol levels in panic disorder patients. The aim of this study was to examine if escitalopram treatment may affect some cardiovascular risk factors in patients with panic disorder. Methods: We examined levels of total cholesterol, low density lipoprotein cholesterol(LDL-C), high density lipoprotein cholesterol(HDL-C), triglyceride, levels of pro-inflammatory cytokines(TNF- α and interleukin-6) and tissue factor in 25 PD patients (14 men and 11 women, mean age 39.7 SD \pm 10.3)before and after escitalopram treatment. The PD patients were treated with escitalopram up to 20 mg/day for 3 months. Some of the patients were also given alprazolam (0.25–1 mg/d) for the first 1 month after starting the treatment. The alprazolam medication was gradually tapered off and completely discontinued after the first month of treatment. All of the subjects were medication-free for at least 2 weeks before participating in this study. All of these patients were medically healthy without any electrocardiographic abnormalities or history of lipid lowering agent and did not have any other comorbid psychiatric illnesses. The clinical severity of PD was measured in the patients using the Panic Disorder Severity Scale (PDSS), Hamilton Anxiety Rating Scale (HAMA) and the Hamilton Depression Rating Scale (HAMD), both at baseline and following 3 months of treatment with escitalopram. The BMI, Weight, Blood pressure was also determined in the control subjects and the panic disorder patients both before and after the treatment.

Results: The levels of cholesterols, TNF- α and interleukin-6(IL-6) were not different between 25 PD patients and 18 normal control subjects at baseline. The baseline tissue factor level of PD patients (0.23 \pm 0.117ng/ml) was higher than that of control subjects (0.12 \pm 0.09ng/ml; $p=0.001$). After 3 months of effective treatment with escitalopram, the levels of total cholesterol(179.4 \pm 29.6mg/dl vs 195.3 \pm 33.3 mg/dl, $t=-2.859$, $P=0.009$), HDL-C(51.0 \pm 11.7mg/dl vs 57.4 \pm 15.4mg/dl, $t=-2.712$, $p=0.012$), LDL-C(109.0 \pm 25.8mg/dl vs 120.0 \pm 31.9mg/dl, $t=-2.657$, $p=0.014$) and tissue factor(0.23 \pm 0.117ng/ml vs 0.24 \pm 0.12ng/ml, $t=-4.215$, $p=0.0001$) were significantly increased in the PD patients,

whereas the mean body mass index(BMI), mean systolic and diastolic blood pressure, and levels of TNF-a and IL-6 were not changed. Conclusion: We suggest that escitalopram treatment can increase some cardiovascular risks in PD patients although escitalopram is an effective anti-panic drug. Thus, clinicians should be more cautious to use escitalopram for PD patients who have overt or covert cardiovascular disorders.

SCIENTIFIC AND CLINICAL REPORT 5

TRAUMA AND EVENTS IN AMERICAN SOCIETY

SCR05-1

SANDUSKY'S LEGACY: REMAINS OF CHILDHOOD TRAUMA IN ADULT LIFE

Speaker: Lenore C. Terr, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To identify long-term adult effects of having been traumatized as a child;2) To recognize sudden, single-appearing manifestations, such as unexpected fears or panic attacks, and impulsive reactive episodes;3) To recognize longstanding repeated manifestation, such as life themes and preoccupation with memory

SUMMARY:

Objectives: To learn from 8 adults who worked with the author during one window of time-July and early August, 2012-what effects were created in their adult lives by incidents of childhood sexual abuse, physical abuse, kidnapping, rape, and/or witnessing murder. Methods: At the time of the "Sandusky Eight," when 8 men abused as children at Pennsylvania State University were presented at criminal trial, the author saw or heard in her practice from 8 adults subjected to traumatic events while they were children. They had ranged in age from infancy to late adolescence during their traumas. The adult manifestations arising in July and early August from their childhood traumas were collected and grouped into single-symptomatic occurrences and long-term, repeated themes and preoccupations. Predictions could then be made-in part-about what might be expected from other traumatized youngsters as they grew to maturity. Results: The single occurrences reported coincidental to the Sandusky trial by the 8 clinical subjects in the author's practice included fears and panic states related to the original traumatic events. These arose suddenly and without warning. A second type of single symptomatic occurrence in adulthood was unexpected, unexplained behavior, which, upon reflection, mirrored a childhood response to the original youthful experience(s). The longstanding type of adult behavior, on the other hand, represented repeated actions that eventually took on the character of a life theme. This theme had become an integrated part of the adults' mature personality. Finally, the preoccupations with childhood memory searches and the returns of memory fragments in these adults represented longstanding aspects of their trauma-engendered psychopathology. Conclusion:

General psychiatrists should be aware that childhood trauma may weigh heavily on their adult patients' symptomatology and psychological traits. Diagnoses that do not include PTSD may still depend on the old traumas for their origins. In psychotherapy, these effects must be examined and thoroughly treated, if the patient is to benefit maximally from our interventions.

SCR05-2

HURRICANE KATRINA'S PSYCHOLOGICAL AND NEUROENDOCRINE IMPACT ON RELOCATED ADOLESCENTS: A PILOT STUDY

Speaker: Phebe M. Tucker, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Address gaps in psychiatrists' understanding of the literature about how stress and trauma can affect their adolescent patients' emotional and physical health through neuroendocrine and immune changes; 2) Discuss associations of PTSD symptoms and cortisol among adolescent survivors of Hurricane Katrina relocated to Oklahoma with their families

SUMMARY:

Trauma and stress are associated with emotional symptoms and neuroendocrine changes in adults and adolescents, although little research explores these issues after dual traumas of hurricane exposure and relocation in youth. We compared 8 adolescent Katrina survivors relocated with their families to Oklahoma and 8 demographically matched Oklahoma adolescents for psychometric and neuroendocrine measures. UCLA PTSD Index and SPRINT for Children and measured PTSD, and CDI assessed depressive symptoms. Neuroendocrine measures included 8am salivary cortisol, Interleukin-2 (reflecting cell-mediated immunity) and Interleukin-6 (a pro-inflammatory cytokine). Two-sided Wilcoxon rank sum tests and Spearman rank correlations analyzed data, significant at $p < 0.10$. Katrina survivors had significantly more symptoms of PTSD (SPRINT, $p = 0.002$) and depression ($p = 0.09$) and lower cortisols than controls ($p = 0.07$), consistent with low cortisols noted in PTSD in other studies. For all participants, cortisol correlated negatively with SPRINT ($p = 0.097$), supporting other studies associating PTSD with lower cortisols. While groups did not differ in the cytokines IL-2 or IL-6, among Katrina survivors only, IL-6 correlated negatively with UCLA PTSD Index ($p = 0.07$), showing an unexpected lack of inflammatory response in relation to PTSD symptoms. For all participants, cortisol correlated positively with IL-2 ($p = 0.0027$). Similarly, for controls, cortisol correlated positively with IL-2 ($p = 0.046$), and Katrina adolescents trended toward positive correlations between cortisol and IL-2 ($p = 0.12$); these findings support research associating stress responses with both lower cortisol and lower cell-mediated immunity. Our results agree with other studies associating traumatic stress with low cortisol, and suggest that low cortisols are associated with

cell-mediated immune system changes among adolescents exposed to a hurricane and relocation. However, our study did not find increased inflammatory responses after the dual traumas, implying that youth may lack inflammatory changes seen in adults after trauma, or that they may be resilient in some ways. We will relate our results with other investigations of stress's effects on neuroendocrine measures in youth, and with our own investigations of adult Katrina survivors. Possible health implications will be discussed. A small sample size in this pilot study may limit our findings, and underscores the importance of further investigations. We discuss challenges in recruiting adolescents into research studies after disaster, and of identifying demographically matched controls. Co-authors: Haekyung Jeon-Slaughter, Ph.D.; Betty Pfefferbaum, M.D., J.D.; Laura B. Smith, M.D., Theresa Garton, M.D.

SCIENTIFIC AND CLINICAL REPORT 6

GENETICS BROADLY CONSIDERED

SCR06-1

EPIGENETICS, MEMORY, MEMES, AND CULTURE IN MENTAL ILLNESS

Speaker: Hoyle Leigh, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the concept of memes in relation to memory, information, and culture; 2) Explain the role of stress, memory, and memes in epigenetics; 3) Identify the means of enhancing salutary memes that may offset the noxious effects of stress

SUMMARY:

The purpose of this presentation is to answer the question, "How does stress affect genes and influence mental illness?" Childhood abuse has been shown to affect the risk of anxiety and depression through epigenetic changes of the serotonin transporter promoter gene (SERT) among others, (1), and cellular aging as seen in telomere length (2, 3). Genes are turned on or off through methylation, changes in histone code, and other mechanisms within the microenvironment of the cell nucleus. Such micro environmental changes are brought about by hormonal and neurotransmitter secretion controlled by the central nervous system, which, in turn, is affected by memes. Memes are information encoded as reinforced neural connections of clusters of neurons (4). Reinforced neural clusters containing memes undergo Darwinian selection in the brain (5). Memes are based on memory, but may be communicated to other brains as well as being stored outside the brain in books, music, videos, etc. Such extracranial memes undergo Darwinian selection and evolution as culture. Endemic cultural memes are absorbed early in childhood and form filters for future meme infusion. Perception of external stimulus such as abuse and nurturance, as well as new memes from new cultural environment, are processed in the light of existing cultural and experiential memes in the brain, resulting in

specific activation or non-activation of specific pathways such as fight/flight, relaxation, etc. Memes, being specific neural connections, affect specific neural activation causing specific hormonal and neurotransmitter secretion resulting in epigenetic changes and HPA activation. Conclusions: Epigenetic changes and stress reaction in the brain are based on interaction among cultural memes, experiential memes (memory), and genes. Pathogenic memes in the social environment may infect brains and predispose them to illness. By boosting salutary memes, the noxious effects of environmental stress may be prevented.

References 1.Caspi A, Hariri AR, Holmes A, Uher R, Moffitt TE. Genetic sensitivity to the environment: the case of the serotonin transporter gene and its implications for studying complex diseases and traits. *Am J Psychiatry*. May 2010;167(5):509-527. 2.Shalev I, Moffitt TE, Sugden K, et al. Exposure to violence during childhood is associated with telomere erosion from 5 to 10 years of age: a longitudinal study. *Mol Psychiatry*. Apr 24 2012. 3. Drury SS, Theall K, Gleason MM, et al. Telomere length and early severe social deprivation: linking early adversity and cellular aging. *Mol Psychiatry*. Jul 2011;17(7):719-727. 4.Tsien JZ. Real-time neural coding of memory. *Prog Brain Res*. 2007;165:105-122. 5.Edelman GM. Neural Darwinism: selection and reentrant signaling in higher brain function. *Neuron*. Feb 1993;10(2):115-125.

SCR06-2

22Q13 DELETION SYNDROME: RESULTS FROM COMPREHENSIVE CLINICAL AND GENETIC EVALUATIONS

Speaker: Benjamin N. Angarita, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the phenotype and genotype of youth with 22q13 Deletion Syndrome;2) Examine the relationship between phenotype and genotype in 22q13 Deletion syndrome;3) Develop clinical practice parameters for evaluating and monitoring in 22q13 Deletion syndrome

SUMMARY:

OBJECTIVES: 22q13 deletion syndrome (22q13DS), also known as Phelan McDermid Syndrome, is a complex genetic disorder characterized by global developmental delay, motor skills deficits, delayed or absent speech, and autism spectrum disorder (ASD). SHANK3 is the critical gene in this syndrome and loss of one copy of SHANK3 causes a monogenic form of ASD with a frequency of 0.5-1% of ASD cases. Our goal is to comprehensively evaluate subjects with 22q13 deletions/SHANK3 mutations clinically and genetically to fully characterize this syndrome and clarify the prevalence of Autism Spectrum Disorders (ASD) and other features. This poster will: 1) examine the phenotype of 22q13DS; 2) explore the relationship between phenotype and genotype in 22q13DS; 3) propose clinical practice parameters for the evaluation and monitoring of affected individuals. METHODS: Subjects

undergo a comprehensive assessment battery, including: (1) psychiatric evaluation; (2) clinical genetics evaluation; (3) neurological examination; (4) Autism Diagnostic Observation Schedule (ADOS-G); (5) Autism Diagnostic Interview (ADI-R); (6) multiplex ligation-dependent probe amplification (MLPA), Illumina Omni 2.5-8 v1 array, and Sanger sequencing. Descriptive statistics were calculated across all measures and Spearman rank correlation coefficients were used to explore associations between genotype, deletion, and phenotypic features. **RESULTS:** Participants were 18 males and 14 females, ages 1.7-45.4 years old. Analysis of data from the first 32 subjects indicates a consensus diagnosis of Autistic Disorder in 68.75% (N=22), Autism Spectrum Disorder in 15.6% (N=5) and five subjects were not on the autism spectrum (15.6%). The most common dysmorphic features included large fleshy hands in 53% (N=17) and bulbous nose in 47% (N=15). Common medical comorbidities included hypotonia in 75% (N=24), seizures in 38% (N=12), and renal abnormalities in 38% (N=12). One hundred percent of participants had SHANK3 deficiency either due to terminal deletions, ring chromosomes, interstitial deletions, or mutations (N=2). Among the 30 participants with SHANK3 deletions, deletion sizes ranged from 101Kb to 8.45Mb (X=4.21Mb, SD=2.75 Mb). Significant correlations were found between larger deletion size and the total number of dysmorphic features ($\rho = -0.472$, $p = 0.006$) and the total number of medical comorbidities ($\rho = 0.425$, $p = 0.015$). The prevalence and severity of ASD symptoms, cognitive deficits, and motor skill deficits were not significantly correlated with deletion size after correction for multiple comparisons. **CONCLUSIONS:** The majority of the patients with 22q13DS in this small sample have autism spectrum disorders and the number of medical comorbidities and dysmorphic features are associated with larger deletion size. Expansion of the sample size over the next year will advance our understanding of the phenotype in 22q13DS and aid in the development of clinical practice parameters.

SCR06-3

IS THERE A GENE-SPIRITUAL CONNECTION?

Speaker: Albert Gaw, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the role of telomere and telomerase as they affect the longevity of genes; 2) Be acquainted with the data on the possible relationship of telomere, telomerase, stress, aging, and spirituality; 3) Learn the preliminary putative mechanisms for a gene-spiritual connection; 4) Consider implications for psycho-spiritual research and clinical care

SUMMARY:

Advances in research technologies, including functional MRI, sophisticated research designs and powerful statistical analysis, have enabled psychiatric researchers to undertake studies beyond traditional psychopathological entities. Such an area of new inquiry that could be subsumed under positive

psychiatry is psycho-spirituality. The question of a gene-spiritual connection is at the heart of psycho-spiritual research. This presentation will review: 1. Recent studies on telomere, stress, aging, and spirituality and posit a possible "Gene-Spiritual Connection"; 2. Attempt to advance putative mechanisms that may underlie possible gene-spiritual connection; and, 3. Suggest implications for psycho-spiritual research and clinical care.

MAY 19, 2013

SCIENTIFIC AND CLINICAL REPORT 7

IMAGING IN DEPRESSION AND PSYCHOSIS

SCR07-1

QUETIAPINE PREVENTS HIPPOCAMPAL WHITE MATTER DAMAGE IN THE BRAIN OF GLOBAL CEREBRAL ISCHEMIA MOUSE: A MODEL OF VASCULAR DEPRESSION

Speaker: Yanbo Zhang, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the possible mechanism of quetiapine treating vascular depression; 2) Understand the animal model of vascular depression; 3) Understand the role of white matter in the pathophysiology of vascular depression

SUMMARY:

White matter impairment is a feature of vascular depression. The antipsychotic quetiapine has been shown to enhance the therapeutic effects of antidepressants on vascular depression, but the mechanism remains unknown. In this study, we found that two weeks of treatment with quetiapine prior to bilateral carotid artery occlusion and reperfusion, an animal model of vascular depression, resulted in reduced myelin breakdown and oligodendrocyte loss compared to placebo treated mice on postoperative day (POD) 7. For late stage of recovery (POD40), quetiapine treatment resulted in enhanced oligodendrocyte maturation relative to placebo. The results suggest that quetiapine is a potential intervention for oligodendrocyte damage and this may contribute to its antidepressant effects through white matter protection in vascular depression.

SCR07-2

A RETROSPECTIVE CHART-REVIEW STUDY OF INPATIENT ADOLESCENTS AND YOUNG ADULTS WITH FIRST-EPIISODE PSYCHOSIS AND FINDINGS WITH STRUCTURAL BRAIN IMAGING

Speaker: Steven R. Williams, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify which patients with first episode psychosis are least likely to have significant findings with structural brain imaging;2) Recognize the role that cannabis use may have with first episode psychosis and how this may guide treatment;3) Identify the potential effects of radiation exposure in young adults having a CT of the head and the costs of MRI of the head in the context of evidence based medicine

SUMMARY:

METHODS: This was a retrospective chart review of patients ages 12 to 30 admitted to either the adolescent or adult psychiatric inpatient unit with an initial presentation of first episode psychosis (FEP). All charts were reviewed from 2006 to 2012 who had either a CT or MRI of the brain at the time of admission. Exclusion criteria was the following: 1. As best as can be determined by history and urine drug screen, all patients with alcohol abuse or illicit drug use during the one month prior to admission. 2. On physical examination, there are no significant or localizing neurologic findings. 3. The patient does not endorse any significant neurologic symptoms, nor any significant neurologic history such as seizures. 4. No history of recent head trauma. **RESULTS:** A total of 290 charts were found with the above age range with FEP without the above exclusion criteria. Fifty-four were excluded because of cannabis use only. With the exclusion criteria a total of 115 were found. CT-93, MRI-14, CT and MRI-8. There were 6 incidental findings and none of these findings were considered to be causal or of etiologic significance related to the presenting psychiatric symptoms. None of the 6 incidental findings required non-psychiatric treatment. The null hypothesis test is that in 3% or more of cases, brain imaging will help with the diagnosis. However, this null hypothesis will be rejected based on data with a p-value of 0.03, which means that the probability that this hypothesis is true is 0.03, and most likely, even if there is a proportion of imaging cases with significant yields, the proportion will be much smaller than 3%. **CONCLUSIONS:** With the use of exclusion criteria, the diagnostic yield and utility of structural brain imaging with younger FEP patients is minimal. Cannabis use only may be associated and causal with FEP patients. CT scans and radiation exposure and MRI and cost should be considered when evaluating younger FEP patients.

SCR07-3**STRUCTURAL BRAIN ABNORMALITIES IN AFFECTED AND UNAFFECTED RELATIVES OF PATIENTS WITH A PSYCHOTIC DISORDER**

Speaker: Neeraj Tandon

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe structural brain abnormalities in patients with different psychotic disorders and their first degree relatives;2) Understand the genetic diathesis of these morpho-

metric abnormalities;3) Know which of these abnormalities are related to clinical expression of psychosis

SUMMARY:

Structural abnormalities in several brain regions have been well-documented in individuals with schizophrenia, schizoaffective disorder, and psychotic bipolar disorder. There are similarities and differences in the nature of the changes across these conditions. It is unclear as to which of these abnormalities reflect a genetic diathesis and which mark illness expression. To investigate this issue, we compared structural brain abnormalities of 309 first degree relatives of patients with schizophrenia, schizoaffective disorder, and bipolar disorder (177, 106, 162, respectively) and 264 healthy controls enrolled in the Bipolar Schizophrenia Network on Intermediate Phenotypes (B-SNIP) study. Diagnostic groups and relatives were assessed using the SCID; relatives with Axis I psychotic disorders, cluster A Axis II disorders, nonpsychotic Axis I disorders, and those unaffected by any psychopathology were compared. Volumes of cortical and subcortical gray matter regions were obtained from 3T structural MRI using Free Surfer software. ANOVAs were used to compare groups, covarying for age, sex, site, and intracranial volume. Statistically significant reductions in gray matter volume were observed in various prefrontal and temporal regions between relatives with Axis I psychotic disorder and cluster A Axis II disorders compared to other relatives and healthy controls. Relatives of probands with schizophrenia, schizoaffective disorder, and bipolar disorder were found not to differ significantly from one another upon controlling for diagnosis of the relative. We and other groups have previously shown that individuals with schizophrenia and schizoaffective disorder in comparison with healthy controls are characterized by significant reductions in frontal and temporal volumes, with both groups also showing reductions compared to bipolar disorder I. Taken together, these data suggest that different structural brain abnormalities in different psychotic disorders are principally related to expression of psychotic symptoms and that there is a shared genetic diathesis underlying morphometric brain abnormalities across different psychotic disorders.

SCIENTIFIC AND CLINICAL REPORT 8**BORDERLINE PERSONALITY AND DIAGNOSTIC COMORBIDITY****SCR08-1****INTERACTIONS OF BORDERLINE PERSONALITY DISORDER AND ANXIETY DISORDERS, EATING DISORDERS, AND SUBSTANCE USE DISORDERS OVER 10 YEARS**

Speaker: Alex S. Keuroghlian, M.D., M.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the longitudinal reciprocal interactions

of borderline personality disorder with anxiety disorders;2) Identify the longitudinal reciprocal interactions of borderline personality disorder with substance use disorders;3) Identify the longitudinal reciprocal interactions of borderline personality disorder with eating disorders;4) Treat borderline personality disorder and comorbid anxiety disorders, substance use disorders, and eating disorders more effectively

SUMMARY:

Objective: Several studies have assessed the prevalence of axis I disorders in patients meeting diagnostic criteria for borderline personality disorder (BPD). They have demonstrated that borderline patients are at high risk of developing comorbid axis I disorders, including chronic affective disorders, anxiety disorders, substance use disorders and eating disorders. In our previous 10-year report from the Collaborative Longitudinal Personality Disorders Study, we found that BPD and major depressive disorder had strong reciprocal effects on each other's time-to-remission and time-to-relapse, and that BPD and the bipolar disorders had no significant effect on each other's course, with the exception that bipolar II increased BPD's time-to-remission (Gunderson et al., under review). The goal of the current study is to examine the reciprocal interactions of BPD and anxiety disorders, substance use disorders and eating disorders over 10 years of prospective follow-up. **Method:** Borderline patients with comorbid anxiety disorders, eating disorders, and substance use disorders were assessed using yearly diagnostic interviews over a period of 10 years in the Collaborative Longitudinal Personality Disorders Study. Proportional hazards regression analyses were used to assess the effects of improvement or worsening of BPD on time-to-remission and time-to-relapse of anxiety disorders, substance use disorders and eating disorders, and similar effects of these axis I disorders on time-to-remission and time-to-relapse of BPD. **Results:** Over a 10-year period, the presence of BPD was associated with a significantly lengthened time-to-remission of generalized anxiety disorder, PTSD and eating disorders. BPD had no significant effect on the time-to-remission of panic disorder, social phobia, OCD or substance use disorders. The presence of BPD was also significantly associated with shorter time-to-relapse of panic disorder, social phobia and drug abuse/dependence, but had no effect on time-to-relapse of generalized anxiety disorder, OCD, eating disorders and alcohol abuse/dependence. None of the anxiety disorders, eating disorders or substance use disorders studied had any effect on the time-to-remission of BPD. Panic disorder and PTSD both had significantly shortened the time-to-relapse of BPD. **Conclusions:** BPD significantly increases time-to-remission of certain anxiety disorders and eating disorders, however none of the axis I disorders appear to influence the time-to-remission of BPD. BPD significantly decreases time-to-relapse of several axis I disorders, while certain anxiety disorders significantly decrease the time-to-relapse of BPD. Implications of these findings for the treatment of BPD and comorbid anxiety disorders, substance use disorders, and eating disorders will be discussed.

SCR08-2

ECOLOGICAL MOMENTARY ASSESSMENT OF AFFECTIVE LABILITY IN BORDERLINE PERSONALITY AND BIPOLAR II DISORDERS

Speaker: D. Bradford Reich, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the use of ecological momentary assessment in assessing affective lability in borderline personality disorder and bipolar II disorder;2) Understand the different dimensions of affective change that comprise affective instability in borderline personality disorder and bipolar disorder;3) Understand how the profiles of affective lability obtained using ecological momentary assessment differ between borderline personality disorder and bipolar II disorder

SUMMARY:

Background: Previous research using retrospective reports has suggested that the affective lability in borderline personality disorder (BPD) and bipolar II disorder may have different profiles. Research using ecological momentary assessment (EMA) has found that the affective lability in BPD differs from that in depressive disorders. This study used EMA to compare affective lability in BPD and bipolar II disorder. **Methods:** Subjects were 20 women ages 18-55. 10 subjects met DSM-IV criteria for bipolar II disorder; 10 subjects met DSM-IV for BPD and had scores on the Revised Diagnostic Interview for Borderlines (DIB-R) of 8 or higher. Subjects used electronic diaries to record affective shifts in 10 dimensions 3 times per day for 7 days. Each time subjects recorded a shift, they were asked to record the intensity of that shift. At the end of the assessment period, subjects were administered the Affective Lability Interview for Borderline Personality Disorder (ALI-BPD), which assesses affective lability over the previous week. **Results:** Subjects with BPD reported significantly more frequent affective shifts in 5 of 10 dimensions measured. These included shifts between: euthymia and anxiety; euthymia and anger; depression and anxiety; anxiety and depression; and anxiety and anger. In addition, borderline subjects reported significantly more intense shifts between euthymia and anxiety. 16 of 20 correlations between momentary assessment ratings and ratings from the ALI-BPD were 0.70 or higher ($p < 0.005$). **Conclusion:** This study supports previous research suggesting that BPD and bipolar disorder are discrete clinical entities. In addition, it suggests that retrospective assessment of affective lability in BPD and bipolar II disorder over a one week period may accurately capture affective lability as measured by momentary assessment.

SCR08-3**DETERMINE THE IMPACT OF BORDERLINE PERSONALITY DISORDER IN THE TREATMENT OUTCOME OF DEPRESSION**

Speaker: Ruby Mangsatabam, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Determine the impact of Borderline Personality Disorder in the treatment outcome of Depression; 2) Determine the response of Depressive patients with Borderline Personality disorder on SSRIs; 3) Identify the number of patients with both Depression and Borderline Personality Disorder with remission on SSRIs

SUMMARY:

Objective: It has been seen that there is a prominence of Depressive moods and affective lability in the core pathology of Borderline Personality Disorder. Co-morbidity with Axis I affective disorder is highly prevalent with Borderline Personality Disorder. On examining Personality Disorder individuals with co-morbid Axis I diagnosis, there has always been a question about whether the presence of Personality Disorder has any relationship to treatment outcome in depressed patients. The purpose of this paper is to determine if there is a relationship of personality disorder to treatment outcome in depressed patients. Methods: A total 130 patients, who met the DSM-IV-TR criteria for Major Depression. These patients were then evaluated with Structured Interview for DSM-IV personality disorder (SIDP). Determinations were made as to whether the patient did or did not meet the criteria for borderline personality. Overall 52 patients met the criteria for Depression and borderline personality, and 78 met criteria for Depression alone. All patients were rated with the MADRS scale then treated with SSRI'S (Fluoxetine, Sertraline, Paroxetine and Escitalopram) and the response to treatment was measured. A MADRS score with 50% reduction from initial MADRS was considered a response and a MADRS score of 8 or less is considered Remission. Results: Out of 52 patients with Depression and Borderline personality, 7 remitted (MADRS < 8), 17 responded (50% reduction from initial MADRS) with a MADRS endpoint score between 9 and 14. And 28 (53.8%) showed no-response (i.e., <50% reduction in MADRS and MADRS endpoint score 15 or greater). For the group with Depression alone, 27 remitted, 27 responded and 24 (30.7%) did not respond. Conclusion: This study result shows that Borderline Personality Disorder causes less treatment response in Depression, and there is a difference in favor of depression alone. The study result was statistically significant ($P < .001$). This study was a Naturalistic one, further research with Randomized multicentre trials with different Personality Disorders need to be done.

SCIENTIFIC AND CLINICAL REPORT 9**TOPICS IN CHILD AND ADOLESCENT PSYCHIATRY****SCR09-1****MULTI-EXPOSURE AND CLUSTERING OF ADVERSE CHILDHOOD EXPERIENCES: SOCIO-ECONOMIC DIFFERENCES AND PSYCHOTROPIC MEDICATION IN YOUNG ADULTS**

Speaker: Emma Bjorkenstam, B.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Clarify the association between socioeconomic position, adverse childhood experiences, and risk of psychotropic medication in young adulthood; 2) Explore whether the risk of psychotropic medication increases with increasing number of adverse childhood experiences; 3) Investigate whether adverse childhood experiences cluster between and within socioeconomic groups

SUMMARY:

Purpose: Stressful childhood experiences have negative long term health consequences. The present study examines the association between adverse childhood experiences, socioeconomic position, and risk of psychotropic medication in young adulthood. Methods: This register-based cohort study comprises the birth cohorts between 1985 and 1988 in Sweden. We followed 362 663 individuals for use of psychotropic medication from January 2006 until December 2008. Adverse childhood experiences were; severe criminality among parents, parental alcohol or drug abuse, social assistance reciprocity, parental separation or single household, child welfare intervention before the age of 12, mentally ill or suicidal parents, familial death, and number of changes in place of residency. Estimates of risk of psychotropic medication were calculated as odds ratio (OR) with 95% confidence intervals (CIs) using logistic regression analysis. Results: Adverse childhood experiences were associated with increased risks of psychotropic medication. The OR for more than three adverse childhood experiences and risk of psychotropic medication was for women 2.4 (95% CI 2.3-2.5) and for men 3.1 (95% CI 2.9-3.2). The risk of psychotropic medication increased with a higher rate of adverse childhood experiences, a relationship similar in all socioeconomic groups. Conclusions: Accumulation of adverse childhood experiences increases the risk of psychotropic medication in young adults. Parental educational level is of less importance when adjusting for adverse childhood experiences. The higher risk for future mental health problems among children from lower socioeconomic groups, compared to peers from more advantaged backgrounds, seems to be linked to a higher rate of exposure to adverse childhood experiences.

SCR09-2**RISK FACTORS FOR POST-DISCHARGE SUICIDALITY AMONG CHILD AND ADOLESCENT PSYCHIATRIC INPATIENTS**

Speaker: Stephen Woolley, D.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Investigate the interrelationships of major depressive disorder and hopelessness affecting the magnitude of risk of post-discharge child/adolescent suicidal ideation; 2) Describe the risk of and trends in suicidal ideation among children/adolescent inpatients after discharge during 2000-12; 3) Evaluate individually and in combinations patient and family characteristics and patient clinical experiences associated with child/adolescent post-discharge risk of suicidal ideation

SUMMARY:

Objective In an earlier study the investigators found that the frequency of suicidal ideation (SI) in child and adolescent psychiatric (CA) patients rose precipitously after 2010 to 2-3x the rates for 2000-9. The aim of the present study was to identify possible causes of post-discharge SI in this sample. **Method** The sample was inpatients ages 5-17 whose parents responded to a survey 1-month post-discharge (n=656). Responses on a Likert scale indicated SI; variables examined included multiple specific symptoms/issues which were rated at a level of moderate to extreme difficulty (MED), demographics, diagnoses (Dx) and therapies (Rx). **Analysis:** bivariate and regression. **Results** The sample was half female, 68% white (W), 17% Hispanic (H) and 6% black (B). Dx was MDD in 35%, any anxiety disorder in 30%, PTSD in 17%. Most common Rx were antidepressants in 64% and antipsychotics in 51%. 20% reported SI. MED with hopelessness was present in 50%, with school in 58%, with family relationships in 48%, with managing day-to-day in 46% and with anger in 40%. In bivariate analyses, race by sex (M/F) groups varied for risk of SI (2.7x for HF vs BF), for MED with depression (3.7x for HF vs BF) and for impulsivity (4.9x for BM vs WF), and for LOS ?9 days (1.5x for BF vs WM). Risk (expressed as the odds ratio, OR) of SI was associated with being W (1.6), age 15-17 (but not 10-14) vs 5-9 (2.2), diabetes (3.5), hypertension (6.3), and BMI>30 (2.8). The OR for SI was elevated for hopelessness (23.2), self-confidence (14.5), mood swings (6.2), stress (6.0), memory (5.1), anger (3.8), impulsivity (2.5), living with non-family (2.5), anxiety/tension (2.5) and sleep difficulty (2.0). Stratified analyses showed that without hopelessness only 3% had SI vs 37% with hopelessness present. For patients with hopelessness several variables rose to significance: MDD, living with non-family, antidepressants, and MED on several issues (eg, school, mood swings). In adjusted regression models SI was associated with family relationships, living with non-family, and MDD or hopelessness but not substance abuse (SAb) or impulsivity. **Conclusions** This study confirms in CA the reports by Beck, et al. that hopelessness is strongly associated with suicidality (in present study

p<.001). Analyses of CA stratified by hopelessness raises issues for future research of CA risk of SI; as expected risk of SI was substantially elevated in the presence of hopelessness but unexpected were 1) the very low SI risk in the absence of hopelessness and 2) that most risk factors for SI were significant only with hopelessness present. Important SI risk factors also included difficulty with self-confidence, mood, stress, confusion, and anger, but roles of often cited risk factors such as SAb or impulsivity were not consistently supported. MDD and hopelessness may be synergistic for risk of SI. Co-author: John W. Goethe, M.D.

SCR09-3**THE EFFECT OF EARLY TREATMENT ON ADULT OUTCOMES IN AUTISM**

Speaker: Bryna Siegel, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about adult outcomes in autism spectrum disorders; 2) Learn about the effectiveness of early intensive behavioral therapies on adults with autism spectrum disorders; 3) Learn about the relative prognostic value of pre-treatment characteristics versus early treatments in autism spectrum disorders

SUMMARY:

Background: In the last 20 years, early intensive behavioral interventions (EIBI) using applied behavior analysis have become the most costly and controversial evidence-based treatment for autism, yet there are no reports of long-term benefits of such treatment when children who received EIBI become adults. This pilot is the first to report on young adults who were among the first to receive such treatment. **Methods:** Fifteen adults (ages 21-26 years) diagnosed with an autism spectrum disorder in early childhood (23-46 months of age) were prospectively followed to ascertain variance in adult outcomes from EIBI. The sample included initially cognitively higher functioning, and symptomatically mild cases, moderately affected cases, as well as initially severely affected cases with initial significant cognitive delays. **Results:** Results suggests that higher functioning cases, especially those with initially milder symptoms who received substantial EIBI were significantly more likely to not meet ADOS autism spectrum criteria for autism as adults. EIBI for more moderately impaired cases appeared related to increased adaptive ability, but had less impact on 'downgrading' diagnosis. Initially severely impaired cases remained severely impaired and severely autistic whether or not they had received EIBI, though parents of these adults uniformly attributed the gains their adult child had made as due to EIBI. **Discussion:** We will discuss results and implications for quality of life dimensions for adults with autism: education and employability, family dependence, residential status, and health co-morbidities of parents as long-term caregivers. Models for early education given adult outcomes will be raised for discussion.

SCIENTIFIC AND CLINICAL REPORT 10**DEPRESSION: COURSE, REMISSION, RESISTANCE****SCR10-1****A NEW TYPE OF SCALE FOR DETERMINING REMISSION FROM DEPRESSION: THE REMISSION FROM DEPRESSION QUESTIONNAIRE**

Speaker: Mark Zimmerman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the remission should be defined using multiple constructs including symptoms, functioning, and coping ability;2) Become aware of a new measure to evaluate depression remission which assesses multiple components of remission;3) Become familiar with the results of a study suggesting that a multidimensional remission scale is more valid than a symptom measure

SUMMARY:

Background: Current standards for treating major depressive disorder (MDD) recommend that achieving remission should be considered the principal goal of treatment. Recent research suggests that the symptom-based definitions of remission used in efficacy studies do not adequately reflect the perspective of depressed patients receiving treatment in routine clinical settings. We developed the Remission from Depression Questionnaire (RDQ) to capture the broader array of domains considered by patients to be relevant to the construct of remission-symptoms of depression, nondepressive symptoms, features of positive mental health, coping ability, functioning, life satisfaction and a general sense of well-being. The current report is the first study of the reliability and validity of the RDQ. **Methods:** The test-retest reliability of the RDQ was studied in 60 depressed outpatients in ongoing treatment. The convergent and discriminant validity of the RDQ was studied in 274 depressed outpatients who were rated on the 17-item Hamilton Depression Scale (HAM-D) and who completed several self-report scales including the Quick Inventory of Depressive Symptoms (QIDS). **Results:** The RDQ demonstrated excellent internal consistency, with a Cronbach's α of .97 for the total scale and above .80 for each of the 7 subscales. The test-retest reliability of the total scale was .85 and above .60 for each subscale. Both the RDQ and QIDS were significantly associated with patients self-reported remission status. However, the RDQ remained significantly associated with remission status after controlling for QIDS scores ($r = -.32, p < .001$) whereas the QIDS was not associated with remission status after controlling for RDQ scores ($r = -.06$). **Discussion:** The RDQ is a reliable and valid measure that evaluates the multiple domains that depressed patients consider important in determining remission. The results are consistent with prior research suggesting that depressed patients' perspective of remission goes beyond symptom

resolution.

SCR10-2**CHANGES IN PSYCHOTROPIC PRESCRIPTION DURING HOSPITALIZATION OF DEPRESSED PATIENTS CORRELATED WITH INNATE CYP2D6 FUNCTION**

Speaker: Richard L. Seip, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the prevalence and significance of CYP2D6 drug metabolism deficiencies;2) Assess the utility of CYP2D6 Metabolic Reserve in characterizing and individual's metabolic phenotype;3) Utilize CYP2D6 MR to improve psychotropic management

SUMMARY:

Objective: Many psychotropic medications are known substrates for metabolism by the cytochrome p450 2D6 isoenzyme (CYP2D6) encoded by the CYP2D6 gene. Well-characterized sequence alterations in the CYP2D6 gene occur with significant frequency in psychiatric populations. These include 15 loss-of-function alleles encoding a null or deficient metabolizer isoenzyme and 3 gain-of-function alleles encoding a rapid metabolizer isoenzyme. We hypothesized that innate CYP2D6 functional status is related to psychotropic prescription patterns during hospitalization of patients with major depressive disorder (MDD). **Methods:** CYP2D6 functional status was determined by genotyping 18 CYP2D6 alleles in 150 psychiatric inpatients with MDD admitted to the Hartford Hospital Institute of Living. We quantified CYP2D6 Metabolic Reserve (MR) based on the genotype of null, deficient, functional, and rapid alleles for each patient. Patients were grouped (I to VI) according to CYP2D6 MR as follows: I: 0 or 0.5 [null or poor, N=8]; II: 1.0 [deficient, N=36]; III: 1.5 [deficient, N=22]; IV: 2.0 [functional, N=41]; V: 2.5 [functional, N=29]; VI: 3.0 [rapid, N=13]. A total of 17 CYP2D6-substrate (11 major, 6 minor) psychotropic drugs were taken by these patients (10 antidepressants, 7 antipsychotics). We compared the number of CYP2D6-substrate medications prescribed at admission and during hospitalization to those prescribed at discharge for each patient to determine prescription changes during hospitalization. We assessed the effect of CYP2D6 MR on prescription changes using one-way ANOVA (linear model) and Sidak post hoc tests. **Results:** A mean of 2.1 ± 0.1 SE CYP2D6-substrate drugs were prescribed at admission or during the index hospitalization and 1.9 ± 0.1 SE CYP2D6-substrate drugs at discharge ($p < 0.0001$). During hospitalization, CYP2D6 genotypes were not available, and prescription changes were made on clinical considerations alone. When genotyping results and MR are applied, Group membership significantly affected prescription changes ($p < 0.002$). Group I had the most prescription changes (0.88 drugs ± 0.30 SE). It differed significantly from Group IV (0.20 drugs ± 0.06 SE, $p < 0.02$) and from Group V (0.03 drugs ± 0.03 SE,

$p < 0.002$). Group II (0.42 drugs \pm 0.12 SE), Group III (0.36 drugs \pm 0.14 SE) and Group VI (0.31 drugs \pm 0.13 SE) were intermediate between Group I and Groups IV-V. Conclusion: There was a significantly greater reduction in the number of CYP2D6-substrate drugs prescribed to MDD patients with null or poor CYP2D6 MR during hospitalization, compared to patients with functional MR. Patients with deficient and rapid MR were intermediate. Empirical psychotropic management during hospitalization is more intricate in patients with altered (sub- or supra-normal) CYP2D6 MR. Determination of CYP2D6 functional status at admission could improve psychotropic prescription during hospitalization and optimize overall utilization of psychiatric services.

SCR10-3

COURSE OF ILLNESS OVER 12 MONTHS IN PATIENTS WITH SEVERE MAJOR DEPRESSIVE DISORDER

Speaker: Bonnie Szarek, R.N.

Co-Author(s): John W. Goethe, M.D., Stephen Woolley, D.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the outcomes of patients with treatment resistant MDD followed for one year; 2) Identify the clinical and demographic variables associated with poor outcome; 3) Discuss the patterns of service utilization in this sample of severely ill patients

SUMMARY:

Objective: Star-D and other recent studies indicate that many patients with MDD remain symptomatic despite appropriate treatment. However, few studies have specifically examined treatment resistant samples to determine change over time on multiple outcome and service utilization domains. Methods: The sample was 406 patients receiving an SSRI for a clinical diagnosis of MDD who consented to assessments at 3, 6 and 12 months after index episode of care. Via structured interview detailed data were obtained at each time point using the Beck Depression Inventory Fast Screen (BDI-FS) and other measures of clinical and functional status. Data analysis included paired t tests, χ^2 and logistic regression. Results: Illness severity for the sample was high: BDI-FS mean = 7.5 ± 5.4 (well above the cut point for depression of ≥ 4); GAF mean = 36.7 ± 10.3 , 95% with GAF ≥ 50 ; "psychotic features" present in 29.6%; prior treatment for MDD in 77.8%, 25.1% hospitalized in last year. There was statistically significant improvement on several measures: BDI-FS total score (lower at 6 vs 3 months, mean = 6.5 vs 7.4, $p = .005$); self-rated overall health at 6 vs 3 months ("good" or "excellent" in 59.5 vs 50.8%, $p = .005$); self-rated depression "much" or "somewhat" better at 3 months in 73.6%, a rate that was maintained at 6 and 12 months (of those better at 3 months greater than 80% remained so at follow up). However, many patients remained highly symptomatic: BDI-FS ≥ 4 in 69.9,

62.2 and 58.3% of patients at 3, 6 and 12 months; at 12 months 56.2% continued to feel "sad much or all of the time", 36.0% had suicidal ideation, 25.6% reported "no improvement" and 18.2% felt "hopeless". Service utilization analyses revealed that 7% of patients had no follow up visits in the first 3 months after discharge, that many patients had no MD visit between assessment intervals (20.7% at 3, 12.7% at 6 and 14.5% at 12 months) and that 19% were hospitalized by month 12. Conclusions: Response rates were similar to previous reports, but this study shows that a substantial number of patients continue to be symptomatic/dysfunctional despite on-going treatment. The results suggest that outcome is less favorable than previously reported, at least in MDD patients with "severe" illness. Further research specific to this group of patients is needed. Co-authors: John W. Goethe, M.D., Stephen Woolley, D.Sc.

SCR10-4

THE MANAGEMENT OF TREATMENT RESISTANT DEPRESSION

Speaker: Gabor Istvan Keitner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the limitations of a symptom focused approach to treating patients with TRD; 2) Become aware that setting realistic expectations and addressing a patient's functioning, relationships and quality of life can be very helpful; 3) Learn that significant changes in a patient's purpose in life and sense of social support can occur even in the presence of persistent depressive symptoms

SUMMARY:

Up to 30% of patients with depression do not respond to multiple treatment trials and are considered to have treatment resistant depression (TRD). Most treatment trials for these patients continue to focus on symptom reduction as a goal in spite of non-response to treatment. Such an emphasis on symptom reduction may be unrealistic and lead to polypharmacy and increased feelings of hopelessness by the patient and therapist. The management of Depression (MOD) program was designed to focus on how to build a satisfying life with meaningful goals and relationships in the context of persisting depressive symptoms. Subjects. 30 patients with TRD were randomized to treatment as usual (TAU, N=13) and to the MOD program (N=17) for 12 weeks.

Method. All patients continued on medications and current psychotherapy. The MOD group participated in 9 adjunctive sessions of disease management focused therapy. Purpose in life, goals and meaning were assessed by the Scales of Psychological Wellbeing, social support by the Multidimensional Scale of Perceived Social Support and depression severity by the Montgomery-Asberg Depression rating Scale. Patients were assessed at baseline and week 12. Results. Both groups of patients had significant improvements in their depressive symptoms (TAU 35.46 to 25.92 $p < .010$; MOD 31.88

to 22.41 $p < .001$) but continued to experience moderate levels of depression at the end of week 12. The patients in the MOD group also had significant improvement in perception of social support ($p < .034$) and purpose in life ($p < .038$) scores in contrast to the TAU group. Conclusions. Adjunctive treatment focusing on functioning, meaning and relationships, as opposed to mainly symptom reduction, can help patients with TRD to have a more satisfying life in spite of persisting symptoms of depression.

SCIENTIFIC AND CLINICAL REPORT 11

THE INTERNET AND ELECTRONIC COMMUNICATION

SCR11-1

SUICIDE ON FACEBOOK: SUICIDE ASSESSMENT USING ONLINE SOCIAL MEDIA

Speaker: Amir Ahuja, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define the current methods of suicide assessment, and weigh the benefits and drawbacks of the current paradigm; 2) Identify the ways in which social media can allow clinicians to obtain a better suicide assessment and assess more people; 3) Identify the legal and ethical implications of access to a patient's online postings and other material, & weigh risk vs benefit; 4) Recognize the efforts that are already underway to combat suicide using the Internet and social media

SUMMARY:

Often in suicide assessment, an interviewing psychiatrist relies mostly on the patient's oral history. In this case report, we explore the use of online social media to assist in suicide assessment and increasing patient insight. We postulate that, with increased technology usage, social media should be an important source of objective data, both in the form of collateral information and in the form of objective risk factors. With this patient, there was an impulsive suicide attempt without a diagnosable history of depression. With the patient's consent, social media was used to reconstruct a picture of the suicide attempt and establish a clear timeline, which we were unable to obtain from the patient due to his lack of insight. This information helped us assist the patient in gaining more insight into the severity of his condition and helped in getting the patient to agree to a treatment plan. In the future, Facebook and other social media can also be utilized to change the paradigm of suicide assessment to include a proactive approach that would aid in suicide prevention. This would involve the use of mass e-mailing scales and using computer algorithms to detect high risk patients who would not voluntarily come to clinical attention.

SCR11-2

IMPLEMENTATION AND IMPACT OF ELECTRONIC MEDICAL RECORDS IN A PSYCHIATRIC OUTPATIENT SETTING

Speaker: Frank X. Acosta, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review original empirical data based on quality improvement measures to assess the impact of EMR implementation; 2) Discuss the factors serving as barriers of EMR implementation; 3) Discuss the factors contributing to the success of EMR implementation; 4) Discuss the potential implications from EMR use in clinical care, organizational management, reimbursement and training

SUMMARY:

This study describes the efforts to implement electronic charting and electronic centralized scheduling in a large public psychiatric outpatient clinic with the objective to improve documentation and clinical care. The authors present methodology for assessing the impact of such implementation within the clinical operations and services provided. A vehicle for this assessment is the ongoing quality improvement review process. The results and findings are presented and factors contributing to the success of this intervention are discussed. The potential implications in clinical care, organizational management, reimbursement, and training are explored. The authors also present initial data on the perceptions of mental health providers toward the use of EMR. Methods: 1) Data made available through the quality review process are utilized to evaluate the impact of the electronic intervention. The study is divided into a comparative analysis of a 3 year prior and 3 year post period from the point of electronic charting and electronic centralized scheduling implementation. Items from quality improvement review checklists that were comparable in the prior and post periods were used for analysis. The sample size for number of charts reviewed and analyzed ranged from 57 to 158 for different types of clinical notes. 2) Data are presented from completed surveys on the attitudes of over 100 mental health providers toward EMR use. Results: Statistical analyses indicate significant findings that support the study's hypotheses that electronic intervention improves the quality of clinical documentation and clinical care. Conclusions: This study contributes new knowledge to better understanding the barriers and benefits of implementing and maintaining electronic charting and electronic centralized scheduling in mental health settings. Recommendations and cautions for other programs interested in adopting electronic technology to enhance clinical services are presented.

SCR11-3**A WEB-BASED SHARED DECISION MAKING SYSTEM (MYPZYCKES) TO PROMOTE WELLNESS AND EMPOWER VULNERABLE POPULATIONS**

Speaker: Molly Finnerty, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Schizophrenia is not a barrier to MyPSYCKES use and may be a positive predictor of engagement;2) Learn that MyPSYCKES, a shared decision-making and wellness planning tool, has high levels of use by those with serious mental illness and limited English proficiency;3) Learn how Medicaid data can be used to tailor consumer wellness opportunities

SUMMARY:

Molly Finnerty, MD, Elizabeth Austin, MPH, Qingxian Chen, MS, Veronica Hackethal, MD, MSc, Edith Kealey, MSW, Emily Leckman-Westin, PhD Objective: Computer-assisted Shared Decision-Making can potentially promote personal wellness, patient centered care and quality improvement. Yet concerns have been raised whether these technologies can reach those most in need: those with serious illness, socioeconomic disadvantages, and low English proficiency. MyPSYCKES is a web-based application with 3 components: 1) My Treatment Data: user-friendly clinical summaries of 5 years of Medicaid services, highlighting quality concerns, 2) CommonGround: a shared decision making program where consumers enter and track patient reported outcomes, treatment concerns, and wellness activities, and 3) Learning Center: health education and illness management opportunities. MyPSYCKES supports consumers with limited computer literacy and English proficiency. Methods: As of November 2011 MyPSYCKES was implemented in two diverse New York City clinics serving 487 individuals with serious mental illness, multiple medical co-morbidities, and 33% Spanish speaking populations (Phase I). Four additional sites have expected launch dates for MyPSYCKES in late 2012, reaching 800 more consumer users (Phase II). Use logs are being assessed for penetration and use by consumer characteristics. The total clinic population is being compared to the population with schizophrenia for progress on MyPSYCKES engagement steps. We are examining percent users of the Spanish version, and percent logged on outside the clinic. We are comparing consumer endorsement of medication concerns for standard questions vs individually tailored personal wellness questions. Results: During Phase I, user ids were created for 100% (487/487) of consumers: 46% (223/487) completed a first CommonGround Report, 18% chose the Spanish version, 10% accessed MyPSYCKES outside the clinic, and 71% with schizophrenia (12/17) completed first CommonGround reports. For the total clinic population vs those with schizophrenia: 1) 78% vs 100% identified personal wellness activities, 2) 46% vs 82% developed power statements, 3) 30% vs 71% completed first Common Ground reports, and 4) 17% vs 58%

completed multiple Common Ground reports. The most frequently endorsed medication concerns questions were those regarding: 1) medication efficacy, 2) effects of medication on physical health, and 3) side effects. An individually tailored question presented only to those with a Medicaid derived quality flag had the second highest rate of endorsement. Similar analyses of Phase II results will be presented. Conclusion: MyPSYCKES has high levels of use by individuals with serious mental illness and Latino populations with limited English proficiency. Schizophrenia is not a barrier to use and may be a positive predictor of engagement. Creating tailored questions was feasible and had high levels of endorsement.

SCIENTIFIC AND CLINICAL REPORT 12**PERCEPTIONS OF MENTAL ILLNESS AND THE SELF****SCR12-1****PERCEPTION OF DEPRESSION BY SELF AND KNOWLEDGEABLE INFORMANT**

Speaker: Nelya Tarnovetsky, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Determine how the patient defines own depression as different from perception about his /her mental health from a knowledgeable informant;2) Identify potential causes that could lead to the under diagnosis of depression;3) Establish if a bias could be created as a result of poor rapport with the patient when diagnosing depression

SUMMARY:

Perception of depression by self and knowledgeable informant. Nelya Tarnovetsky, Eric D Peselow, Waguih Ishak (Cedars Sinai LA) Introduction: Depression is affecting about 121 million people worldwide; it is the fourth-leading cause of the global disease burden and the leading cause of disability worldwide. In psychiatry collateral information is always taking into consideration in order to correctly diagnose and treat mental illness. This study was conducted with the purpose to determine how the patient defines own depression as different from perception about his /her mental health from a knowledgeable informant who is first degree family member. The data was collected through a naturalistic study. Objective: To determine if there is non concordance in perception of severity of depression by the patient self and by knowledgeable informant. Methods: A total of 150 patients who met criteria for DSM-IV-TR criteria for major depression were evaluated in the study. Patients and knowledgeable informant rated the patient's depression using the MADRS and CGI. The CGI was rated in 0.5 intervals between 1 and 7 for more precise rating. Determinations were made with respect to CGI of concordance between the patient and informant during presentation of the depressive episode at time of full blown pathology. Non concordance was defined as a CGI difference between the patient and informant of >1 point. Results: Of

the 150 patients rated by patient and knowledgeable informant there was concordance for 110 patients (CGI within 1 point at depression) and 40 patients showed that the CGI was >1 point at depression. Of the 40 non-concordant cases patients, the depression was rated >by patient in 34 cases and the depression was rated >by informant in 6 cases. There is 73 % concordance in evaluation of depressive symptoms by the patient and knowledgeable informant with a CGI less than 1 point as depression. There is 26, 6% of non concordance between results. Of the 40 non-concordant evaluations, 85 % of the cases were rated as more severe by the patient. Only 15 % of non concordant cases were rated by knowledgeable informant as more severe than patient rates self. Conclusion: The results of this study indicate a 26.6% rate of significant deviation of perception of self depressive symptoms and how severity of illness is perceived by others. Also the results of this research may support the idea that the difference in interpretation of depressive symptoms could be even higher than 26, 6 % if evaluator would be the clinician who knows the patient understandably not as well as close to the patient informant, bias in evaluation also could be created as result of poor rapport with the patient. This difference in interpretation in clinical setting could lead to under diagnosed depression, to an inappropriate treatment plan and in a setting of house hold may indicate poor support system and lack of communication between patient and family members.

SCR12-2

CHINESE AMERICANS KNOWLEDGE OF BEHAVIORAL AND PSYCHIATRIC SYMPTOMS OF DEMENTIA: A MENTAL ILLNESS LITERACY SURVEY

Speaker: Benjamin K. P. Woo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify knowledge gaps and misconception of dementia among Chinese Americans; 2) Understand the need for culturally sensitive and effective interventions to achieve equity in dementia diagnosis, treatment, and prognosis in Chinese Americans; 3) Gain knowledge about innovative approaches to teach Chinese Americans about behavioral and psychiatric symptoms of dementia

SUMMARY:

Objective: To investigate dementia literacy among Chinese American community. Methods: 139 Chinese Americans were recruited by means of radio, newspapers, posters, and word of mouth to attend an aging workshop in Los Angeles, California. All subjects were surveyed using an 11 question, true/false format questionnaire in Chinese to assess their knowledge base regarding dementia as well as behavioral and psychiatric symptoms of dementia. Participants who were interested in attending future seminars or receiving more information from Alzheimer's Association were encouraged to complete an optional recruitment survey. Dementia knowledge was measured by the number of statements partici-

pants correctly identified as true or false on the 11-question survey. Scores range from 0-11, with a lesser score indicate a knowledge gap in dementia. Results: All subjects were Chinese speaking. There were 70.5% female, 59.7% who did not graduate from high school, 37.4% age sixty-five or older, 61.9% had lived in the US twenty or more years, and 31.7% had a family history of dementia. Of the 139 respondents, 69.8% did not view dementia as a mental illness. The average score for the survey was 6.3 out of a possible 11 points, with a range of 3 to 10 correct. Conclusion: Dementia literacy among Chinese American general community is limited, with knowledge deficits in areas that likely reduce care seeking. These areas include misconception that dementia is inevitable, dementia leads to lower life expectancy, and dementia may not be treatable. Furthermore, it is more concerning that Chinese Americans, due to stigma, may not understand the prevalence of behavioral and psychiatric symptoms in dementia.

SCR12-3

ANCIENT CIVILIZATION CONCEPTS OF MENTAL HEALTH AND ILLNESS

Speaker: Vijoy K. Varma, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Have a larger global view of various approaches to mental health and illness related to different cultures and religions; 2) Develop sensitivity into the key concepts of Hinduism vis-à-vis other religions in concepts of mental illness; 3) Develop a holistic view of mental health and illness

SUMMARY:

Mental illness and health being so important, all cultures have addressed to what contributes to mental health and what causes illness. Earlier concepts have addressed to attributes of the personality that contribute to health, those that cause illness, and the balance between the two. Melancholia and hysteria were described in Egypt and Sumeria as early as 2600 B.C. Indian Ayur-Veda was written about 1400 B.C. Humoral theories, in some form or other, have been with us since Hippocrates. Also, various cultures have alluded to the basic elements – earth, fire, water and air - as contributing to the personality, health and illness. According to ancient Indian Vedic concepts, personality is composed of three elements, Satva (pure qualities), Rajas (pleasure-seeking propensities and emotions) and Tamas (animal-like behavioural tendencies leading to deterioration). A dis-equilibrium between the three leads to mental illness Unmada (severe mental disorder) and other illnesses. Tridosha (vayu, pitta, kafa, the three cardinal defects or aberrations, are the aetiological factors in mental illness. Islam seems to have taken a more benevolent view of the mentally ill, considering them to be blessed or holy. The essence of Taoistic doctrine is wu wei, meaning thereby 'non-action', 'non-doing', 'non-interference', 'not doing anything' and 'doing nothing.' Buddhism seems to extol the importance of balance or taking the middle path. The paper will present

concepts and classification of mental illness, deriving from the major religious, ethnic and national groups. It is expected to add to its current status and controversies associated with it.

MAY 20, 2013

SCIENTIFIC AND CLINICAL REPORT 13

SEXUALITY

SCR13-1

CLINICAL AND RESEARCH IMPLICATIONS OF HYPERSEXUAL DISORDERS AND THE DSM-5

Speaker: Timothy W. Fong, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Become familiar with the proposed DSM-V diagnostic criteria for hypersexual disorders;2) Learn about the clinical characteristics and presentation of hypersexual disorders that occur in primary care, mental health and substance abuse treatment settings;3) Review current treatment options and strategies for hypersexual disorders;4) Identify priority research topics that will improve the understanding and treatment of hypersexual disorders

SUMMARY:

Hypersexual behaviors are known by many names, such as sexual addiction and compulsive sexual behaviors. These behaviors, characterized by excessive engagement in sexual behaviors despite adverse consequences commonly present in a variety of treatment settings, especially in patients with substance use disorders. Currently, the DSM-IV does not formally recognize these behaviors as a clinical condition, other than sexual disorder NOS. Clinicians oftentimes do not receive formalized training or supervision in how to treat hypersexual disorders, even though these behaviors can be disabling and troubling. This workshop will review the history of hypersexual disorders in the scientific literature and will then present results from a recently completed diagnostic field trial that tested DSM-V proposed criteria for hypersexual disorders. This field trial, consisted of structured interviews of 97 patients presenting to 7 different treatment clinics for hypersexual behaviors compared to 37 patients presenting to substance abuse and mental health treatment. Symptom endorsement, manifestations of hypersexual behaviors and interviewer reliability and validity were established. In addition, this workshop will present clinical cases that showcase the wide variety of presenting signs and symptoms of hypersexual disorders. From this a discussion on how clinicians would manage hypersexual disorders will follow. Finally, this workshop will discuss and review the current research and clinical knowledge gaps in the field of hypersexual disorders, which will help to create a roadmap for clinicians and researchers interested in further understanding this disorder.

SCR13-2

EVIDENCE-BASED MEDICINE, PSYCHIATRY, AND BDSM

Speaker: Charles Moser, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the scientific evidence for the inclusion of Sexual Sadism and Sexual Masochism (BDSM) in DSM-5;2) Discuss the scientific evidence suggesting BDSM is a mental disorder;3) Recognize the problems inherent in the DSM-5 proposals;4) Recognize the inconsistencies between the proposed definition of a mental disorder and the proposed definition of a paraphilic disorder

SUMMARY:

Evidence-Based Medicine (EBM) now guides the practice of all branches of medicine. This presentation will discuss the Psychiatry's adherence to the principles of EBM, the inconsistencies of the proposed DSM-5 definitions of a mental disorder and a paraphilic disorder, and the confusion likely to be engendered by these proposals if adopted. The scientific evidence that BDSM (Bondage & Discipline, Dominance & Submission, and Sadism and Masochism) interests describe a distinct mental disorder for some of its practitioners will also be discussed.

SCR13-3

PATERNAL BISPHENOL A EXPOSURE ALTERS SPATIAL MEMORY AND SEXUAL DIFFERENTIATION OF EMOTIONAL RESPONSE IN RAT

Speaker: Ying Fan, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the effects of bisphenol A (BPA) on progeny outcome that are manifested in the preimplantation embryo;2) The present study is to investigate the effects of paternal BPA exposure on cognitive functions in adulthood;3) The present study is to determine the impact of paternal BPA exposure on anxiety and depression in adulthood

SUMMARY:

Introduction: Bisphenol A (BPA) is a widespread environmental endocrine disruptor that is used in the manufacture of polycarbonate plastic and epoxy resins. Numerous clinical and animal studies have pointed to significant long-lasting effects of maternal BPA exposure on biobehavioral development and the development of normal brain architecture. Possible effects of paternal exposure, in contrast, have received little attention. Here, we examined the effects of paternal exposure to BPA on several aspects of rat behavior, including memory, anxiety and depression. Method: Eight 30-day old male wistar rats

were administered vehicle or BPA (50 ?g/kg/day, p.o.) for 20 weeks and mated to virgin females. Their offspring (24 males and 24 females) were divided into two groups (BPA and Control) according to the father's exposure to BPA or vehicle only at 56 weeks of age and were submitted to three tests: the Morris Water Maze (MWM), the Elevated Plus Maze (EPM) and the Forced Swim Test (FST). Results: In MWM: the latency time in Control groups was shorter than that of BPA groups in both sex (Control: 26.681±2.297 (male), 26.462±2.297 (female); BPA: 36.069±2.297 (male), 40.976±2.297 (female); (F3,36 = 9.788, p < 0.01)). Moreover, the number of crossing over the platform location was significantly different in female rats but not in male rats (Control: 2.400±1.265 (male), 2.500±1.716 (female); BPA: 2.400±1.897 (male), 0.400±0.516 (female); (F3,36 = 4.926, p < 0.01)) indicating that paternal BPA exposure impaired spatial memory. In EPM: typical sex differences were confirmed in Control groups, with females spent more time and traveled further in the open arms (OA) than males, however these sex differences were entirely abolished by the treatment, and BPA decreased these parameters in female rats but not in male rats (Duration in OA: Control: 11.780±9.054 (male), 53.200±23.987 (female); BPA: 28.162±16.011 (male), 23.590±11.462 (female); (F3,34 = 11.679, p < 0.01). Distance in OA: Control: 15.070±8.797 (male), 179.290±69.040 (female); BPA: 76.687±47.617 (male), 110.050±54.993 (female); (F3,34 = 18.230, P < 0.01)). In FST: sex difference in limb movement was revealed only in Control groups, but not in BPA groups; furthermore, BPA increased immobile time and inhibited mobile time in male rats but not in female rats (Immobile Time: Control: 179.338±15.230 (male), 208.950±15.341 (female); BPA: 212.110±28.044 (male), 214.860±28.336 (female); (F3,34 = 4.334, p < 0.05). Mobile Time: Control: 120.662±13.248 (male), 91.050±13.841 (female); BPA: 87.890±28.043 (male), 85.120±28.348 (female); (F3,34 = 4.533, p < 0.01)). Conclusion: Overall, our results indicate that rats at the pre-implantation stage are sensitive to BPA, which impairs spatial memory and sex differences in affect with increased anxiety and depression.

SCIENTIFIC AND CLINICAL REPORT 14

MILITARY PSYCHIATRY I

SCR14-1

NEW OPTIONS FOR MILITARY POSTTRAUMATIC STRESS DISORDER AND SUICIDALITY

Speaker: Robert Neil McLay, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Enhance their knowledge of PTSD and suicidality in US military populations;2) Learn about challenges in conducting research on new;3) Learn about challenges in conducting research on new treatment options within the military

SUMMARY:

In the last decade of war, rates of psychiatric problems, particularly suicidality and Post Traumatic Stress Disorder (PTSD), have increased among U.S. Service Members. Many innovative ideas have been brought forward to try to address these issues, but testing these ideas can be challenging. Military populations and military culture pose particular difficulties that need to be overcome when conducting research studies. This presentation will review the overall problem of PTSD and suicidality in the U.S. military, how such rates of these are determined, and interventions that are being developed to counter these psychiatric issues. In particular, this presentation will talk about studies that have been ongoing at or in collaboration with Naval Medical Center San Diego. These studies involve the use of Virtual Reality, Stellate Ganglion Block, computerized home therapy, and Transcranial Magnetic Stimulation for the treatment of PTSD. Also discussed will be studies of the use of ketamine for the acute treatment of suicidality and depression, and consistent patient contact for the long term prevention of completed suicide. Finally, we will review a study that addresses the specific issue of when a Service Member who has been diagnosed with a mental illness or taken psychiatric medication might be safe to carry a firearm again. How the results might influence military health care will be reviewed, as well as the potential spillover into civilian treatment.

SCR14-2

SPICE, BATH SALTS, AND THE U.S. ARMED FORCES: RESEARCH ON DESIGNER DRUGS IN THE U.S. MILITARY

Speaker: George Loeffler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the history of the newest designer drugs (Spice and Bath Salts), their clinical presentation and pharmacology;2) Explore the latest clinical research being conducted by the author on these substances especially as it pertains to active duty US Service Members;3) Discuss directions for future research in this field

SUMMARY:

Abuse of the designer drugs Spice and Bath Salts has quickly emerged as an epidemic in the United States. The US Military has not been spared. We present the two largest case series published to date on psychosis in Spice (synthetic cannabinoid receptor agonists) and psychosis in Bath Salts (substituted cathinones). Significantly, both these case series are of an active duty US military population. We also present data from a large retrospective case control study looking at the relationship between Spice and PTSD in an active duty residential substance treatment facility. Not only is this the first Spice study of its kind, it is also the first to look at the relationship between Spice and PTSD. Lastly, we discuss an epidemiological study using health data covering the entire active

duty Department of Defense population describing a drastic increase in hospitalizations related to the “substance induced mental disorder” diagnosis. It is argued that this strongly correlates to the emergence of Spice and Bath Salts nationally. Collectively, we describe various aspects of the psychiatric impact designer drugs have had on a military still engaged in active combat.

SCR14-3

THE PSYCHIATRY CONSULT SERVICE IN A HOSPITAL AT WAR

Speaker: Harold J. Wain, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe a model for providing Psychiatric Consultation in a tertiary care center treating patients evacuated from a theater of combat; 2) Identify unique issues facing wounded and ill Service Members and their families following medical evacuation from a combat theater; 3) Identify the role of Consult Liaison Psychiatry in supporting hospital personnel providing care to those facing the aftermath of combat

SUMMARY:

Combat, and injury in combat, can have severe psychiatric consequences. With the onset of the wars in Afghanistan and Iraq, and the influx of injured warriors, a novel model was developed at Walter Reed National Military Medical Center to help patients and their providers address psychiatric issues. Because of the barrier to care presented by stigma associated with mental health treatment, (Hogue, 2005) a protocol was initiated to normalize mental health contact as equivalent to any other medical service treating the patient. Psychiatric consultation was made an automatic intervention for all patients returning from a theater of combat, and the concept of “Preventive Medical Psychiatry” was utilized to introduce the service to patients. Fewer than 1% of patients have rejected interventions. There are a number of unique aspects to operating in a tertiary care center supporting the military while combat operations continue. A robust, multi-disciplinary approach has emerged that is integrated with the operations of the hospital at every level. The severity of polytrauma can be extreme, and the number of patients with catastrophic injuries is high. The nature of the injuries, and of combat, presents unique stresses for the patients, their families, and the hospital staff - many of whom are military Service Members facing future deployments to combat zones. The mechanism of injury is often related to IED blasts, and the signature injuries of this conflict are TBI, limb amputation, and genital injuries. Pain management is a prominent issue. Psychological sequelae are often blurred or exacerbated by delirium and medication side effects, and present with a wide range of severity. The psychopathology can vary from irritability, to trauma-related dissociation, to expression of somatic symptoms, to disorganization and psychosis. TBI evaluation must start early and progress to rehabilitation planning for those patients with significant cognitive symptoms. Intensive collaboration with

other medical and surgical services is necessary for effective delivery of care. All patients are screened for deployment-related mental health issues, and supportive psychiatric treatment, to include psychotherapy and medication management, is provided to patients as the needs are identified. Intervention with families helps to maximize the social supports available to the patients as they heal. To date over 4000 warriors have been treated. Grieger et.al (2006) described medically injured soldiers in this population as having fewer psychiatric sequelae than soldiers exposed to trauma without physical injury. These results contrast with Koren’s (2005) findings among Israeli soldiers, which demonstrated that those exposed to trauma without injury had fewer psychological symptoms than those injured in combat.

SCIENTIFIC AND CLINICAL REPORT 15

CROSS-CULTURAL PSYCHIATRY

SCR15-1

LESSONS OF WISDOM FROM INDIGENOUS TERRITORIES: DO CULTURAL CONCEPTS

IMPROVE CLINICAL PSYCHIATRY?

Speaker: Raymond P. Tempier, M.D., M.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Be more familiar with cultural concepts; 2) Improve the care of natives and minorities; 3) Have a better clinical perspective on global mental health

SUMMARY:

The author will bring throughout examples of his clinical practice some words of ‘wisdom’ regarding the treatment and care of natives of Canada and African individuals living in Sub-Saharan Africa and North America.

The concept of illness means a rupture of harmony between the individual, the group and Nature. For example, hallucinations and psychoses are viewed as positive experiences or gifts among native populations. Regarding addictions, the presenter will report on a recent qualitative research showing that spontaneous recovery among natives is possible through sudden awakening leading to complete recovery and sustained abstinence through cultural identity factors such as learning traditional prayers and making handicrafts. How do cultural identity of the individual, cultural explanation of the illness, cultural factors related to social environment, cultural elements of the therapeutic relationship impacting on the care of the patients will also be discussed.

SCR15-2**WORKING WITH REFUGEES AND UNDERSTANDING THE CULTURE OF TRAUMA**

Speaker: Hossam M. Mahmoud, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the difference between refugees and immigrants, especially within the context of complex and chronic trauma; 2) Recognize the limitations of applying the "Western" concept of PTSD in assessing and treating non-Western populations; 3) Understand the complexities of PTSD among survivors of mass conflict and war trauma; 4) Learn about a specific clinical experience on working with Iraqi refugees

SUMMARY:

War is a terrible reality that defines peoples' lives in several countries around the world. It has resulted in and continues to cause significant death, disability and displacement. The number of refugees has been steadily increasing, and the situation shows little hope for improvement. The survivors of such mass violence have often suffered from complex and multiple traumas. A significant number of these civilians are thus left with considerable post traumatic symptoms. Given the magnitude of the refugee problem both worldwide and in the United States, and the psychiatric manifestations of traumatic experiences, mental health care providers, will be more likely to face the challenges entailed in treating refugees. The aim of this paper is to describe the characteristics that distinguish refugees from other patient populations; the experiences they face that impact their mental health and impede recovery; and the challenges that mental health professionals face in working with this population. While reviewing studies, articles and books written on refugee mental health, this paper will also focus on clinical work that the author undertook with an Iraqi refugee population in Chicago. The paper ends with recommendations for clinicians on working with refugee populations.

SCR15-3**THE EFFECTIVENESS OF QIGONG FOR TREATING DEPRESSED CHINESE AMERICANS: A PILOT STUDY**

Speaker: Albert Yeung, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Introduce Qigong, a mind-body tradition originated in China; 2) Describe a pilot study on whether Qigong is feasible, safe, and effective for treating Chinese Americans with major depressive disorder; 3) Discuss potential applications of Qigong as an adjunctive treatment for major depressive disorder

SUMMARY:

Background: Qigong is a form of exercise that incorporates orchestrated body postures, breath practices, and meditation to attain deeply focused and relaxed states (Chodzko-Zajko et al., 2005). Qigong practices are thought to activate naturally occurring physiological and psychological mechanisms of self-repair and health recovery (Jahnke, 2002). This pilot study examined the feasibility, safety, and efficacy of using Qigong for treating major depressive disorder (MDD) in Chinese Americans. Methods: Fourteen Chinese Americans with MDD were enrolled in a 12-week Qigong intervention. The key outcome measurement was the 17-item Hamilton Rating Scale for Depression (HAM-D17); the Clinical Global Impressions - Severity (CGI-S) and Improvement (CGI-I), the Quality of Life Enjoyment and Satisfaction Questionnaire, Short-Form (Q-LES-Q-SF), and the Multidimensional Scale of Perceived Social Support (MSPSS) were also administered. Positive response was defined as a decrease of 50% or more on the HAM-D17, and remission was defined HAM-D17 \leq 7. Patients' outcome measurements were compared before and after Qigong intervention. Results: Participants (N=14) were 64% female, with a mean age of 53 (\pm 14). 71% of participants completed the intervention (attended \geq 62.5% of the training sessions); no adverse events were reported. Qigong intervention resulted in a positive treatment-response rate of 64% and a remission rate of 43%, and statistically significant improvement, as measured by the HAM-D17, CGI-S, CGI-I, Q-LES-Q-SF, and the family support subscale of the MSPSS. Key Words: Depression, Chinese, Qigong, Mind-Body Intervention, Clinical Trial Target Audience(s): Psychiatrists, Psychologists, Social Workers, Primary Care Practitioners, Trainees

SCR15-4**ASSESSING INTERNALIZED STIGMA AND STIGMA RESISTANCE IN INDIVIDUALS WITH MENTAL ILLNESS IN TAIWAN**

Speaker: Yin-Ju Lien, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand more about the role of internalized stigma and SR of mental illness in research and clinical setting; 2) Provide a common ground for international researchers to understand internalized stigma and SR in Taiwanese patients with mental illness; 3) Given a validated measure of internalized stigma and SR, clinicians will be able to be involved in stigma reduction interventions in the context of recovery among individuals with severe mental disorders

SUMMARY:

The Internalized Stigma of Mental Illness Scale (ISMIS) is one of the few tools available to measure a global level of internalized stigma and stigma resistance (SR) simultaneously and has been widely used in a range of clinical and research settings. This self-report scale has already been translated

into several languages, but there has not been a validated Taiwanese version previously reported. We administered the Chinese version (ISMIS-C) to a consecutive sample of 160 outpatients with (n=103; psychotic group including schizophrenia and affective psychosis) or without psychotic disorders (n=57; non-psychotic group including various depressive and anxiety disorders). We calculated Cronbach's alpha coefficients and item-total correlations to assess the internal consistency of the ISMIS-C. Intraclass correlation coefficient (ICC) and factor analysis was used to examine the consistency of ISMIS-C over time and the construct of the ISMIS-C, respectively. The Spearman's correlation was conducted to assess convergent or criterion validity of internalized stigma and SR with demographic and clinical variables in outpatients with or without psychotic disorders. For discriminative validity of this instrument, Mann-Whitney U test was used to analyze differences in ISMIS-C scores between groups of outpatients with and without psychotic diagnoses. Overall, the 29-item ISMIS-C was presented to be internal reliable (Cronbach's alpha = 0.92; item-total correlations = 0.30-0.74), and reliable over time (ICC = 0.63-0.85). Our factor analysis supported the concept distinction between measured internalized stigma and SR subscales of the ISMIS-C. Internalized stigma of mental illness, comprised four-factor solution corresponding to Social Withdrawal, Alienation, Perceived Discrimination, and Stereotype Endorsement Dimensions. The construct of the internalized stigma and SR subscales of the ISMIS-C derived from factor analysis was nearly identical to the original version of ISMIS. As predicted, the internalized stigma subscale scores had positive correlations with measures of mental illness stigma, depressive, and hopeless symptoms ($r = 0.54$ to 0.69) and negatively with self-esteem ($r = -0.58$) and self-efficacy ($r = -0.61$). SR was correlated positively with self-esteem ($r = 0.41$) and self-efficacy ($r = 0.32$), and negatively with mental illness stigma measures, depression, and hopelessness ($r = -0.31$ to -0.36). Our data also demonstrated that psychotic patients experienced a greater level of internalized stigma subscales and total scores than those without psychotic diagnoses ($z = -2.92$ to -3.99). We confirmed the reliability and validity of the Chinese ISMIS. The usefulness of the ISMIS in a psychiatric population was replicated in the Taiwanese sample. The ISMIS-C can be used as an informative device when investigating "internalized stigma" and "SR" among individuals with or without psychotic disorders.

SCIENTIFIC AND CLINICAL REPORT 16

SCHIZOPHRENIA

SCR16-1

RISK ENDOPHENOTYPES IN SCHIZOPHRENIA: ANOMALIES PRESENTED BY ADULT PATIENTS ARE ALSO PRESENT IN CHILDREN AT RISK

Speaker: Michel Maziade, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the presence of disease precursors and risk endophenotypes in children at risk of schizophrenia and bipolar disorder; 2) Understand the relevance of developmental trajectories in the risk mechanisms of schizophrenia; 3) Conceive the translational applications in clinical practice and in prevention means of this research

SUMMARY:

Background: Cognitive deficits are at the core of schizophrenia. A salient observation is that several cognitive impairments displayed by adult patients are also carried by the children at genetic risk many years before disease incidence [1,2]. Some cognitive impairments in children at risk, such as in visual episodic memory, may be strong predictors of adult disease [1]. In parallel, childhood abuse and neglect is also a predictor of schizophrenia [3]. However, little is known about the impact of childhood abuse and neglect on cognitive deficits as potential mediators of the risk effect on later disease. In offspring at genetic risk of schizophrenia, we studied the developmental trajectories of cognitive predictors of the disease across time, from childhood to adulthood and investigated the impact of severe trauma on these deficits. Method: In a high-risk sample of 79 offspring of an affected parent descending from densely affected multigenerational families [1], we used a step by step sampling approach to narrow-down the early disease mechanisms. A 20-year follow-up of 48 densely affected multigenerational kindred (1500 clinically characterized adult members) allowed us to identify 400 DSM-IV schizophrenia or bipolar disorder adult patients. We then focused on 79 offspring, who were administered a neuropsychological battery encompassing visual and verbal episodic memory and other cognitive domains such as motor skills, working memory and executive functions. Cross-sectional trajectories of the offspring cognitive functioning were then constructed. In parallel, lifetime history of childhood abuse or neglect was documented, blind to the neuropsychological variables, according to 5 items (physical abuse; sexual abuse; parental physical or emotional neglect; parental emotional abuse; exposure to violence in the family) derived from known instruments.

Results: Different developmental courses for IQ and memory were observed: if the childhood IQ deficit remained stable until adulthood, visual episodic memory harbored a non-linear two-stage trajectory characterized by a lag during childhood followed by a recuperation until adulthood. Moreover, 42% of the offspring presented a history of childhood abuse or neglect. Offspring who experienced childhood abuse or neglect had even more impairments on visual episodic memory than children at genetic risk without trauma. Conclusion: In children at risk of major psychosis, different cognitive dysfunctions would mark different developmental courses. Childhood abuse and neglect in youths at risk of schizophrenia had an impact on visual episodic memory performance. Considering the predictive value of this cognitive domain for psychosis, our data highlight the importance of focusing future prevention research on the right cognitive function at the right time in the

child's life.1: Maziade et al.; Schiz Bull 2011; 37:1218-28 2. Maziade et al.; PLoS ONE 2011; 6 :e19153 3: Van Os et al.; Nature 2010; 468:203-12

SCR16-2

KYNURENINE, SCHIZOPHRENIA, AND NON-FATAL, SUICIDAL SELF-DIRECTED VIOLENCE

Speaker: Omar F. Pinjari, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the potential role of immune activation in psychiatric diseases specifically Schizophrenia;2) Identify biomarkers of inflammation specifically the importance of Indoleamine dioxygenase activation;3) Learn the potential future therapeutic targets related to Kynurenine pathways and to discuss how this would effect future diagnosis and treatment aspects of Schizophrenia

SUMMARY:

Kynurenine, Schizophrenia and Non Fatal Suicidal Self Directed Violence (NFSSDV) INTRODUCTION: Inflammation has been associated with predisposition, precipitation and perpetuation in severe mental illness and more recently suicidal behavior. The indoleamine dioxygenase (IDO) is an enzyme that catalyzes the conversion of tryptophan (TRP) to kynurenine (KYN) that is further metabolized in microglia and astrocytes to neurotoxic and neuroprotective compounds. Previous studies have implicated the kynurenine pathway in schizophrenia and suicidal behavior in patients with mood disorders. HYPOTHESIS: We hypothesized that a) schizophrenic patients have higher levels of KYN than healthy controls, and b) schizophrenic patients with history of NFSSDV have higher levels of KYN than patients with no history of NFSSDV. METHODS: Schizophrenia patients (N= 950, age 38 ± 11.6) and healthy controls (N=1000, age 53.5 ± 15.8) were recruited in the University of Munich, Germany. Clinical status was confirmed by SCID. Among patients 321(34 %) had history of NFSSDV and 527(55 %) had no history of NFSSDV. History of NFSSDV was obtained by detailed semi structured clinical interviews. TRP and KYN were measured with high performance liquid chromatography (Fuchs Lab Innsbruck Austria). Statistical analysis was based on ANCOVAs (with adjustment for age, gender and level of education). RESULTS:

KYN was higher in schizophrenia patients than in control participants ($p < 0.001$) There was no difference between schizophrenia patients with and without history of NFSSDV ($p = 0.497$). CONCLUSIONS: The study confirmed a hypothesized elevation of kynurenine in schizophrenia patients. As a limitation, we did not measure markers of inflammation or metabolites of KYN, and thus we cannot provide evidence for either an upstream (IDO upregulation) or downstream (reduced metabolism of KYN) mechanism. This result may be important considering novel medications targeting the kynurenine pathway. On the other hand, the association between KYN and NFSSDV previously reported in patients with

mood disorders was not confirmed in schizophrenia patients. Authors: Omar F. Pinjari, Dietmar Fuchs, Ina Geigling, Bettina Konte, Annete M. Hartmann, Marion Friedl, Heike Konnerth, Ayesha Ashraf, Sarah Hinman, Amar Sleemi, Dan Rujescu*, Teodor T. Postolache* Drs. Postolache and Rujescu share senior authorship on this report and have equally contributed to this project. Supported by American Foundation for Suicide Prevention (PI Postolache)

SCR16-3

SCHIZOPHRENIA AND THE CONTENT OF APOCALYPTIC DELUSIONS

Speaker: Palmira Rudaleviciene, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify world end delusions in patients suffering from schizophrenia;2) Identify the content of the world end delusions;3) Recognize the importance of surroundings on the acute psychopathology

SUMMARY:

This study attempts to present the genesis of the world end (Apocalyptic) delusions. Religious idea of the world end given in the Sacred Scripture is being found in the content of delusions but is added with inclusion of modern cultural signs, personal moral values and beliefs and description of apocalypse, produced in delusional thinking of nowadays patients suffering from schizophrenia and related disorders. We have studied the content of delusions in patients with schizophrenia looking for apocalyptic themes using Fragebogen fur psychotische Symptome (FPS) - a semi-structured questionnaire developed by Cultural Psychiatry International research group in Vienna, which was translated into the language of the participating patient, double translation was performed. Examination was conducted on 295 patients (the mean age - 42.4 [SD 9.7] years; women - 51.5%), suffering from schizophrenia at Vilnius Mental Health Center in Lithuania, among whom 69.8% reported apocalyptic delusional themes (lifetime-prevalence), both religious and culture-sensitive. Investigation of the influence of personal importance of their religious beliefs on the content of (Apocalyptic) delusions was made. We divided the content into three groups: religious, modern and global. Religious - explain the world end according to the Sacred Scripture, giving the answers as: "Jesus Christ will come and will not leave"; "brother goes against brother"; "nation will raise against nation"; "we come from dust and we return to dust"; "evil is dominant and God will judge us"; "the Bible says that Jesus Christ will come accompanied by sounds of buzzing trumpets", "there is too much evil foretold in the Scriptures, the God will pass judgment", etc; Modern - show many parallels with Sacred Scripture, but include signs from reality around, answers such as: "people very bad now-days, kill each other even schoolchildren use alcohol"; "there will be a war"; "much terror, old and young are being killed, my wife has had an abortion"; "abundant mafia will offer an explosion on the earth", "was announced on TV", "the priest said", "it is

possible, because there is no love anywhere, God is love", etc.; Global - "the world has gone mad; there is no need to be"; "there will be an accident in the Mazeikiai oil factory"; "I am an atomic war instructor - there will be more Chernobyl disaster"; There will be tsunami", "There will be total chaos"; "planets will collide"; "the Earth will explode" etc. The conclusion may be drawn that schizophrenia patients for whom their faith is of personal importance feel the coming end of the world more often than those for whom it is not. There is no significant difference found between gender or age factor on the development of the world end (Apocalyptic) delusions. Key words: Schizophrenia, world end (apocalyptic) delusions, Sacred Scripture, modern signs, cultural psychiatry.

SCIENTIFIC AND CLINICAL REPORT 17

UNAPPRECIATED DISORDERS IN PSYCHIATRY

SCR17-1

AFFECTIVE MANIFESTATIONS OF STIFF-PERSON SYNDROME: A CASE REPORT WITH CLINICAL IMPLICATIONS

Speaker: Rebecca R. Burson, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss how Stiff-Person Syndrome (SPS) is a rare neurological disorder which is often misdiagnosed resulting in delayed treatment;2) Highlight the physiologic etiology of SPS which is tied to excess Glutamate secondary to a deficiency in GABA and that this imbalance is also shared in many psychiatric disorders;3) Understand that the recognition of psychiatric symptoms related to SPS is critical for clinicians to broaden their differential of psychiatric illness to include neurologic etiology;4) Emphasize that treating affective symptoms associated with SPS through GABAergic agents not only decreases incidence of psychiatric distress but also helps treat the core neurological dysfunction

SUMMARY:

Purpose: Stiff Person Syndrome (SPS) is a rare central nervous system disease characterized by progressive muscle stiffness with painful axial muscle spasms and the absence of neurological signs. The presentation of SPS can be complicated by the presence of psychiatric manifestations such as depression, anxiety and alcohol abuse. Here we present a case of SPS in which the patient's psychiatric symptoms complicated the diagnostic evaluation. We then discuss this case and make suggestions for the pharmacologic and psychological management of psychiatric symptoms that present in association with SPS. **Methodology:** A retrospective medical chart review was conducted along with a literature review of SPS and its correlation with psychiatric manifestations. **Results:** SPS is associated with an antibody to glutamic acid decarboxylase (GAD), an enzyme needed to produce gamma-aminobutyric acid (GABA) from glutamic acid. Recent studies have suggested that mood, thought and anxiety disorders are

all disorders that represent a dysfunction in the GABA system that inherently leads to low levels of GABA in the central nervous system. Furthermore, an excess of glutamate has been implicated in the pathogenesis of many psychiatric disorders. It has been theorized that anti-GAD antibodies may lead to a general deficiency in GABA that predisposes SPS patients to develop psychiatric disorders. We further suggest that the excess of glutamate in SPS may also increase the prevalence of affective symptoms. Treatment for the psychiatric manifestations of SPS should target the GABAergic system resulting in both improved neurologic and psychiatric function. **Conclusion:** The interplay between psychiatric and neurologic symptoms has been the object of speculation in SPS since its first description. By providing treatment for the anxiety and mood symptoms of this disabling disorder, psychiatric services can be helpful in managing the physiologic and psychological stressors which contribute to the exacerbation of the clinical symptoms of SPS. Lastly, affective symptoms should be considered as part of the diagnosis for SPS given that the etiology of this disorder lies in the imbalance between GABA and glutamate which results not only in neurologic symptoms but also in psychiatric distress as well.

SCR17-2

PROBABLE CREUTZFELD-JAKOB DISEASE: A NEUROPSYCHIATRIC PRESENTATION

Speaker: Yi Min Wan, M.B.B.S., M.Med.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the neuropsychiatric manifestations of Creutzfeldt-Jakob disease (CJD);2) Identify CJD as an important differential diagnosis during early presentation;3) Initiate supportive and definitive investigations

SUMMARY:

Creutzfeldt-Jakob disease(CJD) is the commonest form of transmissible human subacute spongiform encephalopathy, with a worldwide distribution of 0.5 to 1.0 per million population. A retrospective review in 1998 from Singapore General Hospital revealed 5 possible cases over 2 years, in an island with a population of 4 million. We present a 76 year-old Chinese man, single and living alone, with a premorbid personality of an independent person who was neat and meticulous, admitted for a 3 month-history of progressive behavioural change, associated with memory impairment and unsteady gait. He had long-standing hypertension which was well-controlled. The abnormal behaviour included frequent complaints of people coming to his house to have meetings, frequent misplacing of his belongings, as well as decreased self-hygiene. This has affected his daily functioning. There were no other symptoms of dementia. There was no recent travel history. Initial MMSE was 16/30, with impairment in 2-point orientation (place/person), the serial sevens, and delayed recall. There was marked inattention. There was no evidence of mood disorder. No perceptual disorder was elicited. The brain MRI revealed subtle cortical hyperintensities ("cortical

ribboning") in right frontal, parietal, temporal, and the caudate nucleus in DW1 sequence. Physical examination on the 5th day of admission revealed mild bradykinesia, mild hypertonia of all 4 limbs, mildly impaired proprioception, mildly unsteady gait, as well as occasional myoclonic jerks of the head. Electroencephalogram showed generalised fronto-central fairly rhythmical periodic complexes with triphasic morphology. Cerebrospinal fluid protein 14-3-3 were negative. Over the next 12 days, his Abbreviated Mental Test (AMT) decreased from 8/10 to 5/10. The clinical picture was highly suggestive of sporadic CJD.

SCR17-3

NARCOLEPSY AND PSYCHIATRIC COMORBIDITY

Speaker: Maurice M. Ohayon, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify better individuals with narcolepsy;2) Recognize potential comorbid disorders associated with narcolepsy;3) Develop a treatment plan better adjusted for the need of narcoleptic patients

SUMMARY:

Narcolepsy is a debilitating neurodegenerative disorder characterized by daytime sleep attacks and REM sleep abnormalities. It is a rare disorder but it has a high burden of illness. Beside the limitations associated with the disorder, little is known about other psychiatric disorders that might be associated with Narcolepsy. This study aims to examine psychiatric disorders associated with narcolepsy. A total of 320 narcoleptic individuals were interviewed sleeping habits; health; medication consumption, medical conditions (ICD-10), sleep disorders (ICSD) and mental disorders (DSM-IV-TR) using Sleep-EVAL. A general population comparison sample (N=1464), matched for age, sex and BMI and interviewed with the same instrument, was used to estimate odds ratios. Most frequent psychiatric disorders among the narcolepsy group were Major Depressive Disorder (OR: 2.67) and Social Anxiety Disorder (OR: 2.43) both affecting nearly 20% of narcoleptic individuals. However, most mood and anxiety disorders were more prevalent among narcoleptic group. Alcohol Abuse/Dependence was comparable between groups. Narcolepsy is associated with a high comorbidity of psychiatric disorders that need to be addressed when developing a treatment plan.

SCR17-4

DISORDER OF SELF-AWARENESS IN SCHIZOPHRENIA: IMPAIRED PSYCHOLOGICAL PROPRIOCEPTION

Speaker: Henry A. Nasrallah, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the disruption in self-awareness in schizophrenia and its clinical manifestations;2) Review possible neurobiological causes for impaired mental proprioception in schizophrenia;3) Discuss the formal assessment of the disruption of sense of self in schizophrenia

SUMMARY:

A large body of clinical and biological evidence portrays schizophrenia as disorder of self-awareness and impaired mental proprioception. Clinically, symptoms such as depersonalization, derealization, anosognosia, avolition, delusions of passivity and beliefs of alien control of thoughts and feelings constitute evidence for self-pathology. In addition, schizophrenia is often associated with failure to realistically recognize one's own face or body parts. In this presentation, several neurobiological hypotheses will be discussed as possible etiologies for the fragmentation of the self in schizophrenia including pathologies in certain brain structures (inferior parietal and prefrontal), neurochemistry (glutamate hypofunction), and disconnection (myelin disorder). Specific questions will be raised related to the prevalence of self-pathology in schizophrenia, its onset, its variable severity, the relationship between physical and mental proprioceptive dysfunctions, response to treatment, and relationships to negative and cognitive symptoms severity and functional capacity.

SCIENTIFIC AND CLINICAL REPORT 18

PAIN AND SUBSTANCE MISUSE

SCR18-1

PAIN AND THE CITY: OBSERVATIONAL EVIDENCE THAT URBANIZATION AND NEIGHBORHOOD DEPRIVATION ARE ASSOCIATED WITH ESCALATION IN CHRONIC ANALGESIC TREATMENT

Speaker: Carsten Leue, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize that chronic pain and chronic analgesic treatment is associated with social pain aspects;2) Recognize that chronic analgesic treatment will profit from adequate psychiatric diagnosis and treatment.;3) Moreover, insurance policy makers will identify that the community will profit from psychiatric treatment strategies to avoid opioid abuse in chronic pain conditions

SUMMARY:

Objective: To examine, in the light of the association between urban environment and poor mental health, whether urbanization and neighborhood deprivation are associated with analgesic escalation in chronic pharmacological pain treat-

ment, and whether escalation is associated with prescriptions of psychotropic medication. Method: Longitudinal analysis of a population-based routine dispensing database in the Netherlands, covering 73% of the Dutch nationwide medication consumption in the primary care and hospital outpatient settings over a six-month observation period, by ordered logistic multivariate model evaluating analgesic treatment. Main outcome measure: Escalation of analgesics (i.e. change to a higher level of analgesic potency, classified across five levels) in association with urbanization (five levels) and dichotomous neighborhood deprivation. Results: 449 410 patients aged 15-85 years were included, of whom 166 374 were in the Starter group and 283 036 in the Continuation group of chronic analgesic treatment. In both Starter and Continuation groups, escalation was positively associated with urbanization in a dose-response fashion (Starter group: OR (urbanization level 1 compared to level 5): 1.24; 95% CI 1.18 to 1.30; Continuation group: OR 1.18; 95% CI 1.14 to 1.23). An additional association was apparent with neighborhood deprivation (Starter group: OR 1.07; 95% CI 1.02 to 1.11; Continuation group: OR 1.04; 95% CI 1.01 to 1.08). Use of somatic and particularly psychotropic co-medication was associated with escalation in both groups. Conclusion: Escalation of chronic analgesic treatment is associated with urban and deprived environments, and occurs in a context of adding psychotropic medication prescriptions. These findings suggest that pain outcomes and mental health outcomes share factors that increase risk and remedy suffering.

SCR18-2

DOES MEDICATION-ASSISTED TREATMENT FOR SUBSTANCE USE DISORDER PROMOTE RECOVERY?

Speaker: Gary M. Henschen, M.D.

Co-Author(s): Fred Waxenberg, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate understanding of the risks, benefits and side effects of buprenorphine, naltrexone, and other medications used in the treatment of substance use disorders; 2) Discuss the numerous barriers to the use of these medications in the treatment of substance use disorders; 3) Practice interventions to encourage physicians to utilize medication assisted treatments for substance use disorders

SUMMARY:

Medication Assisted Treatment (MAT) for substance use disorders have been a neglected tool in the armamentarium of interventions addressing alcohol and opiate use disorders. Buprenorphine has demonstrated effectiveness in opiate abuse and addiction. Naltrexone has proven effective in the treatment of both alcohol and opiate use disorders. Other medications as well have shown effectiveness in the treatment of these disorders. Despite their proven efficacy, these medications have been highly underutilized due to a variety of

psychosocial issues, despite identification as a best practice by organizations such as the American Psychiatric Association, the National Committee on Quality Assurance, and the Veterans Administration. Magellan Health Services beginning in 2010, working closely with its community-based partners, has encouraged the use of these medications where clinically indicated. Nationally, our practitioner partners have not only demonstrated an increase in the use of these medications, but also a significant reduction in readmissions for detoxification for consumers who have received MAT. This reduction is enhanced if the patient is receiving case management services. This presentation will review the science behind the use of this class of medications, and will discuss methods used to increase practitioner application of these medications, along with psychosocial interventions, to reduce recidivism. Co-author: Fred Waxenberg, Ph.D.

SCR18-3

THE BURDEN OF ILLNESS IN DEPRESSION ACCOMPANIED BY SLEEP DISTURBANCES AND CHRONIC PAIN

Speaker: Maurice M. Ohayon, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the importance of chronic pain in depression; 2) Recognize the negative effects of sleep disturbances in the association chronic pain and depression; 3) Develop a treatment plan better adjusted for the need of individuals suffering of these three disorders

SUMMARY:

Sleep disturbances are common in individuals experiencing chronic pain. Subjective measures of sleep in various chronic pain conditions mostly demonstrate a high number of complaints of disrupted and unrefreshing sleep. Similarly, pain is very common in individuals with depression as are also sleep disturbances. This cross-sectional telephone study involved 15,945 individuals representative of the American adult general population (? 18 years) living in 15 states. Participants were interviewed on life and sleeping habits; health; medication consumption, medical conditions (ICD-10), sleep disorders (ICSD) and mental disorders (DSM-IV-TR) using Sleep-EVAL. Overall, 32.6% of the sample reported sleep disturbances (3 nights/week for at least 3 months); 34.9% reported chronic pain (\geq 3 months) and 5.7% a Major Depressive Disorder (MDD). The triple association, MDD, chronic pain and sleep disturbances was observed in 2.4% of the sample; MDD occurred without pain or sleep disturbances in only 0.9% of the sample. Individuals with the triple association had more severe impact on their daily life (daily activities, social and family activities) and were twice more likely to report deteriorated QOL than individuals with MDD alone or MDD with either pain or sleep disturbances. Presence of pain complicated the treatment of MDD. However, negative impacts on functioning are maximal when sleep disturbances

are also present.

MAY 21, 2013

SCIENTIFIC AND CLINICAL REPORT 19

SUICIDALITY AND IMPULSIVITY

SCR19-1

TOXOPLASMA GONDII AND SUICIDAL BEHAVIOR

Speaker: Teodor T. Postolache, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Become familiar with the association between *T. gondii* and suicidal behavior across diagnostic boundaries;2) Learn possible mechanisms connecting *T. gondii* with suicidal behavior;3) Learn CDC guidelines for reducing the risk of infection with *T. gondii*

SUMMARY:

T. gondii is an intracellular parasite that can reproduce sexually in the lumen of any member of the cat family and can infect any warm blooded animal including humans. The common routes of infection in humans are ingestion of oocysts through unwashed hands, vegetables or contaminated water, or ingestion of tissue cysts present in undercooked/raw meat, or on vegetables contaminated by tools used to process raw meat. The most common chronic toxoplasmosis in immunocompetent hosts is traditionally considered minimally symptomatic or asymptomatic, although it has been more recently associated with schizophrenia, personality disorders, personality features, car crashes, migraine headaches and seizures. We have investigated in multiple studies associations between markers of *T. gondii* infection and suicidal behavior across diagnostic boundaries. We have found positive associations between past suicide attempts and *T. gondii* IgG antibodies in patients with mood disorders, and schizophrenia. We have also recently reported an association between admissions for actual attempts and *T. gondii* with relative risk of >7 ($p < 0.008$). In 45,000 Danish mothers we have reported a prospective association between *T. gondii* and subsequent attempts, with 50% increase in relative risk (80% for violent suicide attempts). The clinical association was confirmed by a study by an independent group in Turkey. Although there are no current studies on suicide fatalities and *T. gondii* based on individuals, a hypothesis generating ecological study reported an association between aggregate measures of national suicide rates and *T. gondii* seropositivity in the peripartum period. Although these data are compelling, we are far from being able to demonstrate causality. Potential mechanisms include direct effects (e.g. *T. gondii* reactivation) vs. neuroimmune mediation, both providing novel therapeutic targets for suicide prevention.

SCR19-2

A CLUSTER OF SUICIDE: THE STRUGGLE OF A CLASSROOM OF ELEMENTARY SCHOOL STUDENTS OVER FIFTY YEARS

Speaker: Albert J. Sayed, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) At the conclusion of this session, the participant should be able to recognize the long term impact of childhood physical and emotional abuse upon adult psychopathology;2) The participants will learn to understand and improve treatment of patients when physical and emotional abuse is inflicted by religious authorities;3) The participants will improve their understanding of the psychological processes that contribute to suicidal behavior

SUMMARY:

A cohort of forty six elementary students in one class at a Catholic elementary school in a Detroit suburb is examined after fifty years. Seven of the students are known to have committed suicide and another five allegedly committed suicide. These students were subjected to physical, sexual, and emotional abuse by four of the nuns who were teachers. Although the students had many different life experiences through the years since then, the abuse they were exposed to is recognized as a shared trauma. There has been much publicity about the sexual abuse perpetrated by Catholic priests upon young males. However, the physical, emotional, and sexual abuse inflicted by some nuns teaching in this parochial school was particularly devastating. Unfortunately, abuse by nuns teaching in parochial elementary schools was common, perhaps not to this extent. This potential source of abuse needs to be recognized when evaluating and treating adults with various types of psychopathology including depression and suicidal tendencies. Abuse by adults in positions of authority, especially in religious environments, can have serious and long-term consequences that need to be recognized by mental health professionals.

SCR19-3

IMPULSIVITY, SEROTONIN, AND GENDER

Speaker: Donatella Marazziti, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Get a deeper understanding of the key role of serotonin in the modulation of impulsivity;2) Learn that serotonergic peripheral markers, such as the platelet transporter, are reliable mirrors of the same present in the brain and can be used routinely;3) Understand that the impact of serotonin on impulsivity is different in the two sexes

SUMMARY:

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

SCIENTIFIC AND CLINICAL REPORT 20**BIOLOGICAL PSYCHIATRY****SCR20-1****IMPACT OF TREATMENT WITH INJECTABLE BIOLOGIC AGENT USTEKINUMAB ON PSYCHOLOGICAL STATUS AND HEALTH-RELATED QUALITY OF LIFE IN PATIENTS WITH PSORIASIS**

Speaker: Monica Huynh, B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Evaluate the effect of Ustekinumab (Stelara®), a biologic injectable medication for generalized psoriasis on their mental status pre- and post-treatment;2) Assess the utility of Psychological General Well-Being scale (PGWB) pre- and post-treatment;3) Assess utility of health related quality of life instruments: Dermatology Life Quality Index, Work Productivity and Activity Impairment scale, and Psoriasis Quality of Life pre- and post-treatment

SUMMARY:

Introduction: Psoriasis is a chronic skin disorder that affects a nearly 3% of US population. Psoriasis has a direct negative impact on a patient's psychological, social, and occupational well-being that can result in depression, anxiety, and a significant decrease in quality of life (QoL). Psoriasis patients can often feel poor self-esteem and embarrassment because of the associated stigma. Furthermore, they are more likely to be depressed when compared to the general population, which can lead to increased suicidal ideation. Rapp et al [1] showed that psoriasis patients have a negative QoL and suffer as

much disability as those with other serious illnesses such as heart disease, diabetes, cancer, etc **Methods:** Patients received 36 weeks of Ustekinumab and were followed every 4 weeks for assessment with psoriasis quality of life instruments (DLQI, PQWB, WPAL, POOL-12) psoriasis. **Results:** Preliminary results have shown that patients have experience significant improvement in quality of life measured by change in PGWB and other psychometric instruments at week 36 from baseline **Conclusion:** The study goes beyond the Rapp study by assessing proactively and over time mental status of psoriasis patients undergoing a therapeutic intervention that can improve psoriasis and possibly improve the psychological state and QoL. [1] Rapp SR, Cottrell CA, Leary MR. Social coping strategies associated with quality of life decrements among psoriasis patients. *Br J Dermatol* 2001; 145: 610-16.

SCR20-2**COMBINATION OF KETAMINE AND METHOHEXITAL ANESTHESIA IN ELECTROCONVULSIVE THERAPY: A CASE REPORT**

Speaker: Shaojie Han, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the effectiveness of combination (Ketamine and Methohexital) anesthesia in electroconvulsive therapy (ECT);2) Identify the side effects of the combination of anesthesia by comparing with Methohexital anesthesia alone;3) Treat a patient whose seizure threshold exceeded maximum stimulus intensity by using combination anesthesia in ECT

SUMMARY:

Abstract: Therapeutic responses of ECT decrease when seizure is absent or lasting less than 25 seconds. This may be related to anticonvulsive influence of anesthesia on seizure threshold. In ECT with Methohexital anesthesia, shortened seizure duration and increased seizure threshold were observed in one of our patients. Ketamine anesthesia induced no anticonvulsive effects and prolonged seizure duration. However, side effects from ketamine anesthesia were commonly noted, such as headache, nausea, postictal confusion, and hemodynamic variables. We present a case in which a combination of Ketamine and Methohexital anesthesia at certain ratio, achieved optimal therapeutic effect in ECT of this patient whose seizure threshold exceeded the maximum stimulus intensity under Methohexital only. With the combinations of these two anesthetics, seizure duration was increased effectively and side effects of Ketamine were avoided. **Key Words:** Electroconvulsive therapy, seizure duration, Ketamine, Methohexital, anesthesia

SCR20-3

ROLE OF SERUM BDNF AS A MARKER TOOL FOR BPAD-I: A 3-MONTH LONGITUDINAL FOLLOW-UP STUDY CORRELATING SERUM LEVEL WITH SYMPTOM SEVERITY AND ILLNESS

Speaker: Rajesh Sagar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) assess the relation between the severity and type of symptoms with serum BDNF level;2) assess the duration of illness on the serum BDNF level;3) assess the feasibility of serum BDNF measurement as a diagnostic aid in clinical setting in a developing country like India.

SUMMARY:

Sagar R, Chatterjee B, Vivekanadhan S, Pattanayak RD, Mehta M Department of Psychiatry & Neurochemistry, All India Institute of Medical Sciences, New Delhi, India Background Recent evidence suggests that Brain derived neurotrophic factor (BDNF) may be associated with pathophysiology of Bipolar disorder. Variations in the serum levels of BDNF have been reported during the illness episodes and with disease progression. However, no prior studies are available on the longitudinal variations in serum BDNF in bipolar disorder Objectives The present study aims to investigate serum BDNF levels in manic, depressed and euthymic BD patients and in matched healthy controls in a naturalistic setting at baseline and three months of longitudinal follow-up. Method & Results

Fifteen subjects (total n=60), in each of the group with index episode of mania, bipolar depression, euthymia and control diagnosed using Structured Clinical Interview for DSM disorders- I (SCID-I) were included. Three monthly assessments of symptoms severity was conducted with Hamilton Depression Rating Scale (HDRS) and Young's Mania Rating Scale (YMRS), detailed mood chart and treatment chart. The serum BDNF measurement was done using an enzyme-linked immunosorbent assay (sandwich-ELISA). One-way ANOVA has been used to measure heterogeneity between the groups and Pearson's coefficient for the relationship between clinical scores and serum BDNF level. Regression model was used to assess longitudinal data Results An interesting relationship has emerged between serum BDNF levels with the severity of the symptoms, chronicity of illness and number of episodes. The results will be discussed further in detail during the presentation. Conclusion Serum BDNF levels may be useful as a marker for Bipolar disorder, and needs further evaluation during various phases of illness, preferably in longitudinal studies.

SCIENTIFIC AND CLINICAL REPORT 21

PSYCHOPHARMACOLOGY

SCR21-1

ARE DRUG-INDUCED MOVEMENT DISORDERS LESS WITH SECOND-GENERATION ANTIPSYCHOTICS?

Speaker: Nigel Bark, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know current rates of movement disorders;2) Understand differences in rates of movement disorders in first and second generation antipsychotics;3) Understand why different studies produce different results;4) Better choose the right antipsychotic

SUMMARY:

When the second generation antipsychotics (SGA) were introduced their key studies clearly showed much less tardive dyskinesia (TD), Parkinsonism, and akathisia than first generation antipsychotics (FGA). Studies showed new onset TD five times greater with Haloperidol than Risperidone. A more recent prospective study found little difference in TD between SGA and FGA. And there is a study from China showing the same rate of TD with Clozapine as Chlorpromazine. Some studies have reported little difference in rates of Parkinsonism between FGA and SGA but they do show those on FGA were given more anticholinergic medication. Akathisia is reported with all SGA but FGA reportedly have higher rates. It is unclear how general any of these findings are and what accounts for the differences. A survey of 247 patients in a State hospital in which 170 were examined or observed for movement disorders using the standard rating scales will be described. 154 of these had medication information. The mean age of these was 50. 55% were male, 44% black, 30% Hispanic and 15% white. 41% of the 22 only on FGA had TD, 26% of the 96 on only SGA had TD but only 6% of the 33 on both had TD. 39% of 18 on only FGA, 39% of 83 on only SGA and 41% of the 29 on both had Parkinsonism. Only 5 had Akathisia all of whom were on SGA one on a FGA in addition. 5 had pseudoakathisia, all on SGA. 10% of 143 tested had dystonia and 14% of 109 tested had intention tremor. These rates are comparable with those in the literature for FGAs though the low TD rate in those on both, the high rate of Parkinsonism in SGA and the low rates of akathisia are surprising. The findings of this survey will be further examined and the rates compared with earlier rates in the same hospital as well as rates reported elsewhere. The discussion will aim to understand the differences and the surprises in this and other studies especially why SGAs still seem to cause significant movement disorder.

SCR21-2**THE ROLE OF PSYCHIATRY IN THE DEVELOPMENT OF A COMPREHENSIVE APPROACH FOR THE MANAGEMENT OF CNS PHARMACOTHERAPY**

Speaker: Jose Maldonado, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the basic premise regarding the most important aspects of CNS-Pharmacotherapy through the eyes of the different specialty services;2) Review the process undertaken by the multidisciplinary team and the rationale for specific treatment choices;3) Discuss how the psychosomatic medicine consultant helped facilitate the communication process allowing for the development of these algorithm and protocols

SUMMARY:

Delirium is the most common psychiatric syndrome found in the hospital setting. Because its etiology is often multifactorial and because patients in all clinical services are at risk of developing it any approach to the prevention and treatment will require a multisystem, multidisciplinary approach. As consultants, Psychosomatic Medicine specialists are in a unique position to assist and guide medical colleagues in the development of a system's approach to a multisystem problem. At our tertiary medical center we put together a multidisciplinary ICU team dedicated at developing a comprehensive approach to CNS-Pharmacotherapy. That is, the management of all psychoactive substances affecting patient's behavior, primarily targeting management of sedation, delirium and pain. The team brought together members of all ICU services, including critical care, pulmonary, anesthesia, neurocritical care, nursing, pain management, and psychosomatic medicine in an attempt to improve the management and quality of care of intensive care patients. We had the extraordinary opportunity to work closely with a neuropharmacologist and members of our pharmacy staff in developing a set of "CNSPharmacotherapy Guidelines" containing specific prevention and treatment modules. The result of this working group was the development of a series of algorithms designed to (a) prophylax against commonly encountered neuropsychiatric problems in the ICU, such as optimizing pain management, addressing potential neuropsychiatric side effects of the ICU environment [e.g., anxiety, PTSD, sleep deprivation], instituting daily awakening routines & promoting early mobilization strategies, and minimizing the occurrence of delirium, while (b) developing robust and standardized algorithms to adequately address unavoidable ICU complications, such as detection of prodromal delirium, prediction and detection of early substance withdrawal, better pain management algorithms, and the management of neurological and psychiatric syndromes common to the ICU environment. This lecture will review the evolution and workings of the multidisciplinary team's and provide a review of the stages of development and protocol implementation throughout our Intensive care Units.

SCR21-3**THE ROLE OF GABAA RECEPTOR IN THE SYNERGISM BETWEEN SSRI AND ANTIPSYCHOTIC DRUGS IN SCHIZOPHRENIA**

Speaker: Henry Silver, M.B.B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the role of the GABAA receptor in the mechanism of SSRI-antipsychotic synergism in schizophr

SUMMARY:

Currently available antipsychotics are effective against positive symptoms of schizophrenia but have limited effect in treating core features such as negative or cognitive symptoms. New drugs developed on the basis of current dogmas have shown no breakthroughs in effectiveness and novel understandings of the mechanisms responsible for symptom productions and treatment response are needed. Clinical studies have shown that resistant negative symptoms may improve when antipsychotics are augmented with selective serotonin reuptake inhibitor (SSRI). This augmenting effect cannot be explained by summing pharmacological effects of the individual drugs. We reasoned that study of this synergism may reveal novel mechanisms relevant to the core features of schizophrenia and their treatment. Here we present results of in vitro and in vivo laboratory studies showing that the SSRI-antipsychotic combination produces unique changes in gamma-aminobutyric acid (GABA)-A receptor and its regulating system which are different from each individual drug. The changes include GABAA receptor phosphorylation and cellular compartment distribution and changes in signal transduction proteins and neurotrophic factors modulating GABAA activity, including PKCbeta, GSKbeta, ERK 2, CREB, TRK-B and BDNF. Results are also presented from clinical studies showing that SSRI augmentation in schizophrenia patients results in changes in blood mononuclear cell mRNAs encoding for GABAA receptor and related proteins which are similar to those observed in preclinical experimental systems and associated with clinical improvement. Taken together these findings support the view that GABA A receptor modulation may be part of the mechanism mediating SSRI-antipsychotic synergistic effect ameliorating some core features of schizophrenia.

Authors :Henry Silver, Einuch Reef, Moussa Youdim, Orly Weinreb

SCIENTIFIC AND CLINICAL REPORT 22

SUICIDE PREVENTION AND PROGRAMS IN INDIA

SCR22-1

EXPERIENCE AND EVALUATION OF HOSPITAL-BASED TRAINING OF UNIVERSITY TEACHERS FOR SUICIDE PREVENTION IN MUMBAI, INDIA

Speaker: Amresh K. Shrivastava, M.D., M.R.C.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Evaluate training of teachers for suicide prevention in students;2) Discuss complexities in suicide prevention means to deal with lack of awareness;3) Explore if the model of hospital based training will be sustained one

SUMMARY:

Amresh Shrivastava, Nilesh Shah, Megan Johnston, Shubhangi Parkar Background In India, suicide rates are high amongst the student population,(2% as per National Crime Research Bureau) This study examines a community-based awareness initiative and the outcome of a two week hospital-based training for a group of teachers who are in an advantageous position for identification and intervention for suicide behavior because they are in close contact with students MethodThe study was conducted in two phases. The first was a needs assessment of the mental health capacity of teachers. Designated teaches from 110 colleges affiliated with Mumbai University participated in a full day seminar that was addressed by faculties from stakeholders of multidisciplinary agencies. Ten speakers had 30 minutes each to address the participants and make a qualitative assessment, which was a semi-structured report based upon their interaction with participants. In the second part, 15 participants agreed to participate in two weeks of training conducted at a university site for morning sessions, and in 4 hospital sites in a general hospital's emergency room and psychiatric inpatient services for afternoon sessions. Twelve faculties participated in conducting this training. Qualitative responses from the participants were evaluated at the end of two weeks. Results The main observations from this study were: (1) that there was a very poor level of awareness.. The majority of them did not know that conditions like depression were an illness or that it falls in preview of physicians to treat. They reported that suicide represents a 'weak mind' and that psychiatric illness is primarily because of the poor capacity of the student. However; they did recognize the family's role in prevention and opined that they can do very little to help due to its origin in the family. (2) They reported that hands-on training could motivate and build up their skills.. - that they can play a role in identification of depression and stress-related problems. The study shows that improving awareness through seminars, building motivation for referrals, and taking some responsibility for identification of suicide behavior by hospital-based training may be useful for prevention of student suicide.

SCR22-2

PATTERN OF SERVICE UTILIZATION OF SUICIDE PREVENTION HELPLINE TOGETHER WITH COMMUNITY MENTAL HEALTH SERVICES IN MUMBAI

Speaker: Amresh K. Shrivastava, M.D., M.R.C.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Examine how helplines for suicide prevention are utilized;2) Examine the advantages of facility of community mental health services together with suicide prevention helpline;3) Examine how economical are these services for access to care

SUMMARY:

Amresh Shrivastava, Nilesh Shah Avinash Desouza Shubhangi Parkar Background : Suicide behaviour is a global public health problem and remains highly underreported and under treated. It is often difficult to reach out to people who are suicidal and need intervention whereas timely referrals are central to treatment and prevention. Helplines in these cases offer people in crisis a chance to seek help whenever they need it. Objective : The present study examines the service utilization of one such helpline along with the risk factors amongst patients referred to a community mental health clinic (CMHC) from such a helpline facility. Methods : Services of a helpline and CMHC in Mumbai were sought to gather the data. Qualified professionals were involved in attending all calls. Outpatient and counselling facilities were available at the centre. The patients selected for the study were outpatients and were encouraged to undergo further psychiatric assessment. Data was collected in semi-structured format over a 5 year period and was statistically analysed. Results : 15,169 calls were received in a 5 year period. 15.4% (2341) subjects were reported to the CMHC. Totally of these 1015 patients were seen by the psychiatrist with 82.6% (848) having a psychiatric diagnosis. Of these the commonest diagnosis was non affective psychosis (23.7%) and major depression (15%). More men reported than women and educational and financial stressors were the main factors. More male callers made first contact than female callers. Risk factors for suicide in the callers and cost involved in running such a facility is discussed. Conclusions : A helpline does offer some definite advantages allowing people with suicidal ideation to connect and opens up opportunities to seek mental health care. It is an economical facility that can be developed to suit the mental health needs of developing countries. 1.Shrivastava AK, Johnston ME, Stitt L, Thakar M, Sakel G, Iyer S, Shah N, Bureau Y. 2. Reducing treatment delay for early intervention: evaluation of a community based crisis helpline. Ann Gen Psychiatry. 2012 Jul 24;11(1):20. 3.Coveney CM, Pollock K, Armstrong S, Moore J.Callers' Experiences of Contacting a National Suicide Prevention Helpline.Crisis. 2012 Jul 2:1-12 4.Gould MS, Munfakh JL, Kleinman M, Lake AM. 5.National suicide prevention lifeline: enhancing mental health care for suicidal individuals and other people in crisis.Suicide Life Threat Behav. 2012 Feb;42(1):22-35

SCR22-3**DEPRESSIVE SYMPTOMS AND SUICIDAL IDEATION AMONG COLLEGE STUDENTS IN BOMBAY: A STUDY OF 3,300 STUDENTS**

Speaker: Shamsah Sonawalla, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize that depressive symptoms and suicidal ideation are prevalent among college students; 2) Understand the significance of screening for depression and suicidal ideation in this population; 3) Discuss the importance of planning effective intervention strategies in this population

SUMMARY:

Objective: Previous studies have reported significant depressive symptoms among college students. The purpose of this study was to assess the prevalence of depressive symptoms and suicidal ideation among college students in Bombay. **Method:** 3300 students across two colleges in the Greater Bombay area were screened for depressive symptoms (mean age: 19.2 + 1.1; 66.8 % women; 33.2% men, Arts: 45%, Science: 30.3%, Commerce: 15.6%, Management Studies: 9.1%). After obtaining written, informed consent, the Beck Depression Inventory (BDI) was completed by all students. Students who scored greater than or equal to 16 on the BDI, and/or greater than or equal to 1 on BDI-item-9 (suicidal ideation) and consented to be contacted were interviewed using the MDD module of the Structured Clinical Interview for DSM-IV-TR (SCID-P). Chi square tests, logistic regression & linear regression used for data analysis. **Results:** 17.2% of the students scored > 16 on the BDI. There was no significant difference in BDI total scores across age, gender and year in college. Mean total BDI scores were found to be highest among management and science students compared to commerce and arts students ($p < 0.0001$).

17% of the students reported suicidal ideation (as assessed by BDI item 9 score > 1). There was no significant difference in suicidal ideation across age, year in college and stream of study. Significantly more women reported suicidal ideation compared to men (18.8% vs 13.6%; chi square = 13.81, $P < 0.001$). Severity of depression, as assessed by total BDI scores, was a significant predictor of suicidal ideation ($R^2 = 0.51$; $p < 0.0001$). BDI items of crying, depressed mood, feelings of being punished, worthlessness and pessimism were found to be the most significant predictors of suicidal ideation ($R^2 = 0.23$). **Conclusions:** Significant depressive symptoms are noted in 17.2% of this urban college population in India, comparable to that reported in similar studies in other parts of the world. The prevalence of suicidal ideation is 17%, also comparable to similar studies in this population. Our study emphasizes the importance of screening for depression among college students across cultures and the need to plan effective intervention strategies in this population. Co-authors: Salima K. Jiwani, M.B.B.S., Meghana Srinivasan, M.A., Tanvi

Ajmera, B.A., Niyati Gandhi, M.A., Salomi Aladia, M.A., Ishita Pateria, B.A., Rajesh M. Parikh, M.D.

SCIENTIFIC AND CLINICAL REPORT 23**SUBSTANCE MISUSE: OPIOIDS, CANNABIS, TOBACCO****SCR23-1****ELIMINATING TOBACCO-RELATED HEALTH DISPARITIES: UNDERSTANDING INTERNALIZED STIGMA AND MOTIVATION TO QUIT IN PERSONS WITH SERIOUS MENTAL ILLNESS**

Speaker: Nicholas M. Orozco, B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Assess levels of internalized stigma in persons with serious mental illness in three domains (mental illness, ethnicity, identity as a smoker); 2) Describe the association between levels of internalized stigma and motivation to quit smoking in persons with serious mental illness; 3) Recognize the association between levels of internalized stigma and abstinence goals in persons with serious mental illness

SUMMARY:

Context: Tobacco use is a hidden epidemic among persons with serious mental illness (SMI), a group dying 25 years prematurely with major causes being chronic, tobacco-related diseases. Unstudied is the association between tobacco use and internalized stigma, which has been associated with negative health outcomes including delayed treatment seeking, increased hospitalizations, and high-risk behaviors. **Purpose:** The current study examined the association between smokers' with SMI thoughts about quitting and internalized stigma assessed in three domains (mental illness, ethnicity, identity as a smoker). **Sample:** Current smokers ($N = 701$) were recruited from psychiatry inpatient units at two hospitals in the San Francisco area; recruitment rate = 76%. The sample was 50% male with a mean age of 39 years ($SD = 13$); 45% were non-Hispanic White, 25% African American, and 30% other ethnicity; 46% reported annual household income < \$10,000; years smoked averaged 19 ($SD = 14$); 52% met criteria for PTSD; 31% for bipolar depression; 39% for unipolar depression; and 27% for psychotic disorders. **Results:** Internalized stigma scores averaged 2.4 ($SD = 0.7$) for mental illness, 2.2 ($SD = 0.6$) for smoking, and 1.9 ($SD = 0.6$) for ethnicity, indicating mild to moderate internalized stigma. Ethnicity-based stigma was highest among African-Americans $M = 2.2$ ($SD = 0.6$) and lowest among Caucasians $M = 1.8$ ($SD = 0.5$), relative to other groups $M = 2.0$, $SD = 0.6$, $F(2, 672) = 35.6$, $p < .001$. Desire to quit smoking was greater for those reporting greater smoking-related stigma ($stdBeta = 0.33$, $p < .001$) and lower for those reporting more ethnicity-based stigma ($stdBeta = -0.10$, $p = .027$). Participants who endorsed complete abstinence had higher internalized stigma scores for mental illness with

M(SD) of 2.6 (0.7), $F(2,678)=5.4$, $p=.005$, smoking with $M=2.4$ (0.6), $F(2,678) = 24.0$, $p<0.001$, and ethnicity with $M=2.0$ (0.6), $F(2,672) = 3.1$, $p<.05$, compared to participants with either an intermediate or no goal. Discussion: The association between stigma and desire to quit smoking was domain specific: higher for stigma related to smoking and lower for stigma related to ethnicity. Greater stigma in all domains was associated with a complete abstinence goal. Tobacco treatment interventions ought to consider the discrimination experiences of diverse smokers with co-occurring disorders and the relationship to motivation to quit. Funding: R01 MH083684

SCR23-2

MOTIVATIONS TO QUIT CANNABIS USE IN NON-TREATMENT-SEEKING ADULT CANNABIS SMOKERS

Speaker: David Gorelick, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize how motivational factors for initiating quit attempts in non-treatment-seeking drug users vary by drug of abuse, age, and gender;2) Recognize motivational factors important for initiating quit attempts in non-treatment-seeking adult cannabis users;3) Identify those motivational factors most associated with successful quitting

SUMMARY:

David A. Gorelick*, MD, PhD; Emeline Chauchard*#, PhD; Kenneth H. Levin*. MD; Marc L. Copersino@, PhD, Stephen J. Heishman*, PhD *Intramural Research Program, NIH, NIDA, Baltimore, MD; #Université de Toulouse-Le Mirail, France; @McLean Hospital/Harvard School of Medicine, Belmont, MA Background: The majority of cannabis smokers quit use without formal treatment, suggesting that motivations to quit are an important part of the cessation process. However, little is known about how motivations relate to success of the quit attempt. Method: A convenience sample of 385 non-treatment-seeking adult cannabis smokers who made a "serious" (self-defined) quit attempt without formal treatment while not in a controlled environment were administered the 176-item Marijuana Quit Questionnaire (MJQQ) to assess their motivations to quit and outcome of the quit attempt. Exploratory factor analysis was performed to identify significant motivational factors. Comparisons by gender and age used t-tests and ANOVA, respectively. T-tests and Cox proportional hazard regression were performed to evaluate the influence of motivational factors on relapse status at time of interview and risk of relapse over time, respectively. Results: Exploratory factor analysis identified 6 motivational factors (eigenvalue > 1.0) accounting for 58.4% of the total variance: self-image/self-control, health concerns, interpersonal relationship concerns, legal concerns, social acceptability concerns, and self-efficacy. Women were more likely than men to be motivated by self-image/self-control, health concerns, and social acceptability concerns. Older individuals were more likely

to be motivated by health concerns. Self-image/self-control, health concerns, interpersonal relationship concerns, and social acceptability concerns were associated with greater likelihood of abstinence at the study interview. Legal concerns and social acceptability concerns were associated with lower risk of relapse. Conclusion: These findings show gender and age differences in motivations to quit cannabis smoking. Overall, adult cannabis smokers have motivations to quit that are similar, but not identical, to those of adolescent cannabis smokers, and similar to those of adults who quit alcohol and tobacco use without formal treatment. The findings suggest areas of focus to improve prevention and psychosocial treatment efforts. Acknowledgement: Supported by the Intramural Research Program, NIH, National Institute on Drug Abuse

SCR23-3

PATIENT CHARACTERISTICS THAT PREDICT BUPRENORPHINE-NALOXONE TREATMENT OUTCOME FOR PRESCRIPTION OPIOID DEPENDENCE: RESULTS FROM A MULTI-SITE STUDY

Speaker: Roger D. Weiss, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know patient characteristics that predict successful outcome in treatment among patients dependent upon prescription opioids;2) Recognize effective treatment approaches for patients dependent upon prescription opioids;3) Understand the difference between detoxification and maintenance treatment for prescription opioid dependence in terms of likelihood of success

SUMMARY:

Background: Prescription opioid dependence is a growing problem, but little research exists on its treatment, including patient characteristics that predict treatment outcome. Methods: A secondary analysis of data from a large multisite, randomized clinical trial, the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study (POATS) was undertaken to examine baseline patient characteristics (N=360) associated with success during 12-week buprenorphine/naloxone treatment for prescription opioid dependence. Baseline predictor variables included self-reported demographic and opioid use history information, diagnoses assessed via the Composite International Diagnostic Interview, and historical opioid use and related information from the Pain And Opiate Analgesic Use History. Results: In bivariate analyses, pre-treatment characteristics associated with successful opioid use outcome included older age, past-year or lifetime diagnosis of major depressive disorder, initially obtaining opioids with a medical prescription to relieve pain, having only used opioids by swallowing or sublingual administration, never having used heroin, using an opioid other than extended-release oxycodone most frequently, and no prior opioid dependence treatment. In multivariate analysis, age, lifetime major depressive disorder, having only used opioids

by swallowing or sublingual administration, and receiving no prior opioid dependence treatment remained as significant predictors of successful outcome. Conclusions: This is the first study to examine characteristics associated with treatment outcome in patients dependent exclusively on prescription opioids. Characteristics associated with successful outcome after 12 weeks of buprenorphine/naloxone treatment include some that have previously been found to predict heroin-dependent patients' response to methadone treatment and some specific to prescription opioid-dependent

patients receiving buprenorphine/naloxone.

SCR23-4

CHARACTERISTICS AND TREATMENT OUTCOMES IN PRESCRIPTION OPIOID-DEPENDENT PATIENTS WITH AND WITHOUT CO-OCCURRING PSYCHIATRIC DISORDER

Speaker: Margaret L. Griffin, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize clinical differences between prescription opioid dependent patients with and without co-occurring psychiatric illness;2) Recognize the need to evaluate prescription opioid dependent patients for the presence of a co-occurring psychiatric disorder;3) Understand that a subset of prescription opioid dependent patients respond to buprenorphine-naloxone stabilization

SUMMARY:

Background: Prevalence of prescription opioid dependence has increased dramatically over the last decade. Given the high rates of additional psychopathology in drug dependence, we compared patients with and without a co-occurring psychiatric disorder on sociodemographic and clinical characteristics, as well as treatment outcomes. Patients were dependent on prescription opioids with minimal or no heroin use. **Methods:** Patients dependent on prescription opioids (N=653) participated in a multi-site, two-phase, randomized, controlled trial to assess different lengths of buprenorphine-naloxone pharmacotherapy and different intensities of counseling. Among the 653 participants entering the trial, 360 received extended treatment and are reported here; half of those (180/360) had a current co-occurring psychiatric disorder in addition to substance dependence. **Results:** Sociodemographic characteristics were similar overall between those with and without a co-occurring psychiatric disorder, but women were 1.6 times more likely than men to have a co-occurring disorder. On several clinical indicators, participants with a co-occurring diagnosis had greater impairment: they were more likely to have additional drug and alcohol use disorders, greater opioid craving, more severe nicotine dependence, worse scores on addiction-related severity, and lower mental and physical quality of life. However, they had better opioid use outcomes at the conclusion of buprenorphine-naloxone stabilization than did participants without a co-occur-

ring diagnosis: 55% vs. 43% ($p<.03$) met study criteria for "success," i.e., abstinence from opioids in at least 3 of the final 4 weeks of buprenorphine-naloxone treatment. **Conclusions:** The subset of prescription opioid dependent patients with a co-occurring psychiatric disorder had a better response to buprenorphine-naloxone treatment. Perhaps this subset had greater motivation to change. Additional research is needed, however, to determine the mechanism of this finding and to adapt treatments to address this population.

SCIENTIFIC AND CLINICAL REPORT 24

ANXIETY DISORDERS: SOCIAL ANXIETY AND OCD

SCR24-1

LONG-TERM EFFECTIVENESS OF SSRI'S ON SOCIAL ANXIETY DISORDERS

Speaker: Rodwan Mahfouz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To determine the effectiveness of SSRI's on Social Anxiety disorder not just acutely but rather on maintenance over longer periods of time;2) To identify the response of SSRI's on Social Anxiety disorder over a 5 year year period;3) To identify the duration of time patients maintained response to treatment before relapse;4) To determine the yearly probability that the patient remained well after treatment over 5 years

SUMMARY:

To determine the LONG TERM effectiveness of SSRI's on Social Anxiety Disorders. Rodwan Mahfouz, Eric D Peselow
Introduction: Social anxiety disorder also known as social phobia, is an anxiety disorder characterized by intense fear in social situations causing considerable distress and impaired ability to function in at least some parts of daily life. Over the last 20 years or so, the treatment of Social Anxiety Disorder with SSRI's alone or in combination with CBT has been used with great effectiveness. The purpose of this study is to determine the effectiveness of SSRI's on Social Anxiety disorder not just acutely but rather on maintenance over longer periods of time. **Method :** A total of 120 patients seen over 18 years in a community outpatient clinic were evaluated for social anxiety disorder using Liebowitz Social Anxiety scale. These pts met criteria for DSM-IV social anxiety disorder AND had a score of 75 or greater on the Liebowitz social anxiety scale. Patients were then treated with Anti-depressants alone or Anti-depressants with Benzodiazepines in a naturalistic manner over a 8 week period and determination of response to treatment was made. Response was defined, as a decrease in the Liebowitz social anxiety scale to a score of 40 or less. These patients were then followed for up to 5 years to evaluate whether they maintained that response or relapsed. Relapse was defined as again meeting criteria for DSM-IV for social Anxiety Disorder and having a Liebowitz social anxiety scale score of 75 or greater. **Results:** Of the 120 pts, 43 patients relapsed

within the 5 year period. The probability of remaining well at 1 year was 90.0 %, at 2 years 83.3%, at 3 years 78.3 %, at 4 years 70.0 %, and at 5 years 64.2 %. Conclusion: The study suggests that the majority of patients maintained a response to the treatment over 5 years but cases of relapse varied over time. In view of the fact that there are few studies on this issue, more studies are needed on the long term affects of pharmacological treatment of Social Anxiety Disorder alone and with the combination of other modalities (SSRI's, other medications, supportive therapy, CBT...) as part of the treatment plan and should be further investigated in respect to effect on overall response and possible relapse.

SCR24-2

A SINGLE-BLIND RANDOMLY CONTROLLED TRIAL OF COGNITIVE BEHAVIOURAL THERAPY WITH SSRIS ON GENERALIZED ANXIETY DISORDER

Speaker: Yueqin Huang, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize CBT could be a standard treatment for patients with GAD;2) Consider to use combination-treatment with SSRIs and CBT for patients with GAD;3) Understand epidemiological design for a clinical trial

SUMMARY:

This randomized single-blind controlled trial evaluated the efficiency of 12-week combination therapy with Selective Serotonin Re-uptake Inhibitors (SSRIs) and Cognitive Behavioral Therapy (CBT) for patients with generalized anxiety disorder (GAD). Forty eight GAD patients were randomly divided into the SSRIs and CBT treatment group and the SSRIs control group. Hamilton Anxiety Rating Scale (HAMA) was administered to evaluate the efficiency of therapies. Repeated measures analysis of variance was used to test differences of efficiency both inter-group and intra-group. Scores of HAMA of the treatment group (baseline?28.53±4.39, 6th: 14.60±4.27, 12th week: 11.20±3.26) significantly decreased (F=5.83, P<0.01) compared with the control group (baseline?23.27±8.16, 6th week: 16.82±7.44, 12th week: 15.36±8.52). This randomized control trial proves that the combination therapy of SSRIs and CBT is more effective than the SSRIs treatment for GAD.

SCR24-3

A SINGLE-BLIND RANDOMLY CONTROLLED TRIAL OF COGNITIVE BEHAVIOURAL THERAPY WITH SSRIS ON OBSESSIVE-COMPULSIVE DISORDER

Speaker: Zhaorui Liu, M.P.H., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize, that CBT could be a standard treatment for patients with OCD;2) Consider to use combination-treatment with SSRIs and CBT for patients with OCD;3) Understand epidemiological design for a clinical trial

SUMMARY:

This randomized single-blind controlled trial evaluated the efficiency of 12-week combination therapy with Selective Serotonin Re-uptake Inhibitors (SSRIs) and Cognitive Behavioral Therapy (CBT) for patients with obsessive-compulsive disorder (OCD). Fifty one OCD patients were randomly divided into the combination treatment group (SSRIs+CBT) and the control group (SSRIs only). Yale Brown Obsessive Compulsive Scale (Y-BOCS) was administered to evaluate the efficiency of therapies. Repeated measures analysis of variance was used to test differences of efficiency both inter-group and intra-group. The results showed scores of Y-BOCS in the treatment group (baseline?24.16±3.33, 6th week: 17.45±5.32, 12th week: 6.83±3.45) significantly decreased (F=4.325, P<0.05) compared with the control group (baseline?23.15±6.06, 6th week: 13.92±3.94, 12th week: 21.46±3.33). This randomized control trial proves that the combination therapy of SSRIs and CBT is more effective than the SSRIs treatment for OCD.

SCIENTIFIC AND CLINICAL REPORT 25

TRAUMA AND PHYSIOLOGY

SCR25-1

POSTTRAUMATIC STRESS DISORDER IS ASSOCIATED WITH INCREASED INCIDENCE OF INSULIN RESISTANCE AND METABOLIC SYNDROME

Speaker: Naser Ahmadi, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Post-traumatic stress disorder (PTSD) is associated with increased risk of multiple medical problems including myocardial infarction(MI) and diabetes mellitus (DM);2) PTSD is associated with incidence of IR and metabolic syndrome independent of age, gender, and conventional risk factors;3) Insulin resistance (IR) increases atherogenesis and atherosclerotic plaque instability and further increases risk of MI, which is independently associated with PTSD

SUMMARY:

Background: Post-traumatic stress disorder (PTSD) is associated with increased risk of multiple medical problems including myocardial infarction (MI) and diabetes mellitus (DM). Insulin resistance (IR) increases atherogenesis and atherosclerotic plaque instability and further increases risk of MI, but its potential association with PTSD has not been evaluated. This study assessed the association of PTSD with incidence of IR and metabolic syndrome. Methods: This study

included 207,954 Veterans in VISN 22 at Southern California and Nevada (mean age 60 ± 14 , 93% male, without known CAD and DM) with and without PTSD were followed for the median of 2-years. VA electronic medical records were used to obtain demographic, clinical and laboratory findings. The incidence of insulin resistance, (defined as triglyceride over HDL-c ratio > 3.8) and metabolic syndrome, (defined based on NCEP ATP III guideline), were assessed. Multivariable mixed regression analyses were employed to assess the relation of PTSD with incidence of IR and metabolic syndrome. Results: There were no differences between subjects with and without PTSD in age, gender, lipid profile, fasting blood sugar and conventional risk factors at baseline ($p > 0.05$). During a median 2-year follow up, IR was significantly higher in PTSD as compared to non-PTSD (34.8% vs. 19.3%, $p = 0.00001$). Similarly, metabolic syndrome was significantly higher in PTSD as compared to non-PTSD (52.5% vs. 37.3%, $p = 0.00001$). After adjustment for risk factors, incidence rate of IR and metabolic syndrome was 14.2% (95%CI 7.83 – 18.53, $p = 0.0001$) and 12.07% (95%CI 9.73 – 14.42, $p = 0.0001$) in PTSD as compared to non-PTSD, respectively ($p < 0.05$). The population risk of IR attributable to PTSD individuals was 49%. The population risk of metabolic syndrome attributable to PTSD individuals was 41%. Conclusion: In this population, PTSD is associated with incidence of IR and metabolic syndrome independent of age, gender, and conventional risk factors.

SCR25-2

A BRAIN CONNECTIVITY PERSPECTIVE OF PTSD

Speaker: Xiaodan Yan, M.S., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Promoting awareness of PTSD neural basis; 2) Enhancing interdisciplinary interaction between neuroscience, bioinformatics and psychiatry; 3) Introducing the state of the art method of resting state fMRI into the research about neural mechanisms of PTSD; 4) Discussing the role of insular neural network in PTSD

SUMMARY:

Previous neuroimaging studies of PTSD have been focused on the abnormal structure or activity of several brain regions such as the amygdala, the medial prefrontal cortex and the anterior cingulate cortex, however the connectivity in the brain has not been systematically investigated. The present study investigated the functional connectivity of multiple brain regions with resting state fMRI data of combat veterans of Iraq and Afghanistan. Forty nine male veterans diagnosed as PTSD patients (PTSD+) and fifty male veterans not meeting the diagnostic criteria of PTSD (PTSD-) were included in the present study, with the two groups matched on age, gender and ethnicity. In the PTSD+ group compared to the PTSD- group, functional connectivity with the amygdala was decreased in the middle frontal cortex but increased in the parahippocampal gyrus; functional connectivity with the ventral anterior cingulate cortex (vACC) was decreased in the

ventral medial prefrontal cortex, the superior frontal cortex and the caudate; functional connectivity with different nuclei of basal ganglia showed different patterns of change; functional connectivity with the right anterior insula was decreased in the default mode network including the precuneus and medial prefrontal cortex; functional connectivity with the precuneus was decreased in the default mode network. Furthermore, graph theory based analysis on the properties of the whole brain neural network suggested decreased efficiency and less distinguishable hubs in the neural networks of PTSD patients. Such results suggest decreased connectivity between the fear circuitry and the cognitive circuits; however, the cognitive circuits do not only include frontal regions, precuneus of the default mode network, which plays important functions in self-consciousness and memory known as a “hub” between parietal and prefrontal regions, could also contribute significantly to PTSD pathology, furthermore the whole neural network also demonstrates changed properties due widespread changes in functional connectivity.

SCR25-3

MORGELLONS VERSUS PSYCHIC TRAUMA: A CASE OF TACTILE HALLUCINATIONS AFTER ORAL SURGERY

Speaker: Lorenzo Santos, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the controversy behind the diagnosis of Morgellons; 2) Approach to a patient with tactile hallucinations and thorough trauma history; 3) Acknowledge the importance of collaboration between community psychiatry, primary care specialists and dentistry

SUMMARY:

Morgellons is a rare controversial disease that has caught the eyes of the CDC in recent years but has yet to reach consensus. It is believed by some to be no more than delusional parasitosis. Patients present with the sensation and the belief that there is something beneath their skin. In our case a 70 y.o. man with history of uncontrolled DM, HTN but no prior psychiatric history presents with new onset oral and perioral tactile hallucinations shortly after multiple tooth extractions. Patient has coped with symptoms by compulsive cleaning with harsh chemicals, spraying gasoline throughout his bedroom and covering his head with pillow cases during the night. To date patient has been unresponsive to psychopharmacology interventions and minimally responsive to behavioral interventions. This case represents the importance of collaboration between community psychiatry, primary care practitioners and dentistry.

MAY 22, 2013

SCIENTIFIC AND CLINICAL REPORT 26**TOPICS IN PERSONALITY DISORDERS AND NEURODEVELOPMENT****SCR26-1****THE RELIABILITY, FACTOR STRUCTURE, AND VALIDITY OF THE PERSONALITY INVENTORY FOR DSM-5 IN A PSYCHIATRIC SAMPLE***Speakers: Michael Bagby, Ph.D., Lindsay Ayearst, Ph.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) None are required;2) None are required;3) None are required

SUMMARY:

Authors: Bagby, R.M., Ayearst, L.E., Quilty, L.C., Chmielewski, M.S., & Pollock, B.G. Abstract: We report the internal reliability, validity and factor structure of the Personality Inventory for DSM-5 (PID-5; Krueger et al., 2012) in a sample of psychiatric patients (N = 281, 137 women; 144 men), 190 of whom had previously participated in the DSM-5 Field Trial (CAMH site). The PID-5 is a self-report measure composed of 220 items. This instrument is designed to measure five higher-order (domain) personality trait scales -- Negative Affect, Detachment, Antagonism, Disinhibition, Psychoticism -- and 25 lower-order (facet) dimensional personality traits. These traits were identified by the DSM-5 Personality and Personality Disorder Work Group and their consultants; this group also developed and performed initial validation studies of the PID-5 in a community sample (Krueger et al., 2012). Scores on the facet and domain scales serve as the basis for the diagnosis of one or more of six specific personality disorder types (PD) in DSM-5. The internal reliability (Cronbach's alpha) for the five domains was excellent, ranging from .93 to .96, and good to excellent for the facets, ranging from .74 to .96. We applied the same factor analytic procedure employed by Krueger et al. (2012) (i.e., an EFA with targeted-rotation followed by estimation of congruence between the proposed and obtained structure). We were able to replicate and confirm empirically the proposed structure of the PID-5 reported by Krueger et al. (2012) in our psychiatric sample. The factor congruence coefficients for the domains were acceptable to excellent, ranging from .90 to .98. Correlations among the five factors/domains were mostly small or non-significant, ranging from .05 to .36; mean $r = .23$. To assess validity we correlated the domain scales of the PID-5 with the domain scales of the NEO PI-R, an instrument designed to measure the Five-Factor Model of personality (FFM), a model that influenced greatly the DSM-5 personality dimensional trait model. Of the five domain traits of the FFM -- Neuroticism (N), Extraversion (E), Agreeableness (A), Openness (O), and Conscientiousness (C), four have correspondent traits with four of the five PID-5 domain scales;

N with Negative Affect, E (reversed) with Detachment, A (reversed) with Antagonism, C (reversed) with Disinhibition. (The FFM does not include psychoticism and the PID-5 does not include O). In a subsample (n = 263) who completed both the PID-5 and NEO PI-R, the domain scales of the PID-5 correlated with corresponding domain scales of the NEO PI-R; correlations ranged from $|.48|$ to $|.80|$; mean $r = .66$. Overall, we believe that these findings support the reliability and validity of the PID-5 and think that this instrument offers a sound foundation to assess the dimensional traits used to diagnose DSM-5 PD types.

SCR26-2**MORTALITY IN PATIENTS WITH PERSONALITY DISORDER***Speaker: Charlotte Björkenstam, M.Sc.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Be aware that patients diagnosed with personality disorder have a highly increased mortality risk;2) The highest increased risk was for unnatural causes of death;3) Question whether patients with personality disorder in general receive adequate and appropriate care

SUMMARY:

Introduction An estimated 6-10% of individuals in society have a personality disorder, causing a considerable burden on the societal level and suffering on the individual level. Earlier studies based on a limited number of individuals have indicated a considerable excess mortality in this patient group. The present study, which is based on the Swedish health data registers, is carried through to validate previous findings in a cohort of considerable size. The end point is the overall as well as cause-specific mortality. Methods This register-based cohort study includes all patients hospitalized in Swedish health care with a registered primary diagnosis of personality disorder at least once in the ages 15 and 64 between 1987 and 2010 (n=22 329 whereof 13 021 women and 9 308 men). The patients were followed from date of first discharge until the date of death or until the end of the follow-up period, i.e. 31st of December 2010. Standardized mortality ratios (SMRs) with 95 % confidence intervals (CIs) were calculated. Results In total 11% of the women and 18% of the men died during follow-up. About half of individuals with a personality disorder died of unnatural causes (women 50 %, men 51%) compared to expected 14% and 22 %, respectively. Patients treated for a personality disorder had higher than expected number of deaths regardless of cause of death (SMR 6.1; 95% CI 5.8 - 6.4 for women and SMR 5.0; 95% CI 4.8 - 5.3 for men). Mortality for natural causes was moderately increased (SMR 3.6; 95% CI 3.3 - 3.8 for women and SMR 3.3; 95% CI 3.0 - 3.5 for men). The excess mortality was least expressed for malignancies (SMR 1.6; 95% CI 1.4 - 1.8 for women and SMR 1.5; 95% CI 1.2 - 1.7 for men). Mortality due to unnatural causes was highly increased (SMR 22.1; 95% CI 20.5 - 23.8 for women and SMR 11.5; 95% CI 10.7 - 12.3 for men). The

highest excess mortality was suicide (SMR 33.6; 30.7 - 36.7 for women and SMR 16.7; 15.3 - 18.3 for men). Conclusion Patients with a personality disorder have an excess mortality of both natural and unnatural causes. Attempts to combat this excess mortality begin with an analysis of underlying mechanisms. Irrespective of which the dominating mechanisms are, the magnitude of the excess mortality raises the question whether patients with personality disorder in general receive adequate and appropriate care.

SCR26-3

ADOLESCENCE AND THE REORGANIZATION OF INFANT DEVELOPMENT: A NEURO-PSYCHOANALYTIC MODEL

Speaker: Frans Stortelder, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the levels of adult personality functioning of self and interpersonal functioning from a developmental perspective;2) Recognize the interplay of neurobiological and psychoanalytic developmental models;3) Identify the development of the main psychic dimensions across childhood and adolescence

SUMMARY:

The psychoanalytic view of adolescence as a phase of turbulence and reorganization occupied a central position in child and adolescent psychiatry until about 1980. The view of adolescence as a silent-transition phase then prevailed and diverged from the psychoanalytic perspective. This article reviews infant and adolescent development using an interdisciplinary, neuro-psychoanalytic model in which psychoanalytic, neurobiological, and developmental perspectives converge and complement each other. Recent empirical research focuses attention on adolescence as a phase in which a far-reaching neurobiological and psychological reorganization takes place. According to the ontogenetic principle of psychoanalysis, the development and organization of the basic psychic functions occur in the first five years of life, while a reorganization takes place in adolescence. Neurobiological research confirms that the basic growth and maturation of the brain occurs in the first five years of life, and that a substantial reorganization in brain development transpires in adolescence. Research also verifies the clinical psychoanalytic concept that neurobiological and psychological maturation in adolescence remain unfinished till approximately age 23. The long-term and late biopsychosocial maturation in adolescence implies that adequate monitoring by parents and school remains necessary. The view that adolescents need to separate, and discover their individuality and independence alone, is unsupported by recent findings. The adolescent must acquire his independence, personal identity and self-agency ("scaffolding") step by step. It is important that the adolescent knows that his parents are in the background monitoring and intervening as necessary; that he is not entirely alone, adrift

and at risk for potential fragmentation. The long-term plasticity of the brain in adolescence implies greater vulnerability for the development of psychopathology, but offers opportunity for psychotherapeutic interventions to have greater impact.

SCIENTIFIC AND CLINICAL REPORT 27

TREATMENT OF DEPRESSION

SCR27-1

CHANGES IN PHARMACOTHERAPY IN SEVERE MAJOR DEPRESSIVE DISORDER: A 12-MONTH STUDY OF PHYSICIAN AND PATIENT TREATMENT DECISIONS

Speaker: John W. Goethe, M.D.

Co-Author(s): Bonnie L. Szarek, R.N., Stephen Woolley, D.Sc

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe current prescribing practices for treatment resistant MDD patients followed for one year;2) Identify and discuss variables associated with change in pharmacotherapy over the 12 month follow up;3) Compare the pharmacotherapy reported to STAR-D and other published treatment guidelines for MDD

SUMMARY:

Objectives Recent studies describe pharmacotherapy practices in MDD, but there is little published data specific to patients with severe and persistent (treatment resistant) depression and the "course of therapy" they receive in routine clinical settings. This study followed a sample of both in- and outpatients with a clinical diagnosis of MDD to determine (1) frequency and type of medication changes over time, (2) patient-reported reasons for these changes, and (3) the variables associated with change/non-change.

Methods 406 patients receiving an SSRI for a clinical diagnosis of MDD consented to assessments at 3, 6 and 12 months after the index episode of care in 2001-03. Data were obtained at each time point via structured telephone interview. Type of/reason for change in treatment as well as associated variables were examined using descriptive statistics, χ^2 and stepwise regression. A companion study about treatment of an MDD sample from 2010-12 was used to compare prescribing practices in the two time frames. Results The sample was severely ill: GAF mean=36.7 \pm 10.3, GAF \leq 50 in 95%; prior treatment for MDD in 77.8%; 25.1% hospitalized in last year; "psychotic features" present in 29.6%. The majority of patients (87-92%) received an antidepressant (AD) and most remained on index SSRI at all follow ups (75.4% at 3, 64.6% at 6, 57.6% at 12 months). Adding an additional drug was common between 3-6 and 6-12 months (51.7 and 35.6%); frequently added were antipsychotics (AP) and benzodiazepines (BZ) (29.6 and 20% at 3 months). AP ($p < 0.002$) but

not BZ use subsequently decreased. Notable was the very low use (<2%) of lithium and thyroid hormone. Among all who discontinued index SSRI (n=151) most did so at 3 months (66%). By 12 months 16% were not on any SSRI. Less than 12% of patients reported no medication use at 3, 6 and 12 months. The most common patient-reported reasons for stopping index SSRI at each follow up were no benefit (42-45%) and side effects (33-51%). Prescribing practices in the study period vs 2010-12 were similar overall, but SSRI and AP use was greater in the latter (68.6 vs 63.4%, $p=.003$, and 57.7 vs 45.2%, $p<.001$). Conclusions Recent studies have not focused on severely ill patients receiving usual care nor included inpatients, those likely to need hospitalization and those with psychosis. The proportion of the sample prescribed a new or "add on" medication within 3 months (25%) was similar to that found at first follow up in STAR-D and the course of treatment was generally consistent with current guidelines. However, that within 6 months 6.1% of patients were on no medications is not consistent with usual recommendations. Further studies are needed that focus specifically on patients with severe and persistent MDD, individuals for whom existing therapies and treatment algorithms may not be adequate. Co-authors: Bonnie L. Szarek, R.N., Stephen Woolley, D.Sc.

SCR27-2

EFFECT OF L-METHYLFOLATE ON MAIER SUBSCALE SCORES IN A RANDOMIZED CLINICAL TRIAL OF PATIENTS WITH MAJOR DEPRESSION

Speaker: Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the role of L-methylfolate as an adjunct to treatment resistant depression;2) Understand the value of subscales for assessing the response to drug treatment of depression;3) Recognize the potential value of markers for determining response to L-methylfolate

SUMMARY:

Background: Major depressive disorder (MDD) includes a metabolic component that is associated with poor antidepressant response, and correction may improve core symptoms. This analysis assessed the effect of L-methylfolate 15 mg as an adjunct to SSRIs on the Maier subscale of the HDRS and correlations with inflammatory biomarkers. Methods: 75 inadequate responders to SSRIs were enrolled in a 60-day, multi-center, double-blind, placebo-controlled trial. Patients received L-methylfolate 15 mg/day for 60 days, placebo for 30 days followed by L-methylfolate 15 mg/day for 30 days, or placebo for 60 days. In a sub-analysis, mean change from baseline to endpoint was evaluated for the Maier subscale (HDRS items 1, 2, 7-10, and 13) for L-methylfolate and placebo. In addition, correlations between BMI and hs-CRP were examined. Results: 74 patients were enrolled. For pooled data, mean change on the Maier subscale was -3.3 ± 3.7 for L-methylfolate vs. -1.5 ± 3.2 for placebo (95% CI: -2.936,

-0.296 , $p=0.016$). Mean improvement in symptoms was significantly greater with L-methylfolate vs. placebo (-7.4 ± 7.9 vs. -2.4 ± 5.3) among patients with a BMI ≥ 30 kg/m² (95% CI: -7.449, -1.871, $p=0.001$). Mean symptom improvement was significantly greater with L-methylfolate than placebo (-7.7 ± 7.4 vs. -3.7 ± 7.5) in patients with elevated baseline hsCRP >median (2.25 mg/L) (95% CI: -7.227, 0.002, $p=0.050$). Conclusions: A robust response in core symptoms on the Maier subscale was observed with L-methylfolate as an adjunct to SSRIs. Addressing metabolic imbalances (BMI or inflammation) may enhance the treatment effect.

SCR27-3

EFFECTIVENESS OF TRANSCRANIAL MAGNETIC STIMULATION (TMS) FOR ANXIOUS DEPRESSION

Speaker: Gretchen Diefenbach, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the effectiveness of TMS for reducing depressive symptoms among MDD patients with and without anxious depression;2) Describe the effectiveness of TMS for reducing anxiety symptoms among MDD patients with and without anxious depression;3) Describe remission rates for MDD patients with and without anxious depression following TMS

SUMMARY:

Objective. "Anxious depression" is a commonly described presentation in MDD and has been associated with poor response in some but not all studies. The aim of the current study was to determine if, in a sample of MDD patients non-responsive to pharmacotherapy who received TMS, those with anxious depression had a significantly poorer outcome after TMS than did those without anxious depression. Methods. The sample was 32 treatment-resistant MDD patients clinically treated with TMS. Participants were grouped into those with (n = 8) and without (n = 24) "anxious depression" using the anxiety/somatization subscale of the HAMD (score ≥ 7 = anxious depression). The 17-item HAMD was administered pre and post treatment. Remission was defined as a ≥ 8 HAMD total score. Treatment was administered using the FDA-approved Neuronetics model 2100 Therapy System and was targeted at the left DLPFC. Mean number of treatments = 31 ± 5.39 (range = 22-42) at 91% of the motor threshold (SD = 14.4) for 4016 maximum pulses per session (SD = 673.6) and 101,787 total pulses (SD = 20,048.3). Results. HAMD scores for the sample improved from pre to post treatment [$F(1, 30) = 26.22$, $p < .001$], and the amount of change from pre to post treatment was similar in both groups [$F(1, 30) = 2.52$, $p = .123$]. The pre to post treatment effect sizes for the entire sample and for the anxious group were large ($d = 0.87$ and $d = 1.47$, respectively) but for the non-anxious group only moderate ($d = 0.76$). Remission rates were similar in the anxious (n = 2, 25.0%) and non-anxious

($n = 7, 29.2\%$) groups. Scores on the anxiety/somatization factor improved for the entire sample [$F(1, 30) = 14.71, p < .001$]. As expected, the anxious group scored higher on this subscale [$F(1, 30) = 38.38, p < .001$], but unexpectedly they showed a larger improvement than did the non-anxious group [$F(1, 30) = 4.50, p < .05$]. The pre to post treatment effect size was large for the anxious group ($d = 1.22$), and moderate for the entire sample and for the non-anxious group ($d = 0.53, d = 0.48$, respectively). Three-fourths of the patients in the anxious group no longer met criteria for anxious depression at post treatment ($n = 6$). Conclusions. Both depressive and anxiety symptoms improved following TMS. However, anxious depression was not associated with poorer treatment response. Contrary to prediction, the anxious group compared to the patients without “anxious depression” showed similar improvements in depressive symptoms and superior improvements in anxiety symptoms. Study limitations included small sample, no structured diagnostic assessment, and using the anxiety/somatization subscale of the HAMD rather than an independent anxiety scale. Despite these limitations, this study contributes important and novel data to the evolving literature on the outcome of TMS in naturalistic settings.

SCIENTIFIC AND CLINICAL REPORT 28

MILITARY PSYCHIATRY II

SCR28-1

BATTLEFIELD ETHICS AND PSYCHOLOGICAL HEALTH: THE IMPACT OF A TRAINING INTERVENTION

Speaker: Christopher H. Warner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the risk factors associated with psychological stress and unethical battlefield conduct; 2) Understand the relationships between PTSD and unethical battlefield behavior; 3) Recognize the impact and effectiveness of leader led interventions in changing battlefield behaviors

SUMMARY:

Objective: Breakdowns in battlefield ethical conduct toward non-combatants are of grave concern in war, and are sometimes attributed to the stresses of combat or post-traumatic stress disorder (PTSD), although systematic studies are lacking. Evidence-based training approaches to prevent these behaviors are also lacking. This presentation assesses risk factors for unethical battlefield conduct, and the impact of battlefield ethics training.

Methods: A training package, based on movie vignettes and leader-led discussions, was administered to soldiers approximately three months into a 15 month high intensity combat deployment to Iraq. Soldiers from one infantry brigade combat team were randomly selected and invited to complete an anonymous survey three months after completion of the train-

ing. Reports of unethical behavior and attitudes in this sample were compared with a randomly selected pre-training sample from the same brigade. Risk factors for unethical conduct, including combat experiences and PTSD, were assessed using validated scales. Results: Of 500 randomly selected soldiers, 84.2% ($N=421$) participated in the anonymous post-training survey. The training was associated with significantly lower rates of unethical conduct and increased willingness to report and address misconduct post-training. Anonymous reports of damaging or destroying private property when it was not necessary or physically hitting or kicking a non-combatant when it was not necessary decreased from 13.6% to 5.0%, and from 6.1% to 3.3%, respectively, pre- to post-training. Nearly all participants (97.4%, $N=410$) reported that training made it clear how to respond towards non-combatants. Combat frequency/intensity was the strongest predictor of unethical behaviors; PTSD was not a significant predictor after controlling for combat experiences. Conclusion: Unethical battlefield conduct was associated with high intensity combat but not PTSD. Leader-led battlefield Ethics training, based on movie vignettes, positively influenced soldiers' understanding of how to interact with and treat non-combatants, and reduced reports of ethical misconduct.

SCR28-2

EMBEDDED BEHAVIORAL HEALTH: THE ARMY'S NEW MODEL OF COMMUNITY BEHAVIORAL HEALTH CARE

Speaker: Christopher Ivany, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the differences in the traditional model of outpatient care and Embedded Behavioral Health care; 2) Identify challenges inherent in extending behavioral health clinics into the Army community; 3) Recognize advantages for patients served by a community-based model of outpatient care

SUMMARY:

Objective: To describe the effectiveness of a new, community-based, multidisciplinary model of outpatient behavioral health care within U.S. Army medical treatment facilities to determine whether it improves access to care and the effectiveness of care. **Method:** Comparisons between groups of Soldier/patients supported through the traditional model of BH care and those supported by care in the Embedded Behavioral Health (EBH) model were made. **Results:** Units that received care from the EBH model had 62% fewer Soldiers who were unfit to deploy due to a BH condition. Units whose Soldiers received care through the EBH model required between 40% and 72% fewer admissions to acute inpatient psychiatric care. Soldiers accessed BH care more frequently through the EBH model. **Conclusions:** EBH care better aligns the BH system with Army organization and structure by creating enduring working relationships between individual BH providers and

Army unit leadership teams. This presentation will review both the advantages and challenges associated with implementing EBH and the potential application to civilian community settings. The Department of the Army ordered replication of the EBH approach to all Army combat units before the end of 2016.

SCR28-3

EFFECTIVENESS OF MENTAL HEALTH SCREENING AND COORDINATION OF CARE THROUGH THE MILITARY DEPLOYMENT CYCLE

Speaker: Christopher H. Warner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the limitations of pre/post deployment mental health screening and identify potential mechanisms for decreasing stigma and barriers to seeking care.;2) Recognize the impact of coordination of care through the transition phases of deployment on mental health outcomes;3) Recognize the factors and mechanisms which maximize the effectiveness of pre/post deployment mental health screening

SUMMARY:

Objective: This presentation assesses the effectiveness of a systematic method of pre/post-deployment mental health screening to determine if screening and coordination of care decreased negative mental health outcomes. Methods: Primary care providers performed directed mental health screenings during standard pre/post-deployment medical screening. If indicated, on-site mental health providers assessed occupational functioning with unit leaders and coordinated ongoing mental health care for those identified. Furthermore, reporting of mental health problems on the routine post-deployment health assessment (PDHA) was compared with their reporting on an anonymous survey administered simultaneously. Results: 10,678 soldiers were screened prior to deployment. Soldiers in screened units had significantly lower rates of clinical contacts than in unscreened units for suicidal ideation, combat stress as well as lower rates of occupational impairment and air evacuation for behavioral health reasons. Separate studies of returning units showed similar outcomes in negative behaviors including domestic violence, suicidal ideation, and drug/alcohol abuse. Willingness to report was 2 to 4 fold higher in anonymous surveys compared with the primary care screening. Conclusion: Deployment mental health screening and coordination of care is associated with significant reductions in occupationally impairing mental health problems, however, these tools are dependent upon soldiers honestly reporting their symptoms. Further efforts are required to reduce stigma of reporting, and improve willingness to receive care for mental health problems.

SCIENTIFIC AND CLINICAL REPORT 29

MEASUREMENT, SCREENING, AND PARTICIPATION

SCR29-1

REAL-LIFE DECISION MAKING OF PATIENTS WITH SERIOUS MENTAL ILLNESS: OPT-IN AND OPT-OUT RESEARCH PARTICIPATION

Speaker: Yoram Barak, M.D., M.H.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify ethical concerns that the psychiatric clinical research may expose those being studied to potential harm;2) Evaluate the role of defaults in serious mental illness (SMI) patients' decisions to participate in clinical research in real-life;3) Characterize SMI patients willing to participate in clinical research

SUMMARY:

Background: Patients' decisions in relation to participation in clinical research depend on individual values and relevant outcomes. Presenting possible decisions by way of defaults (opt-in or opt-out) has been used to achieve desired outcomes. Our objective was to characterize patients willing to participate in clinical research and to assess the impact of defaults on patients with Serious Mental Illness (schizophrenia, schizoaffective disorder, major depression and bipolar disorder; SMI) during the decision process. Methods: Patients admitted to the Abarbanel Mental Health Center were recruited between Jan and June, 2012 according to the following eligibility criteria: (1) a DSM-IV diagnosis of a SMI, (2) availability to participate within 48 hours of admission and (3) aged 18 years and older. We excluded patients with cognitive impairment and patients who had already participated in other studies related to informed decision making. Enrollment took place consecutively until the planned sample size was achieved. SMI patients were requested to accept or reject participation in research using either the (1) opt-in condition, wherein they were told that our center's policy is not to automatically include them in research; (2) the opt-out condition, wherein they were told that our center's policy is to include them in research; and the (3) neutral condition that required patients to state their preference with no prior information. Results: 311 SMI patients completed the brief questionnaire within 48 hours of admission to a psychiatric ward. There were 227 (73%) patients suffering from schizophrenia, 40 (13%) suffering from bipolar disorder and 44 (14%) suffering from major depressive disorder. There were 156 men (50%) and 155 women in the sample, mean age 47.8 ± 16.2 years. In the opt-in condition, 58% abstained, while 42% opted-in ($p=0.003$). In the opt-out condition, 58% participated, while 42% opted-out. In the neutral condition 51% indicated willing-

ness to participate, 33% refused and 16% were undecided. The “willing” patient was characterized by younger age, previous hospitalizations, affective illness and more comorbid physical disorders. Conclusion: Taken together these findings reveal the “profile” of SMI patients willing to participate in clinical research and demonstrate a 15% increase in participation through the use of defaults.

SCR29-2

DATA AVAILABLE ON ADMISSION PREDICT 30-DAY READMISSION IN PSYCHIATRIC INPATIENTS

Speaker: Harold I. Schwartz, M.D.

Co-Author(s): John W. Goethe, M.D., Bonnie L. Szarek, R.N., Stephen Woolley, D.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe a method for rapid identification of inpatients at increased risk of readmission within 30 days of discharge; 2) Distinguish among clinical and demographic variables that are vs are not associated with readmission within 30 days; 3) Discuss the potential impact of Centers for Medicare and Medicaid Services’ (CMS) new reimbursement policies on psychiatric inpatient practice

SUMMARY:

Objective: Recent changes in reimbursement policies underscore the importance of early identification of patients at high risk for readmission within 30 days of inpatient discharge. The authors examined demographic and clinical data available in the first day of hospitalization to identify variables associated with readmission. Methods: The sample was all patients admitted to the psychiatric service of a large urban hospital between 1/1/2002 and 5/1/2008 (n=12,830), 63.4% of whom were white, 12.3% black, and 18.7% Hispanic; 52.6% were female and the mean age was 40±19.8 years (range 4-99 years). Patients readmitted within 30 days were compared to all others using SPSS® V19 to perform bivariate (t-test, chi-square, ANOVA, relative risk), stratified, and Cox proportional hazards regression analyses. Independent variables in the regressions were demographic and clinical data (e.g. diagnoses, medications) and admissions prior to index hospitalization (yes/no for 30, 90, 180 days prior).

Results: 9.5% (n=1217) of patients were readmitted in ? 30 days, and these patients were more likely than all others to have a history of prior inpatient care. bivariate analyses showed that the odds of readmission within 30 days of discharge from the index hospitalization were 3.59 times greater for patients who had been hospitalized within the prior 30 days; risk for readmission was also increased for patients hospitalized within the previous 90 (OR=2.78) and 180 (OR=2.65) days. Readmission in ? 30 days was associated with receiving a greater number of psychotropics: 8% of those on ? 2 drugs were readmitted vs 19% of those on 7;

for patients on ? 3 drugs, the odds of readmission were 1.44 times greater than for patients on ? 2 drugs. Other variables associated with rapid readmission included sex (female), race (black), age (18-60), diagnosis (anxiety disorders, OR=1.22) and medication prescribed (antipsychotics, OR=1.63; benzodiazepine, OR=1.45; ? 2 benzodiazepines, OR=1.59; anticonvulsant, OR=1.32). Diagnosis of drug/alcohol abuse was not associated with readmission. Among the subset of patients with MDD (n=4822) but not other primary diagnostic categories, risk of readmission was increased in those with any of 4 co-diagnoses: PTSD (OR=1.44), a personality disorder (PD) (OR=1.25), a Cluster B PD (OR=1.67), borderline PD (OR=1.59). Conclusions: These findings indicate that patients at increased risk for rapid readmission can be identified based on data available on day one of hospitalization. Early identification is necessary in order to allow intervention prior to discharge. This study, confirming some but not all previously reported associations with ? 30 day readmission, provides new data for more precise quantification of individual risk, allowing clinicians to prioritize patients most in need of interventions that may reduce these risks. Co-authors: John W. Goethe, M.D., Bonnie L. Szarek, R.N., Stephen Woolley, D.Sc.

SCR29-3

MEASUREMENT OF CLINICAL RISK OF STIGMA AND DISCRIMINATION OF MENTAL ILLNESSES USING QUANTIFICATION OF STIGMA SCALE: PRELIMINARY FINDINGS

Speaker: Amresh K. Shrivastava, M.D., M.R.C.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand if stigma can be measured; 2) Understand if scale for quantification of stigma for clinical use can be constructed; 3) Examine results of field trial of quantifying stigma in a hospital based population of schizophrenia

SUMMARY:

Amresh Shrivastava, Yves Bureau, Nitika Rewari, & Megan Johnston, Nilesh Shah Background: Stigma and discrimination continue to be a reality in the lives of people suffering from mental illness, particularly schizophrenia, and prove to be some of the greatest barriers to access care, continue to remain under care, and regain a normal lifestyle and health. Research advances have defined stigma, assessed its implications and have even examined intervention strategies for dealing with stigma. The delay in treatment due to stigma causes potential complications like suicide, violence, harm to others and deterioration in capacity to look after one’s physical health. These are preventable clinical complications. In order to deal with the impact of stigma on an individual basis, it needs to be [1] assessed during routine clinical examination, [2] assessed for quantification in order to obtain measurable objective deliverables, and [3] examined if treatment can reduce stigma and its impact on individuals. Purpose and hypothesis: We are of the opinion that stigma has several

domains: personal, social, cultural, illness-related, treatment-related, and environmental. Each of these domains has several factors, which may or may not contribute to the degree of stigma affecting a given individual. Components of these domains can be used to design a tool, which can then be standardized and validated in controlled studies. Quantifying stigma in terms of its impact and consequences requires attention to four different components: 1) events of discrimination that have taken place, 2) the real-life experience, 3) the patients' perception of this discrimination, and 4) how has the patient coped to live with discrimination. A reasonable quantification of stigma would be to measure the consequences and its perception in an individual. We hypothesize that the efficacy of an intervention can be successfully measured by comparing it before and after treatment. Method: We have constructed a 39-item scale for quantification of stigma for clinical utility, based upon the above principle. In this study we present the constructs of the scale and preliminary findings based on a field trial done in Mumbai, India with a cohort of 30 individuals suffering from schizophrenia. Results: A total score of stigma and discrimination was computed from four subscales: psychological consequences, social consequences, illness-related consequences, and coping strategies. These total scores correlated negatively with age, duration of illness, and duration of treatment. The number of previous hospitalizations was not related to stigma, although there was a trend towards a greater number of relapses predicting higher scores of stigma. Levels of violence did not predict stigma scores, nor did knowledge of other patients. However, a greater presence of suicide risk was associated with more consequences of stigma and discrimination.

SCR29-4

TAILORED SCREENING FOR MULTIPLE MENTAL DISORDERS

Speaker: Philip Batterham, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the need for more efficient screening methods in a range of care settings; 2) Understand and apply two novel methods for increasing the efficiency of screening for mental disorders; 3) Identify the advantages and disadvantages of using tailored screening in a specific population

SUMMARY:

Background: Screening for mental disorders can increase help seeking and directly link individuals with appropriate services. However, with the advent of new models of care such as virtual clinics, there is a need for briefer approaches to screening. The present study tested two tailored measurement methods for increased screening efficiency: hierarchical screening and tailored scales. Hierarchical screening involves initial screening for general psychological distress, followed by specific disorder screening contingent on a criterion being met. Tailoring scales involves reducing the number of items by adapting the order of item presentation, such that criteria

can be met or ruled out using fewer items. Method: Three community-based Australian cohorts were used to test the two tailored screening approaches: an adult sample with elevated rates of psychopathology (aged 18+, n=981), a school-based sample (aged 12-17, n=1370) and a sample of older adults with elevated depression symptoms (aged 60-75, n=898). The Kessler-6 scale was used to assess general psychological distress in all samples. Depression and anxiety were assessed using self-report scales. In addition, social phobia, panic disorder and adult attention deficit hyperactivity disorder were assessed in the general adult sample. Results: The hierarchical screening method increased efficiency only in the school-based sample, reducing mean items presented from 57.0 to 34.4 with negligible reduction in precision. However, using a decision tree approach to tailor the presentation of items within scales led to greater increases in efficiency without any loss of precision. As a result of more rapid exclusion of non-cases, scale tailoring reduced mean items from 57.0 to 23.8 in the school sample, 14.0 to 7.8 in the elderly sample and 29.3 to 14.8 in the general adult sample. Conclusions: Programs that screen for multiple mental disorders should consider using a tailored approach to screening to reduce the burden on respondents. However, the efficiency of tailored screening for identifying caseness needs to be balanced with the need to assess severity, the rates of mental health problems in the population of interest, and the length of the assessment. Further development of adaptive screening approaches show promise for more effective identification of mental health problems in the community.

SCIENTIFIC AND CLINICAL REPORT 30

MILITARY TRAUMA, DISSOCIATION, AND EPILEPSY

SCR30-1

ADDRESSING PTSD IN PRIMARY CARE IN THE VETERANS HEALTH ADMINISTRATION: A WORK IN PROGRESS

Speaker: Andrew S. Pomerantz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the VA model of integrated care in the Patient Centered Medical Home; 2) Improve understanding of effective approaches to managing PTSD in primary care, particularly for individuals resistant to specialty mental health care; 3) To develop hypotheses to guide further research into the treatment of PTSD in Primary Care

SUMMARY:

Introduction: Post Traumatic Stress disorder is among the most prevalent mental conditions in public health systems in general and in VA in particular. In addition to screening for depression and at-risk alcohol use, all veterans receiving primary care services in VA are screened for PTSD, using

the four question PTSD-PC screen. In recent years, several evidence based psychotherapies have been implemented in the VA nationwide and these treatments comprise the core of specialized treatment for the disorder. Despite the efficacy of these treatments, many Veterans from the recent and ongoing wars in Afghanistan and Iraq have either not engaged in or failed to complete such specialized intensive treatments, leading many VA clinical programs and researchers to search for other ways to effectively address trauma. The Primary Care-Mental Health Integration began a nationwide implementation in 2007 (Post, et al 2010). The VHA programs added an additional component to the evidence based care management programs, embedding mental health clinicians in primary care teams (APA, 2005). These clinicians, along with care managers are now an integral component of the interdisciplinary Patient Aligned Care Team (PACT), which is the VA model of the Patient Centered Medical Home (Pomerantz, et al, 2010). These clinicians provide a broad range of interventions from addressing health behaviors to brief treatments for common mental disorders, as well as providing disease specific care management programs for depression, anxiety and at-risk drinking and referral management. These integrated care programs have led to a significant increase in the number of Veterans in the primary care population being identified and treated for mental disorders, many entirely with in the context of the PACT. The difficulties engaging Veterans in specific evidence based psychotherapies for PTSD and the frequent preference for treatment in primary care have spurred the development of brief interventions for individuals who screen positive for PTSD. These interventions consist of a limited number of 30 minute sessions that incorporate diagnostic assessment, psychoeducation, problem solving and other approaches. Many of these interventions, developed by clinicians, are now undergoing rigorous testing in research trials. In addition, both local performance improvement studies and the national evaluation program are beginning to yield data suggesting that these approaches may be effective ways to address trauma in the primary care setting. Method: Mental health interventions in the PACT are identified with specific codes as either individual or group treatments. All data are transmitted to a national database which maintains all coding and other information regarding every clinical encounter for the more than 6 million Veterans who use VHA for all or a portion of their healthcare. Such data are routinely evaluated by a number of different program evaluation centers

SCR30-2

WHAT CAN FERENCZI STILL TEACH US ABOUT THE TREATMENT OF VETERANS WITH COMBAT STRESS?

Speaker: Thomas B. Horvath, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the impact of Ferenczi's military service on his personal and professional development as reflected in his correspondence with Freud; 2) Identify Ferenczi's approach to trauma and his "active" and "relaxed" techniques

as analyzed by his biographers; 3) Discuss the potential additions of Ferenczi's theories and techniques to our current armamentarium for reducing combat stress reactions.

SUMMARY:

Despite the availability of evidence based psycho- and pharmacotherapy at no cost for recent veterans, only half of them come to the VA, and many drop out of treatment. Freud's best friend and collaborator, Sandor Ferenczi, did not seem to lack patients towards the end of the Great War. He served in the Austro-Hungarian Army for four years, and was installed by acclamation as Professor of Psychoanalysis, and was given a military hospital in Budapest to treat War Neuroses. He chaired the 5th International Psychoanalytic Congress in 1918. Freud wanted Budapest to become the center for psychoanalysis. Tragically, the Red Terror, then the White Counterrevolution destroyed these plans, and prevented Ferenczi's further work with veterans. Yet his trauma theories developed, and the Budapest School survived, and its subsequent diaspora (Balint, Alexander, Benedek, Rado, Bak etc) deeply influenced Post Freudian analysis. Yet Ferenczi's reputation suffered, and his military work was overlooked.

The Freud-Ferenczi correspondence, his Clinical Diary, the original work of Hungarian Ferenczi scholars (Haynal, Eros, Meszaros) and items in the Library of Congress throw new light on Ferenczi's recognition of the reality of trauma, his "active" and "relaxed" techniques, and most importantly on his warm, empathic and reciprocal relationship with his patients. The roots of these innovations can be traced to his military years. Their subsequent development led to Freud's disapproval and Ernest Jones' distortions of Ferenczi's character. Yet Ferenczi maintained his loyalty to Freud, while actively helping his traumatized patients, and learning from his occasional boundary violations. Lessons for today: 1. Ferenczi's military identification, comradely interests, warm personality could be usefully emulated by behavioral and pharmacotherapists, and would attract and retain veterans.

2. Brief dynamic therapies pioneered by Ferenczi should be studied for improving symptoms and quality of life outcomes especially in early PTS. 3. As the roots of attachment theory can be traced to the Budapest School, it is appropriate that mentalization therapy, already evidence based for Borderline Personality Disorders, should be tested for chronic, complex PTSD. (Fonagy) 4. Ferenczi's "Confusion of tongues" paper should be studied for adaptation to address a neglected component of war trauma: the loss of trust veterans experience in the miscommunications of war zone and homecoming (Jonathan Shay)

SCR30-3

DISSOCIATIVE DISORDERS AND EPILEPSY: THE CHALLENGES IN DIAGNOSIS AND MANAGEMENT

Speaker: Rochelle M. Kinson, M.B.B.S., M.Med.

ED

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify a rare presentation of Dissociative disorder NOS;2) Diagnose accurately when dissociative disorders co-occur with epilepsy;3) Describe appropriate investigations that will aid in diagnosis and management

SUMMARY:

Background : It is clinically challenging to differentiate behaviour changes resulting from epilepsy, primary psychosis and dissociative states. These two cases described illustrates this challenge. Case description 1: X is a 56 yr old Chinese female with no significant medical or psychiatric history. She presented with episodes of bizarre behavior – erratic movements of all four limbs, mumbling to herself, unresponsive and staring blankly. She had been experiencing this for 20 years and it occurred 1-2 times per year. During these episodes she believed that her body was taken over by a Taoist God and would speak and gesture as she was asked to. She retained no memory of these events. Extensive investigations were normal. Case description 2 : L is a 51 year old Chinese male with a background medical history of Generalized Tonic-Clonic Seizures (GTC) diagnosed at age twenty with multiple admissions for break through seizures due to partial adherence to his antiepileptic drugs. He sustained a head injury following a GTC in 2011 and his seizures increased in frequency and duration despite adherence to medication. Mr L typically had a period of post-ictal confusion where he was disoriented lasting minutes to several hours; this period too had increased over the years. He also experienced episodes where he would take on the persona of a Taoist God - speak, gesture, chant and perform rituals; heard the voices and saw images of other Gods. These episodes had been ongoing for 6 years. He retained no memory of these episodes. Mr L, his family and religious circle believed he was 'possessed'. Neurological investigations were unremarkable. Discussion : Dissociative disorders and epilepsy share many clinical features including amnesia, fugue, depersonalization, derealization and identity change making it a diagnostic challenge. A definitive diagnosis of epilepsy vs dissociation can be made using video-electroencephalogram monitoring which in dissociative states not related to seizure activity should be normal. This is however labor intensive and expensive. In patients with dissociative disorders abnormal EEG's are seen in 30-44% and co-morbid epilepsy is seen in 10% - this is higher than the general population however there is no definite etiological link. Studies of patients with epilepsy and dissociative states shows that organic fugue states are common. When postictal personality changes occur they are usually time limited and not complex. Dissociative symptoms can be misdiagnosed as epilepsy in the absence of an ictal EEG; conversely epilepsy can be misdiagnosed as a dissociative disorder if there is a normal nonictal EEG. Conclusion: The diagnostic challenge between epilepsy and dissociative states especially when they are co-morbid conditions can be minimized with careful history taking, strict adherence to diagnostic criteria, use of structured tools, neurological investigations and longitudinal follow up.

SCIENTIFIC AND CLINICAL REPORT 31**MOOD DISORDERS****SCR31-1****MAJOR DEPRESSIVE DISORDER CO-OCCURRING WITH BINGE-EATING DISORDER: SEQUENCE AND ASSOCIATIONS WITH OTHER COMORBIDITIES AND EATING PSYCHOPATHOLOGY**

Speaker: Daniel F. Becker, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize that MDD commonly co-occurs with binge-eating disorder;2) Identify the correlates of this pattern with respect to eating psychopathology, psychological functioning, and axis I psychiatric comorbidity;3) Identify the associations of onset sequence;4) Understand the implications for subtyping binge-eating disorder;5) Apply these findings to the evaluation and treatment of patients with binge-eating disorder

SUMMARY:

Objective: Binge-eating disorder (BED) is associated with elevated rates of co-occurring major depressive disorder (MDD). However, the significance of this diagnostic comorbidity is ambiguous--as is the significance of the onset sequence for these two disorders. In this study, we compared eating psychopathology, psychological functioning, and overall axis I psychiatric comorbidity in three subgroups of patients with BED: those in whom the onset of BED preceded the onset of MDD, those in whom the onset of MDD preceded the onset of BED, and those without MDD or any other axis I comorbidity. Method: Subjects were a consecutive series of 444 treatment-seeking patients (79% women, 21% men) who met DSM-IV research criteria for BED. All were assessed reliably with semi-structured interviews in order to evaluate lifetime DSM-IV axis I psychiatric disorders (Structured Clinical Interview for DSM-IV Axis I Disorders – Patient Edition) and eating disorder psychopathology (Eating Disorder Examination). Additional self-report instruments were used to evaluate psychological functioning. Results: In this study group, 161 (36%) subjects had the onset of BED preceding the onset of MDD, 103 (23%) had the onset of MDD preceding the onset of BED, and 180 (41%) had BED but had no co-occurring axis I disorder. These three groups did not differ with respect to sex, ethnicity, or level of education--nor did the groups differ significantly with respect to body mass index or binge eating frequency. Groups did differ significantly with respect to eating disorder attitudes, with both of the MDD groups demonstrating higher eating psychopathology levels relative to the group without co-occurring axis I disorders. The two MDD groups also showed significantly higher levels of negative affect and lower self-esteem ($p < .001$). Not surprisingly, several differences were observed between groups with

respect to ages of onset for obesity, specific eating behaviors, and BED. Finally, some differences were noted with respect to axis I psychiatric comorbidity, with the group having earlier onset of MDD showing elevated rates of anxiety disorders compared to the group having earlier onset of BED. Conclusions: MDD occurs frequently among patients with BED. Although we found few differences in current eating psychopathology levels associated with the relative order of onset for these two disorders, we did observe higher rates of comorbid anxiety disorders in those patients for whom MDD preceded BED. Moreover, we found that MDD in combination with BED--with either order of onset--had a clinically meaningful adverse effect on eating psychopathology, psychological functioning, and overall axis I psychiatric comorbidity. These findings suggest approaches to subtyping BED patients based on psychiatric comorbidity, and may also have implications for treatment.

SCR31-2

PREVALENCE OF ANTENATAL DEPRESSION: A STUDY FROM A DEVELOPING COUNTRY

Speaker: Hegde S. Shruti, M.B.B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the prevalence of antenatal depression;2) Assess the risk factors in development of antenatal depression;3) Plan community level intervention

SUMMARY:

Introduction: Recent metaanalysis on prevalence of antenatal depression in middle and low income country showed a weighted mean prevalence of 15.6%. There has far been very less empirical research on the occurrence of antenatal depressive morbidity among Indian women. Hence the present study was undertaken to identify the prevalence of antenatal depression and risk factors associated with it. **Methods:** The present cross-sectional study was carried out in obstetric outpatient department of tertiary care hospital, Mangalore. A total of 253 women attending the routine antenatal clinic during the study period formed the study subjects. Edinburg postnatal depression scale (EPDS) was administered to all the participants. EPDS score greater than or equal to 10 was taken as possible depression and score greater than 13 as depressive illness. **Results:** The prevalence of depressive illness was found to be 36.75%. Male gender preference, unemployment, poor relation with the husband, term pregnancy and lack of recreation were independently associated with antenatal depression, while support from family and husband, being satisfied with pregnancy and being employed were associated with a reduced likelihood of depression. **Conclusion:** Prevalence of antenatal depression was found to be high in our population. Further community based studies are required to address this issue. **Co-authors** 1. Hulegar A Abhishekh Medical student. Bangalore Medical College & Research institute. India 2. Kulamarva R Sandeep. MBBS Father Muller Medical College, India 3. Arjun Lakshmana Balaji Yale school of public health, USA 4. Keshav Pai, MD Kasturba Medical College. India

SCR31-3

SOCIAL RELATIONSHIPS AND DEPRESSION: TEN-YEAR FOLLOW-UP FROM A NATIONALLY REPRESENTATIVE STUDY

Speaker: Alan R. Teo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify quality of social relationships as a risk factor for major depressive episodes;2) Appreciate the degree of effect poor quality of social relationships on depression risk;3) Recognize how to assess patients' quality of social relationships

SUMMARY:

Background: Social relationships have long been associated with mental health, but the longitudinal impact of social relationships on depression has been less explored. We determined whether quality of social relationships and social isolation predicts the development of major depression. **Method:** This is a longitudinal cohort study of 4,642 community-residing adults who participated in the Midlife in the United States study. Participants age 25-75 completed surveys at baseline in 1995-1996 and at ten-year follow-up. Weighting adjustments were applied to make the sample nationally representative. Quality of relationships was assessed with multi-item scales of social support and social strain. Social isolation was measured by presence of a cohabiting spouse/partner and reported frequency of social contact. The primary outcome was past year major depressive episode ascertained at follow-up. Multiple logistic regression was conducted, adjusting for the presence at baseline of major depression and other potential confounders. **Results:** Risk of depression at 10-year follow-up was significantly greater in those with social strain (OR, 2.03; 95% CI, 1.49 - 2.76), lack of social support (OR, 1.79; 95% CI, 1.36 - 2.36), and poor overall relationship quality (OR 2.65; 95% CI, 1.86 - 3.76) with spouse/partner, family, and friends. Poor quality of relationship with spouse/partner (OR, 1.47; 95% CI, 1.16 - 1.87) and family (OR, 1.45; 95% CI, 1.10 - 1.90) each independently increased risk of depression. Those with the lowest overall quality of social relationships had more than double the risk of depression (14.1%; 95% CI, 12.0-16.1; $p < .001$) than those with the highest quality (6.6%; 95% CI, 5.2-8.0; $p < .001$). Social isolation did not predict future depression, nor did it moderate the effect of relationship quality. **Conclusions:** Quality of social relationships is a major risk factor for major depression. Depression interventions should consider targeting individuals with low quality of social relationships.

SCIENTIFIC AND CLINICAL REPORT 32

THE DIVERSITY OF PSYCHIATRY

SCR32-1

REFLECTIONS ON HUMAN EXISTENCE: A PSYCHIATRIC PERSPECTIVE

Speaker: Vijoy K. Varma, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the basic driving force of the development of personality;2) Relate the instinct theory to conflict and cosmology;3) Correlate ancient religious concepts to the development of personality and society

SUMMARY:

When Lord Buddha propounded the theory of DUKHA some 2500 years ago, He conceived it in terms of age-old problems of old age, disease and death. Over the centuries, the roots of misery have somewhat shifted, increasingly to the interpersonal realm. The paper will review the driving forces of life, in the context of the Freudian instinct theory, supplemented by later concepts of a hierarchy of drives; incorporating social drives as also those for self-realization and self-actualization. In simple terms, it can be said that we strive for - in that order - MONEY, WEALTH, POWER, and FAME. Conflict is to be viewed in terms of one's craving for more than a fair share of the world's resources. Striving for more than one's fair share is the root cause of such problems as discord and conflict, anxiety and depression. Sullivan's concepts of SATISFACTION and SECURITY can be translated into drives for NEED versus GREED. Insecurity leads to greed and greed to FEAR; with hoarding, stealing, manipulation, and aggression. Our relationship with the society leads to the development of "me-not me" differentiation, to AUTONOMY versus DEPENDENCE. Different cultures tend to differ on this variable, with the autonomy based societies developing increasingly judgmental and litigious traits. A concept of the COSMOS and GOD is universal. However, we tend to understand God in human terms; our capacity to do so is clearly limited. Our concept of God can be more or less abstract; religions that permit various grades of abstraction may have an advantage, as people vary in this trait. Similarly, polytheistic religions may represent an advantage to some. Our INDIAN PHILOSOPHY has contributed richly to an understanding of human existence. Karma theory attests to fatalism and to our limitations. Sanskar theory tells us that we had a past, a genetic base. Theory of re-incarnation mitigates our guilt and gives hope for the future. The world has learnt from India the arithmetic of numbers; it has yet to learn the arithmetic of ABUNDANCE.

SCR32-2

ASSOCIATION BETWEEN SEASONALITY AND EVENING CHRONOTYPE IN THE OLD ORDER AMISH

Speaker: Layan Zhang, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify Morningness and Eveningness;2) Recognize the relationship between Eveningness and Seasonality of Mood and Seasonal affective disorder;3) Understand circadian phase delaying effect of bright light and that, this effect is unlikely the mediator of the association between eveningness and seasonality

SUMMARY:

Background: It has been suggested that having an evening circadian chronotype is associated with higher seasonality of mood and higher prevalence of seasonal affective disorders (SAD) (Murray et al., 2003; Hakkarainen R et al., 2003; Natale et al., 2005; Natale et al., 2005, Tonetti et al., 2007 ; Lee et al., 2011 Tonetti et al, 2012). However, all of the above studies were performed in populations using network electric light. Evening bright light exposure phase delays circadian rhythms and might lead to both "eveningness" and SAD. The Old Order Amish are a unique population that prohibits use of network electric light by its members. Thus this is the first study to evaluate the association between seasonality and chronotype in a population that does not use network electric light. Methods: 484 Old Order Amish adults (47.6% females), with average (SD) age of 49.6 (14.1) years, completed both a Seasonal Pattern Assessment Questionnaire (SPAQ) for assessment of seasonality (Global Seasonality Score=GSS) and SAD, and a Morningness-Eveningness Questionnaire (MEQ) for determination of chronotype (MEQ scores). Results: GSS was inversely associated with MEQ scores ($p=0.005$). GSS was higher in evening types than in nonevening types ($p=0.021$). Categorical analyses found no significant association between SAD and chronotype. Conclusion: The results confirmed the association between eveningness and seasonality, but for the first time in a population that does not use bright electric light at home. Although we did not yet measure indoor light intensity in the Old Order Amish, the negative association between MEQ and GSS scores is more likely not the consequence of circadian phase delaying effects of bright artificial light. Co-authors: Daniel S. Evans PhD; Uttam Raheja, MD; Sarah Stephens, Ph D; Braxton D. Mitchell, PhD; Kathy Ryan, MS; Dipika Vaswani, MD; Ayesha Ashraf, MD; Hassan McLain; Wen-Chi Hsueh, PhD; Alan R. Shuldiner MD; John W. Stiller, MD; Soren Snitker MD; Teodor T. Postolache, MD Supported by NIMH 1K18MH093940-01 (PI Postolache)

SCR32-3**UNDIAGNOSED MENTAL ILLNESS IN THE PEDI-
ATRIC POPULATION**

Speaker: Leslie Zun, M.B.A., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To determine the number and type of pediatric patients who have an undiagnosed mental illness; 2) To learn if the emergency department can be used to detect mental illness in the pediatric population; 3) To understand the response of the emergency physicians to identification of mental illness in pediatric patients

SUMMARY:

Objective: The purpose of the study is to identify unsuspected psychiatric illnesses in pediatric patients who present to the ED with non-psychiatric complaints. **Methods:** The study consisted of a convenience sample of pediatric patients 12-17 years of age, chosen at random who presented the Emergency Department at an inner city, level 1 trauma hospital with a non-psychiatric complaint to the ED. Patients are stable, able to communicate, English speaking who present in the ED with a parent or guardian and who both consent to the study. They were then administered the MINI International Pediatric Neuropsychiatric Interview to determine what if any undiagnosed mental illnesses were present. **Results:** A total of 127 pediatric patients were enrolled in the study with an equal percentage of male and female children. 53% were between 12-14 and 47% were 15-17 years of age. Of the 127, 60% (76) of the patients did not test positive for any of the modules while 40% (50) tested positive as having a mental illness. The top undiagnosed illnesses found in the ED were 14% Oppositional Defiant Disorder, 13% ADHD combined; 9% ADHD inattentive, 9% Conduct Disorder, 7% Depression and 7% Separation Anxiety. **Conclusion:** The MINI International Pediatric Neuropsychiatric Interview Tool was effective at identifying potential undiagnosed mental illness in the pediatric population. The top diagnosis identified within the pediatric population were related to ADHD and differed from the diagnosis's the MINI identified within the adult population. The emergency department can be used to identify patients with undiagnosed mental illness but the emergency physicians will need education about appropriate referrals.

SCR32-4**GENERALIZABILITY IN THE FAMILY TO FAMILY
EDUCATION PROGRAM RANDOMIZED WAIT-
LIST CONTROL TRIAL**

Speaker: Lisa B. Dixon, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand limitations of external validity in ran-

domized controlled trials; 2) Understand an innovative method for expanding the generalizability of randomized controlled trials; 3) Identify the potential benefit of the National Alliance on Mental Illness Family to Family program for relatives of individuals experiencing mental illness

SUMMARY:

Objective: Randomized controlled trials (RCT) may have limited generalizability for the community when a high proportion of individuals refuse randomization or otherwise do not participate, a not uncommon phenomenon. We previously evaluated the Family-to-Family Education Program (FTF), a 12-week course offered by the National Alliance on Mental Illness (NAMI) for family members of adults with mental illness, in a randomized wait-list control trial. We now assess the generalizability of the FTF versus waitlist estimate of effectiveness from the RCT to individuals who participated in FTF but declined randomization. **Methods:** We used propensity score matching to create five quintiles, each containing FTF, waitlist and decliner subjects, and which were matched within each quintile with respect to multiple baseline characteristics. We derived estimates of effectiveness with standard errors for the decliner population using effectiveness estimates derived from the RCT, weighted to the baseline decliner distribution of quintiles. We focused on knowledge, family member distress, and family functioning which showed benefits in the RCT. **Results:** For each outcome, estimates of the effect sizes observed in the RCT were very similar to the effect sizes observed for decliner population; confidence intervals also had a high degree of overlap. **Conclusions:** This study suggests that the benefits of FTF observed in the RCT are generalizable to the group of individuals who declined to participate in the RCT, providing further evidence of FTF's effectiveness. Propensity score matching is a useful statistical tool for addressing selection bias due to high rates of non-consent in randomized waitlist control trials.

SCIENTIFIC AND CLINICAL REPORT 33**SCHIZOPHRENIA AND PSYCHOSIS****SCR33-1****URINARY TRACT INFECTIONS IN ACUTE RE-
LAPSE OF PSYCHOSIS**

Speaker: Chelsea Bodenheimer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize an association between urinary tract infection (UTI) and acute relapse of psychosis; 2) Identify clinical features associated with UTI in subjects with an acute relapse of non-affective psychosis; 3) Recognize the potential importance of monitoring for co-morbid UTI in acutely relapsed patients with psychosis

SUMMARY:

Objective: Schizophrenia is associated with immune abnormalities and increased mortality from infectious diseases. We previously found an association between an increased prevalence of UTI and acute relapse of nonaffective psychosis. The aims of this study were to replicate this association and examine if it extends to subjects with affective psychosis, and to explore clinical features associated with UTI in subjects with an acute relapse of nonaffective psychosis. Method: We recruited subjects age 18-64 who were hospitalized between January 2010 and July 2012 for an acute relapse of nonaffective (n=134) or affective (n=102) psychosis, or for alcohol detoxification (n=104), as well as healthy controls (n=39). UTI was defined as positive leukocyte esterase and/or positive nitrites on urinalysis and $\geq 5-10$ leukocytes/high-powered field on urine microscopy. Results: The prevalence of UTI was 21% in subjects with nonaffective psychosis, 18% in affective psychosis, 13% in alcohol use disorders, and 3% in controls. Compared to controls, there was a significantly increased prevalence of UTI in subjects with nonaffective ($p < 0.01$) and affective ($p = 0.03$) psychosis, but not in alcohol use disorders ($p = 0.11$). Subjects with nonaffective psychosis and a UTI were more likely to have a positive urine drug screen than those without a UTI ($p = 0.03$). Otherwise, subjects with nonaffective psychosis did not differ with respect to the number of previous hospitalizations, length of stay, family history of schizophrenia, or the prevalence of hallucinations, delusions, suicidal ideation, or homicidal ideation, based on UTI status. Conclusions: We replicated our finding of an association between an increased prevalence of UTI and acute relapse of nonaffective psychosis. This association may also extend to affective psychosis, although the mechanism remains unclear. The results also highlight the potential importance of monitoring for co-morbid UTI in acutely relapsed patients with psychosis. Chelsea M. Bodenheimer, MD1*; Krystle L. Graham, DO1*; Amaka Ezeoke, MD1; Peter F. Buckley, MD2; Brian J. Miller, MD, PhD, MPH1 1 Department of Psychiatry and Health Behavior, Georgia Health Sciences University, Augusta, Georgia U.S. 2 Medical College of Georgia, Georgia Health Sciences University, Augusta, Georgia U.S. * Denotes shared first authorship and co-presenters

SCR33-2**VIOLENCE TO SELF AND OTHERS DURING FIRST-EPIISODE PSYCHOSIS**

Speaker: Olav B. Nielssen, M.B.B.S., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To review the evidence for an association between the first episode of psychosis and violence; 2) To consider possible reasons for any association; 3) To discuss the implications of this finding for clinicians and service providers

SUMMARY:

Background: There is emerging evidence of an increased risk of serious violence during the first episode of psychosis. We aimed to review the evidence for an association between first-episode psychosis and violence, to consider the possible explanations for this association and the implications for clinicians and service providers. Method: A review of recent studies of violence to the self or others in first-episode psychosis.

Results: A small proportion of patients presenting for treatment for psychosis for the first time do so after committing an act of severe violence, such as a homicide or a violent suicide attempt. However, published studies have found that a significant proportion of psychotic patients examined after violent suicide attempts (49%), major self-mutilation (54%), homicide (39%) or assault resulting in serious injury (38%) are in their first episode of psychosis. Moreover, it appears that a significant proportion of first episode psychosis patients commit an act of less serious violence or attempt suicide prior to initial treatment. Conclusions: The high incidence of violent behaviour during a first episode of psychosis supports the need for early intervention and community-wide programs to reduce the duration of untreated psychosis. Earlier treatment could reduce rates of suicide and homicide. We may need to reconsider the thresholds for involuntary treatment of first episode patients.

SCR33-3**PORTLAND IDENTIFICATION AND EARLY REFERRAL (PIER): INDICATED PREVENTION OF PSYCHOSIS AS A PUBLIC HEALTH INTERVENTION**

Speaker: William R. McFarlane, M.D.

Co-Author(s): Exra Susser, M.D., Ph.D., Richard McCleary, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Attendees will recognize new methods of identifying youth at risk for psychosis; 2) Attendees will understand the methods for treating youth at risk for psychosis; 3) Attendees will learn that early intervention can reduce rates of first hospitalization for psychosis among youth

SUMMARY:

im: Portland Identification and Early Referral (PIER) is a population-based system for early detection and treatment for people ages 12-35 at Clinical High-Risk (CHR) for psychosis, with the goal to reduce the incidence of psychotic disorders in a defined population by indicated prevention. This study tested the effect of this system in reducing first hospitalizations for psychosis as a proxy for true incidence. Methods: PIER trained over 7300 health, education and youth-related professionals to identify young people at high risk for psychosis within and throughout a defined catchment area, greater Portland, Maine. Eligibility for preventive treatment

was established by the criteria of the Structured Interview for the Prodromal Syndrome (SIPS). Persons at CHR received a CHR-specific version of Family-aided Assertive Community Treatment and psychotropic medication by symptom indication ($n=89$) or family education and crisis intervention and medication by the same protocol ($n=50$), both for 2 years. First hospital admissions for psychosis (DSM IV 295, 296.x4, 297 and 298) in the same age range of 12-35 were collected from a state database. Counts were compared between historical control (July, 1998-April, 2001) and experimental (May, 2001-September, 2007) periods. The same data was collected for three comparable urban control areas, Bangor, Augusta and Lewiston-Auburn, the last two of which were contiguous to the experimental area. Rates before and after initiation of the intervention in 2001 were compared with Poisson analysis, controlling for trends and seasonality. Results: 139 CHR youth met SIPS criteria and were assigned to a treatment condition. 70-80 youth found to be in the early phase of psychosis were referred to outside, primarily outpatient, treatment. Conversion to psychosis occurred in 8.8% of those offered PIER treatment. The mean rates of first hospital admissions in the experimental catchment area were 10.52 admissions per month during the historical control vs. 7.98 in the experimental periods. The rates in 3 control catchment areas were 6.33 in Bangor, 7.15 in Augusta and 4.79 in Lewiston-Auburn vs. 7.10, 7.55, and 4.93 admissions per month, respectively. The change in the Portland experimental area was a decrease of 24.1% vs. increases of 12.2%, 5.6% and 4.9%, respectively, in the control areas. The net difference was a decrease of 31.8% (Mantel-Haenzel Odds Ratio=1.42, log odds ratio=0.35, S.E.=0.09, $t=4.00$, $p<0.001$). The mean reduction in admissions (33/year) approximated the number of youth either treated at PIER (22/year) or assessed and referred for treatment of early-onset psychosis (~12/year; total~34/year). Conclusion: Reduction in incident hospitalizations for psychosis supports an association with both accuracy of identification and efficacy of treatment for persons at CHR. This outcome has important implications for reduction in the total burden of disease, if implemented more widely.

SCR33-4

EARLY DETECTION AND INTERVENTION FOR THE PREVENTION OF PSYCHOSIS (EDIPPP): A NATIONAL MULTISITE EFFECTIVENESS TRIAL OF INDICATED PREVENTION

Speaker: William R. McFarlane, M.D.

Co-Author(s): Steven Adelsheim, M.D., Cameron S. Carter, M.D., Barbara Cornblatt, Ph.D., Roderick Calkins, Ph.D., Bruce Levin, Ph.D., Ezra Susser, M.D., Ph.D., Stephan Taylor, M.D., Mary Verdi, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Attendees will learn methods for early identification of psychosis;2) Attendees will identify methods for treating prodromal and early psychosis;3) Attendees will gain

knowledge of the effects of early identification and intervention for psychosis

SUMMARY:

Aims: EDIPPP tested indicated prevention of first episode psychosis and its associated disabilities in a nationally representative sample at 6 sites, at the individual and community level. This is the largest trial of indicated prevention for psychosis yet conducted. **Methods:** EDIPPP conducted area-wide education to identify youth at-risk and provided rapid access to treatment for those assessed as high risk. The experimental treatment consisted of family psychoeducation, assertive community treatment, supported education/employment, and psychotropic medication. Six organizations implemented EDIPPP and assessed outcomes: Maine Medical Center, Portland; University of California, Davis; Washtenaw Community Health Organization, Ypsilanti, MI; Mid-Valley Behavioral Care Network, Salem, OR; Zucker-Hillside Hospital, Queens, NY; and University of New Mexico, Albuquerque, NM. Among youth aged 12-25 referred by community professionals in defined catchment areas, the study identified at-risk subjects with the Structured Interview for the Prodromal Syndromes (SIPS). In a risk-based allocation design, clinically-lower-risk (CLR) youth were those scoring sum 6 or less on the SIPS Positive Symptom scale and received no treatment; those scoring 7 or higher were considered at clinically-higher-risk (CHR) and assigned to experimental treatment. Participants were assessed over 24 months for positive, negative and other symptoms and social and role functioning. A site-adjusted mixed-model regression-discontinuity analysis, including data from all time points, was used to adjust for baseline differences in the assignment score. Rates of first hospital admissions for psychoses for 5-7 years prior to the intervention (the historical control period) were compared to an experimental intervention period of 3 years, using Poisson analysis, controlling for trends and seasonality. Change in rates was compared to that in a control catchment area. Results: Of 520 referred, 87 were assigned to the CLR condition; 205 CHR and 45 having early first episode psychosis (EFEP; psychosis for <30 days) were assigned to the treatment condition. The primary effect, improvement in positive symptoms, was highly significant (for CHR vs. CLR: $t=-2.89$, $p=0.0042$; for EFEP vs. CLR: $t=-6.15$, $p<.0001$). Rates of conversion to psychosis were 2.3% in the low-risk control group vs. 6.3% for the CHR subsample (n.s.). The relapse rate for the EFEP group was 11.1%. Preliminary data for rates for first hospitalization for psychosis for Maine were 10.52 per month in the control period vs. 6.46 in the experimental period ($p<0.01$); for Queens, the rates were 14.1 and 8.4 ($p<0.05$). There were no significant changes in the control areas. Other sites' data are not yet available but will be reported.

Conclusion: Early intervention was associated with significant reductions in positive symptoms across six representative U.S. urban areas and in first hospitalizations for psychosis at two sites.

SEMINARS

MAY 18, 2013

**SEMINAR 01
COGNITIVE BEHAVIOR THERAPY FOR SEVERE
MENTAL ILLNESS**

Director: Jesse H. Wright, M.D., Ph.D.

Faculty: Michael E. Thase, M.D., Douglas Turkington, M.D., David Kingdon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify key modifications of CBT for treating patients with severe mental illness; 2) Describe core CBT methods for modifying delusions and hallucinations; 3) Detail CBT strategies for severe and chronic depression; and 4) Describe CBT methods for bipolar disorder

SUMMARY:

In recent years, cognitive-behavior therapy (CBT) methods have been developed to meet the special needs of patients with chronic and severe psychiatric symptoms, and outcome research has documented the effectiveness of CBT for these patients. This symposium details these newer CBT applications for the treatment of persons with chronic or treatment resistant depression, schizophrenia, and bipolar disorder. Cognitive-behavioral conceptualizations and specific treatment procedures are described for these patient groups. Attendees at this symposium will learn about CBT methods for patients with problems such as hopelessness and suicidality, hallucinations, delusions, hypomania, and nonadherence to pharmacotherapy recommendations.

**SEMINAR 02
THE INTERNATIONAL MEDICAL GRADUATE IN-
STITUTE**

Directors: Jacob Sperber, M.D., Nyapati R. Rao, M.D., M.S.

Faculty: Andres F Sciolla, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Pursue professional development with increased knowledge and skills for cultural self-awareness, fruitful participation in psychiatric residency education, coping with immigration stressors, and personal growth in relation to career progress; 2) Show self-awareness of her/his own ethnocultural background and of how these qualities influence her/his interactions with patients, teachers, colleagues, and other healthcare providers; 3) Use her/his increased cultural selfknowledge

to better learn and teach effective psychiatric interviewing skills for success in clinical psychiatric work and Clinical Skills Verification examinations and treatment of maladaptive human behaviors; 4) Demonstrate understanding of the ways immigration presents both obstacles and opportunities for personal growth throughout all stages of the life cycle;

SUMMARY

In the context of North American psychiatry, International Medical Graduates (IMGs) constitute 34% of all psychiatric trainees. Historically, IMGs have played a vital role in healthcare delivery to the poor and underserved, and many IMGs have distinguished themselves in clinical, scholarly, and administrative careers. As a group, however, IMGs are heterogeneous in their cultural, linguistic, and educational backgrounds, as well as in their exposure to psychiatry in medical school. While this diversity may be an asset in a multicultural society like ours, it also creates obstacles for IMGs at the beginning of their careers as residents, so that they may find that North American health care systems are vast and confusing, that the educational demands of residency are overwhelming, and that the sociocultural norms are hard to fathom. These challenges may manifest themselves as deficits in practice of the psychosocial aspects of psychiatry, poor performance on clinical and knowledge assessments, and conflicts in doctorpatient and interdisciplinary relationships. There may be specific difficulties with language and cultural norms and values underlying these deficits, which are especially problematic in a specialty in which facility with communication and proficiency in psychosocial areas are so central. This course seeks to promote understanding of these factors and communication among psychiatrists at different stages of professional development who share these issues. In so doing, it will better prepare IMG residents and their teachers to optimize the experience of residency training and the subsequent practice of psychiatry.

**SEMINAR 03
MINDFULNESS: PRACTICAL APPROACHES FOR
PSYCHIATRISTS AND THEIR PATIENTS**

Director: Susan Abbey, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) define mindfulness; 2) list characteristics common to mindfulness based therapeutic programs; 3) describe indications and contraindications for referral to mindfulness based therapeutic programs such as MBSR, MBCT and MB-EAT; 4) explain how mindfulness approaches may be tailored to

specific psychiatric disorders; and 5) provide a basic answer to patient's questions about how meditation impacts brain function

SUMMARY:

Mindfulness is assuming ever increasing importance in both the culture and in therapeutic interventions. There are increasing numbers of empirically validated mindfulness-based therapeutic interventions, the best known of which are MBSR (Mindfulness-Based Stress Reduction) and MBCT (Mindfulness-Based Cognitive Therapy for the Prevention of Relapse of Depression). Perspectives drawn from mindfulness are informing psychotherapeutic care. Mindfulness-based interventions are being tailored to a wide variety of psychiatric conditions. Patients and clients are reading about mindfulness in the popular press and are coming to their psychiatrists and other mental health professionals wanting to discuss its potential benefits for their care. The personal benefits of mindfulness in improving practitioner resilience are increasingly recognized.

Most psychiatrists and other mental health professionals had no exposure to mindfulness in their training. This course is designed to provide a comprehensive introduction to foundational knowledge in mindfulness through a combination of didactic teaching and direct experience with the mindfulness practices used in therapeutic interventions. Participants will leave with a range of resources and a plan for incorporating mindfulness interventions into clinical care and their own daily lives.

SEMINAR 04 TRAUMA-INFORMED CARE: PRINCIPLES AND IMPLEMENTATION

Director: Sylvia Atdjian, M.D.

Faculty: Lyndra Bills, Tonier Cain, Joan Gillece, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify trauma-spectrum disorders.;2) Understand the phenomenology of traumatic adaptations.; and 3) Implement trauma-informed practices.

SUMMARY:

Trauma is very prevalent among individuals seeking psychiatric treatment and it is central to symptom formation and behavioral manifestations. Trauma often goes unidentified or unaddressed in treatment and that hampers full recovery. This course will review the phenomenology of traumatic adaptations emphasizing that symptoms are adaptations and that all behavior has meaning. A trauma survivor will relate her experiences before, during and after her admission to a program that finally addressed her trauma. Finally strategies for implementing trauma-informed services will be discussed.

MAY 19, 2013

SEMINAR 05 MIND! LESSONS FROM THE BRAIN

Director: Philip T. Ninan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explore how the human mind emerges from brain function.;2) Examine the dimensions of disease processes that underlie symptom based disorders.; and 3) Understand the mediating mechanisms of psychotherapeutic, pharmacologic and device treatments.

SUMMARY:

Recent advances in the neurosciences span molecular and complex genetics, brain development, circuitry mediation of symptoms, and top-down executive control. These permit hypotheses of how the mind emerges from brain function. Modeling the mind permits a deeper understanding of 'mental' illnesses and their key dimensions, with implications for clinical practice. Enhanced understanding of the mind will permit moving beyond our current symptom based disorders to defining and validating mental 'diseases'. A foundation can be laid for the development of the next generation of treatments, those that can go beyond symptom control to disease modification.

Brain functions that are within conscious perception constitute the mind. The 'what' question of the mind, just as the 'qualia' of consciousness, is a subjective experience that is beyond our current scientific understanding. The 'how' question of the mind on the other hand, is within the realms of scientific inquiry. This course examines how the brain crafts an internal 'virtual' reality for the mental sphere. The mental world parallels external actuality – a fundamental discordance between the two is common in major psychiatric illnesses.

SEMINAR 06 ADULT SEXUAL LOVE: MEANINGS, PROCESSES, AND IMPEDIMENTS

Director: Stephen B. Levine, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Articulate nine distinct meanings of the noun love.;2) Clinically employ the concept of the vital adult developmental task of maintaining a harmonious sexual loving relationship.;3) Recognize the psychopathologies of love that are impediments to being loved and those behaviors that cause psychiatric symptoms.;4) Calmly, knowledgeably, skillfully use concepts of love in psychotherapy; and 5) Understand infidelity without intense moral censure as a quest in some unfaithful people for the promises of love as a grand ambition

SUMMARY:

Despite the concept that health is characterized by the ability to love and to work, mental health professionals have been

loathe to employ concepts of love in their work. Rather we often employ other paradigms to understand developmental processes and psychopathology. One has to wonder if the high rate of discontinuing outpatient therapies is contributed to by the failure to skillfully and directly address experiential issues that are relevant to the patient. The reasons for our assiduous avoidance of the topic will be reviewed before nine definitions of the meanings of love (as a noun) are presented. The key adaptive challenges of falling in love, being in love, and the most difficult developmental task, staying in love will be discussed. A compendium of love's psychopathologies will be analyzed in terms of the patterns that make obtaining a loving relationship difficult or impossible (often psychiatric diagnoses) and those behaviors that tend to generate psychiatric symptoms and sexual dysfunction. This seminar aims to enhance the psychiatrist's understanding of love's processes so that doctors can more efficiently recognize that failures at love's processes lurk behind many requests for help for anxiety and depressive states. The final topic, infidelity, a commonly emotionally evocative problem for patients and therapists alike, will be discussed from several perspectives, including counter-transference responses. This seminar aims at understanding the importance of love and the moral complexities and subjective ambivalence that are embedded in its lifelong processes.

SEMINAR 07 POSTTRAUMATIC STRESS DISORDER AND CORONARY ARTERY DISEASE

Directors: Rachel Yehuda, Ph.D., Naser Ahmadi, M.D., Ph.D.

Faculty: Rohit Arora, M.D., Ramin Ebrahimi, M.D., Nutan Vaidya, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Lifetime prevalence of combat PTSD is 5-20% in United States. There is critical need for early Detection and differential diagnosis of PTSD in the primary care setting.;2) PTSD is associated with increased rates of cardiovascular disorders (CVD) and myocardial infarction (MI). Understanding biomolecular of PTSD and its related CAD is the key step for PTSD management;3) Early Detection of PTSD related CAD requires understanding the reversible and irreversible phases of diseases to implement and optimize patient care in PTSD.;4) Effect of Medical Therapy on PTSD and its related CAD including SSRI, statin therapy etc above and beyond treating PTSD symptoms; and 5) Effect of Psychotherapy on PTSD and its related CAD, Future Directions and Guidelines. Considering the linkage of PTSD and CAD with mortality, the scientific strategic plan is required

SUMMARY:

Posttraumatic stress disorder (PTSD) is a growing and lifetime prevalence of combat PTSD is 5-20% in United States and is even more prevalent in military personnel serving in Iraq and Afghanistan. In addition to debilitating physical and psy-

chological health declines, PTSD is associated with increased rates of multiple medical disorders including cardiovascular disorders (CVD) and myocardial infarction (MI) as well as many surrogate and biomarker abnormalities. We recently reported that PTSD is associated with the presence and severity of subclinical atherosclerosis measured by coronary artery calcium (CAC) and that it predicts mortality independent of age, gender and other conventional risk factors in primary care patients. Unfortunately, the atherosclerosis test for asymptomatic individuals with PTSD is not part of the current practice. This course will provide evidence of linkage of PTSD with atherosclerosis and cardiovascular mortality, also demonstrates innovative steps in early detection and management of PTSD related atherosclerosis.

SEMINAR 08 TRANSFERENCE-FOCUSED PSYCHOTHERAPY FOR BORDERLINE PERSONALITY DISORDER: DESCRIBING, OBSERVING, AND DISCUSSING THE THERAPY

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

Faculty: John F. Clarkin, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) understand and appreciate the central role of an individual's internal concept of self and others in personality and in personality disorders;2) understand the need to appropriately structure therapy with borderline patients in order to decrease acting out and direct emotions into the treatment; and 3) utilize interpretation to help the patient become aware of and gain mastery of aspects of the self that were previously denied and acted out

SUMMARY:

The seminar will describe and demonstrate Transference-Focused Psychotherapy (TFP), an evidence-based psychotherapy for Borderline Personality Disorder that can also be used to treat other personality disorders. The seminar will begin by describing an understanding of personality and personality disorders based on representations of self and others that are internalized in the mind over the course of development and have a major impact on an individual's experience of self and of others throughout life. This understanding of personality and personality disorders is in line with the new DSM V conceptualization of personality disorders. The seminar will go on to describe the techniques used in TFP to address both the symptoms of BPD and the underlying personality structure. This combined focus on symptoms and personality structure helps patients improve both in terms of behaviors and also subjective well-being and engagement in relationships and work. The course will present video segments of demonstration sessions to allow seminar participants the chance to see the therapy in action.

SEMINAR 09 HOW TO GIVE A MORE EFFECTIVE LECTURE

Director: Phillip Resnick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn teaching techniques to hold audience attention.;2) Learn how to involve the audience.; and 3) Learn how to improve skills in using audio visual aids.

SUMMARY:

This course will provide practical advice on how to make a psychiatric presentation with punch, passion, and polish. Instruction will be given on planning a scientific paper presentation, a lecture, and a half day course. The course leader will cover the selection of a title through to the choice of closing remarks. Teaching techniques to hold the audience's attention include the use of humor, anecdotes, and vivid images. Participants will be taught to involve the audience by breaking them into pairs to solve problems by applying recently acquired knowledge. Participants will be told that they should never (1) read while lecturing; (2) display their esoteric vocabulary; or (3) rush through their talk, no matter what the time constraints. Tips will be given for making traditional word slides and innovative picture slides. Pitfalls of Powerpoint will be illustrated. Advice will be given on the effective use of videotape vignettes. A videotape will be used to illustrate common errors made by lecturers. The course will also cover preparation of handouts. Finally, participants will be strongly encouraged to make a three minute presentation with or without slides and receive feedback from workshop participants. Participants should plan to bring Powerpoint slides on CD or memory stick.

MAY 20, 2013

SEMINAR 10 CURRENT PROCEDURAL TERMINOLOGY CODING AND DOCUMENTATION

Director: Ronald Burd, M.D.

Faculty: Tracy Gordy, M.D., Allan A. Anderson, M.D., David Nace, Chester Schmidt, M.D., Jeremy S. Musher, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) understand the use of the new psychiatric evaluation and therapy codes that went into effect in 2013;;2) understand as well as the traditional codes in the Psychiatry section of CPT; and 3) understand the evaluation and management codes that are an essential element of the new coding framework.

SUMMARY:

The Current Procedure Terminology (CPT) codes used by psychiatrists have undergone major changes in 2013. This course will familiarize attendees with these new codes and how to document for them, as well as providing them with information about the remaining codes in the Psychiatry section of CPT, and the codes in the Evaluation and Management section of CPT, which are critical to psychiatrists under the coding framework put in place for 2013. The course is for clinicians (psychiatrists, psychologists, and social workers) and their office personnel who may assist them with coding and billing. Course attendees are encouraged to obtain the AMA's 2013 CPT Manual (CPT codes are developed and copyrighted by the AMA) and read the following : 1) the Guideline Section for the Evaluation and Management codes; 2) the Evaluation and Management Codes themselves; and 3) the section on "Psychiatric Evaluation and Therapeutic Procedures." The objectives of the course are two-fold: first, to familiarize attendees with all the new CPT coding framework that went into effect in 2013 and all the codes that are now being used by mental health clinicians and to review issues and problems associated with payer-imposed barriers to payment for services denoted by these codes; and second, attendees will review the current AMA/CMS guidelines for documenting the services/procedures provided to their patients. Templates for recording evaluation and management services, initial evaluations, and psychotherapy services will be used to instruct the attendees in efficient methods of recording data to support their choice of CPT codes and the level of service provided.

SEMINAR 11 NARRATIVE HYPNOSIS WITH SPECIAL REFERENCE TO PAIN

Directors: Lewis Mehl-Madrona, M.D., Ph.D., Barbara Mainguy, M.A., M.F.A.

Faculty: Lewis Mehl-Madrona, M.D., Ph.D., Barbara Mainguy, M.A., M.F.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Participants will be able to describe a mechanism by which hypnosis can affect pain in the central nervous system through changes in neuroplasticity.;2) Participants will be able to list seven common techniques of hypnosis and differentiate between them.;3) Participants will be able to recognize forms of dysnarrativia and their corresponding brain areas.;4) Participants should be able to describe two techniques for using narrative to change stories about pain.; and 5) Participants will be able to give some examples of disorders in which narrative competency is decoupled:

SUMMARY:

Pain is a central phenomenon and its management can be proposed as an epigenetic phenomenon. It has been suggested that narcotics medicate social isolation and disenfranchisement more than they medicate the pain of physical injury. The

persuasive conversation that is hypnosis has been particularly effective in managing the experience of pain. Nowhere is this more clear than in the myriad examples of hypnosis used as anaesthesia. We propose that the experience of pain is subjective and mediated by the life story - the expression of stress and emotional injury - such that changes to the experience of these stressors can result in a change in the experience of pain. Hypnosis, and especially narrative hypnosis has the ability to make use of a meditative state to create a shift in thinking about pain in order to work with the attendant causes and consequences in a direct way and provide relief and a sense of empowerment in the pain management process. By changing the story of the origin of pain and its meaning, we can impact the experience of pain. Further, by composing a narrative around the sensations of the body, we can facilitate a change in the perception of the physical pain experience. Narrative hypnosis enables brain remodeling by facilitating people performing different stories and creating new synaptic connections. Hypnosis technique centers around the tools of persuasive conversation. Narratives are said to be mental structures designed to make meaning of our world experience. Story is particularly useful in this conversation with the brain, as a way to facilitate a new perspective on experience and a new experience of pain.

MAY 21, 2013

SEMINAR 12 SEXUAL ADDICTION AND COMPULSIVITY

Directors: Patrick Carnes, Ph.D., Ken Rosenberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the diagnostic categories of sexual disturbances.;2) Become familiar with the common terminologies and treatments particular to sexual addiction and compulsivity.; and 3) Be able to use their pre-existing skill set as psychiatrists to initiate treatment for sexual addictions and make appropriate recommendations.

SUMMARY:

Patrick Carnes, PhD, Executive Director, Gentle Path Healing program at Pine Grove Behavioral Health and Editor-in-Chief of the Journal of Sexual Addiction and Compulsivity and Kenneth Paul Rosenberg, MD, Associate Clinical Professor of Psychiatry at the Weill Cornell Medical College and Contributing Editor of the Journal of Sex and Marital Therapy will introduce psychiatrists to the diagnosis, evaluation and treatment of sexual compulsivity and addiction. In the DSM V, the diagnosis of Substance Abuse Disorders may be replaced with term Addiction and Related Disorders, which will include a sub-category of Behavioral Addictions, with a further sub-categories of Pathological Gambling and Internet Addiction which will include Cybersex Addiction. The change in phenomenology is the result of clinical experience, research and current theories which put greater emphasis on the reward, control and memory systems responsible for addictions. In light of these changes, psychiatrists can expect to see more

patients with complaints such as cybersex and sexual compulsivity. This course will teach participants the basics of evaluating and treating these patients, as well as highlighting the controversies and neurobiological supportive evidence. Session Objectives: Discuss proposals for DSM V diagnoses related to sexual compulsivity and addiction. To understand the evolution and research of the Sexual Addiction Screening Test-Revised (SAST-R). To utilize the SAST-R in a clinical setting. To describe the PATHOS, a sexual addiction screening test being developed for physician use. To introduce the Sexual Dependency Inventory Revised (SDI-R). To describe gender differences and co-occurring patterns of sexual aversion. To provide overview of Cybersex and Internet pornography. To provide overview of sex addiction treatment. To describe evidenced-based data about recovery. To introduce the concept of task-centered therapy. To specify the research and conceptual foundations of a task centered approach to therapy. To understand task one including performables and therapist competencies. Review the theoretical neurobiology.

MAY 22, 2013

SEMINAR 13 PRIMARY CARE SKILLS FOR PSYCHIATRISTS

Directors: Lori Raney, M.D., Erik Vanderlip, M.D.

Faculty: Jeffrey Rado, M.D., M.P.H., Sarah Rivelli, M.D., Robert M. McCarron, D.O., Jaesu Han, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review the causes of excess mortality in the SMI population and discuss lifestyle modifications that are useful;2) Understand the current state of the art in treating diabetes, hypertension, dyslipidemias, smoking cessation and obesity;3) Develop skills in understanding the use of treatment algorithms for chronic illnesses;4) Explore the use of a primary care consultant to assist in treatment of patients if prescribing desired; and 5) Discuss the rationale for psychiatrist prescribing with emphasis on liability and scope of practice concerns.

SUMMARY:

The excess mortality in persons with Serious and Persistent Mental Illnesses leading to a 25 year reduction in life expectancy is a well-known problem facing psychiatrists nationwide. Attempts to develop models that improve the overall health and health status have proven to be expensive and difficult and await the results of pilot projects that are underway. Many psychiatrists find themselves screening for cardiovascular risk factors (hypertension, diabetes, dyslipidemias, tobacco use and obesity) with continued inability to find adequate primary care resources for referral. In addition, some psychiatrists who have in-house primary care resources are finding themselves in positions where they are supervising primary care providers treating these problems. This leads them to a need to update their knowledge in treating the most common chronic illnesses leading to excess mortality to competently monitor progress that often includes state and local reporting

on specific measures.

This Course aims to provide updated information to psychiatrists on the diagnosis and treatment of Diabetes, Hypertension, Dyslipidemias, Smoking Cessation and Obesity, using both didactic and case presentations. Algorithms for evidence-based treatment will be included. Ideally, physicians dual-boarded in both psychiatry and medicine will teach these modules to enhance the sense of the instructors understanding the predicament many psychiatrists are currently facing. Discussion time will include examining options for provision of care including psychiatrists providing some limited treatment of these disorders in their clinics with appropriate backup and support.

MAY 18, 2013

SMALL INTERACTIVE SESSION 1**THE FUTURE OF PSYCHIATRY***Chair: Dilip Jeste, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Learn about changing trends in psychiatric practice;2) Understand different pathways in a professional career as a psychiatrist;3) Use different treatment techniques in mental healthcare;

SUMMARY:

The future of psychiatry is bright. Today's residents will have varied opportunities to be clinicians, researchers, educators, administrators, and leaders. The practice of psychiatry will undergo major changes during the coming decades. The patient population will be increasingly that of older people as well as individuals from ethnic minority groups. While we will continue to care for seriously mentally ill persons, psychiatrists will serve an equally important role as consultants to our medical colleagues in helping treat psychiatric disorders in people with primary physical illnesses. There will also be a greater need to be public educators in mental health. With advances in neurosciences, the current divergence between biological and psychosocial interventions will narrow. The "Positive Psychiatry" movement, with a focus on traits such as resilience, optimism, social engagement, and wisdom, will bring psychiatry into the mainstream of medicine and general healthcare of people with mental as well as physical illnesses.

SMALL INTERACTIVE SESSION 02**THE SUICIDAL PATIENT: ASSESSMENT AND MANAGEMENT***Chairs: Robert I. Simon, M.D., Jan Fawcett, M.D., Patricia R. Recupero, J.D., M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Perform a comprehensive suicide risk assessment;2) Assess and manage the adolescent suicidal patient;3) Assess and manage the acute and chronic high risk suicidal patient;

SUMMARY:

Suicide risk is a gateway to treatment and management. It is a core competency requirement for psychiatrists. The purpose of suicide risk assessment is to identify treatable and modifiable risks and protective factors that inform the patient's treatment and safety management requirements. Patients at risk for suicide often confront the psychiatrist with life-threatening emergencies. Most psychiatrists rely on the

clinical interview and certain valued questions and observations to assess the suicide risk. Unlike the general physician, the psychiatrist does not have laboratory tests and sophisticated diagnostic instruments available to assess the suicidal patient. The psychiatrist's quintessential diagnostic instrument is systematic suicide risk assessment that is informed by evidence-based psychiatry.

SMALL INTERACTIVE SESSION 3**THE ART OF BEING A GERIATRIC PSYCHIATRIST: INTEGRATING CLINICAL RESEARCH FINDINGS INTO PATIENT CARE***Chair: Carl I. Cohen, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Able to select more appropriate treatment strategies in the care of patients with dementia and other neurocognitive disorders;2) More fully appreciate the course of dementia, depression and schizophrenia in older adults, factors that affect course, and their implications regarding treatment;3) Identify appropriate treatments for various types of depression in later life;4) Identify appropriate treatments for schizophrenia spectrum disorders and delusional disorders in older adults;

SUMMARY:

This session will use a variety of case vignettes that clinicians typically encounter in the care of older adults to illustrate the "art of being geriatric psychiatrist." Scenarios that will be discussed include addressing the cognitive deficits, behavioral problems, depression, and sleep disturbances in persons with dementia; cognitive deficits with depression; late-life depression; and psychotic disorders in later life. After each vignette, we will review evidence from the literature regarding the course, predictors of outcome, and treatment of these clinical problems. For many clinical situations, the data have been limited or have not supported popular strategies. We will then discuss how to integrate these findings with the practical issues facing patients and their caregivers.

MAY 19, 2013

SMALL INTERACTIVE SESSION 4**ESSENTIALS OF PSYCHOPHARMACOLOGY***Chair: Alan F. Schatzberg, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Have an understanding of recent advances in psychopharmacology;2) Demonstrate basic knowledge of mechanisms of action of new agents of action;3) Understand difficulties encountered in drug development;

SUMMARY:

Recent years have witnessed a number of interesting developments in psychopharmacology of the major psychiatric disorders. This session will provide an opportunity to meet one of the Co-Editors of the new edition of the Essentials of Psychopharmacology. We will first provide an update on a number of recent advances in treatment development and review recent work on ketamine in refractory depression, lurasidone for bipolar depression, vortioxetine (a novel 5HT_{1a}/5HT reuptake blocker), nicotinic receptor agonists for attention deficit disorder, pampamperone augmentation of antidepressant response, tumor necrosis factor-alpha blockers for refractory depression, and glucocorticoid receptor antagonists for cognition in bipolar depression and PTSD. The rationales for each of these will be discussed as will be the implications for future research and practice. Following the opening discussion, there will be ample time for questions and answers.

SMALL INTERACTIVE SESSION 5**ADVANCED GERIATRIC PSYCHOPHARMACOLOGY: FOCUS ON THE PSYCHIATRY CONSULTATION/LIAISON SERVICE**

Chair: Sandra A. Jacobson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Distinguish delirium from catatonia, and describe treatment algorithms.;2) Describe two clinical scenarios in which antipsychotic medication would be contraindicated in a hospitalized elder.;3) Diagnose serotonin syndrome, and explain how it would be treated in a hospitalized elder.;4) Identify akathisia, and describe its treatment in the intensive care setting. Also Recognize non-convulsive status epilepticus, and describe its diagnostic work-up and treatment.;5) Describe the use of various mood stabilizers in the treatment of secondary mania; and the issues related to the treatment of anxiety in patients with COPD or other pulmonary diseases (sleep apnea).;

SUMMARY:

The consultation/liaison service provides an excellent opportunity to showcase the skills and knowledge base of psychiatrists who represent our field to our medical/surgical colleagues and the public. Clinical issues that arise at the interface of psychiatry, medicine, and surgery can prove to be complex, and usually require a multimodal approach. Psychopharmacologic interventions are often indicated. This workshop will use a case-based approach to a series of psychopharmacologic recommendations taken from the presenter's personal experiences on consultation/liaison services at several large teaching hospitals. Topics covered will include the differentiation of catatonia from delirium, control of psychosis in patients with Lewy-related disease, rapid control of akathisia in the ICU, recognition and treatment of non-convulsive status epilepticus, treatment and course of secondary mania,

use of anxiolytics in patients with COPD and other pulmonary diseases, and specific recommendations for pharmacologic treatment of patients with hepatic and/or renal impairment. Attendance at this session will be limited, and ample time will be allowed for questions and discussion.

Reference: Clinical Manual of Geriatric Psychopharmacology, 2nd Ed

By SAJ; Publication date 2013

SMALL INTERACTIVE SESSION 6**NEW TREATMENTS IN SCHIZOPHRENIA**

Chair: Donald C. Goff, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) discuss the role of cognitive remediation and other approaches to enhance neuroplasticity.;2) evaluate early intervention strategies for psychosis.;3) identify strategies for treatment of refractory symptoms,;

SUMMARY:

Several new approaches to the treatment of schizophrenia have found their way to the clinic. Cognitive remediation in combination with psychosocial interventions may enhance functioning more than either intervention alone. This approach and others that promote neuroplasticity may be of particular value early in the course of illness. The potential role of folate, antioxidants and anti-inflammatory agents will be discussed. Current strategies for addressing treatment resistant psychosis will also be reviewed, including optimization of clozapine and the limited evidence for polypharmacy. The clinical experience of audience members will be shared in the context of a critical review of the literature.

SMALL INTERACTIVE SESSION 7**BODY DYSMORPHIC DISORDER**

Chair: Katharine A. Phillips, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe clinical features of body dysmorphic disorder (BDD);2) Diagnose BDD;3) Describe efficacious treatments for BDD;

SUMMARY:

This session will allow attendees to meet informally with Katharine Phillips, M.D., who has research and clinical expertise in body dysmorphic disorder (BDD). Body dysmorphic disorder BDD consists of distressing or impairing preoccupations with nonexistent or slight defects in appearance. Body dysmorphic disorder (BDD) is a common yet under-recognized disorder that is characterized by marked impairment in psychosocial

functioning and high rates of suicidality. Dr. Phillips will first provide a clinically focused overview of BDD, including key aspects of the disorder's clinical features, assessment, and treatment. Most of the session will be devoted to audience discussion and interaction. Free exchange on this topic will be encouraged.

SMALL INTERACTIVE SESSION 8

EFFORT, EXAGGERATION, AND MALINGERING AFTER CONCUSSION: WHAT ARE WE MISSING?

Chair: Jonathan M. Silver, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize common predictors of recovery after concussion.;2) Recognize neglected factors that influence effort and symptom reporting;3) Implement strategies that may potentially alleviate the adverse influence of these factors.;

SUMMARY:

Although most individuals who suffer a mild traumatic brain injury have complete recovery, a number experience persistent symptoms that appear inconsistent with the severity of the injury. Symptoms may be ascribed to malingering, exaggeration, or poor effort on cognitive testing. The purpose of this presentation is to propose that previously unconsidered factors, informed by social psychology and behavioral economics, can appear as "symptom magnification" or "poor effort," which are incorrectly interpreted as the result of a conscious process. These are complex and multi-determined behaviors with a unique differential diagnosis, which have important implications for research, evaluation, and treatment.

SMALL INTERACTIVE SESSION 9

EVIDENCE-BASED GUIDE TO ANTIDEPRESSANT MEDICATIONS

Chair: Anthony J. Rothschild, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify information available in the textbook regarding use of antidepressants for major depressive disorder, bipolar depression and psychotic depression and treatment-resistant depression;2) Understand the information available in the textbook regarding use of antidepressants in the management of anxiety disorders, obsessive-compulsive disorder and specific phobias;3) Discuss the use of antidepressants in children and adolescents, medically-ill patients, patients with schizophrenia, patients with substance abuse disorder and geriatric patients;

SUMMARY:

This small, interactive session will be an informal, interac-

tive session with Anthony J. Rothschild, M.D., editor of The Evidence-Based Guide to Antidepressant Medications. The second book in the Evidence-Based Guides series, The Evidence-Based Guide to Antidepressant Medications, provides a clear reference to the current knowledge and evidence base for the use of antidepressants among a variety of patients across a wide range of disorders. Antidepressants are prescribed for many patients in addition to those who have major depressive disorder, including patients with bipolar disorder, posttraumatic stress disorder, schizophrenia, and personality disorders, as well as those with medical illnesses. In addition, antidepressants are increasingly being prescribed by clinicians for so-called off-label use to treat illnesses for which the medications do not have U.S. Food and Drug Administration (FDA) approval-making it more important than ever for practicing clinicians to understand the use of antidepressants among several special populations, including children and adolescents, the geriatric patient, and pregnant and lactating women. Chapters within this guide are authored by experts in their respective areas of practice. Together, they have synthesized a large amount of medical literature into a comprehensive, yet understandable, concise, reader-friendly guide that features useful tables pertaining to the efficacy of specific medications and summaries of important clinical pearls of wisdom that are summarized at the end of each chapter into Key Clinical Concepts. This text is a must-have reference for psychiatrists and other practicing clinicians, residents-in-training, psychiatric nurses, social workers, and researchers. Dr. Rothschild will also discuss his other two recent books: The Evidence-Based Guide to Antipsychotic Medications (2010) and the Clinical Manual for Diagnosis and Treatment of Psychotic Depression (2009).

MAY 20, 2013

SMALL INTERACTIVE SESSION 10

MENTALIZING IN MENTAL HEALTH PRACTICE

Chairs: Anthony Bateman, M.D., Peter Fonagy, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define the concept of mentalizing;2) Evaluate the importance of mentalizing in psychiatric disorder using a developmental perspective;3) Recognize the use of mentalizing treatments in a range of psychiatric disorders;4) Integrate mentalizing into your current practice;

SUMMARY:

Mentalizing lies at the very core of our humanity – it refers to our ability to attend to mental states in ourselves and in others as we attempt to understand our own actions and those of others on the basis of intentional mental states. Without mentalizing there can be no robust sense of self, no constructive social interaction, no mutuality in relationships and no sense of personal security. Throughout this interactive session we will refine this definition further and chart the daunting territory that the concept of mentalizing now embraces. Initially

the breadth of the concept encouraged us to see mentalizing as one of many common factors in psychotherapy. This is not a radical suggestion - if a patient feels his subjective states of mind are understood he is more likely to be receptive to therapeutic intervention. However, this may undersell mentalizing and its clinical application for a number of reasons. First, there is evidence that individuals who have specific deficits in mentalizing in the context of attachment relationships may be those who are currently defined as having a personality disorder. This was our original suggestion about BPD but reflective capacity and sense of self may be potential common factors across all personality disorders. Second, mentalizing is a developmental construct. This raises questions about the variability of mother-child interaction and of families, and the significance of developmental milestones, particularly the importance of the move from childhood to adolescence. Distortions in the development of mentalizing are therefore likely to go beyond personality disorder and contribute to other psychiatric disorders. We will outline the areas in which mentalizing approaches are now being used in mental health practice, for example in patients with eating disorders, conduct disorder and antisocial personality disorder, depression, drug addiction as well as in families, and adolescents and provide an up-date on recent evidence.

SMALL INTERACTIVE SESSION 11

DEPRESSION, INFLAMMATION, AND ADIPOSIT- TY: OBESITY AS A CAUSAL AND PERPETUATING FACTOR FOR DEPRESSION

Chair: Richard C. Shelton, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the connections between inflammation and depression;2) Articulate how stress and depression contribute to visceral adiposity;3) Describe how obesity and depression risk interact to perpetuate the illness;

SUMMARY:

There is now convincing evidence that inflammatory factors such as the interleukins and interferons are associated with depression; that is, they can induce depression, but they also are elevated in depressed patients without known inflammatory disease. There is growing evidence that obesity, particularly visceral (intra-abdominal) fat, may be the causal factor mediating this relationship. This presentation will outline the relationship between depression and inflammation and build the case for a bi-directional relationship between depression and obesity with inflammatory factors serving as the intermediaries. The discussion will also review the evidence that recurrent stressors, including recurrent depression, can alter diet, increase total body fat, and shift fat from extravisceral (e.g., subcutaneous) to visceral fat. This, then, would be expected to increase inflammatory factors such as interleukin-1 beta (IL-1 beta), IL-6, tumor necrosis (TNF) alpha, and interferon gamma. We also will review obesity as a factor that reduces

responsiveness to antidepressants, and alternative treatment strategies to manage comorbid depression and obesity.

SMALL INTERACTIVE SESSION 12

CONTROVERSIES OF CHILD PSYCHOPHARMA- COLOGY

Chair: Barbara Coffey, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Following this small interactive session, the participant will be able to identify and discuss the following::2) 1) use of complementary and alternative agents;3) Following this small interactive session, the participant will be able to identify and discuss the following::4) 2) use of off label indications which are "way beyond the evidence base";5) Following this small interactive session, the participant will be able to identify and discuss the following::6) 3) adverse effects of psychopharmacological agents which appear to most unique in youth;

SUMMARY:

Use of psychopharmacological agents in child and adolescent psychiatry has grown exponentially in the past decade, as has the evidence base for efficacy of treatment, but as might be expected, several controversies have arisen in recent years. Among those that are most current which will be discussed include 1) use of complementary and alternative agents, 2) use of off label indications which are "way beyond the evidence base", and 3) adverse effects of psychopharmacological agents which appear to be unique or most pronounced in youth, such as metabolic effects of antipsychotics, activation on selective serotonin reuptake inhibitors and cardiovascular effects of stimulants. This workshop will provide brief introductory remarks regarding these current issues and ample opportunity for discussion amongst attendees

SMALL INTERACTIVE SESSION 15

GENETIC INFLUENCES IN ALCOHOL AND DRUG USE DISORDERS

Chair: Marc A. Schuckit, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To increase understanding of how genes contribute to complex disorders including alcohol and drug use disorders;2) To understand that any single gene is likely to explain only a small part of the risk, usually operates through intermediate characteristics, and is often mediated and moderated by the environment;3) To give an example of how understanding more about the genes and the environment in which they operate can lead to better prevention approaches.;

SUMMARY:

Alcohol and drug dependence are about 50% genetic, with the genes operating through intermediate characteristics. For alcohol use disorders these include gene effects on metabolizing systems, impulsive behaviors, independent psychiatric disorders (e.g., bipolar disorder and schizophrenia), and via a low level of response (or low sensitivity) alcohol. Different genes are likely to contribute to each risk factor, with some vulnerabilities relating to a predisposition to both alcohol and drugs and some impacting on alcohol alone. This discussion will begin with a brief introduction to these issues, with an emphasis on genes that relate to the low response to alcohol, some environmental mediators and moderators of the relevant genes, and how understanding more about this process led to a prevention program now being tested at the University of California, San Diego.

SMALL INTERACTIVE SESSION 13**A DISCUSSION OF PSYCHO-ONCOLOGY**

Chair: Thomas N. Wise, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how to stage psychologically the patient with cancer;2) List the various psychotherapies used in end of life situations;3) Recognize distress, demoralization and depression in the patient with an oncological disease;

SUMMARY:

The patient with cancer faces an existential crisis that will depend upon many factors including the nature and stage of the neoplastic disease, the individual's personality traits, and treatments as well as other variables. This session will give attendees the opportunity to meet with one of the editors of Psycho-Oncology a new textbook to be released in 2013. Some areas to be discussed include understanding how to stage psychologically the patient with cancer; as well as understanding the distress, demoralization and depression that often accompany the patient with oncological disease. The author will discuss the various psychotherapies used in end of life situations as well as a variety of other psycho-oncology topics discussed in the book. The session will be interactive with plenty of opportunity to discuss relevant issues and cases in psycho-oncology.

SMALL INTERACTIVE SESSION 14**SEEKING FULFILLMENT AND BALANCE IN YOUR PROFESSIONAL AND PERSONAL LIVES**

Chair: Laura Roberts, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To reflect on one's personal and professional de-

velopment as an academic faculty member;2) To gain familiarity with the relevant literature on professional-personal balance in academic medicine;3) To engage in a constructive planning process for future professional-personal development as an academic faculty member;

SUMMARY:

This workshop is a structured conversation regarding the developmental challenges encountered in seeking fulfillment and balance in your professional life as an academic faculty member and in your personal life as, well, a person! We will systematically consider positive approaches to career advancement and self-care. Relevant literature will be offered, and a series of interactive exercises will be conducted. This dialogue-based workshop will involve interactive learning and Q and A formats, and it will have a tone of warmth and collegiality.

SMALL INTERACTIVE SESSION 16**THE INSEPARABLE NATURE OF LOVE AND AGGRESSION: CLINICAL AND THEORETICAL PERSPECTIVES (FOCUSING ON DYNAMICS AND CONFLICTS IN LOVE RELATIONS)**

Chair: Otto F. Kernberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand interplay of love and aggression love relations;2) Assess the unconscious illusions in a couple's conflicts;3) Diagnose severity and prognosis of a troubled relationship;

SUMMARY:

This session will examine the interplay of love and aggression in a couple's overall value system, emotional interaction and sexual relations. Methods of diagnostic evaluation of their conscious and unconscious interactional conflicts will be explored, and their therapeutic approach outlined.

SMALL INTERACTIVE SESSION 17 (WITHDRAWN)**PSYCHIATRY, THE AMA AND MEDICINE: THE NEXT CHAPTER**

Chair: Jeremy A. Lazarus, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the impact of the Affordable Care Act on Residents, especially in psychiatry and other medical specialties.;2) Understand current workforce challenges as they relate to Residents.;3) Understand the future of psychiatry residents and how payment and delivery reforms envisioned in the Affordable Care Act will impact the specialty.;4)

Understand AMA advocacy efforts on scope of practice and truth in advertising issues and how they affect psychiatry.;5) Understand the role Residents play in the AMA and how they advance organized medicine.;

SUMMARY:

Residents are constantly learning and striving for more – better outcomes, better tools, improved systems, and more focused frameworks. With more integration into primary care, psychiatry residents can learn from each other and other physicians. Psychiatrists are also sensitive to their patients overall health and wellness and need tools and guidance to help patients improve their physical wellness and reduce the life expectancy disparities between the general patient population and the psychiatric patient population. The AMA is working to improve outcomes and set the standards for the next generation of team approaches to care as part of its new strategic focus and Dr. Lazarus will discuss this, as well as the impact of the Affordable Care Act on psychiatry residents and physicians in general and the AMA's efforts to shape health system reform going forward.

MAY 21, 2013

SMALL INTERACTIVE SESSION 18

PSYCHODYNAMIC PSYCHOTHERAPY IN THE ERA OF THE INTERNET

Chair: Glen O. Gabbard, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To recognize the professional boundary issues inherent in Internet communication;2) To identify challenges to privacy in the current era of Internet use.;3) To master strategies of dealing with patient communication on text, email, and Facebook.;

SUMMARY:

Dr. Gabbard will provide an introduction and overview of some of the current challenges in the era of the Internet. He will give numerous clinical examples, many with medicolegal implications. He will also discuss the re-definition of professional boundaries. The view of the self has been radically challenged by the Internet, and those considerations will also be considered. The psychiatrist's privacy in light of the ample information available on the Web will be discussed. Residents who attend will be encouraged to participate with clinical examples and questions.

SMALL INTERACTIVE SESSION 19

PROFESSIONALISM AND THE PROFESSIONAL SOCIETY

Chair: James H. Scully Jr., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss aspects of professionalism eg altruism, competence etc;2) Learn the role of professional societies eg APA in helping promote professionalism;3) Develop ideas on how to overcome potential conflicts between professionalism and some activities of societies;

SUMMARY:

Professionalism in Medicine and Psychiatry have received increasing attention in recent years. Aspects of professionalism such as altruism, honesty and empathy in patient care are some examples. In addition professional standing such as certification and maintenance of certification and licensure are considered. Professional societies such as APA can help promote professionalism but there may also be potential conflicts of interest in the Societies actions such as political advocacy that can be seen as challenges.

Participants will discuss these issues with the Medical Director of APA

SMALL INTERACTIVE SESSION 20

FOCUS MAJOR DEPRESSIVE DISORDER MAINTENANCE OF CERTIFICATION (MOC) WORKBOOK

Chairs: Mark Rapaport, M.D., Deborah J. Hales, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand evolving MOC requirements;2) Know about the APA workbook series;3) Have a plan for Parts 2 and 4 of MOC;

SUMMARY:

This session will use the new American Psychiatric Association MDD workbook as a tool for helping participants identify their individual Maintenance of Certification (MOC) needs. We will review the structure of this comprehensive workbook and use a case example to demonstrate its function. This session will use the new American Psychiatric Association MDD workbook as a tool for helping participants identify their individual Maintenance of Certification (MOC) needs. We will review the structure of this comprehensive workbook and use a case example to demonstrate its function.

SMALL INTERACTIVE SESSION 21

COGNITIVE BEHAVIOR THERAPY FOR CHILDREN AND ADOLESCENTS

Chair: Eva Szigethy, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand theory of cognitive behavioral therapy for children and adolescents across a variety of psychiatric disorders such as depression with suicidality, posttraumatic stress disorder, and opposition; 2) Be able to utilize different cognitive behavioral models to treat children and adolescents across a variety of psychiatric disorders; 3) Understand important issues in the application of CBT to the pediatric population across different disorders including developmental and cultural considerations;

SUMMARY:

Although CBT has growing empirical support for efficacy in treating a variety of psychiatric disorders, a common complaint of practicing clinicians is that they have difficulty accessing the CBT protocols that have been tested and found to be effective, and thus they have not been able to build their own proficiency in these potent interventions. This session will showcase a new book to be published soon, *Cognitive Behavioral Therapy for Children and Adolescents*. This book was created to help fill the gap between clinical science and clinical practice for children and adolescents, by making CBT accessible through the written word and companion videos. The goal has been to provide a practical, easy-to-use guide to the theory and application of various empirically-supported CBT techniques for multiple disorders, written by experts in CBT practice from around the world. These experts have presented core principles and procedures, source material from their various workbooks, clinical vignettes, and video-demonstrations of some of the more challenging applications of CBT. The chapters are developmentally sensitive, as well, noting modifications needed to make the techniques applicable to different age-groups and with differing levels of parental involvement. These chapter features are complemented by introductory chapters on general developmental consideration across CBT modalities, as well as cultural and ethnic considerations. This session will give an overview of the book's content and cover case examples using the text and video material to illustrate the application of CBT to several common psychiatric disorders in children and adolescents.

SMALL INTERACTIVE SESSION 22**WOMEN IN PSYCHIATRY: PERSONAL PERSPECTIVES**

Chairs: Donna M. Norris, M.D., Annelle Primm, M.D., M.P.H., Geetha Jayaram, M.B.A., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the personal characteristics- similarities and differences, which influence the career and leadership development of women psychiatrists; 2) Recognize that leadership and successful career/family balance can be achieved from diverse pathways; 3) Analyze session informa-

tion and examples when considering personal career choices.;

SUMMARY:

The authors anticipate that this book discussion will appeal to professional women and men at all stages of their career development. Contributors in attendance will share their life experiences and will present examples of various pathways to productive careers in the face of many challenges. The editors believe that these personal narratives will inspire the readers to reflect on and to utilize these examples when considering their own career decisions. This session provides a unique opportunity for participants to interact with other professionals and to share their own challenges and solutions.

SMALL INTERACTIVE SESSION 23**CURRENT CONTROVERSIES IN FORENSIC PSYCHIATRY**

Chair: Phillip Resnick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify different standards for the insanity defense.; 2) Identify current standards for psychiatric malpractice.; 3) Specify the differing roles of a consulting and testifying expert witness.;

SUMMARY:

This small interactive session will involve a number of current controversies in forensic psychiatry. The speaker will begin with a videotape of Andrea Yates three weeks after she drowned her five children, to initiate a discussion of standards for the insanity defense and the advantages and disadvantages of abolition of the insanity defense. Other discussion will include the trend in standards for psychiatric malpractice in different jurisdictions and the differing roles of a consulting and testifying expert witness and their ethical pitfalls. Depending upon audience interest, there will also be an opportunity to discuss issues of whether to have separate confidentiality rules for psychiatric records in the electronic health record; the advantages and disadvantages of videotaping forensic evaluations; problems in giving out of state testimony; public perceptions of forensic psychiatrists; advantages and disadvantages of giving ultimate issue testimony; and boundary violation standards. In addition, discussion may include the role of psychiatrists giving testimony in death penalty sentencing, and how forensic psychiatrists should balance their duty to strive for objectivity against their desire to be persuasive in conveying their opinion.

SMALL INTERACTIVE SESSION 24**HANDBOOK OF MOTIVATION AND CHANGE: A PRACTICAL GUIDE FOR CLINICIANS (FOCUSING ON THE MOTIVATIONAL INTERVIEWING APPROACH FROM TREATING ADDICTION TO BUILDING ORGANIZATIONS)**

Chair: Petros Levounis, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the fundamental concepts of Motivational Interviewing (MI) as a supportive yet directive approach to addiction treatment.;2) List the four principles of MI using the REDS acronym.;3) Use specific MI approaches to help people or organizations move through the stages of change;

SUMMARY:

This Small Interactive Session provides the interested clinician with the fundamentals of the theory and practice of Motivational Interviewing. With a special focus on substance use disorders and addiction, this session equips its participants with a basic understanding of the Motivational Interviewing approach--an understanding that clinicians can flexibly apply to address patients' issues of motivation and change even beyond substance use.

Clinicians these days do much more than treat patients. Motivating people and helping them change is a ubiquitous request. From managing interdisciplinary teams to directing units, divisions, departments, and hospitals, we are often called on to fill leadership positions. We are routinely recruited for such roles primarily because of our training in human behavior and profound interest in what other people have to say. Although we sometimes frown upon administrative and managerial tasks--"I did not go to medical school to do meetings!"--a number of us are finding that the Motivational Interviewing principles (and techniques) apply to a wide range of activities beyond the psychotherapeutic dyad. Furthermore, managing people from a humanistic perspective can be as rewarding and gratifying as treating patients.

Whether motivating a team to experiment with a new work schedule or planting the seed of ambivalence in an addict's mind, the path to the contemplation stage of change is similar. Negotiating a new contract (either of an employee or of your own) may not be all that different from convincing a patient to come to the Emergency Room. Ultimately, basic motivational skills such as expressing empathy and rolling with resistance can go a long way towards helping people change their behavior in many clinical and non-clinical situations.

SMALL INTERACTIVE SESSION 25**PTSD OPEN FORUM: DISCUSSION WITH THE AUTHORS OF CLINICAL MANUAL FOR MANAGEMENT OF PTSD**

Chairs: Gary H. Wynn, M.D., David Benedek, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the basic aspects of PTSD both within the military and veteran context as well as amongst other populations (e.g. sexual assault survivors) who frequently suffer from PTSD;2) Discuss the ways in which PTSD impacts various groups and the various possible ways to manage such variability;3) Understand those practices discussed within the session that have relevance to a provider's clinical practice and strategize a means to implement such practices.;

SUMMARY:

This session is based on the text 'Clinical Manual for Management of PTSD' from American Psychiatric Publishing, Inc and is intended to give participants the opportunity to hear a brief discussion from the editors (Drs. Benedek and Wynn) about PTSD in general as well as their experience putting together the text. After a brief initial discussion the majority of the session will be dedicated to taking questions and discussing those topics of interest to the audience.

MAY 22, 2013

SMALL INTERACTIVE SESSION 26**ACUTE BRAIN FAILURE: A DISCUSSION ABOUT THE EFFECTS AND MANAGEMENT OF DELIRIUM**

Chair: Jose Maldonado, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the pathophysiology of delirium;2) Understand the research-based, effective treatment options for delirium, including the use of atypical antipsychotic and other novel agents;3) Learn research proven prevention techniques;

SUMMARY:

Psychiatrists are asked to render opinions and help in the management and treatment of a number of conditions whose etiology may be primarily neurological, but its manifestations clearly psychiatric. Delirium or encephalopathy is one of these--and the most common psychiatric disorder occurring in the medically ill patient. It is also not uncommon in the general psychiatric population, particularly the elderly. Delirium is a transient, sometimes reversible organic mental syndrome caused by dysfunction in cerebral metabolism, characterized by an acute or subacute onset. Features of delirium include disturbance of consciousness, change in cognition, perceptual disturbances, global cognitive impairment, attentional abnormalities, increased or decreased psychomotor activity, and sleep-wake cycle disruption. Medication use, intoxication and withdrawal states, and underlying medical and neurological problems are common causes of delirium. This presentation

will explore the pathophysiology of delirium, address preventable causes, review diagnosis, and explore evidence-based prevention and treatment techniques.

MAY 18, 2013

SYMPOSIUM 1 BLOGS, TWEETS, TEXTS, AND “FRIENDS”: PROFESSIONALISM AND THE INTERNET

Chair(s): Sheldon Benjamin, M.D., Sandra M. DeJong, M.D., M.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize potential clinical, legal and ethical problems in the use of the internet in the clinical setting; 2) Identify ways of approaching, resolving and preventing clinical, legal and ethical problems that can arise; and 3) Identify resources available to provide learning and guidelines in this area.

SUMMARY:

The digital revolution has transformed society and forever altered the practice of psychiatry. Technology permeates our daily lives and poses new professional challenges. For example, a 2010 survey of Executive Directors at US state medical boards found that 92% had received reports of online professionalism violations. Another survey found about a third of physicians report having a patient ask to “friend” them on Facebook, and about a third of psychiatrists have experienced a patient bringing into the therapeutic session information they have gleaned about the psychiatrist online. The speed, range and permanence of digital communication magnify both its efficiency and the impact of professionalism breaches. Few but developing standards exist regarding the use of technology in medicine, and those that do exist can become quickly outdated as technology advances and patient expectations and standard-of-care practices continue to change. In psychiatry, professional challenges are heightened by the importance of the psychiatrist-patient relationship. Because of its intimacy, the sensitivity of clinical content, and stigma about mental illness, the psychiatrist-patient relationship must be one of safety and trust. However, psychiatric patients deserve the same access to medical information and up-to-date clinical care practices that all medical patients merit and that technology may enhance. How can psychiatrists integrate technology professionally into clinical practice?

The presenters, who represent AADPRT’s Taskforce on Professionalism and the Internet, will discuss 9 topics pertaining to the interface of online technology with psychiatric practice. The symposium will focus on the interactive discussion of vignettes from the Taskforce’s Curriculum on Professionalism and the Internet (aadprt.org, 2012) using audience response technology. Recommendations, guidelines and resources will be presented.

NO 1 ACADEMIC HONESTY

Speaker: Robert Boland, M.D.

SUMMARY:

As with the clinical setting, the academic setting is both enhanced and challenged by the digital age. Accessibility makes the comprehensive research of a subject less effortful and more efficient than with print. However, with this ease of accessibility, plagiarism, including inadvertent becomes more efficient as well. Although the internet did not create this problem, it has made it easier. In addition, it may have changed the culture and confused concepts of ownership, originality and copyright. The vignettes in this section will consider these issues in detail.

NO 2 LIABILITY AND CONFLICT OF INTEREST

Speaker: Joan Anzia, M.D.

SUMMARY:

The internet has introduced new challenges in the arenas of liability and conflict of interest for psychiatrists. Email communication between physician and patient have presented problems with response time, acute clinical issues, and responsibility. The internet has also enabled multiple opportunities for conflict of interest; psychiatrists may make anonymous endorsements or statements of criticism in online reviews and blogs. In this section we will discuss these two issues in detail.

NO 3 MANDATED REPORTING AND SAFETY CONCERNS

Speaker: Anthony Rostain, M.A., M.D.

SUMMARY:

The availability of online information about patients presents ethical dilemmas for clinicians working with patients who present with safety concerns. Questions arise regarding the appropriateness of conducting on-line searches (so called “Patient Googling”) to verify patient information or to gain access to potential risks to health and safety, and about what to do with information that is obtained in this fashion. This presentation will review the most common issues that need to be considered when carrying out on-line searches, and a rational decision-making framework for determining whether or not to conduct such searches. A case example will be provided to illustrate the concepts outlined in the presentation.

NO 4 PRIVACY AND CONFIDENTIALITY

Speaker: Nadyah John, M.D.

SUMMARY:

Social networking sites are increasingly seen as an integral part of some physicians’ personal life. It allows self-expression. Psychiatrists who spend large numbers of hours at work and involved in patient care may be vulnerable to expressing their thoughts and feelings about their work day and stressful or memorable patient interactions on these sites. Patient privacy can be easily violated. Psychiatrists must be educated about the safe and appropriate use of social networking sites. In this section we will discuss concerns regarding privacy and

confidentiality in using social networking sites.

NO 5 REDEFINING THE PSYCHOTHERAPY “FRAME” IN AN INTERNET-CONNECTED WORLD

Speaker: James W. Lomax, M.D.

SUMMARY:

This presentation will introduce the audience to common internet facilitated or based intrusions on the therapeutic frame and alliance. The purpose will be to describe approaches to both anticipating and managing new boundaries stemming from internet access to information as it affects both patients and therapists.

SYMPOSIUM 2 ADVANCES IN THE NEUROIMAGING OF ADULT ADHD

Chair(s): Joseph Biederman, M.D., Thomas Spencer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how therapeutic doses of stimulants affect the brains of subjects with ADHD; 2) Understand the latest research in cerebro-cerebellar circuitry and resting-state connectivity as they relate to the neural underpinnings of ADHD; and 3) Understand the effects of ADHD risk alleles on the binding of dopamine in the brain.

SUMMARY:

This symposium will present new data on scientific advancements in neuroimaging research in adult ADHD. Dr. Biederman's study reviewed the extant literature on studies that evaluated the impact of therapeutic oral doses of stimulants on the brain of ADHD subjects as measured with MRI-based neuroimaging studies. With few exceptions, data from 29 published studies identified (6 structural MRI, 20 functional MRI, and 3 spectroscopy) suggest attenuation of structural and functional alterations found in unmedicated ADHD subjects, as compared to controls. Dr. Gabrieli's study examined resting state connectivity in a longitudinally followed sample of ADHD children grown up, who did (persistent ADHD, $N = 14$) or did not (remitted ADHD, $N = 22$) currently meet diagnostic criteria and controls ($N = 17$) without ADHD in either childhood or adulthood. Resting-state BOLD fMRI was collected on a 3.0 Tesla scanner. In the persistent ADHD group, vs. both control and remitted ADHD groups, there were significant decreases in connectivity between posterior cingulate and medial prefrontal cortices, and also significant decreases in anticorrelations between medial prefrontal and dorsolateral prefrontal cortices. There were no reliable differences between the control and remitted ADHD groups. These findings suggest that variation in the intrinsic functional organization of the brain may reflect the current clinical status of adult ADHD. Dr. Spencer's study examined the relationship between dopamine transporter (DAT) binding in the striatum in individuals with and without ADHD ($n=34$ in each) attending to the

3'UTR and intron8 variable number of tandem repeats (VNTR) polymorphisms of the DAT (SLC6A3) gene. Striatal DAT binding was measured with PET using 11C Altoprane. ADHD status ($t=2.99$; $p<0.004$) and 3'UTR of SLC6A39 repeat carrier status ($t=2.74$; $p<0.008$) were independently and additively associated with increased DAT binding in the caudate. ADHD status was associated with increased striatal (caudate) DAT binding regardless of 3'UTR genotype and 3'UTR genotype was associated with increased striatal (caudate) DAT binding regardless of ADHD status. Dr. Valera used fMRI imaging while performing n-back working memory and sub-second sensorimotor-timing tasks to probe for cerebellar abnormalities in ADHD adults. The cerebellar motor system was tested using a modified version of the International Cooperative Ataxia Rating Scale measuring posture and gait disturbances, as well as kinetic, speech and oculomotor functions. Relative to controls, ADHD adults showed reduced activation in cerebro-cerebellar circuits while performing the working memory and tapping tasks. ADHD adults also showed significantly higher scores for total ataxia, posture and gait disturbances, and kinetic functions subscales. These findings provide support that the cerebellum and cerebro-cerebellar circuits affect varied facets of ADHD clinical phenomenology.

NO 1 EFFECT OF PSYCHOSTIMULANTS ON BRAIN STRUCTURE AND FUNCTION IN ADHD: A QUALI- TATIVE LITERATURE REVIEW OF MRI-BASED NEUROIMAGING STUDIES

Speaker: Joseph Biederman, M.D.

SUMMARY:

Background: To evaluate the impact of therapeutic oral doses of stimulants on the brains of ADHD subjects measured with MRI-based neuroimaging studies (morphometric, functional, spectroscopy). Methods: We conducted systematic literature searches to identify peer-reviewed MRI-based neuroimaging studies that reported the effects of therapeutic doses of stimulants on the brains of ADHD subjects. We included only original reports with brain measurements of ADHD subjects both on and off stimulants. Results: We found 29 published studies that met our criteria. Most data on the effect of therapeutic oral doses of stimulant medication suggests attenuation of structural and functional alterations found in unmedicated ADHD subjects, as compared to findings in control subjects. Conclusions: Our review suggests that therapeutic oral doses of stimulants decrease alterations in brain structure and function in subjects with ADHD relative to unmedicated subjects and controls.

NO 2 RESTING-STATE FUNCTIONAL CONNECTIVITY IN A LONGITUDINAL STUDY OF ADHD FROM CHILDHOOD INTO ADULTHOOD REFLECTS DI- AGNOSTIC STATUS

Speaker: John Gabrieli, Ph.D.

SUMMARY:

Background: Resting-state studies of subjects with ADHD have reported atypical functional connectivity. We examined connectivity in a longitudinal sample with childhood diagnosis of ADHD, who did (persistent ADHD, N = 14) or did not (remitted ADHD, N = 22) currently meet diagnostic criteria, as well as Controls (N = 17). Methods: We collected resting-state blood oxygen-level dependent (BOLD) functional magnetic resonance imaging (fMRI) on a 3.0 Tesla Siemens Trio scanner. Results: The persistent ADHD group had significant decreases in connectivity between posterior cingulate and medial prefrontal cortices, and significant decreases in anticorrelations between medial prefrontal and dorsolateral prefrontal cortices, relative to both Controls and the remitted ADHD group. There were no reliable differences between the control and remitted ADHD groups. Conclusions: Variation in functional organization of the brain may reflect the current clinical status of adult ADHD.

NO 3**FUNCTIONAL GENOMICS OF ADHD RISK ALLELES ON DOPAMINE TRANSPORTER BINDING IN ADHD AND HEALTHY CONTROLS**

Speaker: Thomas Spencer, M.D.

SUMMARY:

Background: We examined the relationship between dopamine transporter (DAT) binding in the striatum in individuals with and without ADHD attending to the 3'UTR and intron8 variable number of tandem repeat (VNTR) polymorphisms of the DAT (SLC6A3) gene. Methods: Subjects consisted of 34 adults with ADHD and 34 Controls. Striatal DAT binding was measured with PET using ¹¹C Altropane. Genotyping included the 3'UTR and intron8 VNTRs. Results: ADHD status ($p < 0.004$) and 3'UTR of SLC6A3 9 repeat carrier status ($p < 0.008$) were independently and additively associated with increased DAT binding in the caudate. ADHD status was associated with increased striatal DAT binding regardless of 3'UTR genotype and 3'UTR genotype was associated with increased striatal DAT binding regardless of ADHD status. There was no significant association of intron8 with DAT binding. Conclusions: 3'UTR but not intron8 VNTR genotypes were associated with increased DAT binding in both ADHD patients and healthy controls.

NO 4**CEREBRO-CEREBELLAR ABNORMALITIES ASSOCIATED WITH COGNITIVE AND MOTOR PROCESSES IN ADULT ADHD**

Speaker: Eve Valera, Ph.D.

Lecture Chair: Jason Daiger

SUMMARY:

Objective: We used neuroimaging and behavioral testing to probe for cerebellar abnormalities in ADHD adults. Methods: ADHD adults and controls underwent fMRI while performing n-back and sensorimotor-timing tasks. The cerebellar motor system was tested using a modified version of the International Cooperative Ataxia Rating Scale measuring posture

and gait disturbances, as well as kinetic, speech and oculomotor functions. Results: Relative to controls, ADHD adults showed reduced activation in cerebro-cerebellar circuits while performing the working memory and tapping tasks. ADHD adults also showed significantly higher scores for total ataxia, posture and gait disturbances, and kinetic functions subscales. These scores were associated with localized volume reduction in frontal and cerebellar regions. Conclusions: These findings provide additional support that the cerebellum and cerebro-cerebellar circuits affect varied facets of ADHD clinical phenomenology.

SYMPOSIUM 3**UPDATE ON PSYCHOPHARMACOLOGY IN THE MEDICALLY ILL**

Chair: Stephen J. Ferrando, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Employ a strategy to evaluate and treat psychiatric symptomatology in patients with significant comorbid medical illness.;2) Demonstrate knowledge of up-to-date information on psychopharmacology in key areas of medical comorbidity including cardiovascular, renal and hepatic disease; and 3) Evaluate the clinical significance of potential drug-drug and drug-disease interactions in treating patients with comorbid medical illness.

SUMMARY:

This symposium will provide in-depth and practical information regarding the use of psychopharmacological agents to the medically ill. Drs. Ferrando and Levenson will provide information on key aspects of drug-drug interactions and pharmacokinetic alterations in organ system disease; major drug toxicities and alternate routes of drug administration. Drs. Levenson and Ferrando will present information on selected practical clinical questions related to psychopharmacology in organ system diseases, surgery and critical care and transplantation. For example, "SSRI/SNRI/TCAs have been suggested to increase the risk of GI bleeding especially when combined with NSAIDs. Is this a clinically significant concern?" The presenters will discuss the literature evidence for this phenomenon, its clinical implications, and management strategies. Case examples will be provided to illustrate each of these points. Each presentation will last approximately 40-45 minutes with 15-20 minutes for discussion.

NO 1**SEVERE DRUG REACTIONS IN PSYCHOPHARMACOLOGY**

Speaker: Stanley N. Caroff, M.D.

SUMMARY:

Dr. Caroff will present a survey of severe, life-threatening reactions to psychotropic drugs affecting multiple organ systems, including neuroleptic malignant syndrome, cutaneous and hematological reactions. These rare but life-threatening drug reactions may require emergency medical treatment and psy-

chiatrists must be equipped to recognize and initiate evaluation and treatment for these adverse events.

NO 2 PSYCHOPHARMACOLOGY IN PATIENTS WITH CARDIAC DISEASE

Speaker: Peter A. Shapiro, M.D.

SUMMARY:

Dr. Shapiro will present the evidence base, clinical implications and management strategies for psychopharmacological treatment in patients with cardiac disease. Among the issues discussed will be efficacy of antidepressant medications in the treatment of depression and illness course, and QTC prolongation risk among the relevant classes of psychotropic medications.

NO 3 CLINICAL QUESTIONS

Speaker: Stephen J. Ferrando, M.D.

SUMMARY:

Dr. Ferrando will present the evidence base, clinical implications and management strategies for psychopharmacological treatment in several medical illness states, including liver disease, delirium, and cardiovascular disease.

NO 4 CLINICAL QUESTIONS

Speaker: James Levenson, M.D.

SUMMARY:

Dr. Levenson will present the evidence base, clinical implications and management strategies for psychopharmacological treatment in several medical illness states, including renal disease, gastrointestinal illness and neuropsychiatric conditions.

SYMPOSIUM 4 SMOKING CESSATION IN PATIENTS WITH SEVERE MENTAL ILLNESS: NEW RESEARCH FINDINGS AND CLINICAL IMPLICATIONS

Discussant: Douglas M. Ziedonis, M.D., M.P.H.

Chair: Petra Jacobs, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Summarize recent findings on safety and efficacy of varenicline in patients with schizophrenia, schizoaffective and bipolar disorder and ways to implement them in practice; 2) Discuss the impact of concurrent smoking-cessation and stimulant dependence treatment on stimulant dependence outcomes and recognize its implications on clinical practice; 3) Describe contingency management as an adjunctive Tx for smoking cessation, discuss how this intervention improves smoking cessation outcomes & the related implementation; and 4) Describe new technologies used for delivery of smoking cessation intervention that will emulate care provided by

health professionals, and discuss their implementation.

SUMMARY:

Smoking Cessation in Patients with Severe Mental Illness: New Research Findings & Clinical Implications The smoking prevalence among patients with a severe mental illness is 2 to 3 times higher than the general population. Data from the 2010 National Survey on Drug Use and Health (NSDUH) indicate prevalence of current illicit drug use is 5 times higher in cigarette smokers compared to persons who were not current cigarette smokers. Despite the pervasiveness of tobacco smoking in illicit drug users and patients with severe mental illness and the higher mortality rates in smoking than in non-smoking patients, smoking-cessation treatment is typically not provided in community-based substance abuse or mental health treatment programs. Behavioral therapy alone in this population has shown limited efficacy. Integrating behavioral and pharmacotherapies is considered a more beneficial approach. Psychosocial interventions, e.g., CBT combined with NRT's, appear to be safe and effective smoking cessation strategies for those with schizophrenia or illicit substance use disorders. Bupropion is also found to reduce smoking behavior for patients with SMI. Similarly, results from studies suggest that psychosocial interventions, NRT's, and bupropion may be effective smoking cessation treatments for patients with depression. Few recent studies examined safety, efficacy and effectiveness of varenicline in this population. This session will present results from recent studies and discuss their clinical implication. Furthermore, barriers and solutions to addressing tobacco dependence in patients with severe mental illness, including illicit substance use disorders will be discussed. This will incorporate the issue of using e-technologies and contingency management to improve outcomes of smoking cessation. Lastly, advances from a recently completed NIDA Clinical Trials Network (CTN) multi-site randomized controlled trial will be discussed on whether concurrent treatment for nicotine and cocaine/methamphetamine use disorders in community-based treatment programs enhances likelihood of smoking cessation and abstinence from cocaine/methamphetamine use in persons with comorbid conditions. Advances in evidence-based integrated smoking cessation, mental health, and illicit substance use treatments in patients with severe mental illness and nicotine dependence will permit a more rational development of concurrent behavioral and pharmacological treatment for pammamine use disorders in community-based treatment programs enhances likelihood of smoking cessation and abstinence from cocaine/methamphetamine use in persons with comorbid conditions.

NO 1 CONTINGENCY MANAGEMENT FOR TREATING CIGARETTE SMOKING IN SUBSTANCE ABUSERS: EFFECTS, LIMITATIONS, AND OPPORTUNITIES WITH TECHNOLOGICAL ADVANCES

Speaker: Sheila M. Alessi, Ph.D.

SUMMARY:

Substance abusers bear a disproportionate burden of smoking-related morbidity and mortality. Treatments for smoking

effective in the general population are generally effective in people with substance use disorders and other serious mental illness, but less so. Innovative strategies to improve outcomes are needed. Contingency management (CM) therapy is among the most efficacious psychosocial treatments for illicit substance use disorders and may improve smoking outcomes. Results from two clinical trials will be discussed, one of which examined effects of CM for smoking abstinence in residential substance abuse treatment patients and the other effects of CM plus varenicline (Chantix®) on outcomes. Importantly, logistical and resource limitations related to the administration of CM for smoking have largely precluded research to date. An ongoing trial examines administering CM via interactive voice response, video capture and other cell phone technologies, and will be discussed.

NO 2 NOVEL PHARMACOLOGICAL TREATMENTS FOR COCAINE AND NICOTINE DEPENDENCE

Speaker: Mehmet Sofuoglu, M.D., Ph.D.

SUMMARY:

Our first study compared bupropion (300 mg/day) to placebo for the concurrent treatment of opioid and nicotine addiction in 40 opioid-dependent smokers stabilized on buprenorphine. Bupropion treatment was not more effective than placebo for abstinence from nicotine, opioids, or cocaine. These preliminary findings do not support the efficacy of bupropion in combination with buprenorphine, for the concurrent treatment of opioid and nicotine addiction. The second study compared varenicline (2 mg) to placebo for treatment for cocaine and nicotine dependence in 31 methadone-maintained smokers. Treatment with varenicline was associated with a reduced number of cigarettes smoked per day, even though subjects received only a brief education for smoking cessation. The self-report reduction in smoking was corroborated by CO levels and the FTND scores. These preliminary findings point to potential therapeutic value of varenicline for smoking cessation in cocaine users maintained on methadone.

NO 3 THE IMPACT OF CONCURRENT OUTPATIENT SMOKING-CESSATION AND METHAMPHET- AMINE/COCAINE-DEPENDENCE TREATMENT ON STIMULANT-DEPENDENCE OUTCOMES

Speaker: Theresa Winhusen, Ph.D.

SUMMARY:

Cigarette smoking is prevalent in cocaine/methamphetamine-dependent patients and is associated with significant morbidity and mortality, yet, the provision of smoking cessation treatment in conjunction with substance use disorder (SUD) treatment is not standard practice. This is due, in part, to concern that combining smoking cessation with SUD treatment could lead to poorer SUD outcomes. A 10-week, two-group, randomized trial was conducted with 538 cocaine/methamphetamine-dependent cigarette smokers to evaluate the impact of providing smoking cessation treatment (SCT) with SUD treatment as usual (TAU), compared to TAU alone,

on stimulant-use outcomes. The trial was specifically designed to evaluate the relationship between cigarette smoking and stimulant use, which prior research suggests is linked. The findings from this trial and implications for how best to address the co-occurring problems of nicotine dependence and cocaine/ methamphetamine-dependence will be discussed.

NO 4 VARENICLINE AND SMOKING CESSATION IN SCHIZOPHRENIA

Speaker: S. Hossein Fatemi, M.D., Ph.D.

SUMMARY:

Subjects with schizophrenia (SCZ) have higher rates of nicotine addiction and difficulty quitting smoking compared to general population. Smoking cessation strategies effective in general population may be less effective in subjects with SCZ. The negative impact of smoking on physical health requires safe, effective strategies to combat nicotine addiction. A double-blind placebo controlled study was conducted which tested varenicline vs. bupropion HCl vs. placebo in subjects with schizophrenia or schizoaffective disorder. Subjects received varenicline (1 mg BID), bupropion HCl (150 mg BID) or placebo for three months. Outcome measures, results of the study and our conclusions will be presented and discussed during this presentation.

NO 5 VARENICLINE VERSUS PLACEBO FOR SMOK- ING CESSATION IN PERSONS WITH BIPOLAR DISORDER

Speaker: K. N. Roy Chengappa, M.D.

SUMMARY:

As cigarette smoking decreases in the USA, it is startling to note that in any given month, persons with mental illnesses smoke nearly 45% of all cigarettes. Patients with bipolar disorder (BPD) are at least 2-4 times more likely to smoke as the general population, and at rates similar to those reported for people with schizophrenia. Yet, people with these serious mental illnesses are typically excluded from clinical trials. We invited and recruited 60 people with a BPD diagnosis, current smokers, interested in quitting providing written informed consent to participate in a 6-month clinical trial. Patients were euthymic at entry to the study. Varenicline (or placebo) was initiated using the standard titration to a final dose of 1 mg, po, bid, and continued for 3-months. At the time of writing between 25 to 30% of patients met the abstinence criteria for smoking cessation, verified by CO. Details of the clinical trial results, clinical and other issues will be presented at the symposium.

SYMPOSIUM 5 DSM-5 PSYCHOSIS CHAPTER

Discussant: William T. Carpenter, M.D.

Chair(s): William T. Carpenter, M.D., Rajiv Tandon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand changes from DSM-IV to DSM-5; 2) Appreciate the role of dimensions and cognition in psychotic disorders; and 3) Anticipate differences between DSM-5 and ICD-11.

SUMMARY:

In this symposium we intend to present the most critical changes relating to the psychotic disorders. The symposium is designed for audience participation with each speaker and extensive Q and A time at the end of the five presentations. The chair [Carpenter] will introduce the symposium with brief description of the DSM-5 process. Dr. Tandon will present the important changes associated with concepts, criteria and overall organization of the chapter. Dr. Malaspina will describe the addition of a new paradigm based on domains of psychopathology as dimensions. Dr. Gur will present information on the role of cognition impairment in the psychoses and related disorders. Dr. Tsuang will present on the controversial issue of attenuated psychosis syndrome as a new classification. Dr. Gaebel, a member of the DSM-5 Psychoses Work Group and Chair of the Psychosis Section for ICD-11 will present points of difference between the two classification systems.

NO 1**CONCEPTUAL AND CRITERIA CHANGES FROM DSM-IV**

Speaker: Rajiv Tandon, M.D.

SUMMARY:

Changes in the psychotic disorders section in DSM-5 incorporate new knowledge about these conditions and address current limitations in their clinical utility and application. Changes from DSM-IV include: (i) better delineation of boundary between schizophrenia and schizoaffective disorder; (ii) deletion of the current subtypes of schizophrenia; (iii) introduction of specific illness dimensions; (iv) consistent definition and treatment of catatonia across the manual and introduction of a residual category of catatonia NEC; (v) clarification of boundary between delusional disorder and psychotic manifestations of anxiety and somatoform disorders. Proposed changes are intended to increase clinical utility (fewer diagnoses, better demarcation between disorders, greater treatment relevance [dimensions]) and modestly improved validity, while retaining the reliability in diagnosing various psychotic disorders (improving it for schizoaffective disorder).

NO 2**RELATIONSHIPS BETWEEN THE DIMENSIONS AND BEHAVIORAL CONSTRUCTS IN THE DSM-5 PSYCHOSIS CHAPTER WITH THE CONSIDERATIONS OF THE NIMH RDOC INITIATIVE**

Speaker: Dolores Malaspina, M.D., M.P.H.

SUMMARY:

New information is being continually added to our understanding of psychiatric disease entities from research on phenomenology, course and outcome studies, neuroscience and

epidemiology. This information has shaped the subtle transformations in the psychosis chapter in the DSM5. Crucially however, the DSM is retaining the historical approach of making categorical diagnoses even though overlapping behaviors, genes, neurocircuitry and domains of psychopathology clearly cut across quite different disease categories. Unfortunately this information is not yet sufficiently delineated and established to transform the DSM 5, which must serve clinicians, patients and systems of care. It is anticipated that the field will depart from using categorical diagnoses in the future and adopt a system that quantitates dysfunction in separate domains for symptom-specific treatment. The DSM 5 has an enhanced focus on dimensions of psychopathology to bridge with future RDoC informed classifications.

NO 3**NEUROCOGNITION IN PSYCHOSIS**

Speaker: Raquel E. Gur, M.D., Ph.D.

SUMMARY:

Cognitive deficits are evident in individuals with psychotic disorders. In schizophrenia, the impairment is associated with poor functional outcome. Furthermore, psychosis-prone youths also show impaired performance before symptoms meet diagnostic criteria.

This presentation will first highlight the literature where diverse measures of neurocognitive domains have been applied with consistent findings implicating fronto-temporal dysfunction. Against this background, data will be presented on the application of a computerized neurocognitive battery that examines accuracy and response time on tests that evaluate executive (abstraction and mental flexibility, attention, working memory), memory (verbal, facial, spatial), cognition (language, non-verbal reasoning, spatial processing) and social cognition (emotion identification, emotion differentiation and age discrimination) domains. Individuals with schizophrenia are impaired in accuracy and response time in multiple domains compared

NO 4**ATTENUATED PSYCHOSIS SYNDROME**

Speaker: Ming Tsuang, M.D., Ph.D.

SUMMARY:

Existing diagnostic criteria of schizophrenia lack specific information which describe and differentiate its early stages. To address this, and based on the experience of the various early psychosis programs, the Psychotic Disorders Workgroup has considered the inclusion of a new category "Attenuated Psychosis Syndrome (APS)" within the appendix of DSM-V. APS describes a condition with recent onset of modest, psychotic-like symptoms, and clinically relevant distress and disability. The inclusion of APS within the appendix shall encourage more research in order to verify its criteria. A family history of psychosis places the individual with APS at increased risk for developing a full psychotic disorder. In the DSM V context, clinicians can use this category to identify individuals who are at high risk of serious mental illness, and plan suitable interventions that specifically target the very early stages. The implica-

tions and application of APS will be discussed.

NO 5 PSYCHOTIC DISORDERS IN DSM-5: ANTICIPATED DIFFERENCES WITH ICD-11

Speaker: Wolfgang Gaebel, M.D., Ph.D.

SUMMARY:

DSM-5 created a section on “Schizophrenia Spectrum and Other Psychotic Disorders”, which includes both the primary psychotic disorders and those related to other medical conditions or substance use/withdrawal. In ICD-11, the section is entitled “Schizophrenia Spectrum and other primary psychotic disorders” and will only include the primary psychotic disorders. Functional impairment will not be a mandatory general requirement to diagnose a mental disorder in ICD-11. ICD-11 will have a set of specifiers of course and symptoms while DSM-5 will have a similar “dimensional assessment”. Catatonia will be a specifier, also the other schizophrenia subtypes will be represented in symptom specifiers. In schizophrenia, the time criterion of four weeks will be kept in ICD-11 and that of six months in DSM-5. In ICD-11, the delusional and the acute and transient psychotic disorders will be reorganized. An “attenuated psychosis syndrome” will most probably not be a “full” mental disorder in ICD-11.

SYMPOSIUM 6 CURRICULA FOR TEACHING RESIDENTS TO WORK IN INTEGRATED CARE

Discussants: Jurgen Unutzer, M.D., M.P.H., Lori Raney, M.D.

Chair(s): Robert C. Joseph, M.D., M.S., Deborah Cowley, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define core competencies, and rotation goals and objectives, for residents learning to work in integrated care settings; 2) Discuss curricula and teaching methods for educating psychiatry residents to work in integrated care settings; and 3) Discuss the role of the psychiatrist in training residents from other fields to work in integrated care settings.

SUMMARY:

About 20-50% of children and adults in the U.S. have a diagnosable mental disorder. Only one of 8 of these individuals consults a psychiatrist. Instead, most first present to their primary care providers for routine medical care. Those with mental disorders have significant medical comorbidity, decreased life expectancy, and generate higher health care costs than those without psychiatric illness. Common barriers faced by primary care providers in caring for these patients include the lack of access to traditional behavioral health (BH) services plus lack of time, inadequate mental health training, and issues related to poor reimbursement. Efforts to improve outcomes and decrease costs have included embedding mental health clinicians within primary care settings,

integrating primary medical care into mental health settings, and population-based behavioral health care of primary care patients. Integrated care is being incorporated into emerging medical homes and accountable care organizations. To provide psychiatric consultation and oversight of behavioral health needs within primary care populations, psychiatrists must learn new skills in consultation, collaborative care, and supervision of other mental health providers. This symposium highlights educational programs in integrated care for residents and fellows, focusing primarily on the core competencies required for psychiatrists to work in these settings; curricula for teaching these competencies (e.g. didactics, case conferences, co-learning with primary care residents, readings, and rotations); and the role of psychiatrists in training residents in primary care specialties (e.g. internal medicine, family medicine, pediatrics) to work with patients with mental health problems. The symposium will include a discussion of the overall core competencies to teach, as well as specific examples of curricula and teaching methods from five different institutions. At Cambridge Health Alliance, psychiatry residents and psychosomatic medicine fellows provide consultation at several multi-ethnic primary care and specialty medical clinics. At Johns Hopkins, child psychiatry fellows are co-located in an urban general pediatrics clinic and work closely with pediatrics residents. At the Portland VA, psychiatry residents learn to provide both psychiatric and medical care to patients in an elective primary care psychiatry rotation. At UC Davis, combined trained attendings (Family Medicine and Internal Medicine / Psychiatry) teach primary care and psychiatry residents to provide psychiatric consultation and outpatient medicine in primary care and public psychiatry settings. At the University of Washington, psychiatry residents learn skills in population-based care, supervising other mental health care providers. Educators from these programs will discuss core competencies and teaching methods in their settings.

NO 1 INTEGRATED PSYCHIATRY: PRIMARY MEDICAL CARE TRAINING AT PORTLAND VAMC

Speaker: Kristen Dunaway, M.D.

SUMMARY:

In 1998, the Psychiatric Primary Medical Care (PPMC) program was created at the Portland VA Medical Center to teach Oregon Health & Science University (OHSU) psychiatry residents to provide integrated care to patients with chronic mental illness. The goals of the rotation include: 1) increasing resident confidence in addressing medical complaints, 2) increasing knowledge regarding preventative medical care and health maintenance practices, 3) increasing awareness of when to refer patients with mental disorders for medical/subspecialty evaluations and 4) increasing comfort and familiarity with integrated care concepts. While development in all of the 6 core competencies is anticipated and promoted in the rotation, Interpersonal and Communication Skills, Systems-Based Practice, and Practice-Based Learning and Improvement are competencies strongly emphasized in this training model. Teaching methods include structured didactics, direct supervision, peer-to-peer teaching and case review.

NO 2 INTEGRATED CARE AND TRAINING IN A COLO- CATED CLINIC

Speaker: Marshall Forstein, M.D.

SUMMARY:

The Cambridge Health alliance has been integrating mental health and primary care for over 27 years. Cambridge Health Alliance is a primary care system of three hospitals, and 15 neighborhood community health centers. We have two different models of care in which mental health and primary care are integrated. The first is a system wide approach of extending mental health services to each of the neighborhood health centers as well as to the hospital based primary care clinics. Psychiatry faculty and residents work with primary care faculty and residents in a predominantly consultative model of "collaborative stepped care": patients referred by primary care providers to psychiatry are evaluated and initial care is based on the need for increasing involvement of mental health as the case requires. Challenges include space, faculty and resident time in the context of large primary care patient volumes. The second model is a completely integrated co-located care clinic. We will present the inception, design, development and function of an HIV Clinic with co-located staffing from psychiatry, medicine, nursing and social work. Beginning in 1987, the clinic has evolved as a training site for medical students, medical and psychiatric residents, social work trainees and advanced nurse clinician trainees. The administrative functions are jointly managed by a team representing each of the disciplines, and the structure of the clinic is based on the concept of "one stop care". The patient population is diverse, as is the staff. Trainees in the clinic work alongside attendings, senior nurse specialists, and develop collaborative skills. Psychiatric trainees and staff consult informally as well as formally to primary care providers, see patients for medications and psychotherapy based on the patient's severity of illness, culture and expectations. The presentation will describe the structure and format of patient care and outcomes.

NO 3 CHILD PSYCHIATRY AND PEDIATRIC RESI- DENTS: TRAINING AND WORKING AT THE IN- TERFACE

Speaker: Emily Frosch, M.D.

SUMMARY:

The Child & Adolescent Psychiatry and Pediatrics residency programs at Johns Hopkins have worked together to develop a model of integrated care that focuses on the clinical needs of the patients and families. This has been an important first step and represents a paradigm shift that broadens the models of mental health treatment available in a medical home. The next step is to think creatively about shifting the focus of child psychiatry training to broaden the exposure to, knowledge of, and skills at working in an integrated care model. We need to rethink how best to define, design, and implement curricular elements including, but not limited to, didactics, supervision, modeling, and clinical rotations to ensure that the coming cohorts of child psychiatrists will be prepared and in-

terested in working in integrated health care settings and still be in compliance with current RRC/ACGME requirements and service demands.

NO 4 CURRICULA FOR TEACHING RESIDENTS TO WORK IN INTEGRATED CARE

Speaker: Jaesu Han, M.D.

SUMMARY:

UC Davis has two "combined" residency training programs: Family Medicine / Psychiatry (FMP) and Internal Medicine / Psychiatry (IMP). Each five year program trains residents in general medicine, psychiatry and the integration of these two areas. Upon successful completion of these programs, graduates are board eligible in both psychiatry and family medicine or internal medicine. We will discuss the clinical curriculum used to train primary care residents in the area of primary care psychiatry. This same curriculum is used to help psychiatry trainees better understand how to collaborate and cross train their colleagues in primary care -- an increasingly important area of clinical medicine. We will also discuss an ongoing curriculum which provides training in areas at the interface between general medicine and psychiatry.

NO 5 COMBINED MEDICINE/PSYCHIATRIC RESIDEN- CY TRAINING: AN OVERVIEW

Speaker: Robert M. McCarron, D.O.

SUMMARY:

UC Davis has two "combined" residency training programs: Family Medicine / Psychiatry (FMP) and Internal Medicine / Psychiatry (IMP). Each five year program trains residents in general medicine, psychiatry and the integration of these two areas. Upon successful completion of these programs, graduates are board-eligible in both psychiatry and family medicine or internal medicine. Most UC Davis FMP and IMP graduates become board certified in two specialties and become clinical, administrative or research leaders in the area of medical/behavioral health integration. We will discuss the clinical curriculum used to train primary care residents in the area of primary care psychiatry. This same curriculum is used to help psychiatry trainees better understand how to collaborate and cross train their colleagues in primary care -- an increasingly important area of clinical medicine. We will also discuss an ongoing curriculum which provides training in areas at the interface between generations.

NO 6 THE MENTAL HEALTH INTEGRATION PROGRAM ROTATION: USING BRIEF TEACHING MODULES AND IMMERSION TO TEACH COLLABORATIVE CARE CONSULTATION PSYCHIATRY

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

SUMMARY:

The Mental Health Integration Program (MHIP) rotation at the University of Washington was developed to train senior residents in collaborative care consultation psychiatry. In this half-day outpatient rotation, residents work directly with a consulting psychiatrist in a 1-2 hour consultation with a care manager and 1 hour supervision period. The hour of supervision includes reviewing assigned readings, discussion of a 20-30 minute didactic module, and the opportunity to reflect on consultation observations and experiences. Didactic modules include an overview of the evidence for collaborative care, introduction to the MHIP program, the roles of the members of the collaborative care team, assessment of patients in a collaborative care model, making treatment recommendations to primary care providers and a discussion of the potential leadership role for psychiatrists in implementing qualitative improvement and team building. To date, six residents have completed this training.

SYMPOSIUM 7**CUTTING-EDGE TREATMENT OF SCHIZOPHRENIA OVER THE LIFE CYCLE: NEW DATA AND NEW STRATEGIES**

Chair: Ira D. Glick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Provide cutting-edge medication and psychotherapy treatment for patients with schizophrenia and their significant others over the life cycle; 2) Be aware of the data underlying the treatment recommendations; and 3) Provide psychoeducation for patient and family/significant others varying as the needs of the case.

SUMMARY:

New research and recent advances in neuroscience have in major ways advanced treatment of schizophrenia. This symposium will cover both drug and psychosocial-rehabilitation strategies for both patients and their families over the life cycle of this disabling disease. Data from both controlled and uncontrolled studies will be summarized and meta-analytic reviews included (where available) to provide the basis of the treatment recommendations. Prognostic implications will be presented, i. e. what can the clinician reasonably expect in terms of specific outcome domains like symptom relief, work or social function, etc. The life-cycle-treatment phases to be covered include 1) child/adolescent, "early intervention," 2) acute treatment, 3) mid and long-term treatment and 4) geriatric-later-life treatment/management. A special lecture will detail what clinicians need to know about recent neuroscience advances as they bear on treatment strategies. Brief case presentations will illustrate the lecture points. Problems of treatment and "best- of -bad alternative" interventions based on existing data will be discussed.

NO 1**ASSESSMENT AND TREATMENT OF THE ATTENUATED PSYCHOSIS SYNDROME AND PEDIATRIC-ONSET SCHIZOPHRENIA**

Speaker: Christoph U. Correll, M.D.

SUMMARY:

Given the severity of schizophrenia, early recognition and indicated prevention are key. Criteria for the Attenuate Psychosis Syndrome identify people at-risk for psychosis with 2-year transition rates of 35%. However, most people considered at-risk for psychosis do not develop psychosis. Further, the most optimal treatments have not been established and the transferability of research findings to clinical care are even less clear. By contrast, 5 atypical antipsychotics are now FDA-approved for the treatment of adolescents with schizophrenia based on positive, placebo-controlled trials. Diagnostic, dosing and tolerability considerations are essential when treating youth with schizophrenia. This presentation will review the most up-to date evidence base for the assessment and treatment of individuals considered at clinical high-risk for psychosis and of youth with early phase schizophrenia, aiming to increase the clinician's knowledge and armamentarium when treating such individuals.

NO 2**MANAGING ACUTE EPISODES OF SCHIZOPHRENIA**

Speaker: Stephen R. Marder, M.D.

SUMMARY:

This talk will provide an update on the management of acute episodes of schizophrenia in both inpatients and outpatients. It will review the literature on the relative effectiveness of different antipsychotics, the time course of improvement, management of drug side effects, and psychosocial approaches to acutely psychotic individuals. It will also on both evidence-based practices and non evidence based practices that are commonly used for acute patients. It will also address the management of symptoms that persist as patient become more stable.

NO 3**MID-TERM AND LONG-TERM TREATMENT OF SCHIZOPHRENIA FOR PATIENTS AND THEIR SIGNIFICANT OTHERS**

Speaker: Ira D. Glick, M.D.

SUMMARY:

Recent advances in neuroscience and outcome research have in important ways changed the long-term treatment of schizophrenia. This lecture will cover both psychosocial as well as medication strategies for both patients and their "families." Data from both controlled as well as naturalistic studies with a duration of 3 months or longer are summarized. Olanzapine is somewhat more effective than risperidone and both are better than the other first and second generation antipsychotics-except for clozapine which is the most effective of all. For most

patients, only a partial response can be expected. Family psychoeducation and support are crucial to improve outcome. Problems of achieving optimal outcomes will be discussed.

NO 4 TREATMENT OF LATE-LIFE SCHIZOPHRENIA

Speaker: Alana Iglewicz, M.D.

SUMMARY:

The treatment of schizophrenia needs to be modified over the lifespan in light of the biological and psychosocial changes that occur in late life. This presentation will summarize the physiological changes that occur with aging, the medication side effects commonly seen in older individuals with schizophrenia, and the respective need for medication adjustments in late life schizophrenia. It will also review specific psychosocial treatments for late life schizophrenia, including therapy, social skills training, functional skills training, and supported employment.

NO 5 CUTTING-EDGE TREATMENT OF SCHIZOPHRENIA OVER THE LIFE CYCLE: NEW DATA AND NEW STRATEGIES

Speaker: David L. Braff, M.D.

SUMMARY:

The psychiatric neuroscience revolution has led to an explosion of knowledge about new facts relating to human brain function in health and disease across the lifespan. But we are still in a largely serendipitous rather than evidence-based era in terms of drug development for schizophrenia treatment. In parallel, psychosocial treatments such as cognitive behavior therapy (CBT) which aim at recently approved FDA cognitive targets also change brain function but remain a bit overlooked. Schizophrenia has been characterized from phenotype, neural circuit and genomic platforms and some of this information will be presented. Although these exciting new data sometimes outrun clinical reality, new biomarkers targeting endophenotypes, gene and neural networks now are available for combined drug and psychosocial treatments.

SYMPOSIUM 8 TRENDS, UNCERTAINTIES, AND CONTROVERSIES IN THE TREATMENT OF THE TRANSGENDERED

Chair: Stephen B. Levine, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the clinical implications of the recent changes in policy statements about the care of the transgendered; 2) Understand the pros and cons of children's early social transitioning into the desired gender; 3) Consider the diverse long-term developmental outcomes of gender-dysphoric children when planning for decisions on early transitioning; 4) Recognize the implications of psychiatric co-morbidities for

treatment planning in adolescents and adults; and 5) Assist the transgendered in correctional facilities in planning appropriate treatment and protection.

SUMMARY:

Five presentations will discuss the clinical management of children, adolescents, and adults who are considering social transition to their desired gender. Beginning with a review of recent policy documents, the symposium will present data on the diverse developmental outcomes of childhood gender dysphoria, describe early intervention to prevent needless suffering of adolescents, consider various interpretations of psychiatric co-morbidities in the light of the new morbidity and mortality data, and highlight trans phenomena observed in the Massachusetts prison system. Psychiatric treatment needs of transgendered patients before and after transition will be the unifying theme of the symposium.

NO 1 TRENDS, UNCERTAINTIES, AND CONTROVERSIES IN THE TREATMENT OF THE TRANSGENDERED

Speaker: Joel Andrade, Ph.D.

SUMMARY:

The management of transgendered patients in correctional mental health settings presents unique clinical challenges. Transgendered patients are over-represented in correctional facilities. They are likely to have histories of profound aggression, drug use, and behavioral dyscontrol. Personality disorders and paraphilias are common. Their dysphoria, sexual and gender roles mutate and adapt with changing inmate relationships. They typically assertively approach their clinicians with adversarial demands and force decisions through litigation. Real life experiences occur in a strict safety-first facility populated only by men. Demands for special housing, clothing, and hygiene continually challenge the treatment structure. Both the unique features of these inmates, many of whom have committed murder or have life sentences, and their environment suggest that different approaches are required to ensure ethical and humane interventions.

NO 2 POLICY TRENDS IN TRANSGENDER SERVICES

Speaker: Heino F. L. Meyer-Bahlburg, Ph.D.

SUMMARY:

Clinical transgender work is currently in a state of flux. The committees preparing DSM-5 and ICD-11 are challenged by demands to move transgender categories from mental to medical or neurological disorders, or even out of the nosologic nomenclature altogether. For many activists, human-rights considerations trump psychiatric concerns. The function of mental-health service providers is increasingly shifting from psychiatric screening and gate-keeping to collaborative patient assistance, as represented in the "informed-consent model" (aka treatment on demand). Social transitions are implemented as early as first grade, and medical transitions in midadolescence. These shifts in approach are reflected in

recent clinical guidelines of various scientific and professional societies as well as of transgender-specialized hospital-based clinics and free-standing NGOs. Critical examination of implications for patients' outcomes is urgently needed.

NO 3 DEVELOPMENTAL TRAJECTORIES OF CHILDREN WITH GENDER DYSPHORIA

Speaker: Kenneth J. Zucker, Ph.D.

SUMMARY:

This presentation provides an overview of the long-term psychosexual follow-up of children with gender dysphoria (GD). Data sets from several centers, spanning the past 25 years, suggest that a substantial majority of children with GD or marked gender-variant behavior do not persist in their desire to be of the other gender in adolescence and young adulthood. Although the persistence rates are higher than base rates in the general population, the majority show desistance. The most common long-term psychosexual outcome is a homosexual sexual orientation (in relation to natal sex) and a gender identity that is consonant with one's assigned gender at birth. These data can inform current clinical management policies with regard to the treatment of young children with GD.

NO 4 MENTAL HEALTH CARE FOR GENDER DYSPHORIC ADOLESCENTS

Speaker: Peggy Cohen-Kettenis, Ph.D.

SUMMARY:

Good quality care for gender dysphoric adolescents consists of more than the assessment of type and severity of the gender dysphoria and providing hormones. In order to make informed choices, all treatment options and long-term consequences of various treatment modes should be carefully explained. Explanations need to include technical as well as emotional aspects (e.g. loss of fertility) of certain medical interventions. In order to assess readiness for (medical) treatment, addressing co-existing psychiatric problems is of major importance, as certain forms of psychopathology may interfere with treatment. Relatively new is that families need to be made aware that gender dysphoria in children will not necessarily persist after puberty, before any decisions are made about social transitioning (a complete gender change in clothing, first name, use of pronouns, etc.) and that some children who want to transition back once they approach puberty need assistance in the process.

NO 5 WHAT THE NEW FOLLOW-UP DATA ON ALL SWEDISH SEX REASSIGNMENT SURGERY (SRS) PATIENTS MIGHT MEAN

Speaker: Stephen B. Levine, M.D.

SUMMARY:

Data on mortality, suicide attempts, psychiatric hospitalization,

arrests and accidents for all who underwent SRS in Sweden between 1973 and 2003 are now available. Hazard ratios demonstrated that the cohort was at risk for serious medical, psychiatric and legal problems. The innovative methodology and study's 11-year follow-up should dislodge the political stalemate between those who favor hormones and surgery on demand and those who advocate for more cautious psychiatric approach. Underlying these views are differing attitudes toward psychiatric co-morbidities. One position assumes that co-morbidities are primarily due to sexual minority stress and posits that SRS will dissipate them while the other doubts sexual minor stress is the dominant cause and is concerned that these problems will continue to limit the lives of patients after SRS.

NO 6 TREATING TRANSGENDERED OFFENDERS

Speaker: Robert Diener, M.D.

SUMMARY:

The management of transgendered patients in correctional mental health settings presents unique clinical challenges. Transgendered patients are over-represented in correctional facilities. They are likely to have histories of profound aggression, drug use, and behavioral dyscontrol. Personality disorders and paraphilias are common. Their dysphoria, sexual and gender roles mutate and adapt with changing inmate relationships. They typically assertively approach their clinicians with adversarial demands and force decisions through litigation. Real life experiences occur in a strict safety-first facility populated only by men. Demands for special housing, clothing, and hygiene continually challenge the treatment structure. Both the unique features of these inmates, many of whom have committed murder or have life sentences, and their environment suggest that different approaches are required to ensure ethical and humane interventions.

SYMPOSIUM 9 POSTTRAUMATIC STRESS DISORDER CARE IN THE U.S. DEPARTMENT OF VETERANS AFFAIRS

Discussants: Charles Marmar, M.D., Antonette Zeiss, Ph.D.

Chair: Billy E. Jones, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe three ways in which mobile phone apps can support delivery of evidence based treatments for problems related to post-deployment stress and PTSD; 2) Demonstrate knowledge of the results of placebo-controlled clinical trials for PTSD performed in the Veteran population; and 3) Describe interventions demonstrated to be successful in managing PTSD in primary care.

SUMMARY:

Post Traumatic Stress Disorder is among the most prevalent mental conditions in public health systems in general and in VA in particular. In addition to past wars PTSD is now one

of the signature injuries of US recent engagements. It is estimated that 13-20% of the service members deployed to combat operations have or will have PTSD. PTSD care in VA is a top, clinical priority. This symposium will present and discuss the current diagnostic and therapeutic services used by the Department of Veteran Affairs to combat this illness. The symposium will discuss mental health screening, a product of the Primary Care-Mental Health Integration implemented in 2007, that occurs in the primary care services in VA, to include screening for PTSD. The symposium will discuss the Department of Veterans Affairs/Department of Defense (VA/DoD) clinical practice guidelines and how they assist health-care practitioners in providing appropriate clinical care for PTSD. The evidence-based psychotherapies for PTSD will be presented and discussed, along with a discussion of how this information has been spread throughout the VA system. Two phone applications, Prolonged Exposure Coach and Cognitive Processing Therapy Coach, will be described along with their use in therapy. The presentation on evidence-based psychopharmacology for PTSD in VA will review the placebo-controlled drug trials for PTSD performed in Veterans and current prescribing patterns. There are clinical demonstration projects currently being conducted at some VA health care sites on the use of meditation for PTSD. Three types of meditation are being evaluated. The findings from these clinical demonstrations will be presented. The two discussants, experts on PTSD and VA, will comment and add their insights on care in VA.

NO 1
**U.S. DEPARTMENT OF VETERANS AFFAIRS/
 DEPARTMENT OF DEFENSE CLINICAL PRACTICE
 GUIDELINES FOR PTSD**

Speaker: Matthew J. Friedman, M.D., Ph.D.

SUMMARY:

The Department of Veterans Affairs (VA)/Department of Defense (DOD) clinical practice guidelines (CPGs) are recommendations that are made to VA/DoD healthcare providers regarding their approaches to treatment. They are based on the best available clinical evidence and are designed to achieve the most desirable outcomes based on a variety of clinical situations by assisting practitioner and patient in making decisions about appropriate healthcare for specific clinical circumstances. Guidelines are being used throughout healthcare systems as a means of enhancing quality, reducing costs, and optimizing performance. Good clinical guidelines can improve both the process and outcomes of healthcare by providing recommendations for the management of patients. They also support the development of standards to assess outcomes. This presentation will review the methodology and recommendations of the 2010 VA/DOD Clinical Practice Guideline for PTSD, as well as current implementation strategies.

NO 2
**EVIDENCE-BASED PSYCHOPHARMACOLOGY
 FOR PTSD IN THE U.S. DEPARTMENT OF VETERANS AFFAIRS**

Speaker: Murray A. Raskind, M.D.

SUMMARY:

Choosing a pharmacologic treatment for any disorder should be evidence-based; that is, grounded in placebo-controlled treatment trials that demonstrate efficacy and safety for that disorder in the population being treated. This presentation will review the limited number of placebo-controlled drug trials for PTSD performed in Veterans. These include studies of the SSRIs, tricyclic antidepressants, monoamine oxidase inhibitors, antipsychotics, anticonvulsants, benzodiazepines, and the alpha-1 adrenoceptor antagonist prazosin. The presentation also will review how VA prescribing patterns are both concordant with and divergent from VA/DoD treatment guidelines, and how the divergences might be reconciled by further clinical treatment trials and by education.

NO 3
**EVIDENCE-BASED PSYCHOTHERAPY FOR
 PTSD: MOBILE APPS AS IMPLEMENTATION
 SUPPORTS**

Speaker: Josef I. Ruzek, Ph.D.

SUMMARY:

Consistent with recommendations of the 2010 VA/DOD Clinical Practice Guideline for PTSD, VA has taken steps to ensure widespread implementation of evidence-based treatments for PTSD. Large scale training initiatives along with systems changes designed to support treatment delivery are ensuring that these interventions are available throughout the healthcare system. To further enable practitioners and patients to participate effectively in these treatments, mobile phone apps have been developed that assist patients in understanding the treatments, learning associated skills, following through on task assignments, and evaluating their progress. Two phone apps - Prolonged Exposure (PE) Coach and Cognitive Processing Therapy (CPT)Coach - will be described and their role in facilitation of treatment delivery will be explored.

NO 4
**ADDRESSING PTSD IN PRIMARY CARE IN THE
 VETERANS HEALTH ADMINISTRATION: A WORK
 IN PROGRESS**

Speaker: Andrew S. Pomerantz, M.D.

SUMMARY:

Post Traumatic Stress disorder is among the most prevalent mental conditions in public health systems in general and in VA in particular. In addition to screening for depression and at-risk alcohol use, all veterans receiving primary care services in VA are screened for PTSD, using the four question PTSD-PC screen. In an effort to improve identification and treatment of common mental disorders in primary care, VA began a nationwide implementation of Primary Care-Mental Health Integration in 2007. This program includes both care management and co-located mental health providers working as integral components of the VA's Patient Centered Medical Home, known as the Patient Aligned Care Team. This presentation will review the integrated care program and highlight the specific interventions to assess and treat trauma and its

sequelae in primary care.

NO 5 CLINICAL DEMONSTRATION PROJECTS USING MEDITATION FOR PTSD

Speaker: Janet E. Kemp, Ph.D., R.N.

SUMMARY:

A group of 8 demonstration projects was conducted in 2012 at selected sites in the Veterans Health Care System. Each of these sites implemented a different type of meditation strategy designed specifically to help Veterans cope with PTSD symptoms. An evaluation team was established to look at both unique components of each site's implementation as well as overall strategies. Meditation strategies included mindfulness based meditation, mantra based meditations and Transcendental Meditation. Findings from both the symptom reduction component of the study, as well as, overall implementation progress will be presented and discussed.

SYMPOSIUM 10 UPDATE ON THE STATUS OF PSYCHIATRY IN THE ARAB WORLD

Discussants: David V. Sheehan, M.B.A., M.D., Ziad Nahas, M.D., M.S.

Chair(s): David V. Sheehan, M.B.A., M.D., Ossama T. Osman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand an overview of the components of mental health activities in the Arab world including; research, clinical services, policy, education, training and ethics; 2) Appreciate the newly developing infrastructures in psychiatric research and the possible opportunities for improvements including regional and international collaborations; 3) Understand a historical and contemporary view of the state of affairs in Arab mental health legislations, human rights and ethical standards; 4) Appreciate the diversity of the populations in the Arab states how it impacts the characteristics of clinical services provided; and 5) Understand the system of health care education and training in the Arab World and the rapidly developing vision to improve clinical training in many Arab Gulf states.

SUMMARY:

The Middle East is thought of as a cultural entity with a pervasive influence for ancient beliefs and practices on the collective mind of the 22 Arab states in that region. It is estimated that between 100 and 140 million people in the Arab world suffer from one or more psychiatric disorders or may have psychiatric symptoms that result in impairment quality of life. There is also a growing population in the region who suffer from mental health problems as a result of the recent traumatic events due to social and political turmoil in the region. There is a major imbalance between the magnitude of mental health problems and the resources devoted to address it. In

clinical services, there is wide variation in the availability and quality of the services provided with a significant room for improvements. Ethics policies, education and training need to address the pervasive stigma associated with mental illness, with patients, their families, and the institutions that provide these services. As for research, the last few years have witnessed renewed interest on the part of many Arab countries in developing its infrastructures to address the relatively impoverished state of research and scientific publications. In conclusion, this symposium will attempt to present a comprehensive overview of the main components of mental activities in the Arab world. This includes; clinical services, research and publications, education and training, ethics and policies. We will specifically emphasize the needed changes and improvements in the mental health domains throughout the region through advocacy, policy, leadership and integration.

NO 1 MENTAL HEALTH PUBLICATIONS IN THE ARAB WORLD

Speaker: Walid Sarhan, M.D.

SUMMARY:

The Arab world is extending from Morocco to Iraq with various degrees of development and economic status. For centuries, the region was a hub for groundbreaking science. It has become of contemporary strategic importance for its location and wealth of subterranean natural resources. The last few years have witnessed renewed interest on the part of many Arab countries in adopting and developing its infrastructures in psychiatric research and development. The paper will review the general state of research in the Arab world. It will specifically address relevant influencing factors; the science and technology landscape, the political decision and governance in the region. We will also address the possible opportunities for improvements including regional and international collaborations with established research entities.

NO 2 HUMAN RIGHTS OF MENTAL PATIENTS IN MO- ROCCO

Speaker: Driss Moussaoui, M.D.

SUMMARY:

Traditional mental institutions (Maristans) have existed for centuries in Morocco and modern psychiatric institutions were introduced following the French colonization in 1919. In neither of these, human rights of patients were much of a priority. The first Ethics committee for research was established in 1989 at the Faculty of Medicine in Casablanca and the author was one of the founders of this committee, and a member of the WPA Visiting team to the USSR in 1991. In 1995, a committee was created for the Ibn Rushd University Psychiatric Center, and A number of core seminars on Ethics and human rights were organized as an integral part of teaching. Associations for consumers and their families are being formed and the National Committee of Human Rights released a report publicly criticizing conditions of psychiatric institutions in Morocco. Along with the "Arab spring" came a better aware-

ness by citizens which is changing the human rights of mental patients in Morocco.

NO 3 MENTAL HEALTH LEGISLATION IN THE ARAB WORLD

Speaker: Nasser Loza

SUMMARY:

The development of the political and legislative structure in the Arab Countries dates back to the post World War 1 era and the Arab revolt from the Ottoman Empire. The traditional approach of caring for the insane in the Bimaristans of Cairo and Baghdad was replaced by Western style Asylums. The practice of detaining patients involuntarily required regulations and monitoring. Different countries adopted a British or French model of care. Some passed specific legislations in parliament, others had part of their general medical laws address the issue of mental patients, while many countries used ministerial decrees organizing admissions to mental hospitals. The twenty first century saw a renewed interest in the human rights of mental patients. Egypt passed a new law in 2009 replacing the 1944 mental health act. This presentation will address the process of developing mental health legislation. The discussion looks at community needs and professionals working under the new law.

NO 4 CLINICAL PSYCHIATRIC SERVICES IN THE ARAB WORLD

Speaker: Suhaila Ghuloum, M.D.

SUMMARY:

The delivery of mental health services among the Arab countries is variable. These services are highly stigmatised, hospital based, institutional and paternalistic, primarily psychopharmacological, and are usually underfunded. In many Arab Gulf states, the population is highly multi-ethnic with reliance on expatriate clinicians. Language become a barrier and clinicians may then rely on behavioural observations for diagnosis and management. The extended family role remains prominent and often beneficial though at times families discourage help seeking help due to stigma. This fact along with the highly respected traditional healers often delay professional psychiatric help. This may be compounded by the phenomenological presentations that include symptoms of somatisation and dissociation. Vocational opportunities are scarce and rehabilitation is confined to the family support with better integration in the community, but little functional productivity.

NO 5 PSYCHIATRIC EDUCATION AND TRAINING IN THE ARAB WORLD

Speaker: Ossama T. Osman, M.D.

SUMMARY:

The Arab World has traditionally held medical education in high regards. An increasing number of medical graduates are

entering the workforce locally or migrating to more economically affluent states in the Gulf. Post graduate training opportunities have expanded locally and regionally. Most Arab states have their own specialty Boards and grant their own professional certifications. On a regional level, graduates of the Arab Board of Medical Specialization (an affiliate of the Arab League) have increased with structured residency training programs in 14 Arab Countries. Recently, there have been some focused efforts to improve quality of psychiatric training in such programs. A few of them are considering recognition by international accrediting bodies. This presentation will outline the current state of undergraduate medical education and post graduate psychiatric training in the Arab world. The various challenges and opportunities in pursuit of quality improvements will be emphasized.

SYMPOSIUM 11 THE EVALUATION AND MANAGEMENT OF BIPO- LAR DISORDER IN OLDER ADULTS: NEW FIND- INGS FROM CLINICAL RESEARCH

Chair(s): Brent Forester, M.D., M.Sc., Susan W Lehmann, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Differentiate late onset bipolar disorder from disinhibition syndromes related to neurodegenerative disorders; 2) Demonstrate familiarity with the National Network of Depression Centers model and preliminary descriptive data comparing the clinical presentation of older and younger adults with bipolar disorder; 3) Understand the clinical trial results and discuss clinical treatment implications of the landmark NIH-funded Geri-BD study of acute mania; 4) Recognize the impact of aging on cognitive functioning in older adults with bipolar disorder; and 5) Understand the use of magnetic resonance spectroscopy to measure mitochondrial energy metabolism in geriatric bipolar depression.

SUMMARY:

Bipolar disorder in older adults has a heterogeneous etiology and presents with symptoms that overlap with disinhibition syndromes related to neurodegenerative illnesses. Evidence based treatments for acute mania and bipolar depression in later life are primarily derived from open label studies. This symposium will review the differential diagnosis of bipolar disorder in older adults, discuss assessment and evidence-based management strategies and review findings from the recently completed Geri-BD study, the first randomized controlled trial for acute geriatric mania. The National Network of Depression Centers model for larger prospective data collection will be discussed and data on age as a predictor of cognitive functioning in bipolar disorder will be reviewed. Finally, the participant will be introduced to the use of magnetic resonance spectroscopy as a neuroimaging tool to understand the mechanism of mitochondrial energy metabolism in geriatric bipolar depression.

NO 1 GERIATRIC BIPOLAR DISORDER: WHAT DO WE KNOW ABOUT BEST PRACTICES FOR CLINICAL MANAGEMENT?

Speaker: Susan W Lehmann, M.D.

SUMMARY:

Geriatric bipolar disorder presents significant challenges for the clinician. Diagnosing late-onset bipolar disorder and distinguishing it from disinhibition syndromes associated with neurologic disorders can be complex. Late-life bipolar disorder is associated with high rates of psychiatric and medical co-morbidity which affect both clinical course and treatment decisions. Because prevalence rates of geriatric bipolar disorder are low in community studies it has been difficult for individual centers to study. The National Network of Depression Centers (NNDC), a consortium of over 23 medical institutions, is prospectively following older patients with bipolar disorder using common assessment tools. This talk will summarize current research related to the clinical assessment and management of older patients with bipolar disorder. In addition, early findings from the NNDC data base about older patients with bipolar disorder will be presented and discussed.

NO 2 NEUROIMAGING EVIDENCE OF MITOCHONDRIAL IMPAIRMENT IN GERIATRIC BIPOLAR DISORDER

Speaker: Brent Forester, M.D., M.Sc.

SUMMARY:

Structural magnetic resonance imaging (MRI) scans have identified changes in older adults with bipolar disorder that include focal atrophy in the caudate and amygdala and T2 signal hyperintensities in deep frontal white matter. A more specific understanding of neurobiological markers of disease state and treatment response can be illuminated by the application of magnetic resonance spectroscopy (MRS), an in vivo imaging technique that quantifies brain metabolites reflecting neuronal integrity, neurotransmitter function and energy metabolism. This presentation will review the application of MRS to study the hypothesis of mitochondrial dysfunction as a neurobiological mechanism associated with symptom severity and treatment response in late life bipolar depression. Findings from a phosphorus MRS study at 4 Tesla will demonstrate the effects of CoEnzyme Q 10, an energy enhancing antioxidant, on mitochondrial function in older adults with bipolar depression.

NO 3 COGNITION IN THE CONTEXT OF AGING IN BIPOLAR DISORDER: A DOUBLE BURDEN

Speaker: Sara Weisenbach, Ph.D.

SUMMARY:

We studied the impact of aging on eight cognitive factors in bipolar disorder (BD). The first analysis included 35 older (M age=56, SD=5) and 47 younger (M=24, SD=3) euthymic BD

patients, and older (n=30) and younger (n=49) age-matched healthy controls. There was an interaction of age and disease status on Emotion Processing, Verbal Fluency with Processing Speed, and Processing Speed with Interference Resolution (PSIR) ($p < .05$). Clinical variables did not strongly predict cognitive performance in BD patients. Multiple regression analyses performed with 95 BD patients across the lifespan (18-68) demonstrated a significant impact of age on Visual Memory and PSIR, after accounting for symptom severity, genetic variation (CACNA1C and Syn1), and medication load. Findings suggest a double burden of age and disease status in BD.

NO 4 TOWARD RATIONAL PHARMACOTHERAPY IN BIPOLAR ELDERS: FINDINGS FROM GERI-BD

Speaker: Robert C. Young, M.D.

SUMMARY:

These presentations highlight the relatively limited existing database in late life bipolar disorder despite critical needs in this severely ill and heterogeneous population. Guidelines for rational management have been lacking; age-specific treatment literature consists predominantly of retrospective analyses of case series, and analyses of subgroups within larger trials. GERI-BD is an NIH-supported, multicenter (U01), double-blind, randomized, parallel group, concentration-controlled study of tolerability and benefit in the lithium or valproate (divalproex sodium) treatment of aged bipolar I manic, mixed and hypomanic patients. The design emphasizes conservative treatment and limited use of atypical antipsychotics. Preliminary analyses of outcomes in randomized participants (n=224) indicated that both drugs were adequately tolerated and associated with anti-manic response. We will report findings and compare to those from studies in younger adults.

SYMPOSIUM 12 SYMPTOMS AND DISABILITY MEASURES IN DSM-5

Discussant: Norman Sartorius, M.A., M.D.

Chair(s): William Narrow, M.D., M.P.H., Norman Sartorius, M.A., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the patient-reported dimensional measures proposed for the DSM-5; 2) Recognize the feasibility and clinical utility of the patient-reported dimensional measures in clinical settings; and 3) Understand how these dimensional measures function in child and adult patients from various mental health settings.

SUMMARY:

With the advent of measurement-based care, which includes patient-reported outcomes as an integral component, as well as identified limitations in the strict categorical nature of the current Diagnostic and Statistical Manual of Mental Disorders (DSM) system, the Workgroups involved in the Fifth Revision

of the DSM have proposed age-specific patient-reported dimensional measures that cuts across diagnoses, referred to as the cross-cutting measures, and the possible use of World Health Organization Disability Assessment Schedule (WHO-DAS II) for the assessment of disabilities across diagnoses. The systematic measurement of common cross-cutting symptoms and disabilities has the potential to not only help clinicians in documenting and justifying diagnostic and treatment decisions, but also to increase patient involvement in these decisions. This symposium will provide useful information on clinical utility, feasibility and sensitivity to changes on these patient-reported dimensional measures based on the findings from the DSM-5 field trials conducted in large academic centers and routine clinical practices, in both adult and child populations. The study highlights the potential use of patient-reported measures to enhance measurement-based care and have implications for future clinical assessments. The DSM-5 proposals for PRO measures can serve as an initial method for gauging the outcomes of treatments. This is important for the U.S. and Canada given the increased emphasis on evidence-based medicine and measurement-based care.

NO 1
DSM-5 ADULT PATIENT-RATED, CROSS-CUTTING DIMENSIONAL MEASURES: RELIABILITY, SENSITIVITY TO CHANGE, AND ASSOCIATION WITH DISABILITY IN THE DSM-5 ADULT FEMALE

Speaker: Diana E. Clarke, Ph.D.

SUMMARY:

Patients' reports of their symptoms during routine clinic visits have significant impact on diagnosis, treatment, and follow-up care. The Work Groups involved in the Fifth Revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) have proposed age-specific patient-rated cross-cutting measures to better assess and track patients' symptom presentations. Using a multi-site test-retest reliability study with stratified random sampling, we examined the feasibility, clinical utility, reliability, and sensitivity to change of the adult version of the measures. Intraclass correlation coefficients for stratified samples and their bootstrap 95% confidence intervals, using SAS and SUDAAN, were calculated for each measure. Weighted linear regression and correlation analyses were used to examine sensitivity to change. Items on the DSM-5 patient-rated cross-cutting measures mostly fell in the good-to-excellent range for ICC.

NO 2
DSM-5 CHILD AND PARENT/GUARDIAN-RATED, CROSS-CUTTING MEASURES: RELIABILITY, SENSITIVITY TO CHANGE, AND ASSOCIATION WITH LEVELS OF DISABILITY IN DSM-5

Speaker: S. Janet Kuramoto, M.H.S., Ph.D.

SUMMARY:

The child and parent/guardian-rated versions of the cross-cutting measures proposed by the Work Groups involved in the Fifth Revision of the Diagnostic and Statistical Manual of

Mental Disorders (DSM-5) consist of twelve mental health domains that are rated prior to the clinical interview. These are intended to guide clinicians on important areas of further inquiry. This study examined reliability, clinical utility, sensitivity to change and association with levels of disability for these child and parent-rated measures in four child/adolescent psychiatric population across the United States. Using stratified sampling approach, 616 child patients completed Visit 1 and Visit 2, which occurred 4 hours to 2 weeks apart. The third study visit occurred 4-24 weeks after Visit 1. The reliability of these cross-cutting measures was supported in parents and children across the four sites, albeit some differences depending on the domains assessed.

NO 3
DSM-5 PATIENT-RATED DIMENSIONAL MEASURES IN ROUTINE CLINICAL PRACTICE: FEASIBILITY, CLINICAL USEFULNESS, AND ASSOCIATION WITH LEVELS OF DISABILITY

Speaker: Eve Moscicki, M.P.H., Sc.D.

SUMMARY:

This study examined the feasibility and clinical utility of patient-rated, cross-cutting measures in the DSM-5 Field Trials in Routine Clinical Practice Settings, and the association of levels of symptom severity with DSM-5 diagnoses and levels of disability on the World Health Organization Disability Assessment Schedule (WHODAS II). Patients completed structured assessments of cross-cutting psychiatric symptom domains and the WHODAS II. Clinicians conducted a diagnostic interview and completed diagnostic and other measures. Adult patients' ratings of symptom severity were consistently related to their clinician-assigned primary DSM-5 diagnosis. Overall mean scores on the patient-rated WHO-DAS II were highest for adult patients with clinician-assigned DSM-5 diagnoses of bipolar and related disorders and any depressive disorders.

NO 4
THE WORLD HEALTH ORGANIZATION DISABILITY ASSESSMENT SCHEDULE IN THE DSM-5 FIELD TRIALS: RELIABILITY AND ASSOCIATIONS WITH PSYCHIATRIC DIAGNOSIS

Speaker: William Narrow, M.D., M.P.H.

SUMMARY:

The World Health Organization Disability Assessment Schedule (WHODAS II) was recommended by the DSM-5 Disability Study Group for the measurement of disabilities in patients with mental disorders. The DSM-5 Field Trials tested the WHODAS in adults as self-completed and clinician-completed versions. Corresponding instruments, developed by the study group, were tested in child populations. All instruments cover 6 domains of life activities. This study examined the test-retest reliability of the child and adult versions of the WHO-DAS II in the field trials. Mean WHODAS scores for various diagnoses statuses of patients were also examined. Analyses were weighted and used SAS and SUDAAN software. For reliability estimates, intraclass correlation coefficients for

stratified samples and bootstrap 95% confidence intervals were calculated. Test-retest reliabilities of the self-administered WHODAS were good to excellent for all age groups and domains.

SYMPOSIUM 13
THE LONG-TERM COURSE OF BORDERLINE PERSONALITY DISORDER: 16-YEAR FINDINGS FROM THE MCLEAN STUDY OF ADULT DEVELOPMENT

Discussant: Kenneth R. Silk, M.D.

Chair: Mary Zanarini, Ed.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) recovered borderline patients are more likely to marry and have children and less likely to divorce and lose custody of their children than non-recovered borderline patients;2) prediction of ongoing suicide threats is multifactorial in nature;3) an increasing percentage of borderline patients report close relationships over time and this outcome is most strongly predicted by childhood neglect and aspects of temperament;4) emptiness is a common but declining symptom of BPD and its remission is best predicted by positive psychosocial factors;5) physical inactivity is common among borderline patients and best predicted by interlocking psychological, social, and physical factors.

SUMMARY:

Recent research has found that borderline personality disorder (BPD) has a better prognosis than previously recognized. These studies have also detailed areas of ongoing vulnerability. This symposium is composed of five presentations based on 16-year data from the McLean Study of Adult Development (MSAD), which is an NIMH-funded study of the prospective course of 290 patients with BPD and 72 with other forms of personality disorder (OPD). Dr. Mary Zanarini will present data pertaining to lifetime rates of marriage and childrearing. She will also present data pertaining to lifetime rates of divorce and giving up or losing custody of one's children. Dr. Michelle Wedig will present findings pertaining to the most clinically relevant predictors of ongoing suicide threats. Dr. Alex Keuroghlian will present data pertaining to rates of close relationships without conflict reported by those in both study groups and the best predictors of the number of types of these relationships reported by borderline patients. Dr. Robert Biskin will present findings pertaining to rates of emptiness over time in both study groups and the best predictors of this dysphoric state among patients with BPD. Dr. Frances Frankenburg will present data pertaining to rates of physical inactivity in both study groups and the best predictors of physical inactivity among borderline patients. Dr. Kenneth Silk will be the discussant for this symposium, which presents new findings of both a positive and a more guarded nature.

NO 1

STABILITY OF MARRIAGE AND CHILD-REARING AMONG RECOVERED AND NON-RECOVERED PATIENTS WITH BORDERLINE PERSONALITY DISORDER

Speaker: Mary Zanarini, Ed.D.

SUMMARY:

Objective: The purposes of this study were to determine: 1) the rate of marriage and childrearing reported by recovered and non-recovered borderline patients and 2) the stability of these relationships. Method: All subjects were interviewed about these topics using a semi-structured interview with proven reliability and validity. Results: Recovered borderline patients were significantly more likely than non-recovered borderline patients to have married (68% vs. 33%). They were also significantly less likely to have been divorced (39% vs. 73%). Recovered borderline patients were significantly more likely than non-recovered borderline patients to have had or raised a child (48% vs. 31%). They were also significantly less likely to have given up or lost custody of a child (2% vs. 53%). Conclusions: Taken together, the results of this study suggest that stable functioning as a spouse and as a parent are strongly associated with a good overall outcome

NO 2

PREDICTORS OF SUICIDE THREATS IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER OVER 16 YEARS OF PROSPECTIVE FOLLOW-UP

Speaker: Michelle Wedig, Ph.D.

SUMMARY:

Objective: The goal of this study was to identify clinically meaningful predictors of suicide threats in borderline patients. Method: Two hundred and ninety borderline inpatients were assessed during their index admission using a series of semistructured interviews and self-report measures. These subjects were then reassessed using the same instruments every two years for 16 years. Results: We selected 14 inner state predictors from the DAS and five interpersonal predictors from the DIB-R based on expert consensus and clinical experience. Bivariate results showed that all predictors significantly predicted suicide threats across time. Following a multivariate backward deletion procedure, feeling abandoned, hopeless, and hurt, and manipulateness and demandingness were found to be significant predictors. Conclusion: Our findings suggest that suicide threats are related to both dysphoric emotional states and maladaptive behavior patterns that are interpersonal in nature.

NO 3

INTERPERSONAL RELATIONSHIPS REPORTED BY PATIENTS WITH BORDERLINE PERSONALITY DISORDER AND AXIS II COMPARISON SUBJECTS OVER 16 YEARS OF FOLLOW-UP

Speaker: Alex S. Keuroghlian, M.D., M.Sc.

SUMMARY:

Objective: This study has two goals: 1) determine the prevalence of five types of close relationships reported by borderline patients and axis II comparison subjects over 16 years of prospective follow-up and 2) determine the best predictors of the number of types of close relationships reported by those with BPD. Method: The quality of relationships was assessed nine times using a semi-structured interview. Results: Those in both study groups reported an increasing prevalence of each type of close relationship studied. Less severe childhood neglect and higher trait extraversion, agreeableness, and conscientiousness were found to be significant predictors of the number of types of close relationship reported by those with BPD. Conclusions: A higher percentage of borderline patients reported close relationships over time. Both childhood adversity and positive aspects of temperament were found to be the best predictors of the richness of their social supports.

NO 4
EMPTINESS IN BORDERLINE PERSONALITY DISORDER: PREVALENCE, SEVERITY, EMOTIONAL ASSOCIATIONS, AND PREDICTORS OF CHANGE OVER 16 YEARS OF FOLLOW-UP

Speaker: Robert S. Biskin, M.D.

SUMMARY:

Background: This study examines the frequency of emptiness in patients with BPD, distinguishes inner states associated with emptiness, and identifies predictors of change over 16 years of prospective follow-up. Methods: 290 inpatients meeting criteria for BPD and 72 patients who met criteria for another personality disorder at baseline were reassessed every two years. Results: Emptiness is more frequent in patients with BPD and declines over time. It is strongly associated with the thought of being "all alone" and feeling worthless and lonely. Predictors of emptiness over time include the absence of major depressive disorder, having less adult adversity, more emotionally supportive relationships, and good work or school functioning. Conclusions: Emptiness is frequently reported by patients with a diagnosis of BPD and is best predicted by positive psychosocial factors.

NO 5
LONGITUDINAL DESCRIPTION AND PREDICTION OF PHYSICAL INACTIVITY AMONG PATIENTS WITH BORDERLINE PERSONALITY DISORDER AND AXIS II COMPARISON SUBJECTS

Speaker: Frances Frankenburg, M.D.

SUMMARY:

Objective: This study has two purposes: 1) determine rates of physical inactivity reported by borderline patients and axis II comparison subjects over ten years of prospective follow-up and 2) determine the best set of predictors of inactivity in patients with BPD. Method: Physical health including physical inactivity was assessed at 6-16 year follow-up using a semi-structured interview. All of our predictors were time varying in nature. Results: Rates of physical inactivity were signifi-

cantly more common among borderline patients than axis II comparison subjects, although they declined significantly for those in both study groups. Three variables were found to be significant multivariate predictors of inactivity among borderline patients: the severity of trait avoidance, being on disability, and being obese. Conclusions: Physical inactivity is common among borderline patients and is best predicted by interlocking psychological, social, and physical factors.

SYMPOSIUM 14
ADVANCES IN GERIATRIC DEPRESSION: THE PATHOPHYSIOLOGY AND TREATMENT

Chair: Charles Nemeroff, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the relationship of depression to heart disease in the elderly; 2) Understand the relationship between depression and Alzheimer's disease; 3) Understand the evidence base for the psychopharmacological and psychotherapeutic management of depression in elderly; and 4) Understand the pathophysiology of vascular depression and its treatment implications.

SUMMARY:

The burgeoning advances in neuroscience, particularly those of genomics and its related disciplines (transcriptomics, metabolomics, proteomics and epigenetics), and structural and functional brain imaging have provided powerful tools that are now being applied to geriatric depression. In addition, advances in clinical trial design for both psychopharmacological and psychotherapeutic treatments have also occurred and are being applied to studies of geriatric depression. This symposium features four leaders in the field who have contributed to those advances and will summarize the current findings and presage future directions. Charles B. Nemeroff (University of Miami) will discuss the now well-established relationship between cardiovascular disease and depression, highlighting the pathophysiology as well as treatment issues. K. Ranga R. Krishnan (Duke University) will discuss the evolving understanding of the relationship of depression and Alzheimer's disease. George Alexopoulos (Weill Cornell) will provide updates on vascular depression-its pathophysiology and treatment. Charles Reynolds (University of Pittsburgh) will describe the latest data on psychopharmacologic and psychotherapeutic management of geriatric depression.

NO 1
HEARTACHE AND HEARTBREAK: DEPRESSION AND CARDIOVASCULAR DISEASE

Speaker: Charles Nemeroff, M.D., Ph.D.

SUMMARY:

This presentation focuses on the putative pathophysiological mechanisms underlying the increased vulnerability for CVD in depressed patients. These include: (1) increased inflammation as assessed by measurement of cytokines and C-reactive protein (CRP) (2) increased clotting diathesis with alterations

in multiple steps in the clotting cascade including platelet activation and aggregation (3) increased oxidative stress (4) a reduction in endothelial progenitor cells (EPCs) and associated reduction in arterial repair processes (5) decreased heart rate variability (6) increased rate of subclinical hypothyroidism (7) increased sympathoadrenal and hypothalamic-pituitary-adrenal (HPA) axis activity (8) single nucleotide polymorphisms (SNPs) that increase CVD risk (9) epigenetics, particularly in response to adverse early life events, which is associated with increased risk for both depression and CVD. Treatment of depression in patients with comorbid CVD and depression is summarized.

NO 2 DEPRESSION AND ALZHEIMER'S DISEASE

Speaker: K Ranga Krishnan, M.D.

SUMMARY:

Depression is a common feature in Dementia. It is particularly evident in early stages of the disease and when the diagnosis is first made. The diagnosis of depression is more difficult in mid to severe dementia but can still be made. Diagnostic criteria for depression in AD has been developed. These have been used to study the treatment of depression in AD. Early studies have shown that SSRI's could be useful in the treatment of depression in dementia. The presence of these symptoms can be distressing for both patient and family and should therefore be assessed and treated.

NO 3 "VASCULAR DEPRESSION" HYPOTHESIS: FIFTEEN YEARS LATER

Speaker: George S. Alexopoulos, M.D.

SUMMARY:

The "vascular depression" hypothesis generated findings on the mechanisms of depression and led to novel treatment and prevention strategies. There is now evidence that cerebrovascular disease confers vulnerability to various syndromes, including depression, other mood syndromes, psychosis, and cognitive impairment. Executive dysfunction, slow psychomotor speed, and frontal track abnormalities associated with vascular risk factors were shown to predict poor response to antidepressants highlighting the relationship of the cognitive control network to antidepressant response. Non-serotonergic drugs and transcranial magnetic stimulation have been under investigation. Interventions based on problem solving and rehabilitation principles have been found effective in depressed older patients with executive dysfunction who often have cerebrovascular disease, are disabled, and live under continuous stress. Finally, antidepressants used soon after stroke may prevent development of depression.

NO 4 TREATMENT AND PREVENTION OF MAJOR DEPRESSION IN OLDER ADULTS

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

SUMMARY:

This presentation will encompass a review of data on: (1) acute and maintenance treatment of major depression in older adults, (2) psychosocial and biological predictors and moderators of treatment response, (3) the role of ChEI's in maintenance treatment in patients with major depression and Mild Cognitive Impairment, and (4) strategies for prevention of depression in at-risk (selective prevention) and mildly symptomatic (indicated prevention) adults.

SYMPOSIUM 15 ASSESSMENT AND INTERVENTION FOR DOMAINS OF SCHIZOPHRENIA

Chair: S. Charles Schulz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Examine the impact of negative symptoms and explore potential psychopharmacologic interventions; 2) Explore the domains of cognitive impairments in schizophrenia and to learn about clinical trial results; 3) Demonstrate knowledge of neuroplastic characteristics of cognition in schizophrenia and the impact of cognitive remediation; and 4) Demonstrate knowledge of the characteristics of the domain of poor insight and learn about an evidence-based approach.

SUMMARY:

Historically, schizophrenia has been approached as a single entity and most psychosocial and medication treatment studies have included subjects with a diagnosis of the illness, not necessarily focusing on concerning domains. The purpose of this symposium is to describe four domains of schizophrenia and to then discuss recent specific interventions. Dr. Steven Marder will open the symposium by addressing the issue of negative symptoms of schizophrenia—symptoms in the area of flattened affect and amotivation—then discuss the background and potential interventions for this group of symptoms. The next speaker, Dr. Robert Buchanan, will discuss the domain of cognitive impairment in schizophrenia. It is known that the cognitive difficulties in schizophrenia are closely related to social and functional outcome. In this presentation, important issues such as assessment, cognitive symptoms, and current approaches will be described. An emerging treatment for the cognitive difficulties is in the domain of a neurocognitive remediation. This area of intervention has been shown to lead to successful outcomes. Dr. Sophia Vinogradov is investigating the underlying brain functions and interventions. This research may also be leading to new strategies for intervention. A highly-challenging domain of schizophrenia is the lack of insight—also known as anosognosia. Dr. Xavier Amador has described the issues of anosognosia, explored ways to approach the patient with lack of insight, and will discuss the characteristics and interventions for these patients. This has been a difficult issue in the field leading to delays in early assessment and adherence. In summary, the concept of domains within the overall illness of schizophrenia has been emerging as an important part of treatment leading to better outcomes. This symposium provides sophisticated background regarding

these domains and the emerging interventions.

NO 1 COGNITIVE IMPAIRMENTS IN SCHIZOPHRENIA

Speaker: Robert Buchanan, M.D.

SUMMARY:

People with schizophrenia are characterized by a broad range of cognitive impairments. These impairments are a core feature of the illness, are observed in family members, and are one of the major determinants of functional outcome. Cognitive impairments frequently have their onset prior to positive symptoms. Despite appropriate treatment with either first generation or second generation antipsychotics, people with schizophrenia continue to exhibit pronounced cognitive impairments. In order to facilitate the development of new pharmacological approaches, the Measurement and Treatment Research to Improve Cognition in Schizophrenia (MATRICS) initiative was developed to identify core cognitive impairments in schizophrenia, develop a battery to assess cognition in clinical trials (the MATRICS Consensus Cognitive Battery; MCCB), identify promising targets for drug development, and to develop study design guidelines for clinical trials of cognitive-enhancing agents.

NO 2 NEGATIVE SYMPTOMS AS A THERAPEUTIC TARGET

Speaker: Stephen R. Marder, M.D.

SUMMARY:

Negative symptoms, including restricted expressiveness, apathy, and avolition, are an attractive target for treatment development. The severity of negative symptoms is strongly related to a schizophrenia patient's functioning in the community and to the likelihood of success in rehabilitation. Moreover, currently available pharmacological treatments are relatively ineffective for improving negative symptoms. This presentation will focus on different therapeutic approaches to negative symptoms. This will include a review of the literature on the use of adjunctive antidepressants; data suggesting that minocycline may be effective as well as studies using repetitive transcranial magnetic stimulation. This review will also focus on promising pharmacological strategies including drugs that act at cholinergic and glutamate receptors. Finally, recent trials using cognitive behavioral approaches to negative symptoms will be reviewed.

NO 3 NEUROSCIENCE-INFORMED COGNITIVE TRAINING FOR THE NEURAL SYSTEM DEFICITS OF SCHIZOPHRENIA

Speaker: Sophia Vinogradov, M.D.

SUMMARY:

Cognitive remediation has demonstrated efficacy in schizophrenia but little research has investigated its neural system effects. We report longitudinal MEG, fMRI and serum bio-

marker data from adults with schizophrenia who were randomly assigned to either 50 hours of "neuroplasticity-based" computerized cognitive training or 50 hours of a computer games control. The goal of treatment was to increase the accuracy, temporally-detailed resolution and power of speech inputs feeding working memory and long-term memory processes. We report: 1) MEG data indicating improved efficiency in early auditory processing, prefrontal activation, and changes in resting functional connectivity; 2) fMRI data showing "normalization" of activation patterns during a verbal memory task; 3) increases in serum BDNF and d-serine levels after training. These data suggest that 50 hours of "neuroplasticity-based" cognitive training of auditory processes in schizophrenia drives changes in neural system functioning.

NO 4 UNAWARENESS OF ILLNESS IN SCHIZOPHRENIA: ETIOLOGY, IMPACT ON COURSE OF ILLNESS, AND TREATMENT APPROACH INDICATED FOR PATIENTS WITH POOR INSIGHT SPEAKER: XAVIER AMADOR, PH.D.

SUMMARY:

Hundreds of peer reviewed studies point to unawareness of illness as a vitally important domain of psychopathology in schizophrenia. At least half of all patients with schizophrenia have long-standing deficits in awareness of illness that do not improve with pharmacological or psychosocial treatments. Scientific consensus, following a peer review process conducted in 1999, concluded that: "A majority of individuals with schizophrenia lack insight regarding the fact that they have a psychotic illness. Evidence suggests that poor insight is a manifestation of the illness itself, rather than a coping strategy... comparable to... anosognosia. This symptom predisposes the individual to noncompliance with treatment and has been found to be predictive of an increased number of involuntary hospital admissions, poorer psychosocial functioning, and a poorer course of illness." (p. 304, DSM-IV TR). Evidence linking unawareness of illness to brain dysfunction, rather than denial, will be reviewed.

SYMPOSIUM 16 TRANSLATING THE TRANSLATION: BRINGING TRANSLATIONAL NEUROSCIENCE RESEARCH ON DEPRESSION AND ANXIETY TO THE CLINICIAN

Discussant: Mayada Akil, M.D.

Chair: Mayada Akil, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the role of translational neuroscience in the understanding and management of mood and anxiety disorders; 2) Understand the molecular mechanisms of fear learning; 3) Demonstrate knowledge of approaches to prevent fear acquisition or to enhance fear extinction in patients with anxiety disorders; 4) Understand the role of neurotrophic

factors in the acquisition and extinction of fear acquired during early development; and 5) Demonstrate knowledge of the neuronal circuitry involved in emotional regulation and its alteration in mood and anxiety disorders and the development of a non-invasive brain stimulation intervention targeting this circuitry.

SUMMARY:

Translational neuroscience research bridges the divide between rapidly growing neuroscience knowledge and its clinical applications for psychiatry. There have been many exciting advances in translational neuroscience research on fear/anxiety and emotional regulation/mood disorders. These advances can influence our thinking in clinical situations and alter how we understand our patients, communicate with them and manage their disorders. It is difficult for the busy clinician, however, to stay abreast of this growing body of research. Additionally, language and knowledge barriers may prevent clinicians from appreciating advances in translational research and benefiting from them, hence the need to “translate the translation.” In this symposium, I will start with an overview of the concepts of fear and emotional regulation from translational neuroscience perspective and what they can teach us about anxiety and depression respectively. Dr. Kerry Ressler from Emory University will describe how his work on understanding the molecular mechanisms of fear learning in animals has led to the development of different approaches to prevent fear acquisition or to enhance fear extinction in patients with anxiety disorders. Dr. Francis Lee from Weill Cornell Medical College will then discuss his work on brain-derived neurotrophic factor (BDNF) on fear extinction in mouse and human and how that informs our understanding of the developmental aspects of the retention and extinction of early acquired fear. Dr. Amit Etkin from Stanford University will provide an overview of his work on neural circuitry for emotion regulation, its alteration in anxiety, depression and post-traumatic stress disorder, and how neuroplasticity-based training or non-invasive brain stimulation targeting this circuitry may provide an avenue for novel neuroscience-derived clinical treatments. Finally, I will present a clinical case and invite the speakers and the audience to formulate it from a translational neuroscience perspective.

NO 1

ALTERED FEAR LEARNING ACROSS DEVELOPMENT IN BOTH MOUSE AND HUMAN

Speaker: Francis Lee, M.D., Ph.D.

SUMMARY:

The only evidence-based behavioral treatment for anxiety and stress-related disorders relies on desensitization techniques based on principles of extinction learning, yet as many as 40% of patients do not respond to this treatment. Converging evidence from human and rodent studies suggests that insufficient top-down regulation of subcortical structures, such as the amygdala, coincides with impairments in diminished prototypical fear extinction learning. Because this top-down prefrontal regulation mediates by prefrontal cortical regions is necessary for mediating successful extinction learning and may determine the efficacy of exposure therapy, during

re-exposure therapy often used as part of cognitive behavioral therapy (CBT), it is important to discern how immaturity in this regulatory circuitry in developing populations influences fear extinction developing populations with immaturities in the circuitry required for top-down control will respond to classic fear extinction paradigms.

NO 2

CONQUERING FEAR: NEUROBIOLOGICAL ADVANCES IN UNDERSTANDING, TREATING, AND PREVENTING FEAR-RELATED DISORDERS, INCLUDING PHOBIAS AND PTSD

Speaker: Kerry Ressler, M.D., Ph.D.

SUMMARY:

Dysregulation of fear in humans contributes to a variety of Psychiatric Disorders, including Phobias, Panic Disorder, and Posttraumatic Stress Disorder (PTSD). The consolidation of conditioned fear involves upregulation of genes necessary for long-term memory formation, and interruption of this process may prevent memory consolidation. In contrast, once a fear memory has formed, it may be inhibited through similar learning processes involved in extinguishing the fear memory. Understanding the molecular mechanisms of fear learning in animals is resulting in new approaches to prevent fear development or to enhance fear extinction in patients with anxiety disorders. He will present both animal studies as well as data from human patients in which these methods, developed in animal models, appear to be efficacious in treating and possibly preventing fear-related disorders.

NO 3

MEASURING AND MANIPULATING EMOTION CIRCUITS IN PSYCHOPATHOLOGY

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

SUMMARY:

The commonality of excessive, uncontrollable negative emotion across anxiety and mood disorders suggests a core deficit in emotional reactivity and regulation. I will discuss work in the lab defining a neurobehavioral system, involving the anterior cingulate, amygdala, and lateral prefrontal cortex, that is involved in emotional reactivity and regulation. Activity and connectivity within this circuit are perturbed in patients with anxiety and mood disorders, including both changes shared across disorders as well as disorder-specific abnormalities. These findings support the hypothesis that dysfunction in neural circuitry that handles emotion lies at the core of these disorders, and that validated tools are now available for objectively assessing this neural system. Finally, I will illustrate how insight into emotion-related neurocircuitry can drive novel promising neuroscience-based treatments, including through brain training and non-invasive brain stimulation.

SYMPOSIUM 17

THE IMPORTANCE OF PATIENT TREATMENT PREFERENCE IN CLINICAL OUTCOME

Discussant: Peter Roy-Byrne, M.D.

Chair(s): James Kocsis, M.D., John C. Markowitz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the importance of patient preference as a treatment variable; 2) Understand how patient treatment preference may moderate mood and anxiety disorders; and 3) Appreciate patient preference issues affecting pharmacotherapy versus psychotherapy, and among types of psychotherapy.

SUMMARY:

Patient treatment preference may have an important moderating effect on treatment outcome. It makes sense that patients might have strong feelings about receiving treatment with medication versus psychotherapy, or about drastically differing psychotherapeutic approaches. It further seems intuitive that patient preference might influence the treatment alliance and treatment outcome. Randomized trials assign patients to treatment, yet this potentially crucial moderator remains understudied. This symposium will present findings on patient preference from four large randomized treatment trials of mood and anxiety disorders. James Kocsis, M.D. will present data from a multisite study comparing pharmacotherapy, psychotherapy, and their combination as treatments for chronic depression. Dana Steidtmann, Ph.D. will present data from a different study of chronic depression comparing medication with or without one of two different psychotherapies. Boadie Dunlop, M.D. will describe negative findings from a randomized trial of a serotonin reuptake inhibitor and CBT. John Markowitz, M.D. will report findings from a randomized trial of three considerably differing psychotherapies for patients with chronic PTSD. Peter Roy-Byrne, M.D. will serve as Discussant. These presentations should encourage a vigorous audience discussion.

NO 1

PATIENT PREFERENCE AS A MODERATOR OF OUTCOME FOR CHRONIC DEPRESSION TREATED WITH NEFAZODONE, CBASP

SPEAKER: JAMES KOCSIS, M.D.

SUMMARY:

We report outcomes for patients who participated in an RCT of nefazodone, Cognitive Behavioral Analysis System of Psychotherapy or combination therapy for chronic MDD, and who indicated their preference for type of treatment at study entry. We hypothesized that patient preference would interact with treatment group to differentially affect treatment outcome. There was an interactive effect of preference and treatment group on outcome which varied as a function of preference, and was particularly apparent for patients who preferred one of the monotherapies. Patients preferring medication had better outcomes at study exit if they received medication than if they received psychotherapy. Patients who preferred psycho-

therapy had better outcomes if they received psychotherapy than if they received medication. These results suggest that patient preference is a potent moderator of treatment response for patients with chronic forms of major depression.

NO 2

PATIENT TREATMENT PREFERENCE AS A PREDICTOR OF RESPONSE AND ATTRITION IN THE REVAMP TRIAL

Speaker: Dana Steidtmann, Ph.D.

SUMMARY:

We will present findings on the relationship between treatment preference, and symptom outcome and attrition in REVAMP, a large 2-phase chronic depression treatment trial. Phase I was a 12-week, nonrandomized, open-label trial in which all participants (n=785) received antidepressant medication(s) (ADM). Phase I nonremitters were randomized to Phase II (n=473), in which they received 12 weeks of psychotherapy (1 of 2 types) + ADM (n=193), or ADM only. Treatment preference was assessed at study entry (medication only, combined treatment or no preference). A majority of patients preferred combined treatment. In Phase I, patients with no treatment preference showed greater rates of symptom reduction on the Hamilton Rating Scale for Depression than those with any preference; a medication only preference was associated with higher attrition than a combined preference. In Phase II, baseline treatment preference was not associated with symptom reduction or attrition.

NO 3

PSYCHOTHERAPY TREATMENT PREFERENCES OF PATIENTS WITH CHRONIC PTSD

Speaker: John C. Markowitz, M.D.

SUMMARY:

No research has assessed patients' preferences for PTSD psychotherapies. From an ongoing trial of Prolonged Exposure (PE), Relaxation (R), and Interpersonal Psychotherapy (IPT), we report treatment preferences (TPs) of 87 consecutive randomized patients. Patients with chronic PTSD received balanced scripted therapy descriptions pre-randomization and indicated TPs. Linear regression models assessed factors predicting TPs. Sixty-seven (77%) patients voiced TPs: 22 (25%) preferred PE, 23 (26%) were disinclined; 23 (26%) were pro R, 15 (17%) con; 44 (51%) pro IPT, 2 (2%) disinclined. PE-philes had more past psychotherapy, more distant primary traumas, higher symptom-specific Reflective Function. Comorbid MDD negatively correlated with R. Comorbid bulimia, chronic trauma, and no prior pharmacotherapy predicted IPT preference. Novel findings: Patients preferred IPT despite PE's greater empirical data. Clinical factors influenced TP.

NO 4

THE IMPACT OF PATIENT BELIEFS AND PREFERENCES ON OUTCOMES IN DEPRESSION

Speaker: Boadie Dunlop, M.D., M.Sc.

SUMMARY:

Prior to randomization to 12-weeks of treatment with either an antidepressant medication or cognitive behavioral therapy (CBT), 80 patients with major depression completed a self-report form assessing their beliefs about the causes of their depression, their preferred form of treatment, and the strength of that preference. Matching to preference did not influence remission or completion rates. CBT-preferring patients rarely endorsed unknown causes for their depression, and medication-preferring patients were highly unlikely to identify pessimistic attitudes as a source of their depression. Among patients willing to be randomized to treatment, preference does not appear to strongly influence outcome. Pre-consent education may be critical to reducing the effect of preferences on outcomes in clinical trials. Specific preferences for CBT or medication may reflect differing conceptualizations about depressive illness, knowledge of which may enhance treatment retention and efficacy.

SYMPOSIUM 18**NONPHARMACOLOGICAL TREATMENT INTERVENTIONS FOR PERINATAL DEPRESSION**

Discussant: Katherine Wisner, M.D., M.S.

Chair(s): Mytilee Vemuri, M.D., Katherine Wisner, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify patients with perinatal mood disorders who may benefit from non-pharmacological treatment interventions; 2) Identify and educate patients about non-pharmacological treatment options for depression; 3) Discuss with patients the evidence for using non-pharmacological treatment interventions for perinatal depression; and 4) Implement non-pharmacologic treatments for perinatal depression when appropriate, and/or make appropriate referrals for treatment.

SUMMARY:

Mood disorders during pregnancy can have deleterious effects on mothers, infants, and families. The treatment of perinatal depression can be challenging for clinicians and patients, given the limited safety data of in utero exposure to medications, and the limited evidence for alternative treatments. Interest has been growing in non-pharmacologic modalities for treating perinatal mood disorders, with the assumption that such modalities may offer less risk from in utero exposure. In this symposium, recent concerns about psychotropic medication use during pregnancy, trends in prescribing patterns, patient preferences will be reviewed. Treatment decision making (risks/benefits/alternatives) with patients will be reviewed with specific attention to available alternative treatments to traditional psychotropic medications. The evidence for a select group of non-pharmacological treatment approaches will be reviewed for perinatal depression, including psychotherapy, and nutritional supplements. Recent data on acupuncture and sleep/wake therapies will be presented. Clinical implications and future research implications will be discussed.

NO 1**TREATMENT DECISIONS FOR PERINATAL DEPRESSION: THE NEED FOR NONPHARMACOLOGICAL ALTERNATIVES**

Speaker: Mytilee Vemuri, M.D.

SUMMARY:

The treatment of perinatal mood disorders begins with a risk-benefit discussion of treatment options. Mood disorders left untreated can have a deleterious effect on mothers, infants and families. However, pharmacotherapy also poses potential risks to mothers and developing infants. Evidence-based alternatives to pharmacotherapy that have low risk associated with In utero exposure, and clinical guidelines are needed to provide adequate treatment choices for the perinatal patient with mood disorders. In this presentation, recent concerns about medication use during pregnancy, trends in prescribing patterns and patient preferences towards treatment options will be discussed. The role of non-pharmacological interventions (as potential adjuncts or alternatives to medications) will be described. Current available non-pharmacological treatment options and clinical implications will be described.

NO 2**PSYCHOTHERAPY FOR PERINATAL MOOD DISORDERS**

Speaker: Katherine E. Williams, M.D.

SUMMARY:

Recent concerns regarding the safety of antidepressants during pregnancy has led to a renewed focus on the use of psychotherapy for the treatment of depression in the perinatal patient. We will review the indications for psychotherapy in pregnancy, and the current literature regarding the efficacy of different forms of psychotherapy (IPT, CBT, brief dynamic and supportive) in the perinatal patient.

NO 3**SLEEP AND WAKE THERAPIES IN PREGNANCY AND POSTPARTUM DEPRESSION**

Speaker: Barbara Parry, M.D.

SUMMARY:

Aims: To test the hypothesis that depressed women's (DW) mood during pregnancy or postpartum would improve more with late wake therapy (LWT) vs. early wake therapy (EWT). **Methods:** 21 DW (7 pregnant, 14 postpartum) and 37 healthy women (HW)(24 pregnant, 13 postpartum), mean age 28 years, were randomized in a cross-over design to EWT (sleep 03:00-07:00 h) vs. LWT (sleep 21:00-01:00 h) followed by a night of recovery sleep (RS-22:30-06:30 h). Mood ratings (Hamilton Depression Rating Scale-HDRS) were administered pre- and post-treatment (after RS). **Results:** HDRS scores were reduced by LWT in pregnant ($p=.045$) and postpartum (.016) DW, and by EWT in pregnant (.007) and postpartum (.022) DW. LWT improved HDRS scores by 56.2%; EWT by 29.8% in pregnant and postpartum DW, but

the difference was not significant (ns). Conclusion: Both EWT and LWT reduced depressive symptoms as measured by the HDRS in pregnant and postpartum women. The difference between the treatments was ns.

NO 4 ACUPUNCTURE FOR PERINATAL DEPRESSION

Speaker: Rachel Manber, Ph.D.

SUMMARY:

Acupuncture holds the promise as a safe alternative to antidepressant medications for treatment of depression during pregnancy. When properly implemented, acupuncture has relatively mild and transient side effects. There is limited data regarding the use of acupuncture for perinatal depression, however preliminary studies are promising. Data from a randomized-controlled trial estimating the efficacy of acupuncture for depression during pregnancy will be presented. Fifty-two women were randomized to acupuncture specific for depression, 49 to control acupuncture, and 49 to massage. The short 8-week acupuncture protocol led to symptom reduction and a response rate comparable to those observed in standard depression treatments of similar length and could be a viable treatment option for depression during pregnancy. Implications for clinical applications and future research will be discussed.

NO 5 NUTRACEUTICALS IN THE TREATMENT OF PERINATAL DEPRESSION

Speaker: Kristina M. Deligiannidis, M.D.

SUMMARY:

Nutraceuticals are one of a large number of complementary and alternative medicine (CAM) treatments used for depression. Almost 40% of the adult US population uses a form of CAM treatment and in general, women use CAM treatments more frequently than men. The safety and efficacy of these treatments is of particular importance in the perinatal period when CAM treatments may be preferred by women over conventional psychopharmacologic treatment options, despite less rigorous study than conventional treatments such as synthetic antidepressants. Data from randomized controlled trials will be presented on the safety and efficacy of three commonly available nutraceuticals (i.e. omega-3 fatty acids, folate, and S-Adenosylmethionine (SAME)) in the treatment of depression during pregnancy and lactation.

SYMPOSIUM 19 GERIATRIC PSYCHOPHARMACOLOGY: PERILS TO PEARLS

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

Chair(s): Helen H. Kyomen, M.D., M.S., Iqbal Ahmed, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be

able to: 1) Understand how age-associated physiologic changes alter drug pharmacokinetic and pharmacodynamic effects; 2) Select drugs and dose titration strategies that are most tolerable and effective for the acute, continuation and maintenance phases of treatment in elderly patients; and 3) Address special issues in the treatment of geriatric patients: Treatment of patients with dementia, intervention in extended care facilities, care of treatment resistant elderly patients, management of metabolic syndrome in the elderly, consideration of ethnic issues, and obtaining informed consent.

SUMMARY:

The psychopharmacologic management of geriatric patients is challenging due to (1) age associated physiologic changes that alter drug pharmacokinetic and pharmacodynamic effects, (2) an increased potential for multiple comorbid conditions and drug-drug interactions that may affect treatment, and (3) a greater chance that treatment venue and insurance coverage may impact treatment plans. In this session, participants will learn (a) how age-associated physiologic changes alter drug pharmacokinetic and pharmacodynamic effects, (b) how to select drugs and dose titration strategies that are most tolerable and effective for the acute, continuation and maintenance phases of treatment in elderly patients, and (c) how to address special issues in the treatment of geriatric patients such as treatment of patients with dementia, intervention in extended care facilities, care of treatment resistant elderly patients, management of metabolic syndrome in the elderly, consideration of ethnic issues, and obtaining informed consent.

NO 1 TREATMENT OF DEPRESSION ASSOCIATED WITH COGNITIVE SYMPTOMS AND MEDICAL COMORBIDITY: NAVIGATING BETWEEN SCYLLA AND CHARYBDIS

Speaker: Iqbal Ahmed, M.D.

SUMMARY:

Depression in the elderly is notable for both the presence of medical co-morbidity and cognitive symptoms. Cognitive symptoms may be due to the depression itself, what is referred to as the dementia syndrome of depression and formerly known as pseudodementia. The cognitive symptoms could be due to presence of co-morbid dementia. On the other hand both the depression and cognitive symptoms could be due to a common factor such as cerebrovascular disease. This diagnostic dilemma affects management including the choice of antidepressants and the possible use of cholinesterase inhibitors. The presence of medical co-morbidity complicates the management of depression in the elderly due to the risk of increased adverse reactions to antidepressants including cardiovascular adverse effects such as prolongation of QTc, postural hypotension. Additional risks include risk of falls, SIADH, osteoporosis, bleeding risk, and drug interactions. These issues will be illustrated using a case example.

NO 2 MANAGEMENT OF NONCOGNITIVE SIGNS AND SYMPTOMS OF DEMENTIA/MAJOR NEUROCOGNITIVE DISORDER: THINKING OUTSIDE THE BLACK BOX

Speaker: Helen H. Kyomen, M.D., M.S.

SUMMARY:

The noncognitive signs and symptoms of dementia/major neurocognitive disorder [NCSSD/Mnd] encompass a variety of behaviors including disturbances of activity, mood, thought and perception. They are associated with accelerated cognitive decline, increased functional impairment, increased co-morbid conditions, increased danger to self and others, and decreased mean survival time. Noncognitive signs and symptoms of dementia/major neurocognitive disorder also are associated with increased healthcare utilization, higher risk of early institutionalization and greater caregiver stress and burden. Commonly used nonpharmacologic and pharmacologic interventions for NCSSD/Mnd are moderately effective, at best. In this session, the evaluation and treatment of an elderly patient with NCSSD/Mnd will be presented, and potential alternative interventions will be discussed.

NO 3 ANTIPSYCHOTICS AND THE METABOLIC SYNDROME: PECULIARITIES OF THE LATINO ELDERLY PATIENT

Speaker: Bernardo Ng, M.D.

SUMMARY:

Epidemiological studies have identified Latinos in the US to have a prevalence of metabolic syndrome of 44%, compared to 31% in Caucasian populations. Studies in the mentally ill across ethnic groups report a prevalence of 40-60%. Preliminary studies suggest that the Latino vs. Caucasian difference is greater in elderly mentally ill patients, with findings up to 83% and 57%, respectively. This case vignette is of a Latino patient on antipsychotics and with metabolic syndrome. The range of comorbidities will be analyzed, and potential treatment plans will be explored. The need for strong psychoeducation and interaction with non-psychiatric physicians will be particularly emphasized. Considerations for patients who have established diabetes and/or hypertension also will be discussed.

NO 4 CASE DISCUSSIONS: PHARMACOKINETICS AND PHARMACODYNAMICS IN THE AGING BODY

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

SUMMARY:

The aging brain and body respond differently to medications. Slower absorption, altered volume of distribution, and especially diminished hepatic metabolism and renal clearance combine to produce higher peak serum levels and longer elimination half-lives for many of the medications we

prescribe. Increased sensitivity to cholinergic antagonists results in greater vulnerability to anticholinergic medications. Co-administration of medications from separate prescribers offers opportunities for adverse drug interactions. Awareness of prescription-related pitfalls and best practices in the care of older adults can improve patient outcomes and reduce untoward complications. In this presentation, discussion of illustrative clinical vignettes will highlight important principles of geriatric pharmacotherapy.

SYMPOSIUM 20 THE OTHER HALF: BORDERLINE PERSONALITY DISORDER IN MEN

Discussant: Joel Paris, M.D.

Chair(s): Antonia S. New, M.D., Marianne Goodman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate familiarity with how male patients with BPD differ from and are similar to females in symptom domains, comorbid diagnoses and brain imaging; 2) Learn about the developmental antecedents and treatment trajectories in adolescent males with borderline personality disorder; 3) Recognize that men and women with BPD exhibit different patterns of axis I co-morbidity over time; and 4) Understand the course of treatment in male patients with BPD compared to females.

SUMMARY:

This symposium will cover the neglected topic of Borderline Personality Disorder in men. Dr. Marianne Goodman will present data on antecedents to the development of Borderline Personality Disorder (BPD) in male offspring, by comparing parental survey responses regarding 97 male offspring meeting strict criteria for BPD, and 166 non-BPD male siblings. Findings include a developmental trajectory for male BPD of separation anxiety starting in infancy, body image concerns in childhood, and impulsivity, emptiness and odd thinking in adolescence that differs from female BPD. Parental surveys on course of treatment in a sample of 409 BPD female and 86 male BPD probands showed similar patterns of lifetime high-level care, including hospital, day program and halfway house utilization in males and females, but not for drug/alcohol rehabilitation, which was greater in males. Adolescent male BPD patients received significantly less lifetime psychotherapy and pharmacotherapy than female BPD patients, though duration of medication and psychotherapy were similar. Dr. Antonia New will present data from a large sample of patients with BPD (193 males, 232 females). In this sample, symptoms domains and co-morbidities are remarkably similar between male and females patients with BPD. However, men with BPD show more physical aggression directed towards others and more depression than women with BPD. Women with BPD have a higher rate of reported sexual and emotional abuse in childhood. A subset of these patients participated in brain imaging studies. Functional and structural brain imaging abnormalities were similar in male and female patients with

BPD, differing only in Striatum activity. Dr. Barbara Stanley will present data from a large sample of BPD patients. Her results show that men with BPD report a particularly severe history of aggression, experience higher levels of unemployment, substance abuse, and co-occurring psychopathology than women with BPD, or other males with major mental illnesses. She will also show that men with BPD have higher rates of Antisocial Personality Disorder. A subset of these subjects participated in a treatment trial and data will be presented on similarities and differences in treatment course between men and women. Dr. Mary Zanarini will present data from a large extremely well-characterized longitudinal study over 16 years in a sample of 57 men and 233 women with BPD patients. She will show that patterns of longitudinal co-morbidity are strongly influenced by gender in patients with BPD. Dr. Joel Paris will be the expert discussant for this panel.

NO 1 MEN WITH BORDERLINE PERSONALITY DISORDER: CHARACTERISTICS AND COMORBIDITIES

Speaker: Antonia S. New, M.D.

SUMMARY:

Objective: Empirical studies show that BPD is more prevalent in men than was previously thought. This study aimed to learn more about the clinical presentation of men with BPD and to explore sex-specific brain imaging findings to understand better this under-studied group. Method: 193 men and 232 women with BPD were recruited through clinical referral and advertisement for research participation. Diagnoses were made with the SCID-I and SIDP-IV. Subjects completed assessments across a number of symptom domains, including interpersonal functioning. A subset of patients participated in brain imaging also. Results: Symptoms and co-morbidities were similar between male and female patients with BPD. However, men show more physical aggression towards others; women reported more childhood sexual and emotional abuse. The only sex-specific brain imaging finding was in striatal activity. Conclusions: We will discuss the impact of these sex specific findings on our understanding of BPD in men.

NO 2 DEVELOPMENTAL TRAJECTORIES TO BORDERLINE PERSONALITY DISORDER IN MALE OFFSPRING

Speaker: Marianne Goodman, M.D.

SUMMARY:

To identify precursors and presentation of Borderline Personality Disorder (BPD) in males, anonymous Internet surveys were administered to parents about their BPD adult male offspring and non-BPD adult male siblings. Questions covered aspects of probands' lives, from infancy to late adolescence. BPD offspring were identified through self-reported clinical diagnoses and standardized diagnostic criteria embedded within the survey. Data on 263 male offspring will be presented including 97 meeting strict criteria for BPD, and 166 non-affected male siblings. Results include that parents describe the early emergence of a constellation of symptoms in their

BPD sons that include separation anxiety starting in infancy, body image concerns in childhood, and impulsivity, emptiness and odd thinking in adolescence. This trajectory differs from the developmental course found in females diagnosed with BPD.

NO 3 THE CLINICAL PICTURE OF MALES WITH BORDERLINE PERSONALITY DISORDER

Speaker: Barbara Stanley, Ph.D.

SUMMARY:

While prevalence estimates in clinical settings suggest that Borderline Personality Disorder (BPD) is predominantly a female disorder; large scale epidemiological studies suggest equal proportions of men and women with BPD in the general population. Little is known about the gender-specific features of BPD in males. We report a study of clinical studies comparing males with BPD with females diagnosed with BPD. Generally, men had higher levels of psychopathology. In particular, men were higher in aggression, had a history of more aggressive behaviors, higher in suicide ideation, more likely to have co-morbid substance use disorder and antisocial personality disorder. In addition, functional status of male BPD individuals was poorer, a lower rate of employment than their female counterparts. In this presentation, we will describe how these clinical characteristics are manifest in different presentations in treatment and how treatment can be altered to accommodate these differences.

NO 4 GENDER DIFFERENCES IN AXIS I PSYCHOPATHOLOGY REPORTED BY BORDERLINE PATIENTS OVER 16 YEARS OF PROSPECTIVE FOLLOW-UP

Speaker: Mary Zanarini, Ed.D.

SUMMARY:

Objective: The purpose of this study was to compare the axis I psychopathology reported by men and women with borderline personality disorder (BPD) over time. Method: The SCID I was administered at baseline to 57 men and 233 women with BPD and re-administered at eight contiguous two-year follow-up waves. Results: All five types of disorder studied declined significantly over time for both men and women with BPD. However, men with BPD were significantly more likely to meet criteria for a substance use disorder and women with BPD were significantly more likely to meet criteria for a mood disorder, PTSD, and an eating disorder. Rates of other anxiety disorders were the same for both genders. Conclusions: Patterns of longitudinal co-morbidity are strongly influenced by gender in patients with BPD.

SYMPOSIUM 21 HIV UPDATE

Chair: Francine Cournos, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the scope and stigma of the HIV epidemic as well as the role of the psychiatrist in prevention and care; 2) Recognize and address aspects of HIV throughout the life cycle from childhood to older age and the end of life; and 3) Recognize and treat the psychiatric manifestations of HIV and AIDS and address the complexities of psychiatric diagnosis and psychopharmacology of HIV care.

SUMMARY:

This symposium is designed to provide a brief overview of the medical aspects of HIV/AIDS and an update on HIV psychiatry for general psychiatrists, psychiatric residents, and other mental health clinicians. HIV is a severe and complex multimorbid medical illness that impacts patients in a variety of ways over the life cycle. Complicating the clinical picture, some patients with HIV may also have comorbid substance use disorders. Understanding the medical and psychiatric aspects of HIV and AIDS can provide psychiatrists with the skills to prevent risk behaviors, decrease morbidity and mortality, and reduce suffering in persons infected with and affected by HIV and AIDS.

NO 1 HIV/AIDS MEDICAL UPDATE: OPTIMIZING MEDICAL MANAGEMENT IN HIV-INFECTED INDIVIDUALS

Speaker: Marshall Forstein, M.D.

SUMMARY:

There are an increasing number of antiretroviral agents being used to treat HIV-infected patients. To successfully diagnose and treat patients with HIV/AIDS, psychiatrists need to understand the biomedical aspects of AIDS as well as patterns of HIV infection in special patient populations. Treating HIV-infected persons, however, is becoming increasingly complex. Research shows that HIV positive people on anti-HIV medications who are virally suppressed to undetectable levels are much less likely to transmit the virus during sex. Beginning anti-HIV medications as soon as possible after infection may not only decrease community transmission, but positively affect the long term health of infected individuals, with the possibility of decreasing.

NO 2 HIV FROM CRADLE TO GRAVE: KEY CONSIDERATIONS ALONG THE LIFE CYCLE

Speaker: Suad Kapetanovic, M.D.

SUMMARY:

Summary: HIV/AIDS is a serious infectious disease that affects people of all ages. With the advent of antiretroviral ther-

apy, HIV/AIDS has become a chronic, manageable infection. This development has brought psychosocial aspects of HIV/AIDS to the forefront of HIV clinical care. Thus, it is becoming increasingly relevant to evaluate associated psychiatric and behavioral factors in the context of the patients' age, development and clinical milestones, as well as to appreciate how the relevance of these factors evolves as persons living with (or at risk for acquiring) HIV age and assume age-appropriate roles in their significant relationships, family, workforce and society. This presentation will provide an overview of some of the key factors to be considered, including perinatal HIV exposure, diagnostic disclosure, adolescent adherence and other risk behaviors, transition from pediatric to adult HIV care, reproductive health and the multifaceted interaction between aging and HIV/AIDS.

NO 3 HIV PSYCHIATRIC DISORDERS

Speaker: Jordi Blanch, M.D., Ph.D.

SUMMARY:

HIV infection and psychiatric disorders have a complex relationship. Being HIV infected could result in psychiatric disorders as a psychological consequence of the infection or because of the effect of the HIV virus on the brain. Disorders may be as varied as depression, post-traumatic stress disorders, anxiety, sleep disorders, grief or serious mental illness. In addition, psychiatric conditions may predispose individuals to acquiring HIV infection (through high risk behaviors), and/or create a barrier to medical care, communication with clinicians, and adherence to medical recommendations. This presentation will review the assessment and diagnosis of HIV-related psychiatric disorders and discuss current treatment modalities.

NO 4 SUBSTANCE USE DISORDERS IN PATIENTS WITH HIV

Speaker: Philip Bialer, M.D.

SUMMARY:

Summary: Substance abuse and addiction have always been inextricably linked to HIV/AIDS. For many years, people often believed that this connection was due only to injection drug use and needle sharing. However, this way of thinking greatly underestimates the impact that substance use and abuse can have on the prevention of HIV/AIDS and disease management. Substance abuse affects judgment and can lead to high-risk behavior, and facilitate the progress of HIV infection by further compromising the immune system. Moreover, substance abuse and psychiatric disorders commonly occur together. This form of dual diagnosis is notable because it complicates assessment and makes treatment more difficult for both psychiatric and drug abuse problems.

SYMPOSIUM 22 UPDATE ON TREATMENT OF PERSONALITY DISORDER TRAITS

Discussant: Alan F. Schatzberg, M.D.

Chair: James Reich, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize some underlying biological bases of personality traits and understand how that could be used as a rationale for drug treatment; 2) Identify common aspects of different psychotherapy techniques for personality disorder traits that could be used in practice.;3) Recognize commonalities of personality disorder treatment studies which could be used as part of an office based practice of psychiatry; and 4) recognize how group treatment techniques can be of value in treating personality disorder traits.

SUMMARY:

Treatment of personality disorder traits has continued to evolve over time. This symposium will look at the status of various modalities for treatment. There will be a look at treatment based on the underlying brain pathology and specifically targeting these deficits. Recent biological research has created intriguing possible approaches to treatment. This talk will include current status of drug treatment for personality traits. Psychotherapy has always been a mainstay of treatment for personality traits. A presentation will examine common the key elements of different psychotherapy approaches for personality disorder traits and explain how to incorporate some of these common approaches into clinical practice. This will focus especially on diagnosis and assessment of personality traits as they relate to treatment. As clinicians in office practice treat personality traits, often without extensive support, there will be a presentation on the approach for a non-specialist psychiatrist. Major personality trait treatment studies will be reviewed and findings relevant for office practice highlighted. Group treatments and interactions have always been a robust and effective treatment modality. A presentation will review the recent empirical findings on this approach related to personality traits, discuss how they may relate to biological factors. Also discussed will be how they can be incorporated into ordinary psychiatric practice.

NO 1 NEW DIRECTIONS IN THE NEUROPSYCHOPHARMACOLOGY OF PERSONALITY DISORDER AND POTENTIAL IMPLICATIONS FOR CLINICAL TREATMENT

Speaker: Larry Siever, M.D.

SUMMARY:

Pharmacologic interventions in the personality disorders have generally targeted specific symptom dimensions within or across personality disorder diagnoses. Thus psychotic-like symptoms, affective instability, impulsive aggression, cognitive impairment, interpersonal disturbance, anxiety, and psychopathy may all be domains targeted by pharmacologic treatments

with new interventions suggested by recent research. Novel antipsychotic interventions have targeted psychotic-like symptoms. D1 receptor and alpha 2 receptor agonists may ameliorate cognitive impairment. 5HT2A antagonists and 5HT2C agonists show future potential for impulsive aggression. Neuropeptide interventions and glutamatergic antagonists may represent promising new directions for the affective instability, while oxytocin and opioid-related interventions may have promise for interpersonal symptoms. Biomarkers may also help select treatment responsive populations

NO 2 THE ROLE OF DIAGNOSIS AND ASSESSMENT IN THE TREATMENT OF PERSONALITY DISORDERS

Speaker: John Livesley, M.D., Ph.D.

SUMMARY:

The introduction of trait dimensions in DSM-5 creates the opportunity to re-evaluate the relationship between diagnosis, assessment, and treatment planning. Current therapies for personality disorder pay little attention to assessment and treatment planning other than establishing a categorical diagnosis prior to implementation of a fixed treatment protocol. The extensive heterogeneity of personality diagnoses and modest relationship between diagnosis and intervention strategies suggests the need for a detailed assessment of those aspects of personality pathology that are more closely related to the typical level of clinical intervention. Assessment of severity, salient traits, and domains of pathology will be discussed as viable alternatives to categorical diagnosis.

NO 3 HOW EMPIRICAL STUDIES OF PERSONALITY TRAIT TREATMENT INFORM OFFICE-BASED PRACTICE

Speaker: James Reich, M.D.

SUMMARY:

There is now a body of treatment research on personality traits. These studies usually take place in a university or specialized treatment setting far different from the setting where the office clinician practices. Many of the techniques used in these studies require extensive training that most office based psychiatrists often have not completed. This presentation will review some key treatment studies using various modalities of treatment. It will then translate some of these findings as suggestions to office based psychiatrists. Not all of the techniques will transfer of course. On the other hand the office based clinician may have the flexibility to focus on an individual's specific needs with techniques drawn from a variety of modalities that may be highly beneficial to an individual patient.

NO 4 INTEGRATING SOCIAL PSYCHOLOGY INTO PSYCHOTHERAPY FOR PERSONALITY DISORDER TRAITS

Speaker: David Allen, M.D.

SUMMARY:

Psychotherapy treatments that have been subjected to outcome studies are all based on theories that include a major focus on family of origin relationships, yet often the immense literature on social psychology and attachment is ignored in designing treatment strategies. These treatments focus on symptoms and not enduring aspects of personality and positive interpersonal relationships. Neurobiological research often assumes that differences seen on fMRI scans are pathological, when they may instead be the result of neural plasticity in response to repetitive interpersonal interactions. This talk will present emerging models of integrating the various therapies that focus on personality disorder traits with a more comprehensive view of human functioning. Models discussed will include those of the members of the Unified Psychotherapy Project, which aims for integration of existing paradigms in psychiatry and consilience with knowledge from other disciplines.

SYMPOSIUM 23 ANXIETY DISORDERS IN DSM-5

Chair(s): Michelle Craske, Ph.D., Katharine A. Phillips, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about DSM-5 diagnostic criteria for panic attacks, panic disorder and agoraphobia; 2) Learn about DSM-5 diagnostic criteria for social anxiety disorder and separation anxiety disorder; and 3) Learn about DSM-5 diagnostic criteria for specific phobia, selective mutism, and generalized anxiety disorder.

SUMMARY:

This symposium will overview the DSM-5 criteria for anxiety disorders. Changes were made based on the latest empirical data and with the aim of simplifying and clarifying the criteria where ever possible. Michelle Craske will provide an initial overview of the changes to the chapter, and specific changes to Panic Disorder, Panic Attacks and Specific Phobia. The core features of Panic Disorder remain the same, albeit now unlinked from the diagnosis of Agoraphobia. Panic Attacks are now described as “Unexpected” and “Expected” Panic Attacks, and are a Specifier applicable to all DSM-5 disorders. The core features of Specific Phobia remain the same, but with deletion of the requirement for individuals over the age of 18 to recognize that their fear and anxiety is excessive or unreasonable. Susan Bogels will present two disorders that have been added: Separation Anxiety Disorder and Selective Mutism. The core features of Separation Anxiety remain unchanged although the wording has been modified to represent the expression of separation anxiety symptoms in adulthood.

Selective Mutism was added given the high level of anxiety in these children. Uli Wittchen will present Agoraphobia, now a separate disorder, with a new set of diagnostic criteria, and Generalized Anxiety Disorder which is essentially unchanged from DSM-IV. Murray Stein will present Social Anxiety Disorder (formerly named Social Phobia), which includes a number of changes such as deletion of the requirement to recognize that the fear and anxiety is excessive or unreasonable, and replacement of the Specifier: Generalized with the Specifier: Performance Only.

NO 1 AGORAPHOBIA AND GENERALIZED ANXIETY DISORDER IN DSM-5: PROPOSED CHANGES AND THEIR RATIONALE

Speaker: Hans-Ulrich Wittchen, M.D.

SUMMARY:

Based on comprehensive reviews of research, the work group proposed: To define Agoraphobia as an independent diagnosis and condition that may or may not be comorbid with panic disorder. This was supported by strong evidence from nosological and psychometric research and had the advantage of simplifying the manual. A second type of mostly minor changes relates to specifying the criteria and wording for Agoraphobia along the lines that were also applied to other anxiety disorders and specifically the phobic disorders. The substantially increased consistency in wording and structure across anxiety is expected to ease the use of the manual for clinicians. For GAD the work group considered in various rounds partly significant changes regarding the label GAD (“Worry Disorder”) and the number and wording of criteria. However, after careful consideration the empirical evidence available prohibited the proposal of a new name and set of criteria; only minor changes were proposed.

NO 2 PANIC ATTACKS, PANIC DISORDER, AND SPECIFIC PHOBIA IN DSM-5

Speaker: Michelle Craske, Ph.D.

SUMMARY:

Panic attacks, now termed as either expected or unexpected, can be recognized as a Specifier for any DSM-5 diagnosis, given the evidence for them to be a marker of onset, severity and chronicity of a number of disorders, including and extending beyond Anxiety Disorders. Aside from being unlinked from Agoraphobia, the diagnostic criteria for Panic Disorder have changed very little. A number of changes have been made to Specific Phobia. These include deletion of the requirement for adults to recognize their fear as being excessive or unreasonable, and the addition of a duration that is typically six months or more. These changes are consistent with changes to the diagnoses of Social Phobia and Agoraphobia. In addition, phrasing has been simplified and made more consistent with comparable phrasing across Social Phobia and Agoraphobia. Finally, the descriptive Specifiers (animal, situational etc) have remained relatively unchanged.

NO 3**SEPARATION ANXIETY DISORDER IN DSM-5**

Speaker: Susan Bogels, Ph.D.

SUMMARY:

Separation anxiety disorder was classified under the first onset in childhood disorders in DSM-IV. As a result, separation anxiety disorder has been overlooked as a disorder for adults. In DSM-5, separation anxiety disorder is classified under the anxiety disorders, and criteria are slightly changed to meet adult expressions of the disorder as well. This presentation will focus on the diagnosis, prevalence, comorbidity, differential diagnosis, development, etiology and treatment of adult expressions of separation anxiety disorder, based on a literature review. The possible intergenerational transmission of separation anxiety from parent to child through rearing practices is highlighted, as well as possibly evolutionary-based developmental aspects of separation anxiety, such as in the transition from adult to parent. Directions for future research and clinical developments are given.

NO 4**SOCIAL ANXIETY DISORDER IN DSM-5**

Speaker: Murray B. Stein, M.D., M.P.H.

SUMMARY:

DSM-5 will see several modifications of the Social Anxiety Disorder criteria. Of note is the change in the specifiers, going from "generalized" in DSM-IV to "performance only" in DSM-5. Rationale and possible pros and cons of this change will be discussed. Also notable is a change in the criterion which had previously precluded diagnosis of social anxiety disorder in the context of physical problems (e.g., obesity; burns; stuttering) that would be observable by others. Rationale for this change will be discussed. Overall, the changes to the Social Anxiety Disorder criteria are rather modest in DSM-5.

SYMPOSIUM 24**BIOMARKER STUDIES OF POSTTRAUMATIC STRESS DISORDER IN COMBAT VETERANS**

Discussant: Thomas Neylan, M.D.

Chair(s): Xiaodan Yan, M.S., Ph.D., Charles Marmar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the biomarkers of PTSD in the neural, genetics, metabolism and neuroendocrine systems; 2) Recognize the relationships across different biological systems with reference to the pathological mechanisms of PTSD; and 3) Improve diagnosis of PTSD with objective biological measurements.

SUMMARY:

This symposium will present the frontier findings from the studies on biological markers of Posttraumatic Stress Disorder (PTSD) in combat veterans. PTSD accounts for about half

of the total mental health burden in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans. Due to limited knowledge about the underlying biological pathology of PTSD, current diagnosis is based on clinical interviews, which suffers from subjectivity and unreliability; discovering biomarkers would not only aid diagnosis, but also push forward redefining PTSD along biological homogeneous dimensions. This symposium will discuss biomarkers discovered from neuro-cognitive functioning, neuroimaging, neurogenetics, metabolic and neuroendocrinology studies. Neurocognitive studies revealed that PTSD was associated with decreased verbal memory, attention, and processing speed performance. Structural neuroimaging studies revealed reduced volumes of hippocampus dentate gyrus CA1 subfield volumes in PTSD. Functional neuroimaging studies revealed hyperactivity in the fear circuitry and hypoactivity in the dorso-lateral prefrontal cortex in resting state, as well as decreased functional connectivity in amygdala-frontal circuitry and default mode network. Neurogenetics studies discovered significant differences between groups in the SNPs of APOE, BDNF and FKBP5. Metabolic studies revealed higher glucose, BMI, BDNF, CRP and pulse in PTSD. Neuroendocrine studies revealed greater cortisol suppression, higher GR sensitivity, higher urinary norepinephrine and lower cortisol in PTSD patients compared to controls. Proteomics studies discovered PKA1[?] as amygdala region-specific. In summary, these multi-dimensional biomarker studies have collectively provided ground-breaking perspectives in understanding PTSD pathology and leading to revolutionary diagnosis criteria.

NO 1**NEUROCOGNITIVE IMPAIRMENT IN COMBAT-RELATED PTSD**

Speaker: Clare Henn-Haase, Psy.D.

SUMMARY:

It has been well-known that there are neurocognitive impairment in PTSD. Our group compared neuropsychological testing scores in veterans with and without PTSD in terms of estimated IQ and their performance in tasks such as digit span, letter-number-sequencing, spatial addition and Wisconsin card sort. 58 OEF/OIF veterans diagnosed as PTSD+ and 87 OEF/OIF veterans diagnosed as PTSD- went through clinical diagnostic evaluations such as CAPS, PDEQ, PDI, anxiety, major depression, lifetime alcohol abuse/dependence and lifetime substance abuse/dependence. PTSD+ subjects demonstrated significantly higher scores of CAPS and PDEQ, PDI, and higher levels of depression and lifetime alcohol abuse. They also completed self-report questionnaires which demonstrated that PTSD+ endorsed higher scores in PCL-M, Mississippi Combat Scale, SCL-GSI, BDI and ETI. PTSD+ showed significantly lower IQ, and poorer performance in the digit span, letter-number-sequencing and spatial addition tasks.

NO 2**NEUROIMAGING MARKERS OF PTSD***Speaker: Susanne Mueller, M.D.***SUMMARY:**

It has been shown that neural changes associated with PTSD can be identified with neuroimaging techniques. We have used structural MRI (by Susanne Mueller) and functional MRI (by Xiaodan YAN) to study combat veterans with and without PTSD. Structural MRI with high resolution T2 image revealed reduced volumes of hippocampus dentate gyrus CA1 subfield volumes (analysis from manual marking) and lower volumes in the RA cingulate, CA cingulate and insula (analysis with FreeSurfer 5.1 which yielded the cortical thickness, volumes and surface measurements of multiple brain regions). Functional neuroimaging studies revealed hyperactivity in the fear circuitry and hypoactivity in the dorsolateral prefrontal cortex in resting state, as well as decreased functional connectivity in amygdala-frontal circuitry and default mode network. Our results suggest the following valuable neuroimaging markers for PTSD, including hippocampal volumetric change and abnormal spontaneous and functional connectivity.

NO 3**NEUROENDOCRINOLOGY STUDIES OF COMBAT-RELATED PTSD***Speaker: Rachel Yehuda, Ph.D.***SUMMARY:**

Much of biomarker research in PTSD has focused on the hypothalamic pituitary adrenal (HPA) axis. Lower circulating cortisol levels and hypersensitivity of cortisol to dexamethasone suppression, are commonly reported abnormalities, although these are not uniformly replicated. Whether cortisol abnormalities distinguish PTSD endophenotypes is unknown, but they may relate to underlying genetic or epigenetic markers. Besides cortisol, other measurements such as neuropeptide Y (NPY), dehydroepiandrosterone (DHEA), adrenocorticotropic hormone (ACTH) and norepinephrine (NE), are also known to relate to resilience or deregulated stress hormone responses. Our study obtained urine and blood samples from OEF/OIF combat veterans, and analyzed the above candidate neuroendocrinology markers. Preliminary results suggest higher NPY and possibly lower cortisol in PTSD+.

NO 4**METABOLIC AND CELL-AGING MARKERS OF PTSD IN COMBAT VETERANS***Speaker: Owen Wolkowitz, M.D.***SUMMARY:**

Combat related PTSD is a strong risk factor for subsequent poor physical health such as hypertension, obesity, and early mortality. We analyzed group differences between combat veterans with (PTSD+) and without PTSD (PTSD-) on multiple anthropometric, metabolic, endocrine, oxidative, neurotrophic and cell aging variables that are potential biomarkers for PTSD. Preliminary analyses showed that PTSD+ group had significantly higher fasting glucose, higher basal metabolic

index (BMI), higher heart rates, higher plasma BDNF, and larger ratio of CD4:CD8 T-cells. Within the PTSD+ group, patients with higher levels of total PTSD symptoms as indexed by SCL-90 scores had shorter telomere lengths. Such preliminary results suggest that PTSD is associated with increased markers of allostatic load and immune system and metabolic dysregulation, as well as possibly accelerated cell aging, which are directly associated with overall psychiatric symptom severity. Updated data will be presented.

NO 5**GENETICS OF PTSD: A STUDY OF COMBAT VETERANS***Speaker: Steve Hamilton, M.D., Ph.D.***SUMMARY:**

Only a minority of individuals exposed to trauma develop PTSD, raising the possibility that individual factors such as genetic variation might influence the propensity to PTSD. Family studies document familial aggregation and twin studies suggest that 30-40% of the risk to PTSD is heritable. Biological hypotheses have suggested genes that might contribute to the susceptibility to stress, such as BDNF, APOE, and FKBP5. We analyzed the SNP profiles of combat veterans with and without PTSD, in order to elucidate the specific genetic variants that may have predictive value about PTSD susceptibility and to identify novel genetic correlates of PTSD and related phenotypes. Our preliminary results suggest significant between-group differences for BDNF SNPs. We also carried out genome-wide associations to develop novel hypotheses for verification in independent cohorts. Such results suggest that genetic variants may serve as proxies for phenotypes that are difficult or expensive to obtain.

NO 6**INFORMATIVE MOLECULAR MARKERS OF PTSD***Speaker: Rasha Hammamieh, Ph.D.***SUMMARY:**

With blood samples from combat veterans with and without PTSD, we conducted panomic, transcriptomic, epigenomic, microRNA and proteomic analyses to identify molecular markers of PTSD. Results revealed dysregulated genes associated with circadian clock, glucocorticoid catabolic process, serotonin uptake, anti-apoptosis, T-cell activation, hemopoiesis, coagulation, wound healing, stress response, negative regulation of catecholamine and epinephrine secretions, negative regulation of dopamine uptake, anti-apoptosis, and histone acetylation. Epigenomic analyses showed that hypermethylated promoter regions were genes involved in neurogenesis and signal transduction whereas hypomethylated genes were involved in metabolism, and organ development and were largely localized in the nucleus. MicroRNA and proteomic analyses showed good sensitivity and specificity to identify individuals with PTSD.

SYMPOSIUM 25**SUBSTANCE USE DISORDERS IN DSM-5: EVIDENCE AND CLINICAL IMPLICATIONS**

Chair(s): Wilson M. Compton, M.D., Deborah Hasin, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize and identify new criteria for DSM-5 Substance Use Disorders; 2) Recognize and identify the rationale for changes from DSM-IV; and 3) Recognize and identify the implications of the changes for clinical practice and research.

SUMMARY:

The diagnosis of substance use disorders in DSM-IV had important strengths but also many clearly-identified weaknesses that required change. The DSM-5 Substance-Related Workgroup recommended a set of changes in the criteria for Substance Use Disorders that were designed to preserve the strengths while solving the problems of DSM-IV, based on research evidence from over 200,000 participants and feedback from many professional meetings and several hundred internet postings. In this symposium, the DSM-5 substance-related disorders will be presented. Major changes will be reviewed, including their rationale and clinical implications. One major change pertains to the structure of the disorder. In DSM-IV, two disorders were given, dependence and abuse, with abuse only diagnosed when dependence was not present. While abuse was a problematic diagnosis, dependence had many strengths. In DSM-5, this system will be replaced with one disorder that will be indicated by at least two of eleven criteria (7 dependence, 3 abuse and craving). The diagnostic threshold was selected to maintain consistency in prevalence of substance use disorders between DSM-5 and DSM-IV. Severity indicators (mild, moderate and severe) will also be presented. New criteria for withdrawal for cannabis and caffeine will be introduced, as well as the alignment of the criteria for nicotine disorders with those for the other substances. The DSM-5 approach to substance-induced disorders should eliminate problems from DSM-IV by increasing the clarity of the guidelines for when substance-induced disorders can be diagnosed. The rationale for moving gambling disorders to the same chapter as substance disorders will be reviewed, as well as the state of the evidence for other non-substance, behavioral "addictions". While future studies are needed to continue to address some issues that remain, the recommended changes overcome many problems and are intended to reduce clinician burden given the need to consider only one main disorder rather than two.

NO 1**COMBINING ABUSE AND DEPENDENCE INTO A SINGLE DSM-5 SUBSTANCE USE**

Speaker: Bridget F. Grant, M.S., Ph.D.

SUMMARY:

Revisions for DSM-5 Substance Use and Addictions Chap-

ter include combining abuse and dependence criteria into one Substance Use Disorder (SUD) diagnosis and defining a dimensional indicator of SUD. This presentation will focus on national and international studies, using Item Response Theory analyses that support combining the abuse and dependence categories. Based on over 200,000 participants in over 39 published studies, findings consistently show that: (1) combined DSM-IV abuse and dependence criteria are both indicators of a single disorder, and (2) are intermixed in terms of their severity. These findings are consistent across substances: alcohol, cannabis, cocaine, hallucinogens, inhalants/solvents, nicotine, opiates, sedatives and tranquilizers, and stimulants, and across adults and adolescents, and in U.S. and international studies. No differential functioning by sex, age or race-ethnicity was found.

NO 2**DSM-5 SUD THRESHOLD, CRITERIA CHANGES, SUBSTANCE-SPECIFIC CHANGES RELATED TO CANNABIS, CAFFEINE, AND NICOTINE, AND INTERNATIONAL CONSIDERATIONS**

Speaker: Deborah Hasin, Ph.D.

SUMMARY:

Several other DSM-5 SUD issues were addressed. [1] A diagnostic threshold was needed. Because no specific threshold emerged from analyses, other considerations became important, particularly, the interest in not perturbing overall prevalence rates without reason. Therefore, to determine the best threshold for the newly-defined DSM-5, the prevalence of DSM-5 SUD at different diagnostic thresholds (?2, ?3, ?4) was compared to the prevalence of DSM-IV dependence or abuse in different samples. Prevalence was most similar and agreement best when DSM-5 SUD was defined with a threshold of ?2 criteria, with mild, moderate and severe levels indicated by 2-3, 4-5 and ?6 criteria, respectively. [2] Desire to shorten the criteria list led to dropping legal problems due to lack of evidence that it contributed to diagnosis. [3] Interest in craving as a biologically-based addiction indicator and evidence that craving

NO 3**NON-SUBSTANCE ADDICTIONS IN DSM-5**

Speaker: Charles P. O'Brien, M.D., Ph.D.

SUMMARY:

The Substance Use Disorders Workgroup recommended that pathological gambling (PG) be included in the chapter on substance use disorders. Given overlap with respect to diagnostic criteria, neural substrates, biomarkers, and temperamental and environmental risk factors, PG is more aligned to substance use disorders than impulse control disorders not otherwise specified. Additionally, the Workgroup suggested that the criterion related to committing illegal acts be eliminated and the threshold for diagnosis reduced to 4 of 9 criteria. These recommendations are based on literature reviews showing that illegal acts are rarely endorsed in the absence of multiple criteria, and a reduction in threshold improves diagnostic accuracy. Other potential disorders were also consid-

ered: excessive internet gaming, shopping, eating, and sex.

NO 4 SUBSTANCE-INDUCED DISORDERS IN DSM-5

Speaker: Marc A. Schuckit, M.D.

SUMMARY:

This presentation will review the history of substance-induced disorders in the DSMs, with an emphasis on the steps incorporated in DSM-5. The CNS impact of substances of abuse, all of which change brain functioning, and some medications is important to psychiatric practice because they can produce symptoms identical to those seen in independent psychiatric disorders. However, the psychiatric syndromes related to substances are likely to clear within a month or less of abstinence and rarely require the same long term treatments that are needed for independent major depressive disorders, schizophrenia, anxiety conditions, sleep disorders, and similar DSM diagnoses. DSM-5 approaches to these conditions continue the same basic approach as in DSM-IV but with a greater emphasis on full blown, clinically relevant syndromes that meet, or come close to meeting, the independent disorder.

MAY 19, 2013

SYMPOSIUM 26 FRONTOTEMPORAL DEMENTIA: WHERE NEUROLOGY AND PSYCHIATRY MEET

Chair: Bruce L. Miller, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the main clinical presentations of frontotemporal dementia; 2) Explain how degeneration of specific neuroanatomical systems gives rise to specific behavioral dysfunctions and the role of von Economo neurons in neuropsychiatry; 3) Identify the risk for psychiatric misdiagnosis of patients with neurodegenerative disorders; and 4) Describe the diagnostic clues that can be used to distinguish primary psychiatric disorders from neurodegenerative diseases.

SUMMARY:

Frontotemporal dementia is a common but understudied degenerative condition that causes massive psychiatric dysfunction related to disinhibition, overeating, apathy, loss of empathy and decreased executive control. It presents psychiatrically but is driven by a well-understood degeneration of specific brain circuits involved in social control. This panel will focus on the new biology and neuropsychiatry related to emotions, brain circuitry, behavior, neuropathology and molecules associated with this fascinating disorder. The course will offer new insights into the anatomic basis for neuropsychiatric conditions, accurate diagnosis and appropriate treatment earlier. This symposium will introduce participants to the latest diagnostic techniques and algorithms for understanding frontotemporal and subcortical frontal circuits.

NO 1 FRONTOTEMPORAL DEMENTIA NEUROPATHOLOGY AND VON ECONOMO NEURONS

Speaker: William W. Seeley, M.D.

SUMMARY:

Each neurodegenerative disease begins within a small, localized neuronal population before spreading throughout a large-scale distributed network. In the behavioral variant of frontotemporal dementia (bvFTD), early degeneration targets the von Economo Neurons (VENs), large bipolar Layer 5 projection neurons confined to the anterior cingulate and frontoinsular cortices. These regions anchor a cohesive “salience network” in humans and participate in diverse autonomic, social, and emotional functions. Because the VEN-rich and bvFTD-targeted regions have been widely implicated in psychiatric illnesses such as obsessive-compulsive disorder, schizophrenia, and autism, bvFTD anatomical studies have become a powerful model for understanding psychiatric illness and human social-emotional function.

NO 2 CONNECTIVITY NETWORKS INVOLVED WITH FRONTOTEMPORAL DEMENTIA AND BEHAVIOR

Speaker: Suzee Lee, M.D.

SUMMARY:

Early-stage neurodegenerative syndromes are associated with atrophy in distinct “intrinsic connectivity networks” (ICNs), derived using task-free functional connectivity MRI (fcMRI). ICNs are defined as synchronous, low frequency (< 0.08 Hz) fluctuations in blood oxygen level-dependent (BOLD) signal within gray matter regions, and a set of consistent ICNs has emerged in human studies. This talk will focus on ICNs that are atrophied in frontotemporal dementia whose functions involve visceromotor processing of salient stimuli, task control and semantic processing. Neuroanatomical and behavioral correlates will be emphasized.

NO 3 IMAGING AND IMPLICATIONS FOR PSYCHIATRY

Speaker: Howard J. Rosen, M.D.

SUMMARY:

The neuropsychiatric features of FTD bear a striking resemblance to those seen in typical psychiatric syndromes. The similarities are so strong that many patients with FTD are diagnosed with a psychiatric syndrome, often several years prior to the ultimate diagnosis of dementia. Comparison of structural and functional imaging abnormalities in FTD and non-neurodegenerative psychiatric disorders reveals that both types of disorders affect the same brain networks. This overlap explains the similarity of symptoms, but more importantly it suggests opportunities for future work that can facilitate earlier diagnosis of neurodegenerative disease, and provide more insight into the origins of psychiatric symptoms. The talk will review these areas of anatomical overlap and how they can be used to advance clinical care and research.

NO 4 NEW APPROACHES TO MEASURING SOCIAL FUNCTION AT THE BEDSIDE

Speaker: Katherine Rankin, Ph.D.

SUMMARY:

Diagnosis of behavioral variant frontotemporal dementia (bvFTD) relies primarily on evaluation of patients' behavior, yet objective measures of socioemotional functioning are still only rarely incorporated into standard neuropsychological testing batteries. However, quick, precise, well-validated measures of socioemotional behavior in such patients do exist. The behavioral features of bvFTD will be described in the context of the intrinsically connected neural networks underlying social cognitive processes like personality, empathy, emotional experience, reading social cues, theory of mind, and adherence to social norms. Tests used to examine socioemotional cognition and behavior clinically at the bedside will be described, and the structural and functional neuroanatomic correlates of test performance will be examined, discussing how social cognition networks are revealed by brain-behavior analyses of functional connectivity and focal atrophy patterns seen in patients.

NO 5 MEASURING EMOTIONS IN FRONTOTEMPORAL DEMENTIA

Speaker: Virginia E. Sturm, Ph.D.

SUMMARY:

Emotional alterations are common in FTD. Laboratory measurement of emotion is an effective approach to quantifying emotional and social deficits in patients with neurodegenerative disease. By measuring multiple aspects of emotion (i.e., autonomic reactivity, facial behavior, and self-reported experience), we have identified specific areas of emotional preservation and loss in patients with FTD. Although simple emotional reactivity is spared in FTD, emotions including embarrassment and disgust are impaired. In this talk, we will discuss the clinical and behavioral implications of emotion-specific deficits and their relation to specific patterns of neural loss.

SYMPOSIUM 27 THE INTERFACE BETWEEN PSYCHIATRY AND THE CRIMINAL JUSTICE SYSTEM: RECENT PER- SPECTIVES FROM EUROPE

Chair: Michael Doyle, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify recent developments in developing national commissioning guidelines for prison mental health care; 2) Understand the interface between prison and secure psychiatric services and discuss policy and clinical implication; 3) Recognize the challenges in diverting prisoners with mental health problems into health care services; and 4) Highlight the risk factors associated with suicide in serious violent and sex offenders.

SUMMARY:

The Bradley Report (2009) highlighted the problems facing health care services in England and Wales in meeting the challenge of providing mental health services to prisoners. The University of Manchester School Of Medicine have conducted research to address some of the challenges presented. This symposium will provide an overview of four contemporary research studies designed to investigate the interface between psychiatric services and the criminal justice system. The development of commissioning guidelines and new models of care will be presented. Problems with the interface between prison and psychiatric services and the implications will be discussed. Results of a recent evaluation of mental health liaison and diversion services will be shared and the data on the elevated risk of suicide associated with violent offenders will be presented.

NO 1 NATIONAL COMMISSIONING GUIDELINES FOR PRISON MENTAL HEALTH CARE IN ENGLAND

Speaker: Jenny J. Shaw, Ph.D.

SUMMARY:

The prevalence of mental health problems in prisons worldwide is significantly greater than corresponding rates in the community. Prison should provide an opportunity to engage a disengaged, socially disadvantaged group with complex needs. Instead prisons provide disjointed care in 'silos'. For example, physical and mental health care, substance misuse treatment and resettlement provision are not integrated and there are few robust links back into the community on release. Getting this right would improve the health and wellbeing of prisoners and hopefully influence the safety of the individual and society with an impact on recidivism. We will describe the development of the national commissioning guidelines for 'joined up' prison mental health in England and the implementation of a comprehensive model of care in one prison in the North of England.

NO 2 DISCHARGES TO PRISON FROM MEDIUM SE- CURE PSYCHIATRIC SERVICES

Speaker: Michael Doyle, Ph.D.

SUMMARY:

In England over the past 10 years, there has been a 40% increase in medium secure psychiatric services. The majority of admissions come from prison. This study will report on findings from a national study evaluating 829 discharges from 34 medium secure units in England and Wales in 2010/11. Early findings revealed that twice as many patients than expected were discharged back to prison and of these over two-thirds were diagnosed with a mental disorder; half had a psychotic disorder and over a third were diagnosed with schizophrenia. Comparisons between those who were discharged to prison and those who were discharged to the community revealed that prison discharges were significantly more likely to be experiencing symptoms of mental illness and personality dis-

order and more likely to be adjudged as a risk to others. Policy and clinical implications will be discussed and future research priorities will be highlighted.

NO 3 EVALUATION OF CRIMINAL JUSTICE DIVERSION AND LIAISON SCHEMES

Speaker: Jane Senior, Ph.D., R.N.

SUMMARY:

Criminal Justice Mental Health Liaison and Diversion services, designed to divert people with mental illness away from the criminal justice system, have proliferated in England and Wales over the last twenty years. They are universally regarded to be a “good thing”, but there is no robust body of research evidence to support the belief that they improve the health, social or criminal outcomes of people who are in contact with them. The Department of Health commissioned the Offender Health Research Network to review current practices around liaison and diversion and make a number of recommendations for future service development. Site visits and telephone conferences were undertaken with 21 schemes using a semi-structured interview schedule. This presentation will identify their referral processes, methods of screening, assessment and onward referral, and outline the problems identified with service provision, funding, core tasks, and inclusion/exclusion criteria.

NO 4 NATIONAL STUDY OF SUICIDE RISK IN VIOLENT AND SEXUAL CRIMINAL OFFENDERS

Speaker: Roger T. Webb, Ph.D.

SUMMARY:

Suicide risk among violent or sexual offenders has not been accurately or precisely quantified. We conducted a population-based nested case-control study of 27,219 cases matched to over 0.5 million living controls by age and sex. Fully interlinked Danish national registers identified all criminal charges and convictions since 1980, all psychiatric admissions from 1969, and all adult suicides during 1981-2006. We estimated relative risk against people without criminal justice history. Male sexual offenders had elevated suicide risk, but their risk was no higher than that seen in male property offenders. Relative risk was especially high among violent men and women, and risk increased with rising severity of violence. Fatal self-poisonings with narcotics were greatly overrepresented among the violent offender suicides. Our findings indicate a clear need for developing effective multi-agency strategies to effectively target people at raised risk of internalised and externalised violence.

SYMPOSIUM 28 WOMEN'S REPRODUCTIVE ISSUES IN MENTAL HEALTH: UPDATES AND CONTROVERSIES

Discussant: Carol C. Nadelson, M.D.

Chair: Gisèle Apter, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the different women's mental health issues linked to the reproductive cycle; 2) Address and manage women's mental health issues in diverse situations meeting specifically gender oriented needs during the reproductive cycle; and 3) Be updated on benefit/risk of pharmacological treatment and management of medication of the pregnant and lactating woman integrating maternal, infant and mother-infant relationship well-being.

SUMMARY:

Reproductive issues on women's mental health are still to be adequately recognized, addressed, managed and treated. They remain minimized, undervalued, and even denied. Even if some progress has been made, it remains fragile. Description of worldwide situations and how they may specifically be addressed still need to be established. Improvement of women's mental health is a necessity for good health and community development. Poor mental health is associated with social disadvantage, human rights abuses and poor health and productivity, as well as heightened risk of mental illnesses. Therefore we need to address issues in reproductive issues and women's mental health as basis for major prevention and care of women, mothers and their infants. Choice of reproduction remains a major issue. Scientific data has shown that improved access to contraception and abortion jointly enhance both maternal and infant health. When the risk of infertility appears, management of women should be available, addressing its specific stress and anxiety. Risks and benefits of treating psychiatric disorders ie mood and anxiety disorders with or without personality disorders during pregnancy and the postpartum are constantly in need of being reassessed and tailored to meet individual requirement. Recently controversial studies have underlined risk to infant of diverse maternal medication. Methodological issues and benefit/risk evaluation of mother, infant and mother-infant relationship need to be highlighted in order to establish the best available tailored care. An update in psychotropic and non-psychotropic treatment during the peripartum will be described. We will give specific attention to how gender and social policy have implications for promoting women's mental health. The major issue is how to preserve maternal and infant mental health, preventing negative impact of maternal mental health issues while addressing and treating as best as possible maternal psychiatric and psychological issues. A general comprehensive discussion encompassing reproductive women's mental health issues will complete our presentations.

NO 1 PROMOTING WOMEN'S MENTAL HEALTH: PRE- VENTION AND TREATMENT TOGETHER

Speaker: Helen Herrman, M.B.B.S., M.D.

SUMMARY:

Findings from research on women in primary health care suggest that mental health and empowerment are closely aligned concepts. Primary health care programs can indi-

rectly promote mental health by addressing its determinants through empowerment; by enhancing social unity, minimising discrimination and generating income opportunities. Promotion, prevention and treatment are all needed strategies for reducing the burden of mental illness and improving mental health. The World Health Organization (WHO) has recently published reports on mental health promotion and women's mental health, highlighting the emerging evidence base for effective public health actions. Tackling important social and health problems such as violence at home, and maternal and child health requires interventions that focus on assertiveness and appropriate participation in communities, as well as empowering health workers to recognize problems and intervene effectively.

NO 2 ABORTION DOES NOT CAUSE MENTAL ILLNESS

Speaker: Nada Stotland, M.D., M.P.H.

SUMMARY:

Allegations that abortion causes psychiatric disorders have convinced much of the public and provide the rationale for restricting abortion access. Publications supporting these contentions are fraught with methodological lapses: lack of information about pre-abortion mental status; failure to consider the factors leading the women to terminate the pregnancy; lack of appropriate control or comparison groups; and unscientific manipulations of data. Credible research reveals that the factors leading to the decision to abort, including poverty, abandonment, domestic violence, a lack of social supports, the need to care for existing dependents, and psychiatric symptomatology, are themselves psychosocial stressors, exacerbated by the presence of anti-abortion demonstrators at abortion facilities. Anti-abortion rhetoric, shockingly, often neglects to consider the risks of childbirth and the obligations of parenting for women who continue their pregnancies.

NO 3 INFERTILITY AND ITS CONSEQUENCES: ASSISTED REPRODUCTIVE TECHNOLOGY (ART) OR NO ART

Speaker: Malkah T. Notman, M.D.

SUMMARY:

This presentation will focus on the psychological aspects of infertility and the issues that women are faced with when confronted with a diagnosis of infertility. Different assisted reproductive techniques are available today that represent yet another set of emotional hurdles to overcome. An update and discussion on how to help women obtain the support they need and make informed decisions on which treatments they wish to go through will be highlighted.

NO 4 DECISION MAKING REGARDING PSYCHOPHARMACOLOGY DURING THE PERIPARTUM

Speaker: Gail E. Robinson, M.D.

SUMMARY:

Women who have a previous mental health disorder are at increased risk for having a recurrence during pregnancy or postpartum. Women who are still on psychotropic treatment fear that their medication may cause a miscarriage or harm the fetus, however, almost 70% of women who discontinue medication have a relapse during pregnancy. Multiple publications claiming problems to the baby if the mother takes medication add to the dilemma about how to choose an effective treatment. This presentation will address the need for critical review of the literature and how to weigh the risks and benefits of psychopharmacology during pregnancy and postpartum. A practical approach to decision making will be presented.

NO 5 THERAPEUTIC MANAGEMENT, PSYCHOTROPIC MEDICATION, AND THE POSTPARTUM

Speaker: Gisèle Apter, M.D., Ph.D.

SUMMARY:

Advantages and inconvenience of breastfeeding for the mother ie lack of sleep are a major issue. Taking state of the art knowledge on later development of infant and maternal health into account, a number of psychotropic medications, with the exception of Lithium are compatible with breastfeeding. However, controversial studies tend to add to maternal worry about use of medication during lactation while strongly advocating for breastfeeding. Women and physicians often neglect the fact that new mothers need to be able to care for themselves with adequate management of their mental health, in order to cope with the stress linked to the care of a newborn. Updated guidelines of safety of medication and the latest research on psychotropic medication during lactation, infant development, and the mother-infant relationship will be discussed.

SYMPOSIUM 29 SMOKING AND ADHD COMORBIDITY: MECHANISMS AND CLINICAL IMPLICATIONS

Discussant: Nora D. Volkow, M.D.

Chair(s): Yu Lin, M.D., Ph.D., Scott H. Kollins, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the general association between a diagnosis of ADHD and risk for cigarette smoking; 2) Identify at least 3 possible mechanisms that underlie the link between ADHD and smoking; and 3) Recognize the evidence-based treatment options for patients with comorbid ADHD and nicotine dependence.

SUMMARY:

ADHD affects millions of children, adolescents, and adults in the United States and is a significant independent risk factor for a range of adverse smoking outcomes. In spite of the well-described associations between a diagnosis of ADHD and smoking, relatively less is known about the specific factors that confer risk for smoking and nicotine dependence, or how

to effectively reduce such risk and to treat individuals with comorbid ADHD and nicotine dependence. This symposium will convene researchers addressing this critically important public health problem from a range of perspectives. In the first talk (Dr. Kollins), data will be presented on how ADHD symptoms confer risk for smoking outcomes in the general population, along with findings from human laboratory studies on the specific genetic, psychopharmacological, and behavioral processes that are likely to underlie this risk. In the second talk (Dr. Pelham), psychosocial factors that influence the development of cigarette smoking in adolescents with and without ADHD will be described, including both child and parent variables. In the third talk (Dr. Winhusen), results from a large-scale clinical trial of osmotic-release methylphenidate in adult smokers with ADHD will be presented, including data regarding smoking cessation outcomes and other important findings. In the fourth talk (Dr. Newhouse), the role of the nicotinic-acetylcholine receptor system in cognition will be described, along with how this receptor system may be critically involved in smoking and nicotine dependence in individuals with ADHD. Finally, Dr. Nora Volkow, Director of the National Institute of Drug Abuse, will integrate these studies as a Discussant, with insight into how they may collectively inform a research agenda to help reduce the burden of this common comorbidity.

NO 1 GENETIC, NEUROBIOLOGICAL, AND BEHAVIORAL MECHANISMS UNDERLYING ADVERSE SMOKING OUTCOMES IN INDIVIDUALS WITH ADHD

Speaker: Scott H. Kollins, Ph.D.

SUMMARY:

Data from a series of epidemiological, laboratory and neuroimaging studies of adults with and without ADHD will be described to address critical questions on the increased rates of smoking among individuals with ADHD: How do genetic factors contribute risk for the development and maintenance of cigarette smoking in individuals with and without ADHD? Are there differences between individuals with and without ADHD with respect to brain functioning following acute abstinence and do stimulant drugs influence these differences? Is smoking more reinforcing for individuals with ADHD versus those without ADHD? Findings from these studies suggest that there are important components of the ADHD phenotype that contribute to smoking risk and withdrawal severity, and that these are likely to be moderated by genetic factors. Clinical implications of the findings will be addressed with respect to the development of effective prevention and treatment strategies to reduce the comorbidity.

NO 2 NICOTINIC CHOLINERGIC SYSTEM MODULATION OF EXECUTIVE FUNCTION IN ADHD: IMPLICATIONS FOR TREATMENT AND SUBSTANCE USE

Speaker: Paul Newhouse, M.D.

SUMMARY:

ADHD patients have significant executive function deficits that lead to functional impairments such as ADHDemic and relationship difficulties, automobile accidents, and occupational difficulties. One component of executive function, behavioral inhibition, has emerged as a promising intermediate phenotype for ADHD studies. Human studies in our laboratory have found that stimulating nicotinic acetylcholine receptors can improve behavioral inhibition and alleviate ADHD symptoms and blocking nicotinic receptors worsens laboratory measures of executive function in ADHD subjects. Nicotinic stimulation thus appears to be a viable treatment strategy to improve cognition, particularly executive dysfunction, and clinical symptoms in adults with ADHD and may shed light on the vulnerability of these patients for sustained tobacco use.

NO 3 NICOTINE USE IN TEENS AND YOUNG ADULTS WITH ADHD: RESULTS FROM THE PITTSBURGH ADHD LONGITUDINAL STUDY

Speaker: William E. Pelham, Jr., Ph.D.

SUMMARY:

Childhood ADHD is a risk factor for nicotine dependence although the reasons for this association and the unfolding of risk over time have not been widely studied. Findings from the Pittsburgh ADHD Longitudinal Study will be described that reveal the role of persistence of ADHD symptoms into adolescence, the limited importance of conduct problems for ADHD-related risk of cigarette smoking, and the role of stimulant treatment particularly as it relates to childhood and adolescent treatment patterns. Our findings show the intriguing association of coping skills (lack of) in relation to cigarette use for teens with ADHD history, the potential importance of negative emotionality (irritability), and the possible contribution of successful parental monitoring to cigarette use by teens with ADHD histories. Together these findings, using two samples of ADHD probands followed prospectively through adolescence, reveal moderating and mediating factors with important clinical implications.

NO 4 THE ROLE OF SELF-MEDICATION, NICOTINE WITHDRAWAL, AND CRAVING IN SMOKING CESSATION OUTCOMES IN ADULT SMOKERS WITH ADHD

Speaker: Theresa Winhusen, Ph.D.

SUMMARY:

Individuals with attention deficit hyperactive disorder (ADHD) smoke at a higher rate and have greater difficulty with smoking cessation. A randomized double-blind placebo controlled study of osmotic-release oral system methylphenidate (OROS-MPH) to treat ADHD in smokers receiving smoking cessation treatment found that in the sample overall, OROS-MPH, relative to placebo, significantly decreased ADHD symptoms but did not improve smoking cessation outcomes. Secondary analyses show that OROS-MPH was superior to placebo in producing smoking abstinence among patients

with more severe baseline ADHD and in those with the greatest improvement in ADHD. OROS-MPH, relative to placebo, significantly decreased withdrawal symptoms without impacting smoking cessation outcome and withdrawal symptoms were not associated with smoking cessation outcome. Rather, craving was associated with smoking cessation outcome and so may be an important therapeutic target.

SYMPOSIUM 30 WOMEN'S HEALTH ACROSS THE REPRODUCTIVE LIFESPAN

Chair(s): Teresa A. Pigott, M.D., Kay Roussos-Ross, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand that hormones fluctuate widely across the female life cycle; 2) Identify the barriers to optimal recognition and treatment of mood disorders in adolescents; 3) Assess the benefits and limitations of current treatments for psychiatric disorders during pregnancy and the postpartum period; 4) Discuss the potential impact of the perimenopausal period on the course of Bipolar Disorder; and 5) Discuss the potential role of caregiver issues in recognizing and effectively treating depression in older women.;

SUMMARY:

A particular challenge for psychiatrists is the assessment and management of psychiatric disorders in women across the reproductive life cycle. While mood disorders disproportionately affect females after puberty, prompt identification and accurate diagnosis can be challenging. The first speaker, Dr. Dawnelle Schatte will review key diagnostic issues as well as provide an insightful overview of evidence-based treatment strategies designed to circumvent common obstacles and optimize outcome. Dr. Schatte will also discuss techniques to enhance family involvement and improve compliance to treatment. Psychiatric disorders in pregnancy and the postpartum period are common and have profound implications for women and their children. By virtue of her training as both a psychiatrist and as an OB/GYN, our second speaker, Dr. Kay Roussos-Ross is uniquely qualified to provide a comprehensive overview of the management of mood and psychotic disorders throughout pregnancy, delivery, and the postpartum period. There is also increasing data suggesting that the perimenopausal period may have a significant impact on the course of illness in women with pre-existing psychiatric disorders. The third speaker, Dr. Teri Pigott will review the data about psychiatric illness exacerbation during the menopausal transition period and also discuss the potential treatment implication of this finding. Dr. Josepha Cheong, the final speaker, will provide a thoughtful review of many of the psychiatric and psychological issues encountered by women as they enter later life. Dr. Cheong will also present an overview of assessment and management strategies likely to be helpful in addressing mood disorders in post-menopausal women.

NO 1 DIAGNOSIS AND MANAGEMENT OF MOOD DISORDERS IN ADOLESCENCE

Speaker: Dawnelle Schatte, M.D.

SUMMARY:

Estimates of unipolar depressive disorders suggest <1% of children experience depression, but that the prevalence sharply increases after puberty. The one year prevalence of unipolar depression is estimated to be 4-5% by mid-adolescence, with a female preponderance of 2:1 (Thapar et al, 2012). Estimates of the prevalence of bipolar spectrum disorders in adults are close to 6%, with many adults reporting retrospective evidence of illness in adolescence. Some experts suggest the prevalence of bipolarity may be as high as 1% in youth (McClellan et al, 2007). Accurate diagnosis of bipolar disorder can be difficult in adolescent girls due to symptom overlap with other illnesses or developmental factors. The diagnosis is further complicated by the presence of co-existing disorders (especially substance abuse and ADHD). The evidence-based treatments for these disorders will be reviewed, with a particular focus on how to improve compliance and family involvement.

NO 2 MANAGING PSYCHIATRIC DISORDERS IN PREGNANCY AND THE POSTPARTUM PERIOD

Speaker: Kay Roussos-Ross, M.D.

SUMMARY:

Hormone fluctuations occur throughout the reproductive cycle in response to ovulation. During pregnancy and the postpartum period, hormone levels further fluctuate and may lead to relapses or worsening of psychiatric disorders. Frequently, physicians are apprehensive regarding the management of psychiatric disorders in pregnancy, thereby, leaving many pregnant women inadequately treated. Appropriate diagnosis, management, and follow up is imperative in providing both mother and newborn every opportunity for bonding, nurturing and positive outcomes.

NO 3 MENOPAUSAL TRANSITION: A VULNERABLE PERIOD FOR MOOD, ANXIETY, AND PSYCHOSIS?

Speaker: Teresa A. Pigott, M.D.

SUMMARY:

Perimenopause is characterized by widely fluctuating hormone levels with a large decline in circulating estrogen. Since estrogen may have 'psychoprotective' effects, it is not surprising that there is increasing data suggesting that the perimenopausal period may have a significant impact on the course of illness in women with pre-existing psychiatric disorders. The strongest evidence for perimenopausal illness exacerbation exists with unipolar depression, but there is also evidence that women with Bipolar Disorder have more mood episodes during the menopausal transition period. Perimenopause has also been linked to relapse in Schizophrenic women and also in

women with OCD and Panic Disorder. Psychotropic medication response may also be impacted by menopausal status. Clinicians should be particularly attentive to the influence of the menopausal transition period on the course and treatment of women with pre-existing mood, anxiety, and/or psychotic disorders.

NO 4 KEY PSYCHIATRIC ISSUES IN THE POST-MENOPAUSAL ELDERLY WOMAN

Speaker: Josepha A. Cheong, M.D.

SUMMARY:

As women enter into later life, they face a number of unique psychiatric and psychological issues. Although some issues are directly affected by the physiological effects of menopause, many issues are not physiologically based but are a product of the adult developmental issues in late life. This presentation will focus on the evaluation and management of the various psychiatric and behavioral issues including bereavement, depression, caregiver burden. The psychological and developmental tasks of late life will also be examined within the context of the postmenopausal woman.

SYMPOSIUM 31 EATING DISORDERS THROUGH THE LIFESPAN: EXPLORING DIAGNOSTIC AND TREATMENT CHALLENGES THROUGH VARIOUS LIFE STAGES

Discussant: Erin L. Sterenson, M.D.

Chair: Erin L. Sterenson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify similarities and differences in diagnosis and treatment of eating disorders in a variety of populations, including: adolescents, pregnant women, females with Type 1 Diabetes Mellitus, and the elderly; 2) Describe diagnostic considerations, pharmacologic treatments, and psychosocial interventions for children and adolescents with eating disorders; 3) Describe strategies specific to different life stages to help eating disordered patients reach their nutritional goals; 4) Identify risk factors for development of an eating disorder in Type 1 Diabetes and will become familiar with insulin restriction as a form of caloric purging; and 5) Identify psychological struggles pregnancy may pose for women with eating disorders and will become familiar with pregnancy-related complications associated with concurrent eating disorders.

SUMMARY:

Eating disorders have significant medical and psychiatric consequences and have the highest mortality rate of any mental illness. Practitioners are generally familiar with symptoms of eating disorders (ED), as described in the DSM-IV TR. As providers, we envision our eating disordered patients as young, otherwise healthy, women; 90% of those with eating disorders are female and 95% are between the ages of 12 and 25.8. Our discussion will focus on atypical eating disordered populations, those existing beyond the framework

described above. Each portion of this discussion will highlight assessment and treatment options that can be incorporated into our practices to better manage these unique populations. The team will describe eating disorder presentations during childhood and adolescence. We will highlight developmental issues in this age group and will present specialized assessment and management of patients in this developmental stage. We will review eating disorders in pregnancy. The discussion will focus on assessment and treatment, highlighting the psychological struggles pregnancy may pose for women with eating disorders. Eating disorders can be associated with pregnancy-related complications and those will be discussed. Effective psychotherapeutic and pharmacologic treatment strategies will also be reviewed. We will describe eating disorders as a comorbidity in Type 1 Diabetes Mellitus (DM1), focusing on risk factors for development of an eating disorder, unique methods of caloric purging, screening tools, and treatment options in this population. The team will discuss the frequency with which anorexia and malnourishment are seen in the elderly and how these contribute to increased morbidity and mortality in this population. Finally, a registered dietician will speak on how nutrition therapy may change across the lifespan, speaking particularly on the aforementioned populations.

NO 1 EATING DISORDERS IN CHILDREN AND ADOLESCENTS

Speaker: Leslie Sim, Ph.D.

SUMMARY:

Dr. Sim will describe eating disorder presentations during childhood and adolescence. She will highlight developmental issues in this age group. Dr. Sim will also present specialized assessment and management of patients in this developmental stage. Several cases will be discussed.

NO 2 TYPE 1 DIABETES AND EATING DISORDERS: EXAMINING THE CAUSES, CONSEQUENCES, AND SCREENING TOOLS FOR THE COMORBIDITY

Speaker: Erin L. Sterenson, M.D.

SUMMARY:

Dr. Sterenson will describe eating disorders recognized in Type I diabetics, who have a unique form of weight loss readily available, namely insulin-restriction. This is the most common form of eating disordered behavior among diabetic women. Current screening measures focus on symptoms of ED that overlap with diabetic management and fail to assess for insulin omission and restriction. Dr. Sterenson will focus on specialized screening tools as well as treatment and prevention of eating disorders in Type I diabetics. She will emphasize risk factors for the development of the comorbidity as well as associated complications.

NO 3**EATING DISORDERS DURING PREGNANCY AND POSTPARTUM**

Speaker: Katherine M. Moore, M.D.

SUMMARY:

Dr. Moore will review eating disorders in pregnancy. She will focus on assessment and treatment, highlighting the psychological struggles pregnancy may pose for women with eating disorders. Eating disorders can be associated with pregnancy-related complications and those will be discussed. Effective psychotherapeutic and pharmacologic treatment strategies will be reviewed

NO 4**EATING DISORDERS IN THE ELDERLY**

Speaker: Christina Y. Chen, M.D.

SUMMARY:

Advancing age is accompanied by the presence of numerous physiological changes, increasing number of chronic medical co-morbidities, polypharmacy and social challenges that may all contribute to poor appetite. It was identified that almost 85% of long term care residents suffer from malnutrition, 62% of hospitalized elderly patients and 15% of community dwelling older adults who are seemingly able to prepare their own meals. Weight loss is considered a sentinel event in long term care facilities and associated with increased functional decline, frailty syndrome, poor quality of life and mortality. The best approach to understanding this multi-faceted challenge is evaluation from intrinsic and extrinsic angles.

NO 5**FOOD AS MEDICINE: NUTRITIONAL INTERVENTIONS TO GUIDE EATING DISORDER RECOVERY**

Speaker: Therese Shumaker

SUMMARY:

Nutritional therapy requires expertise in nutritional requirements for the life stage of the affected individual. The foundation of nutritional treatment are nutrition education, meal planning, establishment of regular eating patterns and discouragement of dieting. On one end of the spectrum is the adolescent patient who is especially susceptible to the message that severely restricting calories is necessary for popularity and beauty, and on the other end is the middle aged or older woman or man who has either struggled with the problem for decades or are experiencing it for the first time in their lives. To limit progression of eating disorders, the Registered Dietitian strives to send messages specific to individuals based on the total diet approach, which emphasizes that all foods can fit into a healthful diet.

SYMPOSIUM 32**TRAUMATIC BRAIN INJURY IN CIVILIANS, ATHLETES, AND SOLDIERS**

Chair(s): Michele T. Pato, M.D., Aika Gumboc, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate the similarities and compare the differences between single episode TBI and repetitive TBI/head injury in civilians, athletes, and soldiers; 2) Understand the natural history of a mild traumatic brain injury; 3) Improve diagnosis through the use of neurocognitive and neuroimaging measures; and 4) Compare and contrast a postconcussive syndrome and PTSD; and 5) Apply treatment options for TBI/head injury alone and with comorbid conditions.

SUMMARY:

Interest in head injuries in civilians, athletes, and soldiers has grown with the awareness that these injuries often occur in the pursuit of sports, combat, and everyday life. Not only may the head injury be repetitive, but often it goes undiagnosed and untreated and can result in acute and chronic problems. Not every injury results in a skull fracture or even loss of consciousness, like we often expect to see in a traumatic brain injury (TBI). In addition, head injury, TBI, and psychiatric illnesses can often be comorbid or exacerbate each other, including anxiety disorders, depression, cognitive impairment and memory loss, and substance abuse. The best course of treatment requires making accurate diagnosis(es) of the TBI as well as the psychiatric disorders and understanding how they interact. This course will enlist the help of clinicians from sports psychiatry and military psychiatrists to educate our psychiatric colleagues on how best to diagnose this complex interplay of exposures and how to best treat the array of symptoms with which civilians, athletes, and soldiers with TBI (diagnosed or undiagnosed) may present to their office. We will begin by reviewing the symptoms of traumatic brain injury in general and discuss specific instruments for assessment both neurobiological and psychological. Included will be discussion on the effects of head and neck trauma resulting from participation in sports as one of the most important topics in contemporary sports psychiatry. Then we will discuss basic treatment issues with some emphasis on comorbidity. Psychotherapy will include a discussion of CBT, and other psychotherapeutic interventions to deal with "return to work and play" as well as acute and potential chronic functional deficits. Discussion will include how pharmacotherapy may be challenging in a patient with repetitive TBI and how treating one condition can exacerbate an existing comorbid condition. We will highlight the need to start low and go slow with dose and duration of medications. We will review appropriate pharmacotherapy to use in psychiatric conditions that may exist in the context of head trauma/ TBI. The last session will be to highlight the similarities and difference in both diagnosis and treatment issue in those whose injury comes through military service. So discussion will be given to mild traumatic brain injury that can occur with blunt trauma, shearing forces from rapid acceleration and deceleration and blast exposures. We will discuss that while the natural history of mild TBI is recovery within weeks, a small percentage of individuals may have a persistent postconcussive syndrome (PCS) which can include physical, cognitive, and emotional symptoms. Also, given the context of brain injury in combat situations, PTSD is often co-morbid with PCS. Discussion on how the persistent

symptoms of one or the other or both disorders may overlap complicating diagnosis, treatment, and recovery of PCS and PTSD.

NO 1 DIAGNOSIS

Speaker: David Baron, D.O., M.Ed.

SUMMARY:

This presentation will begin by reviewing the symptoms of traumatic brain injury in general and discuss specific instruments for assessment both neurobiological and psychological. Included will be discussion on the effects of head and neck trauma resulting from participation in sports as one of the most important topics in contemporary sports psychiatry.

NO 2 COMORBIDITY AND TREATMENT

Speaker: Michele T. Pato, M.D.

SUMMARY:

This presentation will discuss basic treatment issues with some emphasis on comorbidity. Psychotherapy will include a discussion of CBT, and other psychotherapeutic interventions to deal with “return to work and play” as well as acute and potential chronic functional deficits. Discussion will include how pharmacotherapy may be challenging in a patient with repetitive TBI and how treating one condition can exacerbate an existing comorbid condition. We will highlight the need to start low and go slow with dose and duration of medications. We will review appropriate pharmacotherapy to use in psychiatric conditions that may exist in the context of head trauma/ TBI.

NO 3 SPECIAL ISSUES IN THE DIAGNOSIS AND TREATMENT OF SOLDIERS

Speaker: Aika Gumboc, M.D.

SUMMARY:

The last presentation in the session will highlight the similarities and difference in both diagnosis and treatment issue in those whose injury comes through military service. Discussion will be given to mild traumatic brain injury that can occur with blunt trauma, shearing forces from rapid acceleration and deceleration and blast exposures. We will discuss that while the natural history of mild TBI is recovery within weeks, a small percentage of individuals may have a persistent postconcussive syndrome (PCS) which can include physical, cognitive, and emotional symptoms. Also, given the context of brain injury in combat situations, PTSD is often co-morbid with PCS. Discussion on how the persistent symptoms of one or the other or both disorders may overlap complicating diagnosis, treatment, and recovery of PCS and PTSD.

NO 4 TRAUMATIC BRAIN INJURIES IN CIVILIANS, ATHLETES, AND SOLDIERS: SPECIAL ISSUES IN THE DIAGNOSIS AND TREATMENT OF SOL-

DIERS

Speaker: Marvin Oleshansky, M.D.

SUMMARY:

The last presentation in the session will highlight the similarities and difference in both diagnosis and treatment issue in those whose injury comes through military service. Discussion will be given to mild traumatic brain injury that can occur with blunt trauma, shearing forces from rapid acceleration and deceleration and blast exposures. We will discuss that while the natural history of mild TBI is recovery within weeks, a small percentage of individuals may have a persistent postconcussive syndrome (PCS) which can include physical, cognitive, and emotional symptoms. Also, given the context of brain injury in combat situations, PTSD is often co-morbid with PCS. Discussion on how the persistent symptoms of one or the other or both disorders may overlap complicating diagnosis, treatment, and recovery of PCS and PTSD.

NO 5 SPECIAL ISSUES IN THE DIAGNOSIS AND TREATMENT OF SOLDIERS

Speaker: John R. Magera, M.D.

SUMMARY:

The last presentation in the session will highlight the similarities and difference in both diagnosis and treatment issue in those whose injury comes through military service. Discussion will be given to mild traumatic brain injury that can occur with blunt trauma, shearing forces from rapid acceleration and deceleration and blast exposures. We will discuss that while the natural history of mild TBI is recovery within weeks, a small percentage of individuals may have a persistent postconcussive syndrome (PCS) which can include physical, cognitive, and emotional symptoms. Also, given the context of brain injury in combat situations, PTSD is often co-morbid with PCS. Discussion on how the persistent symptoms of one or the other or both disorders may overlap complicating diagnosis, treatment, and recovery of PCS and PTSD.

SYMPOSIUM 33 LIFESTYLE BEHAVIORS, INTERGRATIVE THER- APIES, AND MENTAL HEALTH ACROSS THE LIFESPAN

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

Chair(s): Helen Lavretsky, M.D., Gary W. Small, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the relationships between healthy lifestyle behaviors and memory and aging; 2) Recognize potential for nutritional supplement use for treatment of mood disorders (focus on SAME); 3) Understand the neural basis of hypnosis and hypnotizability applied to treatment of medically-related pain and anxiety; and 4) Understand the neurobiological mechanisms of response to the mind-body techniques (yoga, meditation, Tai Chi) used for treatment and prevention of

mood disorders in later life.

SUMMARY:

Recent epidemiological and clinical-trials evidence points to mental health benefits from various lifestyle habits and alternative therapies. For example, cardiovascular conditioning is associated with a delay in age-related cognitive decline, and physical conditioning improves mood and cognition. Dietary antioxidants may reduce long-term risk of Alzheimer's disease, and the dietary supplement, S-adenosyl methionine (SAME), benefits depressive symptoms. Chronic stress causes hippocampal atrophy in mice, as well as depression and cognitive impairment in humans. This panel will highlight recent findings demonstrating cognitive and mood benefits of lifestyle behaviors and alternative treatments involving physical exercise, nutrition and stress management and the underlying neural mechanisms for these interactions. Discussions will include the extent of these effects throughout the lifespan from a large-scale sampling of U.S. households; clinical and mechanistic evidence for the antidepressant effects of the SAME; the neurobiology of treatment response to mind-body interventions in chronic stress and mood disorders in late life; and the role of altered functional connectivity in DLPFC and dACC in hypnotizability and the effect of hypnosis on pain and anxiety. Gary Small, MD, UCLA, will describe relationships between nutrition and exercise and responses to meta-memory questions shown to correlate with plaque and tangle brain PET scan measures. David Mischoulon, M.D., Ph.D., Harvard, will present evidence on the physiology and biology of SAME and whether histamine and carnitine moderate response in depressed individuals treated in a placebo-controlled double blind randomized clinical trial of SAME versus escitalopram; Helen Lavretsky, M.D., UCLA, will present results showing that daily meditation improves mood, cognition, neural activation (fMRI and FDG-PET), and activity of immune cell telomerase and gene expression of nuclear factor-kappa B. David Spiegel, M.D., Stanford, CA will present data examining changes in functional brain networks with hypnosis in medically related pain and anxiety. The relationship between these brain changes and improvements in aspects of cognition will also be discussed. Charles F. Reynolds III, M.D., University of Pittsburgh, will serve as the discussant.

NO 1 FUNCTIONAL BRAIN BASIS OF HYPNOTIZABILITY AND HYPNOSIS

Speaker: David Spiegel, M.D.

SUMMARY:

Objective: The main goal of the study was to investigate the brain basis of hypnotizability. Design: Cross sectional, in-vivo fMRI neuroimaging study. Subjects: 12 adults with high and 12 adults with low hypnotizability. Main Outcome Measures: (1) functional MRI (fMRI) to measure functional connectivity networks at rest including default-mode, salience and executive-control networks, (2) structural T1 MRI to measure regional grey and white matter volumes, and (3) diffusion tensor imaging (DTI). Results: High- compared to low-hypnotizable individuals showed greater functional connectivity between

left dorsolateral prefrontal cortex (DLPFC), an executive-control region of the brain, and the salience network composed of the dorsal anterior cingulate cortex (dACC), anterior insula, amygdala, and ventral striatum. Conclusions: Altered functional connectivity in DLPFC and dACC may underlie hypnotizability important for identification of individuals with ability to respond to hypnosis.

NO 2 S-ADENOSYL METHIONINE (SAME) VERSUS ESCITALOPRAM AND PLACEBO IN MAJOR DEPRESSION: EFFECTS OF HISTAMINE AND CARNITINE AS MODERATORS OF RESPONSE

Speaker: David Mischoulon, M.D., Ph.D.

SUMMARY:

Background: We examined the antidepressant efficacy of SAME versus the selective serotonin reuptake inhibitor, escitalopram, and a placebo control; we also examined whether serum histamine or carnitine levels modified treatment response. Methods: We examined a subsample (n=144) from one site of a two-site placebo-controlled randomized clinical trial of adults with Major Depressive Disorder (MDD) who were tested for serum histamine and carnitine levels. Eligible subjects were randomized to SAME (1600-3200mg/daily), escitalopram (10-20mg/daily), or matching placebo for 12 weeks of double-blind treatment (titration occurred at week 6 in cases of non-response). Results: On the primary outcome of the HAMD-17, a significant difference in improvement was observed between groups from baseline to week 12 (p=0.039). SAME was superior to placebo from week 1, and to escitalopram during weeks 2- 6. The effect size was large. These preliminary results provide evidence for the use of SAME in MDD.

NO 3 THE INFLUENCE OF HEALTHY BEHAVIOR ON MEMORY THROUGHOUT LIFE

Speaker: Gary W. Small, M.D.

SUMMARY:

Objective: Previous research has shown that healthy behaviors are associated with a lower risk for Alzheimer's disease and dementia. Methods: Data were obtained from the Gallup-Healthways Well-Being Index, a daily telephone survey. This random sample of 18,552 respondents from all 50 U.S. states included 4,423 younger (18 to 39 years), 6,356 middle-aged (40 to 59 years), and 7,773 older (>60) adults. Results: Older adults were more likely to engage in healthy behaviors than were middle-aged and younger adults. The presence of memory symptoms increased with age and was inversely related to healthy behaviors. Healthy eating was associated with better memory, while not smoking was associated with better memory in the younger and middle-aged groups and regular exercise was associated with better memory in the middle-aged and older groups. Conclusions: These findings indicate protective effect of healthy behaviors on self-perceived memory abilities and function throughout adult life.

NO 4
THE NEUROBIOLOGY OF TREATMENT RESPONSE TO MIND-BODY INTERVENTIONS IN CHRONIC STRESS AND MOOD DISORDERS IN OLDER ADULTS

Speaker: Helen Lavretsky, M.D.

SUMMARY:

BACKGROUND: Nearly two-thirds of elderly patients treated for depression fail to achieve symptomatic remission. New strategies are needed to improve clinical outcomes of late-life mood disorders. **METHODS:** In the first study, we asked whether a mindful exercise, Tai Chi Chih (TCC), added to escitalopram could augment the treatment with escitalopram in 112 older adults with major depression. Subjects in the escitalopram and TCC condition were more likely to show greater reduction of depressive symptoms and to achieve a depression remission as compared with control condition. Another study examined the effect of daily brief yogic meditation to improve distress and coping in 49 stressed family dementia. We found improvement in mood, mental health, cognition, telomerase activity, change in gene expression and brain activation with meditation compared to relaxation. **CONCLUSION:** Complementary use of mind-body intervention can improve clinical outcomes of mood disorders in older adults.

SYMPOSIUM 34
BIPOLAR DISORDER: AN UPDATE ON DIAGNOSIS AND TREATMENT

Discussant: Frederick K. Goodwin, M.D.

Chair(s): S. Nassir Ghaemi, M.D., M.P.H., Michael J. Ostacher, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify and critique recent studies of antidepressants, antipsychotics, anticonvulsants, and lithium in bipolar disorder; 2) Critique and apply data from the above studies to clinical practice; and 3) to recognize proposed changes in DSM-5 to bipolar disorders and evidence for and against such changes, as well as their impact on clinical practice.

SUMMARY:

In this symposium, the audience will receive updates on the most latest studies, critiqued objectively and interpreted clinically, on treatments for bipolar disorder, provided by leading experts. Presenters will cover antidepressants, antipsychotics, anticonvulsants, and lithium, as well as recent changes in DSM-5. Analyses will be critical, and will delineate strengths and weaknesses in studies and data, and will help the audience understand studies from the last few years, and integrate that knowledge with prior studies and their prior clinical experience. Panel and audience interaction and discussion will allow for the airing of multiple perspectives and approaches.

NO 1
DSM-5 CANNOT SOLVE “OVERDIAGNOSIS,” BUT CLINICIANS CAN

Speaker: James Phelps, M.D.

SUMMARY:

Previous DSM revisions have attempted to address concerns about overdiagnosis, particularly for bipolar disorder (BD), by increasing specificity. I will examine criteria changes in DSM-5 for BD, and discuss potential implications for practice. Focusing on the issue of overdiagnosis, and using the concept of predictive value, I will show it is difficult to reach even 50% diagnostic accuracy with DSM by increasing specificity. The relatively low prevalence of BD, like that of most psychiatric conditions, dooms such efforts: without near-perfect criteria, many positives are false positives. However, prevalence is just one aspect of “prior probability”, which clinically can be increased by assessing bipolar markers not found in the symptom-based DSM system, e.g. family history, age of onset, and course of illness. Increasing prior probability to 50% using such markers, then applying DSM criteria, yields a positive predictive value of 83%, thereby solving the overdiagnosis problem.

NO 2
ANTICONVULSANTS IN BIPOLAR DISORDERS

Speaker: Terence A. Ketter, M.D.

SUMMARY:

United States Food & Drug Administration (US FDA) approved treatments for bipolar disorder (BD) include lithium & antipsychotics for acute mania and BD maintenance. Of approximately 30 US FDA approved anticonvulsants, only 3 have BD indications (valproate & carbamazepine for acute mania, lamotrigine for maintenance), with efficacy similar to other approved agents and tolerability similar to lithium and superior to antipsychotics. In this presentation, I will review recent RCTs of new & emerging anticonvulsants in BD and comorbid conditions. These data will be analyzed and put in the context of clinical practice to help understand the potential clinical utility of some of these agents for BD.

NO 3
REVIEW OF EFFICACY DATA WITH NEUROLEPTICS IN BIPOLAR DEPRESSION AND MAINTENANCE

Speaker: Roger S. McIntyre, M.D.

SUMMARY:

During the past decade, there has been a significant increase in the number of pharmacological treatment options for bipolar depression and recurrence prevention. The increased availability of treatment provides treatment alternatives as well as the impetus to define what comprises an “antidepressant” and “mood stabilizer” in bipolar disorder (BD). This presentation will examine recent randomized studies with antipsychotic agents in the treatment of acute bipolar depression and in maintenance treatment. These recent studies will be analyzed

and discussed in terms of their relevance for up-to-date algorithms of treatment for this life-long disorder.

NO 4 ANTIDEPRESSANTS IN BIPOLAR DISORDER: AN UPDATE

Speaker: S. Nassir Ghaemi, M.D., M.P.H.

SUMMARY:

In this presentation, I will review recent randomized clinical trials (RCTs) on antidepressants in bipolar disorder. In particular, I will present and review RCTs from the NIMH-sponsored STEP study in both acute and maintenance treatment of bipolar depression. I will also present the first analysis of a new RCT on citalopram versus placebo, added to mood stabilizers, for acute and maintenance treatment of bipolar depression. This study will be the first placebo-controlled RCT of a modern antidepressant in maintenance treatment of bipolar disorder type I. Other recent RCTs, especially of type II bipolar disorder, will also be presented and analyzed. The audience will learn about the most recent and most valid studies of this topic.

NO 5 EFFICACY AND EFFECTIVENESS: HOW THE BALANCE AND LITMUS TRIALS INFORM CURRENT PRESCRIBING OF LITHIUM FOR BIPOLAR DISORDER

Speaker: Michael J. Ostacher, M.D., M.P.H.

SUMMARY:

Lithium is a well-established treatment for bipolar disorder, yet lithium prescribing is declining in clinical practice. Two practical clinical trials studied the use of lithium in clinical practice. BALANCE, a randomized, open-label study maintenance study of bipolar I disorder that compared combination treatment with divalproex sodium plus lithium to monotherapy with either drug, and used a novel design with an active run-in phase prior to randomization. LiTMUS, a randomized, open-label study of subacute patients with bipolar I disorder, compared a strategy using moderate dose lithium added to optimized pharmacological treatment to a strategy using optimized pharmacological treatment without lithium. The results of these effectiveness studies will be discussed relative to the existing efficacy data for lithium bipolar disorder, with its implications for the clinician trying to manage bipolar disorder in the era of anticonvulsants and atypical antipsychotics.

SYMPOSIUM 35 RESEARCH UPDATES AND NEW DIRECTIONS FOR SUICIDE PREVENTION IN THE VETERANS ADMINISTRATION

Discussant: Peter Gutierrez, Ph.D.

Chair: Marianne Goodman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be

able to: 1) Recognize epidemiological trends regarding veteran suicide completion and attempts; 2) Understand new research in potential biomarkers for suicide risk; and 3) Learn about innovative treatments being investigated for suicide prevention in the VA, with potential applications beyond this system.

SUMMARY:

Suicide in veterans remains a pressing problem that has attracted widespread media attention and become a focus of policy initiatives, as well as clinical and research efforts. This symposium brings together Suicide Prevention experts from across The Veterans Administration (VA) including Dr. Bossarte from the National Center for Suicide Prevention, Dr. Brenner from the VISN 19 Mental Illness Research and Clinical Care (MIRECC), Dr. Gutierrez from the Military Suicide Research Consortium and Department of Defense funded researchers (Drs. Goodman, Rasmusson and Stanley) studying suicidal veterans to discuss recent advances and new directions in research pertaining to suicide prevention. Individual presentations will include VA epidemiological trends in suicide (Dr. Bossarte), novel potential biomarkers including affective startle (Dr. Goodman), and thermal imaging (Dr. Rasmusson) as well as innovative treatment paradigms currently under study including Suicide Safety Planning with structured telephone follow-up (Dr. Stanley) and "Window to Hope", a group-based cognitive therapy designed to decrease hopelessness in Veterans with moderate and severe TBI. Dr. Gutierrez will be the symposium discussant.

NO 1 SURVEILLANCE OF SUICIDE AND SUICIDE ATTEMPTS AMONG VETERANS

Speaker: Robert Bossarte, Ph.D.

SUMMARY:

The Veterans Administration maintains a 24 hour suicide hot line serving veterans across the nation. Epidemiological data including prevalence and characteristics of veterans with suicidal ideation and attempts will be presented along with utilization data from the VA National Hot Line.

NO 2 AFFECTIVE STARTLE IN SUICIDAL VETERANS

Speaker: Marianne Goodman, M.D.

SUMMARY:

The affective startle modulation paradigm is unique in that it yields a nonverbal, objective measure of emotional processing. The startle reflex consists of a set of involuntary responses to a sudden, strong sensory stimulus, and is measured by the amplitude of the eyeblink. This reflex is highly modifiable by environmental stimuli that precede the reflex-eliciting stimulus, thus providing an index of ongoing affective information processing. We have applied the affective startle paradigm to veterans with differing levels of suicidality including ideators, single attempters and multiple attempters. Data from the first 40 veterans, matched for age and gender, revealed significant differences in exaggerated startle amplitude to negative

pictures across groups, This preliminary data highlights the importance of altered emotional processing as a potential biomarker of suicide risk. Updated data will be presented.

NO 3

SAFE: A NON-CONTACT SENSOR OF STRESS-RELATED AROUSAL TO MONITOR PTSD SYMPTOMS AND RISK

Speaker: Ann M. Rasmusson, M.D.

SUMMARY:

Post-Traumatic Stress Disorder (PTSD) and its comorbid disorders - depression, substance abuse, and traumatic brain injury - are highly prevalent among military personnel returning from recent U.S. military engagements and contribute to risk for suicide. Stress analysis by forward-looking infrared (FLIR) evaluation of sweat pore reactivity (SAFE) is a new, remote, non-contact means of monitoring sympathetic nervous system reactivity that correlates highly with traditional measures of skin conductance. PTSD sufferers exhibit sympathetic nervous system hyperreactivity to trauma cues and other stressors. This DOD/VA study aims to validate "SAFE" as a means of monitoring sympathetic responses to trauma-related triggers over the course of PTSD treatment and other interventions such as smoking cessation that may increase arousal and PTSD symptoms as an initial side-effect. We will also evaluate the potential link between increased sympathetic arousal and risk for self/other harm in PTSD.

NO 4

WINDOW TO HOPE: EVALUATING A PSYCHOLOGICAL TREATMENT FOR HOPELESSNESS AMONG VETERANS WITH TRAUMATIC BRAIN INJURY

Speaker: Lisa Brenner, Ph.D.

SUMMARY:

The purpose of this project is to provide further evidence regarding a groundbreaking psychological treatment for suicide prevention in individuals with moderate to severe traumatic brain injury (TBI), Window to Hope (WtoH). The current project aims to adapt WtoH for U.S. military personnel/Veterans (expert Consensus Conference, participant total up to 15), implement the intervention in a VAMC (Pilot Groups 1-4, participant total up to 12), and replicate the results from the original trial in this novel context with a larger sample size ($n=70$ completed protocols [up to 90 recruited]). Deliverables are expected to include an intervention suitable for both dissemination and larger Phase III trials. Data from the cross cultural adaptation will be presented, along with a progress report regarding the clinical trial.

NO 5

SAFETY PLANNING AND STRUCTURED FOLLOW-UP: AN INTERVENTION FOR SUICIDAL VETERANS

Speaker: Barbara Stanley, Ph.D.

SUMMARY:

The Emergency Department (ED) is the setting where many suicidal patients are first assessed in civilian and VA hospitals. ED clinicians have been limited to one of two dispositions for these patients--hospitalize or discharge with a referral. This can result in hospitalizing patients who may not require it or discharging patients with a referral who would benefit from more immediate intervention. The SAFE VET clinical demonstration project targeted this population, i.e. those at moderate suicide risk and provided the Safety Planning Intervention (Stanley & Brown, 2008) in the ED and structured follow-up contact to suicidal Veterans presenting at five VAMC EDs. Results indicate that the program was effective in keeping Veterans safe and engaging them in follow-up care. Many reported that this program prevented their suicide..

SYMPOSIUM 36

ADVANCES IN PEDIATRIC BIPOLAR DISORDER RESEARCH

Chair(s): Joseph Biederman, M.D., Janet Wozniak, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the CBCL and its utility in identifying youth at risk for bipolar disorder; 2) Recognize that pediatric bipolar disorder in youth persists into mid and late adolescent years, and is associated with high levels of morbidity and disability; and 3) Recognize the association between PTSD and BP-I disorder in youth, which indicates that BP-I disorder is a significant risk factor for PTSD in youth.

SUMMARY:

This symposium will provide the audience with new scientific data on key advances in pediatric Bipolar (BP)-I disorder research. Dr. Biederman will present new results from a meta-analysis of the extant family aggregation literature on pediatric BP-I disorder as well as results from the largest family study of pediatric BP-I disorder. The meta-analysis revealed that the pooled odds ratio for BP-I disorder in relatives was estimated to be 7 (95% Confidence Interval (CI): 4.8, 10.1). The family study results showed that first-degree relatives of BP-I probands were at significantly higher risk than first-degree relatives of both ADHD (Hazards Ratio: 3.02; 95% CI: 1.85, 4.93; $p<0.001$) and control probands (HR: 2.83; 1.65, 4.84; $p<0.001$) to have bipolar-I disorder. These results document a robustly increased familial risk for BP-I disorder in relatives of pediatric BP-I probands. Dr. Wozniak will present results from a 4-year prospective follow up study of 78 youth with DSM-IV pediatric BP-I disorder documenting that 73% of them continued to meet full diagnostic criteria for BP-I disorder and that its persistence was associated with high levels of morbidity and disability. Dr. Spencer will present new data addressing the link between pediatric BP-I disorder and PTSD in youth. Participants were 236 youth with BP-I disorder and 136 controls of both sexes along with their siblings. BP-I probands with and without PTSD did not differ in the number or type of symptoms of BP-I disorder or its age

of onset. Familial risk analysis revealed that relatives of BP-I probands with and without PTSD had elevated rates of BP-I disorder that significantly differed from those of relatives of controls. These results indicate that pediatric BP-I disorder is similarly highly familial in pediatric BP-I probands, with and without PTSD, indicating that their co-occurrence is not due to diagnostic error. Dr. Uchida will present data examining the utility of a unique profile of the Child Behavior Checklist (CBCL) consisting of marked (2SDs) elevations in the Anxiety/Depression, Aggression, and Attention (A-A-A) scales (henceforth referred to as CBCL-Severe Dysregulation profile) to discriminate children with a clinical diagnosis of BP-I disorder from those with ADHD and those without these disorders. Analyses were conducted comparing the following groups: 140 pediatric BP-I probands, 83 ADHD probands, and 114 control probands of similar age and sex. We defined the CBCL-Severe Dysregulation profile as an aggregate cut-off score of ≥ 210 on the A-A-A scales. All subjects were assessed with structured diagnostic interviews and a range of functional measures. 57% of children with a diagnosis of BP-I disorder had a positive CBCL-Severe Dysregulation profile vs. only 8% of children with ADHD and 1% of controls ($p < 0.001$). These results indicate that CBCL-Severe Dysregulation profile can be useful as a screen for BP-I disorder for both ADHD and non-ADHD children.

NO 1 FURTHER EVIDENCE FOR ROBUST FAMILIARITY OF PEDIATRIC BIPOLAR-I DISORDER

Speaker: Joseph Biederman, M.D.

SUMMARY:

A meta-analysis was conducted of published family studies of pediatric BP-I probands using the random effects model of DerSimonian and Laird. Our family study included 239 children with BP-I ($n=726$ 1st-degree relatives), 162 ADHD (without BP-I) ($n=511$ 1st-degree relatives), and 136 control probands ($n=411$ 1st-degree relatives). Survival curves and cumulative lifetime risk in relatives were calculated using the Kaplan-Meier cumulative failure function and Cox proportional hazard models. The meta-analysis revealed a pooled odds ratio for BP-I disorder in relatives of 7 (95% CI: 4.8, 10.1). The family study showed that first-degree relatives of BP-I probands were at significantly higher risk than first-degree relatives of both ADHD (Hazards Ratio: 3.02; 95% CI: 1.85, 4.93; $p < 0.001$) and control probands (HR: 2.83; 1.65, 4.84; $p < 0.001$) to have BP-I. Results document a robustly increased familial risk for BP-I in relatives of pediatric probands with BP-I.

NO 2 A FOUR-YEAR PROSPECTIVE LONGITUDINAL FOLLOW-UP STUDY OF PEDIATRIC BIPOLAR-I DISORDER

Speaker: Janet Wozniak, M.D.

SUMMARY:

Objective: We examined the longitudinal course of pediatric bipolar disorder (BPD)-I in youth transitioning into adoles-

cence. Methods: We conducted a 4-year follow-up study of 78 youth with BPD-I 6-17 years old at ascertainment (13.4 ± 3.9 years). BPD was considered persistent if subjects met full criteria for DSM-IV BPD-I at follow-up. Results: Of 78 BP-I subjects, 57 (73.1%), continued to meet full diagnostic criteria for BPD-I. Of those with a non-persistent course, only 6.4% ($n=5$) were euthymic at the 4-year follow-up and were not receiving pharmacotherapy for the disorder. The other non-persistent cases either continued to have subthreshold BP-I ($n=5$, 6.4%), met full ($n=3$, 3.8%) or subthreshold ($n=1$, 1.3%) criteria for major depression, or were euthymic but treated for the disorder ($n=7$, 9.0%). Conclusions: This 4-year follow-up showed the majority of BPD-I youth continue to experience persistent disorder into their adolescent years.

NO 3 CAN PEDIATRIC BIPOLAR-I DISORDER BE DIAGNOSED IN THE CONTEXT OF PTSD? A CONTROLLED ANALYSIS OF INDIVIDUAL AND FAMILY AGGREGATION CORRELATES

Speaker: Andrea E. Spencer, M.D.

SUMMARY:

Background: This study addressed the link between pediatric bipolar-I (BP-I) disorder and posttraumatic stress disorder (PTSD) in youth. We compared clinical correlates of BP-I subjects with and without PTSD and controls across multiple non-overlapping domains of functioning and familial patterns of transmission. Methods: Participants were 236 youth with BPD-I and 136 controls along with their siblings. Participants completed measures designed to assess psychiatric comorbidity, psychosocial, educational, and cognitive parameters. Results: BP-I subjects with and without PTSD did not differ in the number or type of symptoms of BP-I disorder or its age of onset. Familial risk analysis revealed that relatives of BP-I probands with and without PTSD had elevated rates of BPD-I that significantly differed from those of relatives of controls. Conclusions: Pediatric BPD-I is highly familial in probands, with and without PTSD, indicating that their co-occurrence is not due to diagnostic error.

NO 4 FURTHER EVIDENCE THAT SEVERE SCORES IN THE AGGRESSION/ANXIETY-DEPRESSION/ATTENTION (A-A-A) CBCL PROFILE CAN SCREEN FOR BIPOLAR DISORDER SYMPTOMATOLOGY

Speaker: Mai Uchida, M.D.

SUMMARY:

Elevations (2SDs) in the Anxiety/Depression, Aggression, and Attention (A-A-A) scales of the CBCL has been shown to measure the severely dysregulated mood and behavior found in pediatric bipolar disorder (henceforth referred to as CBCL-Severe Dysregulation profile). We examined whether the CBCL-Severe Dysregulation profile would discriminate children with BPD-I from those with ADHD and those without these disorders. 140 pediatric BPD-I probands, 83 ADHD probands, and 114 control probands were compared. We

defined the CBCL-Severe Dysregulation profile as an aggregate cut-off score of ≥ 210 on the A-A-A scales. All subjects were assessed with structured diagnostic interviews and a range of functional measures. 57% of children with a diagnosis of BPD-I had a positive CBCL-Severe Dysregulation profile vs. only 8% of children with ADHD and 1% of controls ($p < 0.001$). The CBCL-Severe Dysregulation profile can be a useful screen for BP-I disorder for both ADHD and non-ADHD children.

SYMPOSIUM 37

WORK, MENTAL HEALTH, AND CULTURAL DIVERSITY: A DYNAMIC TRIAD

Chair: Annelie Primm, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of how discrimination - racial, ethnic, cultural or sexual orientation - can be overt or subtle and insidious, and how discrimination affects one's mental health; 2) Understand how the reality of discrimination and its impact at the workplace can be addressed in clinical practice with people with mental health needs; 3) Understand how psychiatrists help people to succeed at work in the face of overt discrimination or subtle, micro-aggressions; and 3) Learn how the reality of discrimination and mental health plays out at work and how psychiatrists can help their patients thrive at work in the face of this reality.

SUMMARY:

Discrimination in the work place – be it racial, ethnic, cultural, or sexual orientation - affects one's mental health. This symposium will address the effects of such discrimination and the disconnect between corporate policies related to diversity and the reality of everyday life at work. While many companies articulate a commitment to diversity, successfully putting it into practice is a much more difficult reality. A corporate policy alone cannot prevent employees from experiencing the effects of discrimination which exists in society at large. Not all discrimination is overt – it can be subtle, for example, micro-aggressions can affect an employee's experience at work and their overall mental health. This symposium will discuss the important role of employment in recovery. We will examine the reality of discrimination and its impact in the workplace, and how it can be addressed in clinical practice with people with mental health needs. Psychiatrists will learn how to help patients succeed at work in the face of overt discrimination or subtle micro-aggressions.

NO 1

RACE MATTERS IN WORKPLACE MENTAL HEALTH

Speaker: Price M. Cobbs, M.D.

SUMMARY:

The notion of the United States as a post-racial society where racial difference no longer matters has been discussed widely in the media in recent years. For many, this notion is a fallacy,

as borne out by numerous examples of racial discrimination in housing, education and the workplace. In whatever setting it emerges, racial discrimination contributes significantly to stress and takes a toll on the health and mental health of people of color. This presentation will focus on the workplace setting and the mental health impact of differential treatment based on race. The speaker will offer strategies on how victims of workplace racial discrimination can cope and maximize mental health and wellness in the face of this type of adversity.

NO 2

ERADICATING AMERICAN RACISM: A COMMUNITY PSYCHIATRIST'S PERSPECTIVE

Speaker: Donald H. Williams, M.D.

SUMMARY:

American racism is a social construct that rationalizes the continuing subjugation and exploitation of one group of Americans by another. Racism is inherently dehumanizing and is maintained by mechanisms of fear and terror. Racism is a major public and individual health problem and needs to be addressed if and when it occurs within the workplace. Major advances in the historical, social psychologic, neurocognitive, anthropologic, and medical literature have reframed the construct of racism. Community psychiatry has a very important role in eradicating this scourge. This presenter will discuss his models of intervention at the community, professional and clinical level and what psychiatrists should do to best assist and treat people who are experiencing the mental health effects of workplace discrimination.

NO 3

WORKPLACE RACIAL DISCRIMINATION AND HEALTH AMONG AFRICAN AMERICANS: EXAMINING THE ROLE OF THREAT APPRAISAL AND COPING

Speaker: Amani M. Nuru-Jeter, M.P.H., Ph.D.

SUMMARY:

The workplace is a primary source of race-related stress among African American men and women. Previous qualitative and quantitative studies show that workplace is often cited as a source of repeated experiences of racial discrimination. Types of racial discrimination cited in the workplace include: interpersonal microaggressions, career advancement, mentoring and career development, and hiring practices. Workplace racial discrimination has been reported as a chronic stressor and a source of significant psychological distress among African American men and women. Perceptions of threat and coping style weigh heavily in both mental and physiologic responses to stress. Rejection sensitivity and stereotype threat (threat appraisal) as well as superwoman schema and John Henryism (coping style) may exacerbate mental distress associated with workplace racial discrimination among African American men and women; and may serve as logical avenues for intervention.

NO 4**THE IMPACT OF “ISMS” IN THE WORKPLACE**

Speaker: Keris J. Myrick, M.B.A., M.S.

SUMMARY:

People with mental health issues report being turned down for work or may stop themselves from looking for work because they anticipate discrimination due to their mental illness. Disclosure of mental illness in the workplace can also add to discriminatory behavior and actions from managers and colleagues such as micro-management, lack of opportunities for advancement, over inferring of mistakes to the person's illness, gossip and social exclusion. Sanism is a form of discrimination and oppression against a person because of perceived and/or actual mental illness. The intersection of race, gender and mental illness- racism, sexism and sanism can be experienced as a triple threat for people with lived experience who are seeking employment or are employed. The organizational and personal impact of daily interactions, inclusive differential treatment, microaggressions and structural/institutional discrimination will be explored and solutions will be discussed.

SYMPOSIUM 38**THE REVISED DSM-5 GLOSSARY OF CULTURAL CONCEPTS OF DISTRESS**

Discussant: Byron Good, Ph.D.

Chair: Roberto Lewis-Fernandez, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the limitations of the DSM-IV-TR Glossary of Culture-Bound Syndromes; 2) Describe the theoretical and empirical rationale behind the new DSM-5 Glossary of Cultural Concepts of Distress; 3) Identify examples of cultural syndromes, idioms of distress, and causal explanations from diverse cultural groups, emphasizing how to use this cultural information in clinical practice; 4) Discuss future directions in research involving these concepts and their clinical utilization; and 5) Review anthropological perspectives on this way of integrating cultural elements in diagnostic practice.

SUMMARY:

The specific expressions of psychiatric disorders in DSM-IV-TR represent only one of various forms taken by these disorders worldwide and over the historical record. This cultural variation may help explain why DSM-IV-TR diagnoses map only partially onto their putative biological substrates at the genetic or neurocircuitry level. It is more likely that these biological domains constitute dimensional vulnerability factors that pattern disorder expression more generally (e.g., mood dysregulation), and that specific syndromes arise from the interaction of this general vulnerability with other factors, including contextual elements such as culturally patterned illness expressions. Incorporating alternative cultural configurations of disorder (“cultural syndromes”) in DSM-5 could help clarify the process by which specific clinical presentations arise out of particular socio-cultural and biographical contexts and biological diatheses. This symposium presents

the ways in which cultural concepts of distress were included in DSM-5, focusing on the revision of the DSM-IV-TR Glossary of Culture-Bound Syndromes in Section 3 of the Manual and the subsections on Culture-Related Diagnostic Issues for individual disorders. DSM-5 substitutes the older formulation of culture-bound syndromes with three concepts of greater clinical utility. Cultural syndromes are clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts and that are recognized locally as coherent patterns of experience. Cultural idioms of distress are ways of expressing distress that may not involve specific symptoms or syndromes, but that provide shared ways of experiencing and talking about personal or social concerns (e.g., everyday talk about “nerves” or “depression”). Cultural explanations or perceived causes are labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress. Leading experts in cultural psychiatry who participated in the revision process will discuss the limitations of the DSM-IV-TR Glossary that led to the substantial changes in DSM-5, theoretical and empirical rationale behind the revisions, and examples of syndromes, idioms, and explanations from diverse cultural groups. An emphasis of the symposium will be on how to use this cultural information in clinical practice, including the relationship of cultural concepts of distress with psychiatric diagnoses. Future directions in research involving these concepts and their clinical utilization will also be presented, as well as anthropological perspectives on this way of integrating cultural elements in diagnostic practice.

NO 1**LIMITATIONS OF THE DSM-IV-TR GLOSSARY OF CULTURE-BOUND SYNDROMES**

Speaker: Renato D. Alarcon, M.D., M.P.H.

SUMMARY:

A brief historical review of the inclusion of cultural components in the development of DSM-IV and its final content in Appendix I of the Manual are presented. The history, definitions, descriptive accounts and clinical characteristics of the main “culture-bound syndromes” known throughout the last several decades of the 20th Century are discussed, including their meaning and clinical value, utility and utilization. The clinical, historical and epistemological sources of the main syndromes, as well as their structure in DSM-IV are reviewed, pointing out both positive and questionable aspects; among the latter, issues of clinical language, meaning, validity, reliability and nosological location in any new version of DSM will be also discussed. After presenting some of the proposals made prior to the establishment of the Cultural Issues Work Subgroup in connection with this topic, comments and reflections are made related to the future of these conditions in psychiatry.

NO 2**THEORETICAL AND EMPIRICAL RATIONALE FOR THE CHANGES**

Speaker: Roberto Lewis-Fernandez, M.D.

SUMMARY:

This talk will discuss the theoretical and empirical rationale behind the revision of the DSM-5 Glossary of Cultural Concepts of Distress. Three concepts will be distinguished that supersede the older formulation of “culture-bound syndromes”: cultural syndromes, idioms of distress, and causal explanations. The inter-relationships among these concepts will also be discussed. Empirical research characterizing these cultural expressions will be presented, focusing on the example of *ataque de nervios* (attack of nerves), a Latin American cultural syndrome. Textual material from the subsections on Culture-related diagnostic issues in the Anxiety and Trauma- and Stressor-Related Disorders will be used to discuss the relationship between cultural concepts and psychiatric diagnoses. An emphasis of the symposium will be on how to use this cultural information in clinical practice to augment diagnostic validity, therapeutic alliance, and treatment negotiation and engagement.

NO 3 EXAMPLES OF SYNDROMES, IDIOMS, AND EXPLANATIONS

Speaker: Devon Hinton, M.D., Ph.D.

SUMMARY:

Each cultural group has certain ways of understanding and making sense of psychological symptoms and disorders and labels for and explanations of psychological distress. These cultural interpretations have a profound impact on the course of psychiatric disorders in those contexts. The DSM-5 includes nine examples of syndromes, idioms, and explanations (e.g., *ataque de nervios*, *nervios*, and *susto* in Latin American populations, *khyâl* attacks among Cambodians, and *dhat* syndrome among South Asians). The talk will describe in more depth the difference between an idiom and a syndrome, giving examples of each (e.g., *khyâl* and *kufungisisa*), and it will show how a cultural label can be mostly a cause, such as in the case of *susto*. The talk will also discuss how one cultural label of distress may be the presentation of multiple types of disorder: *taijin kyofusho* as combining Body Dysmorphic Disorder, Olfactory Reference Syndrome, Social Phobia, and Delusional Disorder.

NO 4 REFINING CULTURAL CONCEPTS OF DISTRESS IN DSM-5: A RESEARCH AGENDA

Speaker: Laurence J. Kirmayer, M.D.

SUMMARY:

The concepts of cultural syndrome, idiom of distress and causal explanation set out in DSM-5 represent advances in our understanding of culture and psychopathology. Future work is needed on two fronts: (i) refining the cultural concepts to incorporate new research and (ii) documenting their clinical utility. This will require a broad research program employing diverse methods. Cultural syndromes involve interactions between neurobiological, psychological and social processes that can be elucidated by multilevel research in social and cultural neuroscience. Idioms of distress are pragmatic com-

munication strategies that can be studied with ethnographic and other social science methods. Causal attributions or explanatory models involve both cognitive and social processes of attribution and interpretation that can be studied with the methods of cognitive and social psychology. Research can refine these cultural concepts, map their inter-relationships and clarify their clinical application.

SYMPOSIUM 39 ACHIEVEMENT, INNOVATION, AND LEADERSHIP IN THE AFFECTIVE SPECTRUM

Discussant: Frederick K. Goodwin, M.D.

Chair: Michael A. Freeman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Consider the research findings that link mania-proneness to increased reward activation and ambition in both diagnosed and sub-syndromal populations; 2) Review evidence linking both eminent and “everyday” creativity to mood disorders, particularly bipolar disorder; 3) Appreciate advantageous affective states and traits that contribute to the effectiveness of mood-spectrum innovators and entrepreneurs; and 4) Become familiar with research about key affective features of mood-spectrum leadership such as realism, empathy, creativity, and resilience.

SUMMARY:

Psychiatric and psychological research suggests that there may be some aspects of affective disorders, including mania and depression, that are beneficial. For example, hypomania has been associated with creativity while depression has been associated with enhanced realism and increased empathy. This symposium will explore the advantages that affective spectrum conditions may confer with respect to ambition, achievement, creativity, innovation, entrepreneurship, and political and military leadership. This will be the first symposium at an APA meeting to bring together the research on creativity and the other positive aspects of mood conditions from the fields of psychiatry and psychology, and clinical experience. The presenters are prominent experts in the field of bipolar disorder and depression and will present the most recent research on the topic.

NO 1 AMBITION AND ACHIEVEMENT

Speaker: Sheri L. Johnson, Ph.D.

SUMMARY:

This presentation will discuss empirical findings regarding high levels of success among the family members of bipolar probands. A large number of empirical studies indicate that bipolar people demonstrate heightened reward sensitivity (including increased energy and enthusiasm in response to potential goals), and tendencies to set and pursue extremely challenging life goals. These qualities are often adaptive, yet findings suggest that reward sensitivity and heightened ambition can predict the onset of disorder and a more severe

course of mania.

NO 2 CREATIVITY

Speaker: Terence A. Ketter, M.D.

SUMMARY:

Eminent creators have an excess of mood (especially bipolar) disorders and affective temperamental variations. Stanford University research suggested increased “everyday” creativity in euthymic patients with bipolar disorders (at a level similar to that in creative discipline graduate students), but not in euthymic patients with unipolar major depressive disorders. Moreover, concurrent measures of temperament & personality indicated overlapping traits in bipolar disorder patients and creative discipline graduate students. Thus, shared temperamental and personality traits in bipolar disorder patients and creative individuals could contribute importantly to enhanced creativity in individuals with bipolar disorder. Specifically, changeable (cyclothymic temperament) and at times negative (neuroticism) feelings as well as open-minded (openness to experience) and intuitive thought processes may confer creative advantages in bipolar disorder patients and creative discipline graduate students.

NO 3 INNOVATION AND ENTREPRENEURSHIP

Speaker: Michael A. Freeman, M.D.

SUMMARY:

Innovation and entrepreneurship drive economic growth, which in turn engenders job creation and the capital formation that is required to finance further innovation. Affective spectrum states and traits convey unique advantages that support the cognition, affect, motivation, energy, persistence, interpersonal communication strengths and other behaviors required for entrepreneurial success. This presentation will review the foundational tasks of innovation and launching new enterprises within the context of continuous economic disruption, and why affective spectrum innovators and entrepreneurs excel at executing these tasks.

NO 4 POLITICAL AND MILITARY LEADERSHIP

Speaker: S. Nassir Ghaemi, M.D., M.P.H.

SUMMARY:

In this presentation, I will review historical documentation based on primary sources demonstrating evidence for depression or mania in great political and military leaders. I will examine the scientific literature regarding aspects of depression and mania, especially when mild to moderate, that may enhance leadership skills. These traits include empathy and realism (enhanced by depression), and creativity and resilience to trauma (enhanced by mania). I will suggest that there are some positive aspects to mood illnesses that may especially benefit leaders during periods of crisis, such as war or political change.

SYMPOSIUM 40 THE SIXTH VITAL SIGN: ASSESSING COGNITIVE IMPAIRMENT IN HIV-INFECTED PATIENTS

Chair: Marshall Forstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize symptoms of cognitive impairment in patients with HIV/AIDS; 2) Demonstrate knowledge of diagnostic criteria for HIV-associated Neurocognitive Disorders and medical rule-outs; 3) Understand the benefits and limitations of assessment tools for cognitive impairment; and 4) Improve clinical decision-making skills.

SUMMARY:

This workshop is designed to help residents diagnose, treat and manage patients with cognitive changes related to HIV/AIDS. The impact of cognitive impairment on HIV-infected individuals is related not only to their functional status but also to their adherence to the complex drug treatment regimens and medical care, their ability to cope and to work, their adherence to protective sexual practices, the reduction in high-risk behaviors, and their risk of mortality. Cognitive impairment can present as a spectrum of impairment ranging from asymptomatic impairment to severe dementia. Faculty will review the diagnostic issues and assessment criteria for HIV-associated cognitive disorders and the therapeutic and pharmacological strategies for managing impairment in this case-based symposia. Interactive roundtable discussions will allow residents to meet with experienced clinicians to review individual cases and to enhance problems solving, diagnostic and decision-making skills.

NO 1 CLINICAL CASE DISCUSSION: COGNITIVE DECLINE

Speaker: Marshall Forstein, M.D.

SUMMARY:

The clinical manifestations of the HIV-associated neurocognitive disorders have changed over time, with chronic inactive and fluctuating forms of the impairment becoming more common although often unrecognized or misdiagnosed. Case presentations and discussion will illustrate these often subtle deficits in functioning.

NO 2 COGNITIVE DISORDERS

Speaker: Karl Goodkin, M.D., Ph.D.

SUMMARY:

Although HIV-associated dementia and minor neurocognitive disorder have declined in incidence, HIV-associated neurocognitive impairment continues to be a frequent and clinically important focus in the highly active antiretroviral therapy era. Long-term toxicities of the antiretroviral themselves are now known to contribute to the etiology of these disorders,

primarily through the addition of a vascular pathogenic factor. Thus, new criteria have been promulgated for HIV-associated dementia and mild neurocognitive disorder, and asymptomatic neurocognitive impairment has been added as a condition to be diagnosed. Documented, effective therapies for these treatment targets remain largely constrained to the CNS-penetrating antiretroviral regimens and the psycho stimulants.

NO 3 ASSESSMENT AND DIAGNOSIS

Speaker: Lawrence M. McGlynn, M.D.

SUMMARY:

The laboratory measures posing a risk for neurocognitive disorder, HIV progression, and lack of treatment response that were useful previously for these disorders are no longer highly predictive in the HAART era. HIV-associated neurocognitive disorders conditions remain diagnoses of exclusion. Faculty will present clinical tools that may prove useful in helping to make an assessment of cognitive impairment.

NO 4 CLINICAL ROUNDTABLES

Speaker: Suad Kapetanovic, M.D.

SUMMARY:

This session allows residents the opportunity to meet with clinical experts and peers to discuss cases in further depth, explore the clinical challenges of HIV patient care, access additional resources, and expand professional networks.

SYMPOSIUM 41 USING BIOMARKERS TO SELECT TREATMENTS: AN ILLUSTRATION FROM THE INTERNATIONAL STUDY TO PREDICT OPTIMIZED TREATMENT FOR DEPRESSION

Discussant: A. John Rush, M.D.

Chair(s): Alan F. Schatzberg, M.D., Leanne Williams, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) The design, rationale and clinical outcomes of the first 1008 iSPOT-D trial participants; this trial was designed to identify specific pre-treatment measures by which to select among antidepressant me; 2) The clinical factors that predict treatment outcomes for depressed outpatients, including age of onset and exposure to trauma early in life.;3) The behavioral and cognitive tests that may predict which medication to select in the acute treatment of depression.;4) Brain circuits involved in depression and antidepressant medication effects; and 5) Genomic as related to treatment prediction and clinical state.

SUMMARY:

This symposium will update the audience on the ongoing International Study to Predict Optimized Treatment in De-

pression (iSPOT-D) which aims to identify practical, pre-treatment measures by which to select among three commonly prescribed antidepressants; escitalopram, sertraline or venlafaxine-XR. It will inform the attendees of: 1) clinical characteristics and acute outcomes (e.g. response and remission); 2) clinical predictors of treatment outcome and the role of early life risk factors, such as early life trauma; 3) contribution of behavioral tests of emotion and cognition in predicting treatment outcomes; and 4) utility of imaging of the brain circuitry involved in depression and the genomics relationship to clinical response. Method: iSPOT-D mirrors routine practice while employing standardized pre/post-treatment clinical and biological assessments in an 8 week randomized , multi-site acute treatment trial with up to a 44 week follow up. 20 in the US, Netherlands, Australia/New Zealand and South Africa will enroll 2016 outpatients with nonpsychotic major depressive disorder (672 per treatment arm) and 672 matched healthy controls. Patients are either antidepressant medication naïve or willing to undergo wash-out. Baseline assessments include symptoms, risk factors, behavioral tests of emotional and cognitive function, electroencephalogram and blood draws for genotyping, and 10% structural and functional brain imaging. These assessments allow for a structural and functional appraisal of brain systems and circuits involved in depression relevant to treatment selection. Results: In the first 1008 participants, the overall response rate was 62% (remission rate=45%). Concurrent anxiety and prior exposure to trauma early in life were associated with poorer remission rates. Pretreatment behavioural measures were significant predictors of remission, independent of symptom severity. A corresponding profile of limbic hyper-reactivity to emotional stimuli and frontal hypo-activity to cognitive and emotional tasks was revealed by functional neuroimaging. Conclusions: These initial results indicate that a number of measures obtained prior to starting antidepressant medication have the ability to predict outcomes. A combination of these measures may ultimately become tools in usual clinical care that helps us better match treatment to patients. Critical early events, such as exposure to trauma, are likely to modulate these biological predictors.

NO 1 ISPOT-D: A PRACTICAL TRIAL TO IDENTIFY CLINICALLY APPLICABLE PREDICTORS OF ANTIDEPRESSANT OUTCOMES

Speaker: Radu V. Saveanu, M.D.

SUMMARY:

Clinically useful treatment moderators of Major Depressive Disorder (MDD) have not yet been identified, though some baseline predictors of treatment outcome have been proposed. The aim of iSPOT-D is to identify pretreatment measures that predict or moderate MDD treatment response or remission to escitalopram, sertraline or venlafaxine XR; and develop a model that incorporates multiple predictors and moderators.

NO 2 EARLY-LIFE EVENTS MODERATE CURRENT CLINICAL PROFILE AND ANTIDEPRESSANT RE- MISSION OUTCOMES

Speaker: Charles DeBattista, M.D.

SUMMARY:

In depressive disorder, key events earlier in life may heighten risk and moderate treatment outcomes. Exposure to early life trauma has been implicated in both susceptibility for depression and in treatment outcomes. In the international Study to Predict Optimize Treatment in Depression (iSPOT-D), we examined the main effect of exposure to 19 traumatic events on remission at 8 weeks, while covarying for the effects of site, and baseline symptom severity. The presence of exposure to abuse at any age prior to 18 years predicted extent of remission. There was an inverse association between trauma and remission; the greater the exposure to early life trauma, the poorer the remission outcome. This relationship was not moderated by type of treatment, across escitalopram, sertraline or venlafaxine-XR, when dose was averaged.

NO 3 CLINIC-READY PREDICTORS OF ANTIDEPRES- SANT TREATMENT OUTCOMES: USING STAN- DARDIZED BEHAVIORAL TESTS OF COGNITION AND EMOTION

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

SUMMARY:

The international Study to predict Optimized Treatment in Depression (iSPOT-D) is a multi-site pragmatic clinical trial designed to identify predictors of antidepressant outcome. Behavioral performance tests of cognition and emotion are well suited to this goal, because they are straightforward to use, and capture the function of underlying brain circuits. 1008 depressed outpatients were assessed on these tests at baseline, when unmedicated, and then randomized to receive escitalopram, sertraline or venlafaxine-XR for 8 weeks. Core capacities assessed by the behavioral tests included: Emotion identification, delayed emotional memory, psychomotor speed, decision speed, attention, working memory, verbal memory, response inhibition, cognitive flexibility and executive function. We found that the combination of these measures at baseline resulted in prediction of the likelihood of remission, over and above effects related to depression severity or demographic factors.

NO 4 USING IMAGING TO INFORM TREATMENT PRE- DICTION IN MAJOR DEPRESSIVE DISORDER

Speaker: Leanne Williams, Ph.D.

SUMMARY:

In depressive disorder, key events earlier in life may heighten risk and moderate treatment outcomes. In iSPOT-D we examined the main effect of exposure to 19 traumatic events on remission at 8 weeks, while covarying for the effects of site,

and baseline symptom severity. The presence of exposure to abuse at any age prior to 18 years predicted extent of remission. There was an inverse association between trauma and remission; the greater the exposure to early life trauma, the poorer the remission outcome. This relationship was not moderated by type of treatment, across escitalopram, sertraline or venlafaxine-XR, when dose was averaged. However, when the sample was stratified by patients on high doses, the effect of exposure to trauma on remission was even more pronounced. These findings highlight the importance of considering early life traumatic events when identifying biologically-based predictors of treatment outcomes.

NO 5 GENETIC PREDICTORS OF TREATMENT OUT- COMES IN MAJOR DEPRESSIVE DISORDER

Speaker: Stephen H. Koslow, B.S., Ph.D.

SUMMARY:

This study will first use a candidate SNP approach, and then a GWAS, to identify genetic predisposition to predict a positive response to one of the three therapeutic agents used in this trial. Our initial candidate set of SNPs will be a combination of 742 SNPs which have been reported to be implicated in depression, response to therapy, and non-response to therapy. Our initial analysis will focus on SNPs related to the purported mechanism of action of the drugs thereby testing connections to the circuitry involved. A second approach will use a logical clustering of genes according to their function; for example the Hypothalamic Pituitary Axis, Brain-Derived Neurotrophic Factor (BDNF), Serotonergic, Noradrenergic, Protein, Inflammation and behaviors. Additional analysis with specific SNPs will be tested based on their relationship to the questions and measures addressed in the previous presentations in this panel. In our plan for GWAS, we will also consider extending to use next genera

SYMPOSIUM 42 PREVENTING DEPRESSION: LIFE-CYCLE PER- SPECTIVES

Chair(s): Charles F. Reynolds III, M.D., Pim Cuijpers, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Specify and discuss the public health rationale and need for depression prevention across the life cycle; 2) Describe promising strategies (psychosocial, pharmacologic, and nutraceutical), for depression prevention across the life cycle; and 3) List unmet needs confronting the field, such as the need for biosignatures to guide the rational introduction of depression prevention strategies and the use of web-based strategies and lay health counseling.

SUMMARY:

Prevention of depression across the life cycle has emerged globally as a major public health priority for Several reasons: (1) currently available depression treatments are only partially

successful at averting Years lived with disability, (2) current treatments, while effective, have only limited availability, (3) Depression is a major source of global illness burden with respect to the psychosocial disability it imposes and amplification of disability from coexisting medical illness, and (4) there are promising, cost-effective strategies for depression prevention in at-risk persons. The most promising interventions have shown efficacy in persons either with known risk factors for depression (“selective” prevention, using the institute of medicine’s lexicon) and/or those already living with mild or subsyndromal symptoms (“indicated” prevention, per the iom). Interventions with demonstrated efficacy have ranged from the use of brief learning-based psychotherapies delivered in individual or group format (e.g., problem solving therapy and group based cognitive behavioral therapy), to low-dose antidepressant medication administered to patients with known medical or neurologic risk factors. The field is promising but young. Particular areas of necessary further research include the use of web-based interventions and of lay health counselors to reach underserved populations, the development of biosignatures to guide rational introduction of depression prevention, and potentially the use of nutraceuticals, such as vitamin d and/or fish oils.

NO 1 PREVENTING THE ONSET OF DEPRESSIVE DISORDERS: AN UPDATED META-ANALYSIS

Speaker: Pim Cuijpers, Ph.D.

SUMMARY:

A growing number of studies have tested the efficacy of preventive interventions in reducing the incidence of depressive disorders. Meta-analyses of these studies have found that preventive interventions can reduce the incidence of depressive disorders. However, many new trials have been conducted since the publication of the latest meta-analyses, and these trials have been conducted within different domains. In this presentation the results of an updated meta-analysis will be presented. In the initial meta-analysis (Cuijpers et al., 2008) we included 19 randomized controlled trials, and we expect to be able to include 30 to 40 trials in the updated paper. One important goal is to verify if we can confirm the initial results (Incidence rate ratio: 0.78), and to see if this is also found in the different subdomains (school-interventions; postpartum depression; primary care) and age groups (adolescents, adult, older adults).

NO 2 DEPRESSION PREVENTION TRIALS IN ADOLESCENTS: AN OVERVIEW

Speaker: Greg Clarke, Ph.D.

SUMMARY:

First onset of depressive disorder often occurs during adolescence, contributing to reduced psychosocial functioning, elevated rates of other psychiatric and medical comorbidities, and increased risk of suicide. Existing acute treatments have only modest efficacy, contributing to interest in the prevention of depression in youth as a complimentary approach. The

goal of this presentation is to familiarize the audience with the current state of depression prevention in adolescents. This presentation will review prevention trials conducted to date: modes of intervention delivery (school, internet, groups); universal (primary) prevention as well as targeted (selected and indicated) prevention approaches; trials reporting reduced rate of depressive episode onset versus trials reporting changes in depression symptomatology; cost effectiveness; and outcome moderators.

NO 3 LONGER-TERM EFFECTS OF A COGNITIVE-BEHAVIORAL PROGRAM FOR PREVENTING DEPRESSION IN AT-RISK ADOLESCENTS

Speaker: Judy Garber, Ph.D.

SUMMARY:

This study aimed to test the longer term (33 months) effect of a group cognitive-behavioral prevention (CBP) program. A 4-site, randomized controlled trial enrolled 316 adolescent (ages 13-17) offspring of parents with current or prior depressive disorders; adolescents had histories of depression, current elevated depressive symptoms, or both. Youth were randomized to either the group CBP program or usual care (UC). Youth in CBP had significantly fewer depressive episode onsets than those in UC during the 33-month follow-up. When parents were not depressed at intake, CBP was superior to UC (NNT ratio=6), whereas when parents were depressed at baseline, onset rates did not differ. The impact of parental depression on intervention effectiveness varied across sites. Thus, the CBP program showed significant sustained effects compared to UC in preventing the onset of depressive episodes in at-risk youth over a nearly three-year period.

NO 4 PREVENTING DEPRESSION AMONG OLDER ADULTS: HOW FAR HAVE WE COME?

Speaker: Aartjan Beekman, M.D., Ph.D.

SUMMARY:

The aim of this presentation is to provide an update on our progress in preventing depression among older people. As in other areas of medicine, opening up opportunities for prevention and early intervention has the potential to change the face of Geriatric Psychiatry. Over the past decades several strategies to prevent depression among older adults have been tested; with very encouraging results. Epidemiological data will be presented, driving the development of novel preventative interventions. Examples include important risk factors for late life depression (such as hypovitaminosis D) that are open to intervention (selective prevention); and older people who are at very high risk due to their experiencing prodromal symptoms (indicated prevention). Results from a stepped-care trial to prevent depression among very old people in the Netherlands will be presented to illustrate just how (cost)effective prevention may be.

NO 5**LATE-LIFE DEPRESSION PREVENTION IN THE VITAMIN D AND OMEGA-3 TRIAL(VITAL)**

Speaker: Olivia Okereke, M.D., M.S.

SUMMARY:

Prevention of depression in older adults is a public health priority. This presentation describes the methodology of a large-scale randomized trial of primary and secondary prevention of late-life depression: VITAL-DEP (VITamin D and Omega-3 Trial—Depression Endpoint Prevention). Using long-term (5-year) supplementation with vitamin D3 and fish oil in 2x2 factorial design among 20,000 older adults – 10,000 men aged ≥50 and 10,000 women aged ≥55 – VITAL-DEP will estimate the effects of these nutraceuticals on depression risk and mood symptom trajectories. Secondly, VITAL-DEP will test impacts of vitamin D3 on depression risk among African-Americans (who are at higher risk of vitamin D deficiency), and of both agents on risk of clinical depression among a subset of 1,000 participants with high-risk factors or sub-syndromal symptoms. Thus, VITAL-DEP will utilize all modalities of state-of-the-art prevention research – universal, selective and indicated.

SYMPOSIUM 43**ATTENTION DEFICIT HYPERACTIVITY DISORDER AND DRIVING SAFETY**

Chair: Richard L. Merkel Jr., M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List the risks of driving associated with ADHD and how the risks resulting from ADHD are different from those of young adult drivers without ADHD; 2) discuss the risks and benefits of pharmacological treatment of ADHD with stimulants and non-stimulants and the specific benefits of treatment in regard to driving; 3) Identify limitations of pharmacological treatments of ADHD drivers and identify non-pharmacological strategies for improving driving safety in young adults with ADHD; and 4) Discuss the legal and ethical ramifications of driving with ADHD and the specific responsibilities of the psychiatrist in this situation.

SUMMARY:

Attention deficit hyperactivity disorder may affect 5% of the young adult population and causes an increased risk of driving mishaps. Young drivers with ADHD are at least four times more likely to have an auto accident than matched peers without ADHD. Auto accidents are the number one cause of death in young adults in the US. Data reflecting this increased risk of driving accidents for those with ADHD derived from longitudinal follow-up studies, questionnaires, and the use of driving simulators will be reviewed. However, the exact difficulties resulting from ADHD have not been previously demonstrated in day-to-day, on-road driving. Our research examining a matched sample of young adult drivers with and without ADHD compared via blinded ratings of videotaped g-force events recorded by DriveCam technology over 3 months of

on-road driving will be described. Based on the results of this study the increased risk for ADHD drivers appears to be the result of increased risk taking, increased hyperactivity/impulsivity or distraction behavior, increased vulnerability to factors that interfere with driving in general, while the consequences of faulty driving were either higher or potentially higher in those drivers with ADHD.

NO 1**ATTENTION-DEFICIT/HYPERACTIVITY AND DRIVING SAFETY: DO PHARMACOLOGICAL INTERVENTIONS IMPROVE DRIVING SAFETY AND REDUCE COLLISIONS?**

Speaker: Roger Burket, M.D.

SUMMARY:

The use of stimulants and non-stimulant medications for ADHD will be reviewed with special focus on driving. The ADHD core features of inattentiveness, easy distractibility and impulsiveness which may impair driving safety are the natural targets of medication interventions. There are a number of U.S. and European studies that demonstrate the efficacy of stimulants in either experimental simulation driving or on-road driving. The findings and short-comings of these studies will be reviewed, and the possible utility of non-stimulant approaches will be discussed. An actual on-road, day-to-day driving study conducted with a sample of young adult drivers with ADHD using a transdermal methylphenidate formulation in a cross-over method, will be reviewed in detail. This study shows significant improvement of on-the-road driving and fewer collisions during the three months of medication usage in the subjects.

NO 2**LEGAL AND ETHICAL ASPECTS OF PATIENT DRIVING RISK**

Speaker: Richard J. Bonnie, LL.B.

SUMMARY:

Reporting of unsafe drivers is legislated state-by-state. While no state statute specifically addresses driving safety of individuals with ADHD, some statutes have general provisions that could cover ADHD, and general tort law principles require physicians to notify and counsel patients, regardless of the causal medical condition, if their condition (or medication prescribed to treat it) might impair the patient's ability to drive safely. Moreover, even if physicians are not required by statute to report their patients to the DMV, reporting is ethically permitted by most authoritative professional guidelines if the physician believes that a patient poses a risk to the community, and many state medical confidentiality statutes provide exceptions to allow public health reporting, which is also permitted by HIPAA. However, every physician should ascertain what is required and permitted under the law of the particular state in which he or she practices.

NO 3 NONPHARMACOLOGICAL MEASURES TO IMPROVE DRIVING IN ADHD

Speaker: Daniel J. Cox, Ph.D.

SUMMARY:

While significantly effective in supporting driving safety, ADHD medications have a host of limitations for different individuals, including rebound, limited duration of effect, ineffectiveness, side effects, non-compliance and costs. Ideally, what is needed is an effective intervention that does not rely on a patient's implementation, which is effective whenever the driver is behind the wheel that reduces distraction, promotes attention to driving-relevant demands and discourages impulsivity. Several possibilities will be reviewed and their benefits and limitations will be discussed. These include the use of a manual transmission, cell phone blocking systems, rear radar systems, automated braking systems, speed threshold systems, GPS systems, and parking systems. While there is no data suggesting these technologies are efficacious specifically with ADHD drivers, it might be clinically prudent to discuss such technologies with both ADHD drivers and significant others.

SYMPOSIUM 44 PSYCHOTHERAPY AND PSYCHOPHARMACOLOGY IN PATIENTS WITH CANCER: PRACTICAL CONSIDERATIONS FROM DIAGNOSIS TO THE PALLIATIVE PHASES

Chair: Antolin C. Trinidad, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify and define the various stages in the cancer care continuum; 2) Discuss the various psychotherapeutic frames that could be used in emotional problems in each of the stages of cancer care; 3) Discuss psychopharmacological principles in cancer care including drug-drug interactions; and 4) Discuss principles relevant to psychopharmacology in the palliative phases of cancer.

SUMMARY:

Psychiatrists and other mental health professionals have become mainstays in the modern management of cancer patients. Cancer centers are increasingly mandated to provide behavioral and mental health support services. This symposium reviews, in an in-depth way, a comprehensive psychiatric management of clinical problems among cancer patients. We encourage a seamless and organic integration of psychotherapeutic and psychopharmacologic strategies in approaching clinical problems of depression, adjustment disorders, demoralization, existential issues, meanings exploration and other clinical problems. Psychotherapeutic frames using strategies from CBT and interpersonal therapies will be discussed and applied to each stage in the cancer care continuum (diagnosis to remission or palliative/end-of-life care). Case vignettes will be presented. Two psychiatrists from MD Anderson Cancer Center in Houston will discuss psychopharmacologic issues,

with drug-drug interaction and palliative care pharmacology as emphases.

NO 1 DRUG-DRUG INTERACTIONS IN CANCER PATIENTS: A PRIMER FOR PSYCHIATRISTS

Speaker: Anis Rashid, M.D.

SUMMARY:

Drug interactions are a common risks in cancer patients since they receive multiple medications like anti-neoplastic agents, medications to control co-morbid medical illnesses, infections, pain, nausea, sleep problems along with anxiety and depression. Consult Liaison Psychiatrists are often asked to treat hospitalized cancer patients with delirium, alcohol or benzodiazepine withdrawal, severe anxiety and/or depression. Prescribing psychotropic medications to these patients becomes a challenge. This presentation will focus on some of the more common practices and problems encountered in the treatment of co-morbid mental illnesses in cancer.

NO 2 PSYCHOTHERAPY AND PSYCHOPHARMACOLOGY IN PATIENTS WITH CANCER: PRACTICAL CONSIDERATIONS FROM DIAGNOSIS TO THE PALLIATIVE PHASES

Speaker: Antolin C. Trinidad, M.D., Ph.D.

SUMMARY:

In this presentation, we will discuss the different phases of the cancer continuum: diagnosis, remission-induction, remission, recurrence, palliative phases. Specific clinical situations requiring different psychotherapeutic approaches emerge. Although modalities such as CBT and interpersonal therapies can inform the approach, framing these approaches require versatility and flexibility on the part of the clinician. This presentation will conceptualize the problems of patients according to the phases of the cancer care continuum. The psychotherapeutic frames would incorporate CBT and interpersonal psychotherapy strategies along with existential and meanings-oriented explorations. Case vignettes will be presented. The hope is the participants will take with them specific abilities to approach and treat each cancer patients with psychotherapy if appropriate, along with psychopharmacology, and not just the psychopharmacology alone.

NO 3 THE PALLIATIVE PHASES: PSYCHOPHARMACOLOGICAL CONSIDERATIONS

Speaker: Seema Thekdi, M.D.

SUMMARY:

The psychiatrist plays a unique role in the care of the cancer patient in the palliative phase of treatment. In addition to psychotherapeutic interventions for the patient and caregivers, the psychiatrist utilizes psychopharmacology to mitigate both emotional and physical symptoms that arise in the context of terminal illness. In this presentation, indications for psycho-

tropic intervention in palliative cancer care will be reviewed, including depression, anxiety, sleep disturbance, cognitive dysfunction, hiccoughs, anorexia, fatigue, nausea, and pain. For each target symptom, appropriate medication classes will be identified, and clinical pearls regarding specific agents reviewed. Relevant empirical studies conducted in this vulnerable patient population provide the foundation for the interventions discussed, and a brief overview of this data will be referenced for the audience.

SYMPOSIUM 45 OVERVIEW OF THE REVISION OF THE ICD-11 CLASSIFICATION OF MENTAL AND BEHAVIORAL DISORDERS

Chair(s): Michael B. First, M.D., Geoffrey M. Reed, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the overall goals and structure of the revision process of the ICD-11 classification of mental and mental disorders; 2) Be familiar with the major proposed changes in the mood, anxiety, psychotic, stress-related and personality sections of the ICD-11; and 3) Understand the relationship between the ICD-11 revision, the forthcoming implementation of the ICD-10-CM in the United States and their relationship to the DSM-5.

SUMMARY:

The International Classification of Diseases is being revised for the first time since 1990, with publication of ICD-11 expected in 2015. A primary goal of the ICD-11 classification of mental disorders is to reduce the disease burden of mental disorders by facilitating identification and treatment by front-line health workers. Therefore a primary focus in developing ICD-11 revision is clinical utility. Since 1977, the United States has used a clinical modification (CM) to provide additional information relevant to US health systems. Currently, the US continues to use the 1978 ICD-9 classification as the basis for its official classification system and is only now preparing to switch to a clinical modification of ICD-10, with implementation in currently scheduled for October 2014. DSM-5 is thus being published with both the ICD-9-CM and ICD-10-CM diagnostic codes. At some future point, however, the US will adopt ICD-11, so some degree of harmonization between DSM-5 and ICD-11 is important. One major change in ICD-11 is its organizational structure with 22 divisions. Collaborations between representatives of APA and WHO have resulted in a largely harmonized organizational structure for ICD-11 and DSM-5, but important differences remain at the level of individual disorders. As with ICD-10, different versions of the ICD-11 mental disorders section will be produced, each optimized to meet the needs of various user, for example, a brief version is being developed for use in primary care settings, a version consisting of clinical descriptions and diagnostic guidelines is intended for general clinical and educational use, and a version will also be developed for use in research settings. This symposium begins with an overview

of the overall revision process and its guiding principles, and formative field studies carried out as a part of the development of the ICD-11 mental disorders chapter. An international advisory group, with representatives from various countries and professional organizations provides overall guidance to the WHO Secretariat, which is responsible for the technical aspects of the revision. In addition, there are 13 ICD revision working groups. Each comprises experts in their respective fields, representing all WHO global regions, who generate revision proposals using standardized templates (content forms) for the organization of diagnostic content. The symposium will next describe the nature of the ICD-11's clinical descriptions and diagnostic guidelines, their relationship to clinical utility, and their differences from DSM-5 will be described. The remainder of the symposium will highlight the major changes being proposed for ICD-11 in the areas of Psychotic Disorders, Mood and Anxiety Disorders, Stress-Related Disorders, and Personality Disorders, presented by the Chairs of the respective ICD revision working groups.

NO 1 IMPROVING THE CLINICAL UTILITY OF WHO'S ICD-11: CONCEPTS AND EVIDENCE

Speaker: Geoffrey M. Reed, Ph.D.

SUMMARY:

WHO's 194 member countries use ICD as an official framework for health information and reporting. A diagnostic system with poor clinical utility cannot support global practice improvement or provide valid data based on health encounters for health policy purposes. An active program of surveys and field studies has provided information on how to improve the clinical utility of ICD-11's mental disorders classification without sacrificing validity. A global survey of nearly 5000 psychiatrists in 42 countries showed important differences between US psychiatrists and their global colleagues. Two global field studies have shown that clinicians' conceptualizations of the relationships among mental disorders are rational and highly stable, regardless of country, language, profession, or country income level. This presentation will provide an overview of the ICD-11 development process, as well as surveys and field studies conducted to date and how these will be used in developing the ICD-11.

NO 2 OVERVIEW OF THE CONTENT FORMS AS THE BASIS FOR THE ICD-11 CLINICAL DESCRIPTIONS AND DIAGNOSTIC GUIDELINES

Speaker: Michael B. First, M.D.

SUMMARY:

The central focus for the development of the mental disorders chapter of ICD-11 is the Clinical Descriptions and Diagnostic Guidelines (CDDG). To insure consistency of diagnostic information across categories, a standardized template known as a "content form" has been developed that will serve as the source of information for the various diagnostic products. The content form includes information regarding the placement of the disorder within the ICD-11 hierarchy, its definition, diag-

nostic guidelines (focusing on diagnostic features essential for making the diagnosis), differential diagnosis, differential from normality, developmental features, course features, cultural features, gender features, associated features, and assessment issues. Clinical utility is the guiding principle in limiting the potential volume of information that could be included. Examples of the various sections will be provided during the presentation.

NO 3 THE ICD-11 CLASSIFICATION OF PSYCHOTIC DISORDERS

Speaker: Wolfgang Gaebel, M.D., Ph.D.

SUMMARY:

The ICD-11 revision process for schizophrenia and other primary psychotic disorders has been carried out by a working group on psychotic disorders installed in 2010. The group consists of members of all WHO regions. The group strived to simplify the criteria in order to increase their utility. The metastructure of this chapter was revised in that specifiers for symptoms (positive, negative, depression, mania, psychomotor symptoms including catatonia, and cognition) and course were introduced and may be used for those psychotic disorders to whom they apply. In schizophrenia, first-rank symptoms were deemphasized. Schizoaffective disorder will focus on a crosssectional diagnostic approach. ATPD (Acute and Transient Psychotic Disorders) will be reorganised in that schizophrenia-like and mainly delusional disorders will be moved to their appropriate chapters. Delusional disorder and schizotypal disorder remained largely unchanged.

NO 4 CONVERGENCES AND DIVERGENCES IN ICD-11 AND DSM-5: APPROACHES TO THE CLASSIFICATION OF MOOD AND ANXIETY DISORDERS

Speaker: Mario Maj, M.D., Ph.D.

SUMMARY:

ICD-11 and DSM-5 will be more similar than their predecessors in several aspects of the classification of mood and anxiety disorders. Bipolar II disorder and some subtypes of depression will be introduced in ICD-11. Both systems will include increased activation/energy as a defining symptom for mania, and will acknowledge that a manic/hypomanic syndrome emerging during antidepressant treatment qualifies for the diagnosis of manic/hypomanic episode. The current discrepancy in the characterization of panic and agoraphobia will be corrected. There will be also, however, some divergences between the two systems. These will include a different characterization of mixed states, and the inclusion in ICD-11 of a subthreshold anxiety-depressive syndrome (only proposed for further study in DSM-5). The initial divergence in the approaches to bereavement-related depression is now considerably reduced, as an outcome of the public debate on this issue occurring in the past months.

NO 5 DISORDERS SPECIFICALLY ASSOCIATED WITH STRESS: CONCEPT AND FIELD-STUDY PLANNING

Speaker: Andreas Maercker, M.D., Ph.D.

SUMMARY:

The international working group on disorders specifically associated with stress provided a revised grouping and revised versions for the following disorders: Post-traumatic stress disorder, complex post-traumatic stress disorder, prolonged grief disorder, adjustment disorder as well as two subtypes of attachment disorders in childhood and adolescence. All revisions strived to specify, simplify and cross-culturally adapt the definitions and criteria. Field studies in six countries from all world regions are in preparation that investigate validity, reliability, and utility of the definitions and criteria by multi-method assessment in diverse populations including samples from WHO-related humanitarian settings.

NO 6 MAJOR REVISION OF THE CLASSIFICATION OF PERSONALITY DISORDERS

Speaker: Peter Tyrer, M.D.

SUMMARY:

The new revision of the classification of personality disorders in ICD-11 is a major change from previous classifications. Because the empirical evidence for the individual categories of personality disorder is so weak all have been removed from the new classification and replaced by a simple dimensional system of severity. This comprises four levels of personality disturbance; personality difficulty (not coded as a disorder but included as a Z-code), personality disorder, moderately severe (title still not fully determined) and severe personality disorder (Tyrer et al, 2011). The nature of the personality disturbance is described in domain descriptions, which are still under discussion but likely to include four or five only in order to make the classification simple.

SYMPOSIUM 46 THE IMPACT OF CULTURE, ETHNICITY, AND ETHNOPSYCHOPHARMACOLOGY ON MOOD DISORDERS: AN UPDATE

Chair(s): Shamsah Sonawalla, M.D., David Mischoulon, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate that culture and ethnicity significantly impact clinical presentation and treatment response in mood disorders; 2) Understand the principles and clinical application of ethnopsychopharmacology; and 3) Recognize cross-cultural issues in the psychopharmacological and psychotherapeutic treatment of mood disorders.

SUMMARY:

This symposium will discuss the impact of culture, ethnicity and ethnopsychopharmacology on mood disorders and discuss approaches in managing mood disorders across cultures. Cross-cultural psychiatry has emerged as an important and an integral component of psychiatry, especially in the last two decades. It is more relevant today than ever before due to the increasing migration of the world's population across countries, in an era of increasing globalization. It is important for a clinician to understand illness in the cultural context of the individual. Culture has a major influence on symptom expression, help-seeking behavior, attitudes towards treatment, treatment expectations and response, therapeutic compliance, family involvement, and interpretation of side effects, all of which determine treatment effectiveness. Dr. David Henderson will review the basic principles of ethnopsychopharmacology, and highlight the impact of race, sex, and culture on drug-drug interactions and metabolism, adverse events, compliance, and response to treatment. He will also discuss strategies to enhance clinical compliance and outcomes, and the role of genetic screening for poor and slow metabolizers. Dr. Albert Yeung will discuss the impact of cultural beliefs on the treatment of Chinese Americans with mood disorders and discuss possible solutions to improve pharmacological treatment in this population. He will discuss Culturally Sensitive Treatments designed to improve recognition, acceptability, and adherence to treatment of depression in this population, and the outcomes of these interventions. Dr. Rajesh Parikh will discuss management of mood disorders in the Asian-Indian population. He will review the impact of westernization, migration and socioeconomic changes on manifestation of mood disorders in this population, and suggest psychopharmacological and psychotherapeutic modifications to enhance treatment outcome. Dr. Paolo Cassano will discuss challenges faced by clinicians working with the Hispanic population, and review approaches to treatment of mood disorders in this population, including relevant principles of ethnopsychopharmacology, and the role of natural remedies and folk healing. Dr. Shamsah Sonawalla will discuss the impact of cultural and psychosocial factors on the manifestation of mood disorders in women, with a focus on premenstrual, post-partum and perimenopausal depression. She will discuss gender roles across cultures, the role of family, community and social support systems and their impact on depression, and discuss possible strategies for management.

NO 1
ETHNOPSYCHOPHARMACOLOGY UPDATE

Speaker: David Henderson, M.D.

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. Differences in cytochrome P450 enzymes such as the 2D6, 2A6, 2C9/2C19 metabolism rates and their implications for prescribing psychotropic medications will be reviewed. Recommendations will be provided to improve compliance, reduce adverse events and medication interactions, and to improve clinical outcomes. This lecture will also review principles of ethnopsychopharmacology.

NO 2
COLLABORATIVE MANAGEMENT TO IMPROVE TREATMENT OF DEPRESSED CHINESE AMERICANS IN PRIMARY CARE

Speaker: Albert Yeung, M.D.

SUMMARY:

In European and North American cultures, depression is a well-accepted psychiatric syndrome characterized by specific affective, cognitive behavioral, and somatic symptoms. In many non-European cultures, including Nigerians, Chinese, and Canadian Eskimos, equivalent concepts of depressive disorders are not found. Studies exploring illness beliefs of depressed among depressed Chinese Americans with a low degree of acculturation have shown that many of them were unaware of, or unfamiliar with the concept of major depressive disorder (MDD). The discrepancy of illness beliefs between less acculturated Chinese Americans and their physicians has led to under-recognition and under-treatment of MDD among Chinese Americans. The Culturally Sensitive Collaborative Treatment (CSCT) was designed to improve recognition, acceptability, and adherence to treatment of depression. It includes systematic depression screening in primary care and culturally sensitive psychiatric assessment.

NO 3
A CULTURAL PERSPECTIVE ON DEPRESSIVE DISORDERS IN THE ASIAN-INDIAN POPULATION

Speaker: Rajesh M. Parikh, M.D.

SUMMARY:

Asian-Indians are a fast growing community in the United States, and comprise over 16% of the Asian-American community, making it the third largest in the Asian American population. Asian-Indians are a diverse population, with unique cultural norms, family traditions and religious belief systems. Mental illness is often viewed as an embarrassment or stigma and mood disorders are under-diagnosed and under-treated. Family involvement is substantial in treatment and cultural sensitivity is of paramount importance. Alternative treatments are widely used. Data on ethnopsychopharmacology, although limited, suggest differences in metabolism, dose requirements and adverse event profiles for antidepressants. Suggested modifications for managing depression in this 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 4 PSYCHOSIS-LIKE SYMPTOMS IN LATINOS WITH MAJOR DEPRESSIVE DISORDER: CRITERIA, COURSE, AND TREATMENT

Speaker: Paolo Cassano, M.D., Ph.D.

SUMMARY:

The lifetime prevalence of psychosis-like symptoms among Latinos living in the United States is 9.5%, and up to 27% of Latinos with major depressive disorder also experience psychosis-like symptoms. In clinical settings, the prevalence of psychosis-like symptoms among cross-sections of Latino patients ranges from 22% to 46% and is even higher among Latino veterans. Psychosis-like symptoms are associated with higher medical and psychiatric comorbidity and greater suicidality, functional impairment, and utilization of services. The presenter will describe the types of psychosis-like symptoms experienced by Latinos and propose criteria for the differential diagnosis of such symptoms and typical psychotic features. The presenter argues that atypical psychotic symptoms experienced by Latinos with major depressive disorder are nonpsychotic manifestations and that antipsychotic medication should be delayed unless treatment of depression fails to address the psychosis-like symptoms.

NO 5 A CULTURAL PERSPECTIVE ON THE MANAGE- MENT OF DEPRESSION IN WOMEN

Speaker: Shamsah Sonawalla, M.D.

SUMMARY:

Cultural differences exist in the experience and presentation of major depression among women. Women are more prone to 'self-silencing' and 'learned helplessness,' in some cultures. 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 can increase the risk of postpartum depression. 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 illness, e.g., Rajput women in India. This presentation will explore possible cultural factors contributing to gender difference in depression across a woman's reproductive life cycle and discuss implications in management.

SYMPOSIUM 47 MANAGING ILLNESS BEHAVIOR USING ATTACH- MENT THEORY: INTEGRATIVE MODELS IN THE MEDICALLY ILL

Discussant: Susan Abbey, M.D.

Chair(s): Sanjeev Sockalingam, M.D., Jon Hunter, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the utility of attachment theory in understanding illness behavior in medically ill patients; 2) Identify

the association between insecure attachment styles and psychosocial and physical burden in patients with chronic medical diseases; and 3) Formulate an approach to managing health behaviors that result from insecure attachment.

SUMMARY:

Emerging evidence suggests that adult presentations of medical disease are strongly influenced by early caregiving experiences. Attachment theory, a model proposed by John Bowlby, provides a way of conceptualizing these early developmental experiences in terms of their psychological and physiological consequence in adulthood. Studies suggest that insecure attachment styles may precipitate neurohormonal changes increasing vulnerability to stress. Moreover, an understanding of attachment style, specifically secure and insecure sub-types, can provide insights into the illness experience of patients and can help guide medical team management of more challenging patient interactions. Studies have also confirmed an association with insecure attachment style and medically unexplained symptoms, depression and poor adherence to medical treatments. The University of Toronto Consultation-Liaison (C-L) Psychiatry program has adopted attachment theory as a model for understanding and managing patient psychosocial burden and problematic illness behaviors in medical settings. Research on avoidant and anxious attachment style have been examined as predictors of symptoms reporting, health related quality of life and psychological adaptation to medical illness. The following symposium will provide an understanding attachment style and the growing research on attachment theory with respect to medical and psychosocial outcomes. Dr. Hunter's introduction will illustrate why attachment theory is a powerful and clinically effective model to use in C-L psychiatry. Dr. Robert Maunder will provide a summary of research demonstrating links between attachment and health risk behaviours including smoking and problem drinking. Dr. Sanjeev Sockalingam will review data on the association of insecure attachment styles on psychological distress and treatment adherence in patients with chronic liver diseases, including hepatitis C and autoimmune hepatitis. Lastly, Dr. Adrienne Tan will discuss the novel role of attachment style on psychiatric outcomes and adaptation in patients treated on a critical care unit. The symposium will conclude with recommendations on how to manage insecure attachment styles in medical settings using case vignettes (moderated by Dr. Susan Abbey).

NO 1 WHY USE ATTACHMENT THEORY IN CL? AN IN- TRODUCTION AND OVERVIEW

Speaker: Jon Hunter, M.D.

SUMMARY:

This introduction will illustrate why attachment theory is a powerful and clinically effective model to use in CL psychiatry. The current data as it applies to psychosomatic medicine and CL populations will be summarized, and a grounding of attachment theory sufficient to appreciate the model will be provided. The subsequent speakers in the symposium will be introduced, and will use specific clinical situations to elaborate upon the model, finishing with vignettes illustrating how

the CL management plan can be shaped by an attachment perspective.

NO 2 THE ASSOCIATION OF ATTACHMENT STYLE WITH HEALTH-RISK BEHAVIORS

Speaker: Robert Maunder, M.D.

SUMMARY:

Smoking, alcohol consumption and obesity contribute to disease. Adult attachment insecurity may predispose to behaviors that regulate distress. We tested this in adults attending a family practice unit. Of 356 participants, 17% had harmful alcohol use; 5% had BMI > 35 and 19% were current smokers. Harmful alcohol use was associated with attachment anxiety and the interaction of attachment anxiety and avoidance. BMI > 35 was associated with attachment avoidance. Post hoc testing of the interaction suggested that high attachment avoidance combined with high attachment anxiety contributes to harmful drinking beyond the effects of attachment anxiety alone. Attachment anxiety and its combination with attachment avoidance are associated with harmful alcohol use. BMI > 35, which may result from emotional eating, is associated with attachment avoidance. The consequences of attachment insecurity may provide new targets for interventions to modify harmful patterns of alcohol use and eating.

NO 3 ATTACHMENT THEORY, DISTRESS, AND TREATMENT ADHERENCE IN CHRONIC LIVER DISEASE

Speaker: Sanjeev Sockalingam, M.D.

SUMMARY:

Dr. Sockalingam will discuss two studies exploring on the role of attachment style on psychological distress and treatment adherence. The first study is the largest psychosocial study of patients with autoimmune hepatitis (AIH) that explore the impact of psychosocial variables on treatment response and immunosuppressant adherence. In this study, patients with avoidant attachment style had higher treatment non-adherence and poor AIH response. The second study evaluated the association between attachment style and depression and physical symptom reporting in patients suffering from hepatitis C. The results of this study revealed a significant positive association between fearful attachment style, and depression and physical symptoms. A model for understanding the impact of attachment style on depression and physical symptoms in hepatitis C will be discussed.

NO 4 ATTACHMENT AND SURVIVING CRITICAL ILLNESS

Speaker: Adrienne Tan, M.D.

SUMMARY:

Critical illness, by definition, is a life-threatening event that involves uncertain outcomes as well as physical and psy-

chological suffering. Moreover, individuals are often left with long-term sequelae that may result in significant changes in an individual's self-concept and interpersonal relationships. Attachment processes are thought to be activated when an individual feels "distressed, ill or afraid" or in situations involving ambiguity. Coping and adaptation following critical illness, then, may activate attachment behaviours and provide a lens through which to understand an individual's response to critical illness as well as suggest therapeutic approaches to address psychological distress and psychiatric symptoms.

SYMPOSIUM 48 TRANSGENDER WELLNESS ACROSS THE LIFESPAN: WHAT'S NEW IN CLINICAL CARE, EDUCATION, AND RESEARCH?

Chair: Dan H. Karasic, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand new clinical approaches to adult patients presenting with gender dysphoria; 2) Identify and treat gender nonconforming children with mental health needs, including assessing for puberty blockers when appropriate; 3) Utilize the new Standards of Care Version 7 of the World Professional Association for Transgender Health; 4) Understand challenges in research and education in transgender wellness; and 5) Recognize benefits and risks of hormonal and other medical treatments, and principles of health maintenance.

SUMMARY:

The symposium will present talks by experts in transgender health, speaking on current issues in clinical care, education, and research. The speakers, all members of the World Professional Association for Transgender Health (WPATH), will present principles of care of gender nonconforming children and transgender youth as well as transgender adults. Perspectives have broadened from a focus on gender transition, to meeting the mental health and medical needs of trans people across the life span. Mental health care allows for a spectrum of presentations and outcomes in gender identity and expression. These new principles are reflected in WPATH's Standards of Care, Version 7. WPATH's efforts in education and advocacy in support of its Standards of Care and in changing diagnostic nomenclature will be discussed by the organization's president. A model education program in transgender health for Canada will be presented. Principles of medical management, including hormonal therapy and health maintenance will be discussed. New research from Sweden in sexuality in transgender people across the lifespan will be presented.

NO 1 WHAT'S NEW IN PSYCHIATRIC CARE WITH TRANSGENDER ADULTS?

Speaker: Dan H. Karasic, M.D.

SUMMARY:

This talk will review new developments in psychiatric care with transgender adults, illustrated by a brief case presentation.

New perspectives will be discussed on understanding the spectrum of gender identities and expressions. Changes in practice for mental health professionals, reflected in the Standards of Care Version 7 (SOC7) of the World Professional Association for Transgender Health (WPATH), will be applied to a case to illustrate the application of the new SOC7. The proposed DSM V criteria of Gender Dysphoria, and WPATH's recommendations for diagnostic change for the International Classification of Diseases (ICD 11) will be discussed in the context of the case discussion. Psychiatric care of transgender patients with co-occurring mental illness will be discussed, including the perspective of recovery-oriented care.

**NO 2
WHAT'S MY GENDER? TREATMENT CONSIDERATIONS IN FACILITATING AUTHENTIC GENDER IN GENDER-NONCONFORMING CHILDREN**

Speaker: Diane Ehrensaft, Ph.D.

SUMMARY:

Treatment strategies for gender-nonconforming children and families are presented, predicated on the premise that children's gender development is a web that weaves together nature, nurture, and culture and allows for a multiplicity of healthy gender outcomes. Treatment goals are three-fold: promote the child's true gender self; build the child's gender resiliency in the face of external cultural stressors of non-acceptance of gender-nonconforming presentation or identity; strengthen family and social supports for the child. The role of puberty blockers in promoting childhood gender well-being is addressed, along with the clinical challenges of differentiating a child's gender presentation or concerns as a true expression of self or a signal of some other underlying psychological issue. Categories of gender-nonconforming children are outlined and excerpts of a treatment of a young gender-nonconforming child are presented to illustrate the gender-affirmative therapeutic model.

**NO 3
TRANSGENDER HEALTH ISSUES: AN EVIDENCE-BASED REVIEW OF WHAT PSYCHIATRISTS NEED TO KNOW, FEATURING THE UCSF PROTOCOLS**

Speaker: Madeline B. Deutsch, M.D.

SUMMARY:

The UCSF Center of Excellence for Transgender Health Primary Care Protocols for Transgender Care (Transhealth.ucsf.edu) are evidence based best practice guidelines developed by a medical advisory board of clinical experts in transgender medical and mental health care. In this session, Dr. Deutsch will review content covered in these protocols which are of particular concern to psychiatrists. Items covered will include general hormone as well as primary and preventive care, surgical and perioperative considerations, as well as a review of current evidence on selected health outcomes in patients undergoing cross-sex hormone therapy. The session will also include a live demonstration of the protocol website in order to familiarize attendees with their use.

**NO 4
WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH (WPATH) EFFORTS TO IMPROVE TRANS HEALTH CARE IN THE UNITED STATES AND INTERNATIONALLY**

Speaker: Lin Fraser, Ed.D.

SUMMARY:

Founded in 1979, and with over 650 physician, psychologist, social scientist, and legal professional members, all of whom are engaged in research and/or clinical practice that affects the lives of transgender, transsexual and gender nonconforming people, the World Professional Association for Transgender Health (WPATH) is the oldest interdisciplinary professional association in the world concerned with this specialty. Hence, WPATH is in a unique position to impact global trans health care as conceptions, clinical management, research and advocacy efforts evolve and change. This paper will describe the evolution of WPATH's recommendations regarding clinical care as reflected in its international and interdisciplinary Standards of Care, its recommendations on diagnoses to APA and WHO, and its global strategy TIPT (Training, International, Partnerships, Technology) to step up its education, training, advocacy and research efforts to address the need for competent clinical care worldwide.

**NO 5
CREATING STANDARDIZED TRANSGENDER HEALTH TRAINING PROGRAMS ACROSS CANADA**

Speaker: Gail Knudson, M.D.

SUMMARY:

The Canadian Professional Association for Transgender Health (CPATH) is a multidisciplinary association dedicated to increasing access to care for transgender, transsexual and gender-nonconforming Canadians. This mission is best carried out through education and advocacy. Therefore, CPATH has developed a national training program for health care professionals using the World Professional Association for Transgender Health's Standards of Care Version 7 as an anchor. This presentation will highlight the development and delivery of this program across the nation.

**NO 6
SEXUALITY IN TRANSSEXUALS POST-TRANSITION: A CROSS-SECTIONAL SINGLE CENTER STUDY**

Speaker: Cecilia Dhejne, M.D.

SUMMARY:

Introduction: Gender dysphoria denotes incongruence between gender identity and gender phenotype. Sex reassignment (SR) reduces gender dysphoria and improves quality of life (Murad 2009). Method: (n=87) were invited to participate in a follow-up study at least 9 month after SR. Fifty-one males to females (MF), and 17 females to males (FM) were included.

Result: 41/46 MF were sexually active with a partner before transition 12/46 only with men and 16/46 only with women. For MF who were attracted to women pre transition there was a trend towards being involved with men (6/16). FM were sexually active pre and post transition, 7/13 with women and 1/13 with men. Low libido in 10/46 was in 6 of the subjects associated with depression. FM did not report low libido. 25/46 MF and 12/17 FM reported sexuality as very important before and after the transition. For 20/46 MF and 7/17 FM sexuality became more important after transition, when the body was more congruent with the identity.

SYMPOSIUM 49 INTEGRATED TREATMENT FOR PERSONALITY DISORDERS: BEYOND SPECIALIZED TREAT- MENTS

Chair: Jacqueline Kinley, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Articulate how integration moves beyond specialized approaches and leverages effective component to target all domains of personality pathology; 2) Describe the basic principles of mentalization-based treatment as well as the rationale for using of these techniques to enhance the individual's representational capacity; 3) Distinguish the characteristic strategies, tactics, and techniques of transference focused treatment used to identify and integrate internal object relations dyads; and 4) Explain a systemic rationale for integrating groups, to accurately weight and time domain focused interventions, to create synergistic effects and accelerate working through personality pathology.

SUMMARY:

This symposium explores an integrated approach to the treatment of personality disorders as an alternative to the various specialized therapies that have been shown to be effective in randomly controlled trials. There are several reasons for adopting an integrated approach. First, it will be argued that evidence that different treatments for borderline personality disorder produce similar outcomes and that specialized treatments are not substantially better than good clinical care points to the importance of change mechanisms common to all treatments. Second, none of the current therapies for personality disorders provide the comprehensive array of treatment methods needed to treat all aspects of pathology making integration a viable option. Third, integration offers a more parsimonious treatment strategy than combining several specialized treatments. Finally, such an approach allows treatment to be tailored to the needs and psychopathology of the individual that accommodate the extensive heterogeneity of personality pathology and its complex etiology better than a one-approach-fits-all strategy. The presentations will discuss the rationale for integrated treatment and a framework for conceptualizing and organizing treatment; assessment, formulation, and treatment planning required for an integrated approach; a conceptual framework for understanding when, how and why to target domains of pathology in treatment; the role

of general strategies such as mentalizing within an integrated treatment model; and a discussion of how to organize and to deliver integrated domain focused treatment within a group program.

NO 1 MOVING BEYOND SPECIALIZED TREATMENT FOR BORDERLINE PERSONALITY DISORDER

Speaker: John Livesley, M.D., Ph.D.

SUMMARY:

AN INTEGRATED APPROACH IS PRESENTED AS AN ALTERNATIVE TO THE VARIOUS SPECIALIZED THERAPIES THAT HAVE BEEN SHOWN TO BE EFFECTIVE IN RANDOMLY CONTROLLED TRIALS. SPECIALIZED TREATMENTS FOR BORDERLINE PERSONALITY DISORDER PRODUCE SIMILAR OUTCOMES AND ARE NOT SUBSTANTIALLY BETTER THAN GOOD CLINICAL CARE. THE LACK OF ANY CURRENT SPECIALIZED THERAPY'S ABILITY TO PROVIDE THE COMPREHENSIVE ARRAY OF TREATMENT METHODS NEEDED TO TREAT ALL ASPECTS OF PATHOLOGY OR PERSONALITY DISORDERS WILL BE DISCUSSED. CHANGE MECHANISMS COMMON TO ALL TREATMENTS WILL BE CONSIDERED AND A DOMAIN FOCUSED FRAMEWORK PRESENTED. IT WILL BE DEMONSTRATED HOW INTEGRATION OFFERS A MORE PARSIMONIOUS TREATMENT STRATEGY RATHER THAN COMBINING SEVERAL SPECIALIZED TREATMENTS. THIS MAKES INTEGRATION THE MOST VIABLE TREATMENT OPTION, AND SUCH AN APPROACH ALLOWS TREATMENT TO BE TAILORED TO THE NEEDS AND PSYCHOPATHOLOGY OF THE INDIVIDUAL, ACCOMMODATING THE EXTENSIVE HETEROGENEITY OF PERSONALITY PATHOLOGY AND ITS COMPLEX ETIOLOGY.

NO 2 AN INTEGRATED APPROACH TO THE THERA- PEUTIC RELATIONSHIP

Speaker: John F. Clarkin, Ph.D.

SUMMARY:

Personality disordered patients have difficulties in negotiating their relationships with others. This difficulty in interpersonal relations will manifest in the relationship with the therapist in a variety of ways, some subtle and others quite obvious. Given the heterogeneity of patients with pd diagnosis, one must expect a range of patient responses. Attempts to conceptualize and empirically investigate the relationship between therapist and patient have focused on constructs such as the therapeutic alliance, alliance ruptures, managing therapist feelings toward the patient, and transference-countertransference. In this talk, techniques from different schools of therapeutic thought will be summarized and examined for similarities and differences in how the patient-therapist relationship is conceptualized, used as a source of information about the patient, and approached. Symptom severity and sequential treatment goals are introduced as major factors determining therapeutic approach.

NO 3 MENTALIZING AS A GENERIC PROCESS IN THE TREATMENT OF BORDERLINE PERSONALITY DISORDER

Speaker: Anthony Bateman, M.D.

SUMMARY:

All therapies for bpd show certain characteristics; these elements may be responsible for their effectiveness. They a) provide a structure through their manual supporting the therapist and providing recommendations for clinical problems; b) are structured so that they encourage increased activity, proactivity and self-agency; c) focus on emotion processing, particularly on creating connections between acts and feeling; d) increase cognitive coherence in relation to subjective experience in the early phase of treatments by the inclusion of a model of pathology that is explained to the patient; and e) encourage an active therapist stance which invariably includes an explicit intent to validate and demonstrate empathy and generate a strong attachment. This talk proposes the effectiveness of these components is due to their improving mentalizing capacity, a proposed deficit in bpd, and treatment organized to facilitate the mentalizing process will be as effective as specialized treatments.

NO 4 INTEGRATED GROUP PSYCHOTHERAPY FOR PERSONALITY DISORDERS

Speaker: Jacqueline Kinley, M.D.

SUMMARY:

Group interventions provide advantages including containment and amplification of affect, and opportunities for interpersonal learning. We present a systemic rationale integrating groups of different theoretical orientations to accurately weight and time domain focused interventions to meet individual needs in a group context. Treatment work is designed in phases. With severe pathology, cognitive re-structuring and behavioral control (front end work) occur first to establish the emotional containment necessary for core emotional processing. Increasing reflective capacity, differentiating primary and secondary emotions, and increasing affect tolerance, are specifically targeted. The second phase involves working through primitive feelings associated with early attachment trauma, overcoming resistance to experiencing painful emotions, developing an experiential awareness of characteristic defenses and encouraging insight. Consolidation (back end work) integrates and re-constructs the self

SYMPOSIUM 50 THE DSM-5 CULTURAL FORMULATION INTER- VIEW: A STANDARDIZED CULTURAL ASSES- MENT

Discussant: William Narrow, M.D., M.P.H.

Chair(s): Roberto Lewis-Fernandez, M.D., Neil Aggarwal, M.B.A., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the history of the DSM-IV Outline for a Cultural Formulation; 2) Describe the development of the DSM-5 Cultural Formulation Interview (CFI), a 16-item questionnaire with operationalized instructions that can be used with any patient in any clinical setting; 3) Understand results from the international CFI field trial, including clinician and patient assessments of feasibility, acceptability, and perceived clinical utility; 4) Identify the clinical utility of the CFI as well as how and when it should be incorporated into clinical evaluations; and 5) Understand the real-world implementation of the CFI in diverse clinical settings, including the challenges and advantages faced by administrators and clinicians.

SUMMARY:

The inclusion of the Outline for Cultural Formulation (OCF) in DSM-IV provided a template for a cultural assessment to be used during a comprehensive mental health evaluation. Four narrative domains were described in the OCF: (1) cultural identity of the individual, (2) cultural explanations of illness, (3) cultural levels of psychosocial support and functioning, and (4) cultural elements of the patient-physician relationship. A fifth domain noted information that influences diagnosis and treatment. While the OCF has been utilized extensively within cultural competency initiatives and been integrated into professional training guidelines, its outline format has not helped clinicians formulate specific questions for patient care or researchers pursue studies with a standard interview. In response, the DSM-5 Cultural Issues Subgroup has converted the OCF into a set of 16 questions, the Cultural Formulation Interview (CFI), which can be used during routine clinical practice. An APA-supported Field Trial has since tested the feasibility (can it be done?), acceptability (do people like it?) and perceived clinical utility (is it helpful?) of the CFI among patients and clinicians in a simulated intake interview. This symposium by the developers of the CFI presents diverse perspectives on its development and testing. We start by discussing the limitations of the OCF that led to its revision, including its narrative format, lack of standardized design, and limited instructions. The process of developing the CFI is then described, leading to the final version of 16 questions with general guidelines and item-by-item instructions. The CFI is intended as a general cultural assessment that can be used by any clinician with any patient in any clinical setting. It consists of a person-centered review of cultural factors, organized in four sections: (1) cultural definition of the problem, (2) cultural perceptions of cause, context, and support, (3) cultural factors affecting self-coping and past help seeking, and (4) cultural factors affecting current help seeking. These domains may be assessed regardless of the apparent racial/ethnic match between patients and providers. Clinical situations requiring in-depth cultural assessment are guided by supplementary modules, which expand on each domain of the CFI and provide additional questions to assess youth, older adults, and immigrants and refugees. A module for caregivers and an Informant version of the CFI gather collateral information. The third talk presents the findings from the international Field Trial, conducted in 12 cities in 6 countries with over

300 patients. Positive results were obtained from participating patients and clinicians with respect to feasibility, acceptability, and perceived clinical utility of the CFI. The last two talks discuss how to conduct the CFI in the midst of a busy multicultural practice, from the perspectives of clinicians and administrators.

NO 1 A RETROSPECTIVE CLINICAL (AND CRITICAL) HISTORY OF DSM-IV'S OUTLINE FOR A CULTURAL FORMULATION

Speaker: Renato D. Alarcon, M.D., M.P.H.

SUMMARY:

The Outline for a Cultural Formulation was the most concrete tool incorporated into DSM-IV to cover pertinent information of cultural issues related to patients, clinicians and the psychiatric clinical encounter. A brief analysis of its structure and content, and an examination of the pros and cons of the inclusion of an ethnographic tool in an essentially clinical transaction constitute the introductory part of this presentation. Advantages are mentioned but closer attention is paid to its limitations, reflected in its relatively scarce use across the world in the last two decades. Findings of some pertinent studies are reviewed both as a source of clinical information and an objective evaluation of the advantages and disadvantages of the instrument. Alternative proposals made prior to the discussions of the DSM-5 Cultural Issues Subgroup on the topic are briefly mentioned. Brief reflections about the future of this and similar efforts are also presented.

NO 2 THE DEVELOPMENT OF THE CULTURAL FORMULATION INTERVIEW

Speaker: Roberto Lewis-Fernandez, M.D.

SUMMARY:

This talk will describe the development of the DSM-5 Cultural Formulation Interview (CFI), a 16-item questionnaire with general guidelines and item-by-item instructions. The CFI is a cultural assessment that can be used by any clinician with any patient in any clinical setting. It consists of a person-centered review of cultural factors, organized in four sections: 1) cultural definition of the problem, 2) cultural perceptions of cause, context, and support, 3) cultural factors affecting self-coping and past help seeking, and 4) cultural factors affecting current help seeking. These domains may be assessed regardless of the apparent racial/ethnic match between patients and providers. Clinical situations requiring in-depth cultural assessment are guided by supplementary modules, which expand on CFI domains and provide additional questions to assess youth, older adults, and immigrants and refugees. A module for caregivers and an Informant version of the CFI gather collateral information.

NO 3 THE DATA ANALYSIS OF THE DSM-5 CULTURAL FORMULATION INTERVIEW FIELD TRIAL

Speaker: Neil Aggarwal, M.B.A., M.D.

SUMMARY:

The data sources for revising the DSM-IV Outline for Cultural Formulation include systematic literature reviews conducted by experts in cultural psychiatry as well as the DSM-5 field trial to test the Cultural Formulation Interview (CFI). The field trial specifically tests the feasibility, acceptability, and perceived clinical utility of the CFI among patients and clinicians. The field trial has enrolled 330 patients across sites in the United States (5 locations), Peru (1), Canada (3), the Netherlands (3), Kenya (1), and India (2). The design and the data from the CFI field trial will be introduced in this talk.

NO 4 CLINICAL UTILITY OF THE CULTURAL FORMULATION INTERVIEW AND SUPPLEMENTARY MODULES

Speaker: Sofie Baarnhielm, M.D., Ph.D.

SUMMARY:

In psychiatric diagnostics diversity necessitates attention to culture and context. The person-centered Cultural Formulation Interview (CFI) may enhance clinician understanding of a patient's illness perspective and improve diagnostic validity. For patients, the CFI may improve the working alliance and facilitate understanding of medical information. The informant version of the CFI can elicit commitment from family members and other important persons. Supplementary modules are useful in deepening the assessment, e.g. for persons or groups with special needs. The CFI is preferable when used in its entirety in the initial assessment. It can also be incorporated into clinical evaluations as needed, or be used later. The CFI and supplementary modules can be used by clinicians and other team professionals. It should be integrated with other clinical material in a comprehensive evaluation and can contribute to understanding culture and context in an individualized and non-stereotyping way.

NO 5 FEASIBILITY OF USING THE CULTURAL FORMULATION INTERVIEW: ADMINISTRATOR PERSPECTIVE

Speaker: Kavoos G. Bassiri, M.S.

SUMMARY:

This section focuses on the feasibility and benefits of using the Cultural Formulation Interview (CFI) in diverse clinic settings. Besides motivating clinicians to utilize the CFI, there are many factors to consider when implementing new diagnostic tools, including proper training, time limitations, provider resistance, effective application, and ongoing promotion of cultural competency & humility. There are always challenges in implementing new protocols; however, there are key advantages with the CFI, including: Meeting where the patient is at,

building rapport & alliance, understanding a patient's culture & background, enhanced ability to engage the patient, and improved treatment outcomes. Clinically sound & culturally competent service delivery, efficiency, high standards of care, and patient satisfaction are the main goals of a healthcare system. An administrator's perspective will be shared on the challenges and rewards in using and implementing the CFI in clinic operations.

SYMPOSIUM 51 DSM-5 AND MAJOR DEPRESSION

Discussant: Carlos Zarate, M.D.

Chair(s): Lori Davis, M.D., Jan Fawcett, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of major changes regarding Major Depression and related diagnoses in DSM-5; 2) Understand the reasons for changes in the area of Major Depression and related diagnoses in DSM-5; and 3) Understand the expected benefits of the changes in Major Depression in DSM-5.

SUMMARY:

During the process of creating DSM-5, the Mood Disorders work group split into two major sub-workgroups to address Major Depression and Bipolar Disorder and related disorders. The results of this process for Major Depression and related disorders will be presented in this series with a focus on major changes that will appear in DSM-5. Major objectives were to maintain utility while reducing the need for multiple diagnoses, to add specificity to NOS diagnoses through developing an NEC category, to allow representation of symptom dimensions of anxiety severity that has been shown to affect outcome, to remove the bereavement exclusion, to discuss the dropping of the bereavement exclusion for MDE and to focus on suicide assessment more explicitly. Other changes such as addressing the overlap of Dysthymia and Chronic Major Depression will be discussed members of the Major Depression Sub-Workgroup of the Mood Disorders Work Group.

NO 1 RETHINKING DEPRESSIVE NOS CONDITIONS AND SUICIDALITY IN DSM-5

Speaker: Michael Robert Phillips, M.A., M.D., M.P.H.

SUMMARY:

Approximately one-quarter of all initial clinical diagnoses are NOS disorders that include an unmanageable hodgepodge of subsyndromal, atypical and unspecified conditions. In DSM-5 we tried to increase the specificity of these diagnoses but were limited to two code numbers so we recommend clinicians apply multiple labels to each code number. In DSM-IV suicide is only mentioned as a symptom of depression and of borderline personality disorder; to ensure that clinicians keep mindful of suicide in all their patients, we developed a simple scale that clinicians should use to record their level of concern about suicide whenever a diagnosis is made.

NO 2 SPECIFIER FOR MAJOR DEPRESSIVE EPISODES IN DSM-5

Speaker: William Coryell, M.D.

SUMMARY:

The presence of manic symptoms within major depressive episodes (MDE) is clinically important in a number of ways. This mixing, first, increases the likelihood that a patient has a bipolar disorder diathesis evidenced by increases in morbid risks for bipolar disorder among family members, earlier ages of onset, greater risk for treatment-emergent manic or hypomanic episodes and a higher likelihood of an eventual shift to a bipolar diagnosis. Other differences between mixed and non-mixed MDE groups include higher risks for suicidal behavior and substance abuse as well as greater overall severity. The DSM-IV provided criteria for mixed episodes but required the co-existence of both full manic and full major depressive syndromes. Few patients, in fact, meet these criteria and nearly all studies concerning mixed states have instead set symptom number thresholds lower.

NO 3 THE BEREAVEMENT EXCLUSION

Speaker: Sidney Zisook, M.D.

SUMMARY:

The DSM-5 Mood Disorders Work Group has proposed eliminating the 'bereavement exclusion' (BE) from DSM-5. Opponents of this proposal argue that removing the BE will "medicalize" normal grief, stigmatize bereaved people, and lead to inadvisable drug treatment of normal sadness. Conversely, advocates of eliminating the BE argue that MDD is a serious and potentially fatal disorder, regardless of apparent cause or precipitant. Moreover, most research on MDD occurring shortly after bereavement finds it similar to MDD occurring in other contexts: it is most likely to occur in individuals with past personal and family histories of MDD; is genetically influenced; shows characteristic personality characteristics and patterns of co-morbidity; may be chronic and/or recurrent; and is responsive to antidepressant medications. For these reasons, this presentation will conclude that the preponderance of data supports the Work Group's proposal to eliminate the BE in DSM-5.

NO 4 THE IMPORTANCE OF ANXIETY IN COMMON FORMS OF DEPRESSIVE ILLNESS

Speaker: David Paul Goldberg, D.M., M.Sc.

SUMMARY:

Existing data about the importance of anxiety in major depressive disorder under-estimates the true co-morbidity between depression and anxiety: if "current anxiety", instead of GAD is studied, the co-morbidity rises sharply. In the most common form of depressive illness seen in primary care and general medical settings, depression is commonly accompanied by

anxiety, and they both rise and fall in unison. This is the rationale for the “anxiety specifier” to be used when major depression is detected. It will be argued that anxious depression is different in many respects from depression without anxiety.

MAY 20, 2013

SYMPOSIUM 52
THE PSYCHIATRIST’S ROLE IN REDUCING THE NUMBER OF PERSONS WITH MENTAL ILLNESS-ES IN THE CRIMINAL JUSTICE SYSTEM

Chair: Marcia K. Goin, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Enhance clinicians’ awareness of the mental health problems in the Criminal Justice System; 2) The issues of discrimination, children in the justice system and effect of CBI will be highlighted to improve awareness of what the criminal justice system and judges face; and 3) Psychiatrist will be better able to understand the issues confronting the criminal justice system and work to develop alternatives;

SUMMARY:

This symposium, focusing on Justice, Discrimination, Children and Traumatic Brain Injury as they occur and present in the Criminal Justice System will enhance clinicians awareness of the problems that exist in the Criminal Justice System (as well as in everyday life) and look for alternative ways of dealing with these issues. Discrimination is all too prevalent in those who are incarcerated. Children in the system pose very important issues for those involved. With our returning veterans one must be even more aware of the effects of traumatic brain injury and its effect on a person’s behavior. We need to be increasingly aware of how these factors affect the provision of justice in our Country and look for ways to improve it. Our prisons and jails are overflowing. Alternative means to combat the criminalization of the mentally ill must be found. This symposium shines the light on some key issues that affect our patients in the criminal justice system. Justice must be met and Dr. Fred Osher with his vast knowledge of the issue will focus on what this means and how it should be achieved. Discrimination can be seen when one looks closely at the population housed in the correctional system. Dr. Annette Pimm will provide data and discuss this issue. Dr. Stephanie LeMelle with her experience at Reiker’s will discuss the issue of children in the Correctional System and the over representation of minority youth in the criminal justice system. Issues that she will address include “culpability or criminal blameworthiness, treatment vs rehabilitation and legal issues of adolescent competence in court and “less by reason of adolescence”. Dr. David Baron has been studying the effect of Traumatic Brain Injury and how it can present in the mentally ill. This is an increasingly important area of investigation. The awareness of how our returning veterans may suffer from this is important to realize - both in one’s practice but also for the Justice System to be alert to the vicissitudes of the mentally ill offenders who

they may see. Dr Marcia Goin will introduce the speakers and encourage questions from the audience.

NO 1
JUVENILES IN THE CRIMINAL JUSTICE SYSTEM

Speaker: Stephanie Le Melle, M.D.

SUMMARY:

There are many topics concerning young people in the criminal justice system that are of concern for public/community psychiatry. The topics to be discussed in this presentation are: 1) Predictors of juvenile involvement in the justice system including parenting style, peer group association, the over representation of minority youth in the criminal justice system; the legal issues of adolescent competence in court and “less guilty by reason of adolescence” including developmental stages and culpability or criminal blameworthiness; treatment vs Rehabilitation while in the system, including access to Behavioral Health Care, Juvenile Detention Boot camps, and reducing recidivism. To reduce the number of young people in the criminal justice system we must have an understanding of these topics. There are also several model programs and treatments that have shown significant reduction in recidivism and improved functioning in youth offenders that can be implemented in community settings.

NO 2
THE DISPROPORTIONATE REPRESENTATION OF MINORITIES IN THE CRIMINAL JUSTICE SYSTEM

Speaker: Annette Pimm, M.D., M.P.H.

SUMMARY:

Minority populations in the U.S. are known to experience disparities in access to and quality of care for mental illness and substance use disorders. Unmet need for mental health and substance use care and aggressive policing has made these groups particularly vulnerable to enter the criminal justice system. This presentation will provide statistics describing the overrepresentation of people of color in the correctional system including those with mental illness and substance use disorders. The social determinants, medical realities and political underpinnings that serve as the foundation of this disproportionality will be discussed. The speaker will also offer suggestions for what the psychiatrist’s role should be in eliminating racial, ethnic and linguistic disparities in unmet need for mental health and substance use disorder care and associated criminal justice involvement.

NO 3
THE EXPERIENCE OF INDIVIDUALS WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM

Speaker: Terry Kupers, M.D.

SUMMARY:

People with mental illnesses (most of whom have co-occurring substance use disorders) are overrepresented at every

stage of the criminal justice system. Increasingly high numbers are coming into contact with law enforcement agencies, courts, jails, community corrections, and prisons. Recently, researchers documented serious mental illnesses in 14.5 percent of male jail inmates and 31 percent of female jail inmates; rates in excess of three to six times those found in the general population. Psychiatrists have a critical role to play in both the organization and delivery of effective systemic and treatment responses. This presentation will review the factors that contribute to the overrepresentation, and initiatives that seek to address these circumstances.

NO 4 TRAUMATIC BRAIN INJURY AS IT PRESENTS IN THE CRIMINAL JUSTICE POPULATION

Speaker: David Baron, M.D.

SUMMARY:

The prevalence of psychopathology observed in the criminal justice population is striking. An underappreciated potential cause of symptoms may be the long term effect or multiple TBI's. Athletes and soldiers have been the primary focus of media stories across the country, but the well documented increase in mood liability, impulsivity, and depression may be an important factor in the etiology of behavioral disturbances in prisoners. This presentation will review the extant literature on tbi and changes in mood and behavior over time. New data will be presented on evaluating brain pathology associated with multiple tbi and a potential etiology of these changes. Advanced neuroimaging techniques, such as diffusion tensor imaging (DTI) and computerized cognitive performance tests will be discussed from a research and clinical perspective. This population is clearly at high risk for multiple tbi and psychiatrists and judges should be aware of these deleterious potential effects.

SYMPOSIUM 53 ADVANCES IN CLINICAL RESEARCH IN ADHD

Chair: Joseph Biederman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the impact of stimulant treatment on the risk for smoking in youth with ADHD; 2) Recognize the association between ADHD and PTSD in youth, and the greater clinical severity as regards psychiatric comorbidity and psychosocial dysfunction; and 3) Understand the utility of the CANTAB to assess neuropsychological deficits in children with ADHD, and consider its use for clinical and research settings.

SUMMARY:

This symposium will present new scientific data on clinical research in ADHD. Dr. Biederman's study was a prospective 2-year open label study of OROS MPH on cigarette smoking in adolescents with ADHD. 203 subjects signed consent and 154 were treated with OROS MPH (mean age 14.3 years). Smoking rate at endpoint (mean 10 months) was low for all

subjects (7.1%; N=154) and for non-smokers at baseline (2.8%; N=141). Smoking rate was similar to a historical sample of ADHD youth receiving stimulants naturalistically (8.3%, NS) and to non-ADHD comparators (8.6%, NS). Smoking rate in study subjects was significantly lower than unmedicated ADHD comparators (7.1% versus 20.8%, $p=0.007$). These results indicate that long-term treatment with stimulants is associated with a decreased risk for smoking in adolescents with ADHD. Dr. Spencer's study addressed the link between ADHD and PTSD in youth (271 with and 230 without ADHD). PTSD was significantly higher in ADHD probands vs. controls (5.2% vs. 1.7%, $p=0.04$). Irrespective of the comorbidity with PTSD, ADHD subjects had similar ages at onset of ADHD, similar type and mean number of ADHD symptoms, and similar ADHD-associated impairments. PTSD in ADHD was significantly associated with a higher risk of psychiatric hospitalization, school impairment, poorer social functioning and higher prevalence of mood, conduct disorder, and anxiety disorders. The mean onset of PTSD (12.6 years) was significantly later than that of ADHD and comorbid disorders (all $p<0.05$). ADHD was equally familial in the presence of PTSD in the proband indicating that their co-occurrence was not due to diagnostic error. Findings also indicate that the comorbidity with PTSD in ADHD leads to greater clinical severity. Dr. Fried's study examined the utility of the computerized Cambridge Neuropsychological Test Automated Battery (CANTAB) to evaluate executive function deficits (EFDs) (unmedicated youth with ($n=107$) and without ($n=45$) ADHD. Except for the Affective Go No Go (AGN) total omissions, ADHD youth were significantly more impaired on all subtests of the CANTAB assessed vs. controls. Effect sizes for individual CANTAB tests were largely in the medium range with the largest effect sizes seen in Spatial Working Memory total and between errors. These results are highly congruent with those reported in studies using traditional neuropsychological testing batteries, supporting the utility of the CANTAB to assess EFDs in children with ADHD. Dr. Kotte's study reviewed the extant literature examining whether autistic traits (operationalized as presence of autistic symptoms in the absence of a diagnosis of autism spectrum disorder) can be identified in children with ADHD. Only 3 articles met a priori inclusion and exclusion criteria and were included in this review. The prevalence of autistic traits ranged from 7% and 60% and its presence was associated with more severe dysfunction in general and in the social domain in particular.

NO 1 DO STIMULANTS REDUCE THE RISK FOR CIGARETTE SMOKING IN YOUTH WITH ADHD? A PROSPECTIVE, LONG-TERM OPEN-LABEL STUDY OF OROS METHYLPHENIDATE

Speaker: Joseph Biederman, M.D.

SUMMARY:

This was a prospective 2-year open label study examining the effects of OROS MPH on cigarette smoking in adolescents with ADHD. 154 youth began OROS MPH; 74% male, mean age 14 years. Treatment responders at 6 weeks remained in the study. Smoking rate at endpoint (mean 10 months

OROS MPH) was low for all subjects (7.1%) and for non-smokers at baseline (2.8%). Smoking rate was similar to a historical sample of ADHD adolescents receiving stimulants naturalistically (8.3% $p=0.81$) and to non-ADHD comparators (8.6% $p=0.63$). Smoking in study subjects was significantly lower than un-medicated ADHD comparators (7.1% versus 20.8%, $p=0.007$). These prospective results are consistent with naturalistic retrospective studies indicating that longer-term treatment with stimulants is associated with a decreased risk for smoking in adolescents with ADHD.

NO 2 EXAMINING THE NATURE OF THE COMORBIDITY BETWEEN PEDIATRIC ATTENTION-DEFICIT/HYPERACTIVITY DISORDER AND POSTTRAUMATIC STRESS DISORDER

Speaker: Thomas Spencer, M.D.

SUMMARY:

Objective: To address the link between ADHD and PTSD in youth. Method: Participants were 271 youth with ADHD and 230 controls without ADHD of both sexes along with their siblings. Results: PTSD was significantly higher in ADHD probands vs. controls (5.2% vs. 1.7%, $\chi^2(1)=4.36$, $p=0.04$). and was associated with a higher risk of psychiatric hospitalization, school impairment, poorer social functioning and higher prevalence of mood, conduct, and anxiety disorders. Siblings of ADHD and ADHD+PTSD probands had significantly higher prevalence of ADHD vs. siblings of controls and siblings of ADHD+PTSD probands had a significantly higher prevalence of PTSD compared to the siblings of ADHD and control probands. Conclusions: Findings indicate that PTSD comorbid with ADHD leads to greater clinical severity in psychiatric comorbidity and psychosocial dysfunction. ADHD is equally familial in the presence of PTSD in the proband indicating that their co-occurrence is not due to diagnostic error.

NO 3 HOW INFORMATIVE IS THE CANTAB TO ASSESS EXECUTIVE FUNCTIONING IN CHILDREN WITH ADHD?: A CONTROLLED STUDY

Speaker: Ronna Fried, Ed.D.

SUMMARY:

Background: Individuals with attention-deficit/hyperactivity disorder (ADHD) have high rates of deficits in executive functions (EFs). Objective: We examined the utility of the computerized Cambridge Neuropsychological Test Automated Battery (CANTAB) to evaluate EFDs in children with ADHD. Method: Subjects were unmedicated children with ($n=107$) and without ($n=45$) DSM-IV ADHD. We administered the CANTAB Eclipse battery. Results: Except for the Affective Go No Go (AGN) total omissions, ADHD subjects were significantly more impaired on all other subtests of the CANTAB in comparison to controls. Conclusions: These results are highly congruent with those reported in studies using traditional neuropsychological testing batteries, supporting the utility of the CANTAB to assess neuropsychological deficits in children with ADHD.

NO 4 HOW PREVALENT ARE AUTISTIC TRAITS IN CHILDREN WITH ATTENTION-DEFICIT/HYPERACTIVITY DISORDER? A QUALITATIVE REVIEW OF THE LITERATURE

Speaker: Amelia Kotte, Ph.D.

SUMMARY:

Some of the social impairments of children with ADHD are due to the core features of the disorder, whereas some children struggle with interpersonal deficits that are reminiscent of more severe social interaction deficits seen in children of autism spectrum disorders. A better understanding of the prevalence of such traits among children with ADHD may encourage the development of individualized alternative treatment approaches. Methods: We conducted a literature search of all controlled scientific articles published in English that assessed the presence of autistic traits in children with ADHD who did not meet criteria for ASD. Only 3 articles met our inclusion and exclusion criteria and were included in this qualitative review. Results: The prevalence of autistic traits in three samples with ADHD studied ranged from 7% and 60%. The presence of autistic traits was associated with more severe dysfunction in general and in the social domain in particular.

SYMPOSIUM 54 UPDATES IN NEUROPSYCHIATRY

Chair: Jose Maldonado, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Attendees will be familiar with the variety of neuropsychiatric "insults" inherent to CNS malignancies and infectious agents- and their treatment; 2) Understand the effects of HIV and comorbid disorders (including opportunistic infections and common substances of abuse) in the central nervous system; and 3) Understand the epidemiology, manifestations and improve the recognition of NCSE among medically ill patients.

SUMMARY:

Limbic encephalitis (LE) was once thought to be rare but recent studies have found surprisingly high rates of LE, particularly the non-paraneoplastic variant. LE can be challenging to diagnose given the wide spectrum of physical, neurological, and psychiatric symptoms produced, however, studies such as MRI, EEG, CSF analysis, and antibody panels can be helpful. A wide range of auto-neuronal antibodies have been discovered which target plasma membrane, cytosolic, and extracellular antigens of both the central and peripheral nervous system. Diverse mechanisms of antibody production can lead to variable response rates to immunosuppressive treatments such as IVIG, steroids, rituximab, plasmapheresis, and cyclophosphamide. Improving treatment efficacy will require identification of, as yet, unknown auto-antibodies and a deeper understanding of mechanisms by which auto-antigens are attacked. Progress in the diagnosis and treat-

ment of infectious diseases today has improved greatly due in large part to advances in systemic antimicrobials. The central nervous system remains a reservoir for some pathogens, and signs of infection may first present themselves as changes in mental status. This presentation will focus on those infectious diseases, including syphilis and tuberculosis, which may initially be noticed through behavioral, cognitive, or emotional changes. Clinical pathology, diagnosis, and treatment will be reviewed. With continued advances made in cancer treatment, patient suffering from primary or metastatic CNS disease are living longer and encountering various neuropsychiatric complications. Dr. Kilbane will review the various ways (e.g., lesion location, treatment side effects, psychiatric co-morbidity, “chemo-brain”) in which CNS malignancies can alter neuropsychiatric functioning. He will also review current strategies to ameliorate these negative effects. Non-Convulsive Status Epilepticus (NCSE) is characterized as a change in mental processes and behaviour in association with continuous epileptiform changes without major motor signs. It may present as delirium, but its diagnosis is often delayed and even missed. In the critically ill patients, it is associated with high rates of morbidity and mortality. In this presentation, Dr. Sher will discuss epidemiology and various presentations of NCSE, as well as its diagnosis, prognosis, and treatment. 30% of patients admitted to neurology are diagnosed with NES. These patients require prompt diagnosis and treatment and tactful approach. Dr. Maldonado will discuss diagnosis, prognosis, psychiatric and neurologic comorbidities, and treatment of NES.

NO 1 LIMBIC ENCEPHALITIS

Speaker: Diana L. Wertz, M.D., Ph.D.

SUMMARY:

Limbic encephalitis (LE) was once thought to be rare but recent studies have found surprisingly high rates of LE, particularly the non-paraneoplastic variant. LE can be challenging to diagnose given the wide spectrum of physical, neurological, and psychiatric symptoms produced, however, studies such as MRI, EEG, CSF analysis, and antibody panels can be helpful. A wide range of auto-neuronal antibodies have been discovered which target plasma membrane, cytosolic, and extracellular antigens of both the central and peripheral nervous system. Diverse mechanisms of antibody production can lead to variable response rates to immunosuppressive treatments such as IVIG, steroids, rituximab, plasmapheresis, and cyclophosphamide. Improving treatment efficacy will require identification of, as yet, unknown auto-antibodies and a deeper understanding of mechanisms by which auto-antigens are attacked

NO 2 NEUROPSYCHIATRIC MANIFESTATIONS OF CNS INFECTIONS

Speaker: Lawrence M. McGlynn, M.D.

SUMMARY:

Progress in the diagnosis and treatment of infectious diseases

today has improved greatly due in large part to advances in antimicrobial agents and chemotherapy. The central nervous system remains a reservoir for some pathogens, and signs of infection may first present themselves as changes in mental status. This presentation will focus on those infectious diseases, including syphilis and tuberculosis, which may initially be noticed through behavioral, cognitive, or emotional changes. Clinical pathology, diagnosis, and treatment will be reviewed.

NO 3 CNS MALIGNANCIES

Speaker: Edward J. Kilbane, M.A., M.D.

SUMMARY:

With continued advances made in cancer treatment, patient suffering from primary or metastatic CNS disease are living longer and encountering various neuropsychiatric complications. Dr. Kilbane will review the various ways (e.g., lesion location, treatment side effects, psychiatric co-morbidity, “chemo-brain”) in which CNS malignancies can alter neuropsychiatric functioning. He will also review current strategies to ameliorate these negative effects.

NO 4 NONCONVULSIVE STATUS EPILEPTICUS

Speaker: Yelizaveta Sher, M.D.

SUMMARY:

Non-Convulsive Status Epilepticus (NCSE) is characterized as a change in mental processes and behaviour in association with continuous epileptiform changes without major motor signs. It may present as delirium, but its diagnosis is often delayed and even missed. In the critically ill patients, it is associated with high rates of morbidity and mortality. In this presentation, Dr. Sher will discuss epidemiology and various presentations of NCSE, as well as its diagnosis, prognosis, and treatment.

NO 5 NON-EPILEPTIFORM SEIZURES

Speaker: Jose Maldonado, M.D.

SUMMARY:

30% of patients admitted to neurology are diagnosed with NES. These patients require prompt diagnosis and treatment and tactful approach. Dr. Maldonado will discuss diagnosis, prognosis, psychiatric and neurologic comorbidities, and treatment of NES.

SYMPOSIUM 55 U.S. DEPARTMENT OF VETERANS AFFAIRS/ DEPARTMENT OF DEFENSE CLINICAL PRACTICE GUIDELINE FOR SUICIDE PREVENTION

Chair(s): John Bradley, M.D., Brett Schneider, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should

be able to: 1) Evaluate the evidence-base for performing a Suicide Risk Assessment using validated risk factors and protective factors that can improve the clinician's confidence in the assessment.;2) Treat patients at risk for suicide with the most evidence-based psychological and biological therapies and psychosocial interventions to minimize the risk of suicide re-attempt and death by suicide; and 3) Identify future directions for clinical research to further improve the interventions available for suicide prevention.

SUMMARY:

Suicide is the 11th leading cause of death in the United States amongst all age groups and the 3rd leading cause of death in young adults. It is the leading cause of preventable death for the Military and Veteran population, resulting on 1 death per day among Active Servicemembers and 18 deaths per day among Veterans. It is the leading cause of morbidity, mortality and clinical risk in psychiatric practice and the leading cause of tort litigation for mental health clinicians. Suicide risk stratification is complex and often difficult to perform in the increasingly brief clinical encounters throughout to continuum of healthcare settings. The positive prediction of suicidal behaviors and death by suicide is even more complex still. This presentation will describe the work of national experts in Suicidology to develop a clinical practice guideline for the assessment and management of suicidal behaviors in the Military and Veteran population that guides the care of patients presenting to primary care, specialty care, emergency care, and mental health care settings. While the focus is on military and veteran populations, the recommendations may be generalized to wider populations. We will describe the Guideline development process, review the literature that served as the basis for the recommendations of the Guideline, and present the recommendations for the assessment of suicide risk and prediction of self-directed violence and the referral and treatment recommendations for patients at risk.

NO 1

[To Be Determined]

Speaker: John Bradley, M.D.

SUMMARY:

see abstract

No 2

[To Be Determined]

Speaker: Janet E. Kemp, Ph.D., R.N.

SUMMARY:

see abstract

No 3

[To Be Determined]

Speaker: Brett Schneider, M.D.

SUMMARY:

see abstract

SYMPOSIUM 56

PSYCHOTHERAPY IN LATE-LIFE ADULTS

Discussant: Patricia A. Arean, Ph.D.

Chair: Alexander Threlfall, M.A., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn how to identify and diagnose depression, anxiety and/or substance abuse in late-life and the nuances that are associated with each category in late-life.;2) Understand cognitive, cultural, and medical factors in late-life that function as predictive measures of outcome in the use of psychotherapy for late-life mood, anxiety and substance abuse disorders.;3) Recognize which psychotherapies in late-life are most appropriate and gain an appreciation of the key elements in these psychotherapies that aid in the positive outcomes of treatment.;

SUMMARY:

According to the 2012 Institute on Medicine Report on workforce issues related to mental health coverage for older adults, up to 8 million or nearly one in five older adults has one or more mental health and substance use conditions. This number is expected to grow considerably over the next few decades with the projected population of 72.1 million adults age 65 and older by 2030. The nearly 80% increase in older adults will place a significant burden on the current mental health workforce and create a unique challenge for all of geriatric care. The general mental health provider alongside his or her primary care colleagues will likely continue to serve as the first line of care for older adults for the foreseeable future, thus necessitating the development of a strong fund of knowledge regarding the complexities of psychological, social and medical comorbidities pervasive throughout the geriatric population. This knowledge will be invaluable in providing the appropriate management of geriatric mental health needs. Psychotherapy for depression, anxiety and/or substance abuse disorders in late-life often follows the same guidelines as that in younger adults. Recent research has shown, however, that the application and efficacy of psychotherapy in older adults can be significantly affected by complicating factors inherent to geriatrics, including cognitive function, cultural background and medical comorbidities. This session will educate the mental health provider on how to identify, diagnose, and predict outcomes in the management of geriatric patients based on the appropriate methods of screening and evaluation, selection of targeted psychotherapies, and implementation of augmentation strategies. The attendee will gain an appreciation of these elements and an understanding of the variations in psychotherapies, including CBT, IPT, motivational interviewing, and mindfulness-based approaches, proven effective in treating late-life depression, anxiety and/or substance abuse.

NO 1

COGNITIVE-BEHAVIORAL THERAPY FOR LATE-LIFE DEPRESSION: RESPONSE PREDICTORS AND STRATEGIES FOR IMPROVING OUTCOMES

Speaker: Dolores G. Thompson, Ph.D.

SUMMARY:

Due to the complexity of our geriatric population, assessment of the effectiveness of psychotherapy and the predictors of response requires more attention. Treatment for depression is clearly heterogeneous: ~65% of older depressed outpatients mount a significant response to treatments – including psychotherapy, i.e. cognitive behavioral therapy (CBT). Recent research has identified factors that predict positive response to CBT, such as the ability to process complex information and perform “homework” type assignments between sessions. In addition, cognitive processing variables (primarily executive function) have been suggested as key outcome predictors, along with cultural background, gender, and social context. We will discuss findings of a recent fMRI study assessing executive function at baseline and its impact on response to CBT. We will also review other factors associated with CBT outcomes and augmentation strategies that can help improve outcomes in non-responders.

**NO 2
FROM WORRY TO WELLNESS: PSYCHOTHERAPY WITH OLDER ADULT ANXIETY**

Speaker: Jeremy Doughan, Psy.D.

SUMMARY:

Late life anxiety disorders continue to permeate the geriatric population, yet limited psychotherapeutic treatments have been found effective for older adults with anxiety. While prevalence rates for anxiety disorders are lower for older than younger adults, late life anxiety rates are >10%, 3 times more common than depression in older adults, and considered by some to be the most prevalent psychiatric disorder among the elderly. Evidence that has been conducted reports primarily cognitive-behavioral therapy (CBT) as the most effective psychotherapy and therefore considered the “gold standard”. In addition to CBT, other proposed psychosocial treatments for late life anxiety include psychoeducation, problem-solving therapy (PST), exposure based skills and mindfulness techniques. Older adults also experience anxiety in three facets of life: loss, conflict and change. Therefore, future research may include interpersonal psychotherapy (IPT) for anxiety.

**NO 3
PSYCHOTHERAPY FOR OLDER ADULTS WITH ALCOHOL OR DRUG PROBLEMS**

Speaker: Derek Satre, Ph.D.

SUMMARY:

Older adults comprise a large and fast-growing segment of the U.S. population. This presentation addresses clinical issues relevant to older adults, including consequences of alcohol and drug problems, screening and assessment, and outlines what is currently known regarding treatment approaches and outcomes, including recommendations for psychotherapy. For older adults who report hazardous drinking but are not dependent, brief motivational interventions (one to five short sessions) focused on health risks and other potential problems associated with drinking may be effective in

reducing alcohol consumption. Motivational interviewing techniques can be incorporated into a brief intervention approach in order to elicit reasons that an older patient may have to cut back on drinking, i.e. impact on family, health or finances. Many patients can benefit from longer-term psychotherapy.

**SYMPOSIUM 57
DSM-5 INTELLECTUAL DISABILITY (INTELLECTUAL DEVELOPMENTAL DISORDER): NEW CRITERIA, CO-OCCURRING PSYCHIATRIC CONDITIONS, AND FORENSIC IMPLICATIONS**

Chair(s): James C. Harris, M.D., Mark J. Hauser, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the new DSM5 criteria for Intellectual Disability (Intellectual Developmental Disorder); 2) Use the new DSM5 criteria to diagnosis Intellectual Disability (Intellectual Developmental Disorder); and 3) Apply the New DSM5 criteria in forensic settings including Atkins Hearings regarding eligibility for the death penalty.

SUMMARY:

The DSM5 proposes a new name for mental retardation, intellectual disability (intellectual developmental disorder), and moves this diagnosis from Axis II of the multiaxial classification of DSM-IV-TR to a major psychiatric diagnosis. Consistent with the change from an Axis II diagnosis a specific definition of intelligence is included as part of the diagnostic criteria. Because the diagnosis requires both clinical judgment and IQ testing the requirement for standardized intelligence testing is retained. This is consistent with ICD 10 and the proposed ICD 11 criteria. The DSM5 eliminates subtypes of intellectual disability (intellectual developmental disorder) and introduces a table with specifiers for 4 levels of severity (mild, moderate, severe, and profound) in 3 domains (conceptual, social, and practical). These changes are consistent with terminology in federal law and national and international usage in naming. They are consistent with the clinical descriptions of other DSM5 Axis I diagnoses. Persons with Intellectual Disability (ID) are at increased risk for co-occurring psychiatric disorders and require psychiatric care that takes into account their cognitive and adaptive deficits. This has implications for clinical practice and in forensic settings. Forensic considerations are especially significant following the supreme court decision in *Atkins v. Virginia* that held that the death penalty is cruel and unusual punishment for persons with mental retardation under the 8th amendment. The new definition seeks to address issues raised in *Atkins Hearings* regarding eligibility for the death penalty.

**NO 1
UNDERSTANDING THE NEW DSM-5 DEFINITION, ITS RATIONALE, AND IMPLICATIONS FOR ITS USE IN PRACTICE**

Speaker: James C. Harris, M.D.

SUMMARY:

The DSM-5 provides a new name for mental retardation, intellectual disability (intellectual developmental disorder) and a specific definition of intelligence consistent with its new placement in DSM-5. The requirement for standardized intelligence testing is retained. A table with specifiers replaces the 4 levels of severity (mild, moderate, severe, and profound) with examples of adaptive functioning in 3 domains (conceptual, social, and practical). This presentation will review the rationale for the revised definition and its implications in clinical practice.

NO 2**INTELLECTUAL DISABILITY AND PSYCHIATRIC DISORDERS: IMPLICATIONS OF THE NEW DIAGNOSTIC CRITERIA FOR THE PRACTICING PSYCHIATRIST**

Speaker: Mark J. Hauser, M.D.

SUMMARY:

Persons with Intellectual Disability (ID/IDD) are at risk for the full range of psychiatric disorders. In the setting of co-occurring disorders the psychiatrist faces many challenges. Evaluation, assessment and treatment are complicated by impairments inherent in ID/IDD. Many psychiatrists are made uncomfortable by the prospect of evaluating or treating ID/IDD patients. This presentation explores the role of psychiatrists, and reviews the service delivery models used to engage psychiatrists. The presentation will explore common pitfalls encountered with this population, strategies for success and sources of career satisfaction. Special circumstances include the need for collateral sources of information, interdisciplinary teamwork and shared decision making. There is often uncertainty about the relative contributions of overlapping emotional and behavioral aspects of ID/IDD with psychiatric and neurologic symptoms.

NO 3**ELIGIBILITY FOR THE DEATH PENALTY AND THE NEW DSM-5 DEFINITION**

Speaker: Stephen Greenspan, Ph.D.

SUMMARY:

Guided by the 2002 US Supreme Court ruling in *Atkins v. Virginia*, adult homicide defendants are automatically exempted from the death penalty if they qualify for a diagnosis of Mental Retardation (the current term in most legal statutes and in DSM-IVTR) or Intellectual Disability (the term used by the AAIDD). Since DSM-III, mental retardation has been modeled almost entirely, both in terminology and constitutive elements, on the AAIDD manual. In DSM-5, mental retardation is renamed Intellectual Disability (Intellectual Developmental Disorder), with revised constitutive elements and as a health condition as opposed to disability. This paper proposes that the DSM-5 definition is superior to that of DSM-IVTR and the AAIDD in forensic settings as illustrated with reference to actual "Atkins" death penalty hearings. In these settings ID/IDD offers a more flexible, and thus valid, framework for understanding a defendant's functional limitations and can lead to

more just judicial decisions.

SYMPOSIUM 58**COMORBID PSYCHIATRIC AND SUBSTANCE USE DISORDERS: COMMON AND SPECIFIC INFLUENCES AND IMPLICATIONS FOR EARLY IDENTIFICATION AND TREATMENT**

Discussant: Wilson M. Compton, M.D.

Chair: Wilson M. Compton, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Anticipate and more effectively mitigate the impact of psychiatric disorders on the development of substance use disorders; 2) Apply behavior genetics research findings to the diagnosis and treatment of comorbid internalizing psychopathologies and substance use disorders; 3) Specify the adverse interactive effects of prenatal cocaine exposure and later stress reactivity with application to the diagnosis and treatment of adolescent drug use; 4) Prescribe more effectively when treating comorbid anxiety and substance use disorders by applying pharmacogenetic principles; and 5) Coordinate the complex treatment of comorbid disorders for greater efficiency in real world environments.

SUMMARY:

It is well established that comorbidity of psychiatric and substance use disorders and comorbidity of multiple substance use disorders are highly prevalent and comorbidities are associated with greater treatment difficulties and poorer outcomes. Research continues on the relationship of comorbid disorders and the extent to which common and specific predisposing and underlying influences determine their occurrence and course. Research findings on the patterns of interaction of co-occurring disorders, the potential for enhanced early identification, and possibilities for improved treatment are issues of concern to clinicians and researchers. The presentations in this symposium will elucidate the complex clinical nature of comorbidity through discussion of research findings from the WHO World Mental Health Surveys, genetic epidemiological data on internalizing psychopathologies among cannabis users, fMRI data on prenatally cocaine exposed adolescents, the pharmacogenetic study of substance dependent patients with comorbid anxiety disorders, and the NIDA Clinical Trials Network.

NO 1**COMORBID PSYCHIATRIC AND SUBSTANCE DISORDERS IN THE WORLD HEALTH ORGANIZATION WORLD MENTAL HEALTH SURVEYS**

Speaker: Ronald Kessler, Ph.D.

SUMMARY:

Research on patterns of lifetime comorbidity among common DSM disorders using latent variable models has documented strong internalizing and externalizing factors along with a number of less stable subfactors. These models tell us little,

though, about the temporal unfolding of comorbidity over the life course. Recent analyses of the WHO World Mental Health (WMH) Surveys were carried out to develop models to address the issue of temporal unfolding. These models are expanded here to examine the associations of temporally primary DSM-IV mental disorders with the subsequent onset of DSM-IV substance use, abuse among users, and dependence among abusers. Results show that the relative importance of the diverse mental disorders considered in the analysis varies significantly in predicting the different drug use-abuse-dependence transitions both within and between countries.

NO 2 COMMON AND CORRELATED LIABILITIES IN THE DEVELOPMENT OF COMORBID DISOR- DERS

Speaker: Arpana Agrawal, Ph.D.

SUMMARY:

It is now well documented that common predisposing factors underlie substance use problems and putatively externalizing behaviors (e.g. conduct problems, general impulsivity). This presentation will focus on the relationship between substance use problems and internalizing psychopathology, in particular aspects of major depressive disorder and suicidality. To illustrate, the genetic relationship between cannabis involvement and internalizing psychopathology will be examined from a genetic epidemiological perspective.

NO 3 THE RELATIONSHIP BETWEEN EARLY ADVER- SITY AND ADOLESCENT RISK TAKING, PSY- CHOPATHOLOGY, AND BRAIN STRUCTURE AND FUNCTION

Speaker: Linda Mayes, M.D.

SUMMARY:

This presentation will cover fMRI data regarding relationships among prenatal cocaine exposure and later stress reactivity in adolescence (ages 14-17) as mediated by adverse early experiences. Data will also be presented describing how adolescent drug use and related risk taking are impacted by prenatal exposure, early stressors, later psychopathology in mood and anxiety, and individual differences in brain activation in response to stress and appetitive imagery.

NO 4 DUAL DIAGNOSIS AND PHARMACOGENETICS

Speaker: Thomas Kosten, M.D.

SUMMARY:

Substance dependent patients with comorbid anxiety disorders like post traumatic stress disorder suffer from an excess of noradrenergic (NA) activity and a deficit of dopaminergic (DA) activity. The key enzyme for transforming DA to NA is dopamine beta hydroxylase (DBH), and the gene for this enzyme has a potent functional polymorphism leading to a 10 to 100 fold variation in DBH levels. The DBH inhibitor disulfiram is

therapeutic for both disorders, and its efficacy is enhanced in patients with high DBH levels.

NO 5 COMORBIDITY AND PRACTICAL ISSUES OF TREATMENT IN THE NIDA CLINICAL TRIALS NET- WORK

Speaker: George Woody, M.D.

SUMMARY:

Three CTN related studies have addressed psychiatric and medical comorbidities and a fourth is evaluating the impact of an intervention to get substance-abusing patients on medical units into treatment and reduce healthcare costs. One practical issue in psychiatric comorbidity studies is the time necessary to differentiate substance-induced disorders that clear with drug-focused treatment, from independent disorders that are the focus of the psychiatric intervention. Another is the separation of substance abuse treatment from other parts of health care delivery, making it difficult to find sites with the administrative structure and staffing to conduct comorbidity studies. This presentation will provide an overview of these points and the potential of the Patient Protection and Affordable Care Act to make comorbidity studies easier to do.

SYMPOSIUM 59 APPROACHES TO SCHIZOPHRENIA ACROSS THE LIFESPAN

Chair(s): S. Charles Schulz, M.D., John M. Kane, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Compare and contrast the characteristics of anti-psychotic medications when used in adolescents with schizophrenia; 2) Examine psychosocial treatments in combination with psychopharmacology for first-episode patients with schizophrenia; 3) Review the steps of treatment in the middle-age person with schizophrenia, including issues of poor response to medications; and 4) Investigate the characteristics of the course of schizophrenia in the elderly population.

SUMMARY:

Schizophrenia is a severe psychiatric illness that has its onset in adolescence and young adulthood and most often persists through a lifetime. A significant amount of research on etiology and treatment has examined the overall disorder without addressing diagnostic/symptom assessments or treatments at different stages of the illness. The purpose of this symposium is to focus on stages of the illness from adolescence to elderly patients with schizophrenia in order to discuss strategies for improved specific interventions. To begin the symposium, Dr. Christopher Correll will address the major issues of initial assessment and treatment of teenage patients. This is a particularly challenging age group as there is significant stress in patients and families at the onset of psychosis and many difficult issues of medication effects and side-effects. Dr. John Kane will then present an update on the diagnosis and management of the young adult with first-episode psycho-

sis. The field is aware of issues of early recognition; however, now Dr. Kane's findings of medication and psychosocial treatments are crucial to lead to best outcomes. Following the early stages of schizophrenia, the middle age years of the schizophrenic patient present substantial challenges of treatment programs for best outcomes and assessment of the 30% of patients who are non-responders. Dr. Charles Schulz will discuss the issues of adequate trials of treatment and issues of treating non-responders. The elderly patient with schizophrenia has been somewhat ignored in psychiatry. Dr. Carl Cohen will discuss the issues of later onset schizophrenia and the approach to specific issues of management of this group. In summary, much has been written about approaches to schizophrenia, yet less has been described about specific issue and approaches for different stages of the illness. This symposium addresses stages of schizophrenia specific issues that are crucial to best outcomes.

NO 1 CHANGING PERSPECTIVES ON OUTCOME OF SCHIZOPHRENIA IN LATER LIFE: IMPLICATIONS FOR TREATMENT, POLICY, AND RESEARCH

Speaker: Carl I. Cohen, M.D.

SUMMARY:

Although older adults are the most rapidly growing group of persons with schizophrenia, little is known about the course and outcome of the disorder in later life. For much of the 20th century schizophrenia was viewed as having a severe end-state, whereas recent studies suggested more favorable clinical and social outcomes. However, the latter used cross-sectional data in later life and considered outcome to be a fixed state. In our new longitudinal studies of persons with early-onset schizophrenia (age 55+), clinical remission and community integration were not static, showed considerable flux between favorable and unfavorable states, and the core groups of favorable outcomes were smaller than found in cross-sectional analyses. From policy and clinical perspectives, outcomes were less optimistic than had been believed; thus, caring for older adults will require more intensive services. Finally, examining the predictors of outcome may augment treatment strategies for this age group.

NO 2 MANAGEMENT OF THE VERY FIRST EPISODE OF SCHIZOPHRENIA

Speaker: John M. Kane, M.D.

SUMMARY:

Management of first episode schizophrenia is challenging. Early treatment is important for best outcomes. Although antipsychotic medications are effective in bringing about symptomatic remission in most patients, rates of recovery are far lower. The role of evidence-based psychosocial treatments and state-of-the-art psychopharmacology is critical. However, psychosocial treatments are not consistently available to those patients who might benefit from them, and they are often not fully integrated with other therapeutic modalities in a team-based approach. Large-scale studies of psychosocial

therapies need to be conducted in "real world" settings under usual reimbursement constraints. The NIMH Recovery After an Initial Schizophrenia Episode (RAISE) project is one such attempt. Dr. Kane will provide an overview of the design and implementation of the RAISE Early Treatment Program.

NO 3 EFFICACY AND TOLERABILITY OF ANTIPSY- CHOTICS IN CHILDREN AND ADOLESCENTS WITH SCHIZOPHRENIA

Speaker: Christoph U. Correll, M.D.

SUMMARY:

Youth with schizophrenia have worse outcomes than adults, but controlled antipsychotic (AP) data have been sparse until recently. In 2 underpowered trials, typical APs did not separate from placebo (PBO), yet all but 2 atypical AP trials showed superiority over PBO for all studied doses. In 1 weight-based dosing trial of paliperidone, only the medium dose separated from PBO, although all 3 therapeutic doses individually beat placebo. In 1 flexible dose study, ziprasidone did not separate from PBO. The number-needed-to-treat for response ranged from 3-10 for aripiprazole, olanzapine, quetiapine, paliperidone and risperidone. Across 7 active-controlled trials, the only significant differences favored clozapine vs haloperidol or olanzapine. Response rates were lower in youth than adults, but youth have more sedation, EPS, withdrawal dyskinesia, prolactin elevation, weight gain and metabolic abnormalities, with large differences among APs. Careful AP selection and monitoring are needed.

NO 4 TREATMENT STRATEGIES FOR THE MID-STAGE PERSON WITH SCHIZOPHRENIA

Speaker: S. Charles Schulz, M.D.

SUMMARY:

After initiation of treatment of schizophrenia, there are substantial challenges faced by middle-aged patients, their families, and the treatment team. The focus of this presentation is to review the current evidence for evidence-based treatments and to utilize the research to determine the best approaches to not only decrease psychosis in a brief interaction, such as a hospitalization, but also over longer periods of time. Such approaches include the use of cognitive behavior therapy, family approaches, and social skills treatment. Another challenge in addressing the needs of the mid-life patients is to assess adequate treatment and to determine the next steps for the poorly-responsive patient. This phase of treatment depends on not only careful assessment of adequate medication, but also the application adherence programs and other support interventions. More recently, approaches to domains (such as cognitive remediation) are emerging the schizophrenic patient.

SYMPOSIUM 60 COMORBIDITY, MECHANISMS OF TREATMENT RESISTANCE, AND NOVEL TREATMENT DEVELOPMENT FOR LATE-LIFE DEPRESSION

Chair: George S. Alexopoulos, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how a working model of late life depression was generated from studies on the cognitive and medical comorbidity of late life depression; 2) Familiarize himself/herself with recent neurobiological findings on the pathogenesis of late life depression and their impact on response to classical antidepressants; 3) Learn about structured brief psychotherapies aiming to reduce the experience of chronic stress and unburden the biological systems contributing to depression; and 4) Understand the principles of neuroplasticity-based computerized cognitive remediation aiming to improve the function of neural networks associated with poor response to antidepressants.

SUMMARY:

Depression is a major health hazard because it is common and has devastating outcomes in all people. In older people, it is also fatal as it increases substantially medical morbidity and both suicide and non-suicide mortality. The typical depressed elderly person faces a bewildering constellation of interacting health threats and social stressors and constraints compromising their outcomes. While the clinical complexity of late life depression has been traditionally viewed as a barrier to understanding its etiology and pathogenesis, studies on the comorbidity of late-life depression have provided the impetus for a model integrating aging- and disease-related brain changes with responses to stress. This symposium selectively reports on findings that led to this model and on novel treatment approaches that may emerge as a consequence. Genetic predisposition, epigenetic modifications, vascular changes, and other aging-related changes confer vulnerability to depression. Once depressive episodes occur, neuroendocrine, inflammatory, oxidative stress, diminished neurotrophic activity and related processes further accelerate cell aging leading to apoptosis and cell death. These biological events increase both medical burden and mortality and may contribute to resistance to antidepressants. Microstructural, metabolic, functional connectivity, and electrophysiological changes occurring during late-life depression have begun to be identified and may be used to further clarify the mechanisms of treatment resistance of late life depression. This knowledge provided targets for novel treatment approaches. Structured brief psychotherapies aim to reduce the experience of chronic stress and unburden the biological systems contributing to depression. Neuroplasticity-based computerized cognitive remediation aims to improve the function of neural networks associated with poor response to antidepressants. Finally, anti-inflammatory agents began to be investigated in late-life depression. This symposium presents findings that led to the proposed model of late life depression and on select novel treatments targeting depressed older patients resistant to

classical antidepressants.

NO 1 FROM SADNESS TO SENESCENCE: MAJOR DEPRESSION AND ACCELERATED CELLULAR AGING

Speaker: Owen Wolkowitz, M.D.

SUMMARY:

MDD and other mental illnesses are associated with comorbid medical illnesses that are more commonly seen with old age, raising the possibility that these psychiatric illnesses are associated with accelerated physical aging. An emerging biomarker of cell aging and risk of medical illness is shortened leukocyte telomere length (LTL). Shortened LTL has been demonstrated in MDD and other psychiatric conditions, at least in subgroups of patients. LTL is inversely correlated with oxidative stress and immune activation, suggesting a mechanistic pathway of accelerated cell aging in these conditions. Few studies have assessed activity of the telomere-lengthening enzyme, telomerase, in these illnesses, but accumulating data suggest that it not only moderates cell aging but influences neurotrophic and antidepressant processes. Certain serious psychiatric illnesses appear to have systemic manifestations beyond the brain; further understanding of these should uncover novel treatment targets.

NO 2 PREDICTORS OF TREATMENT RESPONSE IN LATE-LIFE DEPRESSION

Speaker: Ian A. Cook, M.D.

SUMMARY:

In the treatment of late-life depression, many patients do not remit with the first agent they try, but the consequences of our current paradigm of multiple, sequential treatment trials pose more dire risks in elders than in younger adults, including deconditioning from inactivity, bedsores from immobility, prolonged periods of altered autonomic function, and poor nutrition from diminished dietary intake. Prediction of response to treatment could allow physicians to employ a "personalized medicine" paradigm and match treatment to patient more rapidly. In this presentation, studies of clinical and physiologic predictors of treatment response will be critically reviewed and we will examine the next steps needed to bring these approaches closer to readiness for clinical use.

NO 3 BRAIN IMAGING PREDICTORS OF TREATMENT RESISTANCE

Speaker: Faith Gunning, Ph.D.

SUMMARY:

Cognitive and emotional control systems enable individuals to flexibly and dynamically adjust their behavior in response to changes in environmental demands and personal goals and are critical for emotional regulation. A hallmark clinical feature of depression is difficulty focusing on goal-directed behavior

while ignoring irrelevant - particularly negatively valenced - stimuli and thoughts. Further, specific aspects of cognitive and emotional control systems are particularly vulnerable to advancing age. We will present data from structural and functional MRI studies that support the contribution of specific frontolimbic abnormalities to the persistence of late-life depression by impairing the functions of cognitive and emotional control systems. The identification of specific network abnormalities that sustain late-life depression can provide a target on which new treatments can be tested.

NO 4 ECOSYSTEM-BASED INTERVENTIONS FOR LATE-LIFE DEPRESSION

Speaker: George S. Alexopoulos, M.D.

SUMMARY:

Chronic stress may lead to depression through changes in inflammatory responses, dendritic remodeling, neurogenesis, and functional connectivity. Accordingly, we developed interventions targeting behaviors contributing to chronic stress. We modified Problem Solving Therapy (PST-ED) to address the cognitive deficits of depressed patients with executive dysfunction and compared it with Supportive Therapy in 221 subjects. PST-ED led to greater reduction in depression and disability at weeks 9 and 12. The advantage of PST over ST was retained for 24 weeks after the end of treatment. We developed Ecosystem Focused Therapy (EFT), a 5 component intervention for post stroke depression (PSD) offering: 1) new perspective, 2) treatment adherence structure, 3) "problem solving structure, 4) reengineering of family goals, involvement, and plans, and 5) care coordination of specialized therapists. EFT led to a higher remission rate and less disability than an education-based intervention.

NO 5 COMPUTERIZED COGNITIVE REMEDIATION FOR GERIATRIC DEPRESSION: A NOVEL INTERVEN- TION BASED ON THE PRINCIPLES OF NEURO- PLASTICITY IN THE AGING BRAIN

Speaker: Sarah S. Morimoto, Psy.D.

SUMMARY:

In geriatric depression, deficits in executive functions are common and disabling. Replicated findings from our group suggest that certain executive deficits are associated with poor response to antidepressants. Our analyses were the first to identify semantic organizational strategy, as the discrete domain of executive dysfunction that predicts antidepressant response, regardless of the task by which it is elicited. We and others have also shown that susceptibility to interference is associated with poor SSRI response. New and converging findings suggest that computerized cognitive remediation (CCR) can reduce age-related cognitive decline through neuroplasticity. This emerging CCR methodology along with our findings suggesting that network abnormalities underlying semantic strategy impairment predict poor SSRI response provides an opportunity for a novel intervention. Accordingly, we propose to utilize CCR to target semantic strategy deficits

associated with low remission rates.

SYMPOSIUM 61 DECISIONS AND DILEMMAS: UPDATE IN THE MANAGEMENT OF PERINATAL MOOD DISOR- DERS

Chair: Lucy Hutner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the impact of mood disorders in the perinatal period; 2) Understand the current treatments for mood disorders in the perinatal patient; 3) Identify current strategies for examining the data in perinatal mental health; and 4) Understand the complexity that arises when balancing optimizing perinatal mental health while minimizing obstetric and psychiatric risks.

SUMMARY:

Mood disorders in the perinatal period can present substantial risks to the pregnant woman and the developing fetus. Perinatal psychiatrists must take into account both the risks of exposure to treatment and the risks of untreated mental illness. They must also have an understanding of the limitations of evidence derived from case series and grouped databases. Established guidelines exist to guide complex decision-making. However, treatment ultimately may need to be individualized for each patient. This symposium will provide an up-to-date overview of mood disorders in the perinatal period. Discussants will first provide a comprehensive summary of evidence-based treatments for depressive and bipolar disorders. Discussants will also provide strategies for reviewing current evidence in perinatal mental health. Last, discussants will provide examples of decision-making with patients, taking into account the need to optimize perinatal mental health while balancing obstetric and psychiatric risks.

NO 1 TREATMENT OF DEPRESSION IN THE PERINA- TAL PERIOD

Speaker: Madeleine Becker, M.A., M.D.

SUMMARY:

Depression is widely described as the most common complication of childbirth. This presentation will focus on the treatment of depressive disorders in pregnancy and postpartum. The focus will be on the data examining the risks and benefits of specific antidepressants in the perinatal period, as well as a summary of the risks of untreated depression in this population.

NO 2 REAL-LIFE DECISION MAKING IN THE PERINA- TAL PERIOD

Speaker: Vivien K. Burt, M.D., Ph.D.

SUMMARY:

This talk will focus on the management concerns faced by psychiatrists and their patients as they aim to optimize mental health in the perinatal period while minimizing obstetric and psychiatric risks.

NO 3**OVERVIEW OF THE PERINATAL CONSULTATION**

Speaker: Elizabeth Fitelson, M.D.

SUMMARY:

This talk will provide an overview of the components of the perinatal consultation for the general psychiatrist. The focus will be a summary of the risk-risk analysis commonly addressed with perinatal patients as well as a summary of the decision-making process for patients. Evidence-based guidelines for treatment of mood disorders in this period will also be provided.

NO 4**REVIEWING THE EVIDENCE IN PERINATAL MENTAL HEALTH**

Speaker: Ruta Nonacs, M.D., Ph.D.

SUMMARY:

This talk will examine the process of examining the data in perinatal mental health. It will focus on strategies for reviewing current evidence as well as providing a summary of the limitations of the current data and how it impacts clinical care.

NO 5**TREATMENT OF BIPOLAR DISORDER IN THE PERINATAL PERIOD**

Speaker: Christina L. Wichman, D.O.

SUMMARY:

This presentation will focus on the treatment of bipolar disorder in pregnancy and postpartum. The focus will be on the data examining the risks and benefits of mood stabilizing medication in the perinatal period, as well as a summary of the risks of untreated bipolar illness in this population.

SYMPOSIUM 62**THE PRACTICE PARAMETER FOR LESBIAN, GAY, BISEXUAL, GENDER VARIANT, AND TRANSGENDER YOUTH FROM THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY**

Chair: Richard R. Pleak, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the 2012 AACAP Practice Parameter for working with LGBT youth; 2) Understand the strengths and weaknesses of the evidence for developing guidelines for working with LGBT youth; and 3) Be more comfortable working with LGBT youth and/or in referring LGBT youth to experienced practitioners.

SUMMARY:

The first psychiatric guidelines for working with lesbian, gay, bisexual, and transgender (LGBT) youth were approved and issued by the American Academy of Child & Adolescent Psychiatry in mid-2012 and published in September 2012. This Practice Parameter (PP) was developed by members of the AACAP's Sexual Orientation & Gender Identity Issues Committee (SOGIIC) and members of an affiliate organization, the Lesbian and Gay Child & Adolescent Psychiatric Association (LAGCAPA); the working drafts were reviewed and edited by the AACAP's Quality Issues Committee, which initiated the stimulus and guidance for its creation. The PP was formulated over a course of seven years, with an extensive literature review, consultation with renowned and experienced clinicians in the field, and review of drafts by expert clinicians. Five child and adolescent psychiatrists who were involved in writing and reviewing this PP will present on the PP, highlighting various aspects of the PP. Dr. Pleak will chair the Symposium and will provide a brief overview. He will also present on the PP in terms of guidelines for working with gender variant children and transgender adolescents, and will give updates from conferences and publications available since the PP were written. These parts of the PP are the first psychiatric guidelines issued for working with people of any age with gender identity issues. Dr. Adelson, the primary author of the PP, will present on the history and process of developing the PP: how the literature was reviewed and winnowed, the definition of terms and strategies used. This information will be salient for understanding the other talks. Drs. Ng and Womack will each present on different aspects of family and social issues and guidelines for working with families of LGBT youth. Dr. Womack will focus on issues of culture, race, ethnicity, and social status, and how these need to be considered in working with LGBT youth. Dr. Ng will focus on the impact of the family on LGBT youth and the process of youth coming out to families. Dr. Carter will present on lesbian identity development, how this differs from gay male and transgender development, and how the PP addresses these issues. The Symposium will conclude with ample time for audience discussion and questions.

NO 1**AACAP'S NEW LGBT PRACTICE PARAMETER: BASIC CONCEPTS**

Speaker: Stewart Adelson, M.D.

SUMMARY:

This talk will review the process by which AACAP's LGBT practice parameter was developed. It will define terms and review foundational concepts described in the parameter, upon which the practice principles are laid. These will include influences on sexual orientation, gender nonconformity, and gender discordance, their developmental relationships to each other, and the concepts of risk and resilience in relation to factors such as developmentally salient stigma. This talk will provide background for discussion of practice principles to follow.

NO 2 THE ROLE OF FAMILIES OF SEXUAL AND GENDER MINORITY YOUTH

Speaker: Yiu Kee W. Ng, M.D.

SUMMARY:

Families of sexual and gender minority youth respond in many different ways, often reflecting their larger cultural context of the family and community. These responses have a profound effect on the youth and their understanding and experience of their psychosexual development. There are many variables within the youth and family that can influence these responses including class, ethnicity, religion, and geography. Challenges arise also for the youth and their family during different phases of the youth's psychosexual development. The experience of coming out for sexual minority youth can be a complex experience mediated by their cognitive and emotional maturation. However, the experience of a younger gender discordant child who is struggling to understand their experience may have a greater dependence on their parents and family for help. Despite the many differences among sexual and gender minority youth, the impact of their families remains significant and worthy of understanding.

NO 3 ETHNICITY, RACE, AND CLASS INFLUENCES ON GAY, LESBIAN, AND BISEXUAL SEXUAL IDENTITY

Speaker: William Womack, M.D.

SUMMARY:

Families treat sexual minority youth with considerable variation. Whereas some accept their children, others explicitly or implicitly disparage or reject them. They may evoke shame or guilt and may force them to leave home. Youth who are rejected by their parents can experience profound isolation, which adversely affects their identity formation and capacity for intimacy. Sexual minority youth may experience unique developmental challenges relating to the norms of their ethnic group. Ideals of masculinity, femininity, family loyalty, social conformity, authoritarian parenting norms are all factors which can lead to sanctions. Gay and lesbian youth who belong to an ethnic minority may negatively stereotype gays and can be hesitant to disclose a gay identity. When working with youth who belong to both ethnic and sexual minorities, it is important to understand the unique complexities of identity formation for these groups. Case vignettes will be used for the presentation and discussion.

NO 4 LESBIAN IDENTITY DEVELOPMENT: THE EARLY YEARS

Speaker: Debbie Carter, M.D.

SUMMARY:

This presentation will focus on evolving an understanding of lesbian development in childhood and adolescence using the framework of guidelines for working with LGBT youth as

reflected in the 2012 AACAP Practice Parameter (PP). In considering lesbian development in youth, it is important to remember that gender and orientation differences make issues in this population different from transgender and gay male youth. In addition, lesbian youth development is impacted by cohort issues that impact heterosexual female development: sexuality and sexual fluidity, school bullying, cultural/ethnic, issues of body image (such as attractiveness), gender role expression, and self-identity development. Mental health practitioners' greater awareness of the differences from gay and transgender youth can help in working with lesbian youth with mental health issues while using the PP.

NO 5 PRACTICE PARAMETER FOR GENDER-VARIANT AND TRANSGENDER YOUTH

Speaker: Richard R. Pleak, M.D.

SUMMARY:

The past several years has seen many more youth openly identifying as gender variant or transgender, with a small but growing number of clinicians and programs set up to meet their needs. The evidence regarding gender non-conformity in youth will be reviewed as to its origin, its challenges for the child and for the family, its natural history and outcome, and ways for clinicians to help these youth. The parts of the AACAP Practice Parameter that pertain to gender variant and transgender youth will be examined, with the strengths and limitations of such guidelines. These are the first psychiatric guidelines to address gender identity issues in youth, and they will be compared to guidelines issued by the World Professional Organization for Transgender Health (WPATH's Standards of Care) and those proposed for development by the American Psychiatric Association. Further recommendations will be made using information available since the publication of the Practice Parameter.

SYMPOSIUM 63 SLEEP-WAKE DISORDERS IN PSYCHIATRIC PRACTICE: GUIDANCE FROM DSM-5

Chair(s): Charles F. Reynolds III, M.D., Ruth O'Hara, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Diagnose Insomnia Disorder and specify its differential diagnosis, including comorbidities important to psychiatric practice; 2) Diagnose Hypersomnolence Disorder and specify its differential diagnosis, including narcolepsy, breathing related sleep disorders, and comorbidities important to psychiatric practice; and 3) Diagnose other important dyssomnias important in psychiatric practice, including REM sleep behavior disorder (RBD) and Restless Legs Syndrome (RLS).

SUMMARY:

Understanding the differential diagnosis of sleep disturbances is of central and first-rank importance to psychiatric practice,

and of the interface of psychiatry with internal medicine and neurology. Such disturbances may represent : (1) risk factors for the subsequent development of common mental disorders, (2) core symptoms of mental disorders, (3) indicators of co-existing sleep-wake and other medical/neurological disorders, and (4) significant residual symptoms that presage a chronic, relapsing illness course. Within this context, the DSM-5 classification of sleep wake disorders embodies several significant departures from DSM-IV: (1) new criteria for the diagnosis of Insomnia Disorder, with concurrent specification of co-existing psychiatric and medical disorders, (2) new criteria for the diagnosis of Hypersomnolence Disorder and Narcolepsy, again with concurrent specification of co-existing psychiatric and medical disorders, and (3) elevation of several dyssomnias to full fledged diagnostic status, such as REM sleep behavior disorder and Restless Legs Syndrome. These changes rest upon extensive clinical epidemiological studies, studies of pathogenesis, and interventions research. They were designed to make the DSM-5 sleep wake disorders criteria clinically useful by the non-sleep disorders expert.

NO 1 INSOMNIA DISORDER: DIAGNOSTIC UPDATES AND IMPLICATIONS FOR TREATMENT

Speaker: Charles Morin, Ph.D.

SUMMARY:

Insomnia is a frequent complaint among patients with psychiatric disorders. Despite its high prevalence and public health burden, it often remains unrecognized and untreated. This presentation will provide an update of DSM5 diagnostic criteria of insomnia disorder, review the rationale and evidence supporting these changes, and discuss their implications for clinical practice. The main changes for DSM5 include replacing "Primary Insomnia" and "Insomnia related to another mental or medical disorder" with "Insomnia Disorder", and specification of clinically comorbid conditions; deleting the construct of non restorative sleep and adding sleep dissatisfaction; adding a minimal frequency criterion for sleep disturbances; and raising the minimum duration threshold to 3 months. It is expected that these changes will improve recognition of insomnia disorder by simplifying its differential diagnosis and potentially optimizing treatment outcomes.

NO 2 SLEEP, SLEEP DISORDERS, AND MENTAL ILL- NESS: BIDIRECTIONAL RELATIONSHIPS

Speaker: Dieter Riemann, Ph.D.

SUMMARY:

Mental illness is often accompanied by sleep disturbances, including insomniac or hypersomniac symptoms. This is true for depressive disorders, where research indicates almost 90 % of afflicted individuals display insomniac symptoms, difficulty falling asleep, or maintaining sleep. Depression is associated with decrements of Slow Wave Sleep and a disinhibition of REM sleep (shortened REM latency and increased REM density). Recent epidemiological work indicates that not only insomniac symptoms precede or accompany depressive

disorders, but may be present for very long time intervals prior to the onset of the first depressive episode. Data indicates that insomnia may be an independent predictor for depressive disorders and that the treatment of insomnia may serve to prevent mood disorders. The relationship between depression and sleep alterations might be conceptualized as bi-directional, offering new and interesting approaches for pathophysiological concepts and treatment approaches.

NO 3 HYPERSONNOLENCE DISORDERS, INCLUDING NARCOLEPSY

Speaker: Maurice M. Ohayon, M.D., Ph.D.

SUMMARY:

Hypersomnolence disorders, formerly Hypersomnia disorders, had important modifications in the formulation of the criteria. Among the most significant changes were the addition of frequency and severity for hypersomnolence symptoms. The definition was also extended to include not only individuals with a prolonged sleep duration but also those who complain of excessive sleepiness despite a normal sleep duration. The diagnosis of Narcolepsy was also modified to include the recent findings on hypocretin deficiency. This presentation will review the most important scientific findings behind the modifications of the diagnostic criteria.

NO 4 ELEVATION OF DYSSOMNIAS TO FULL DSM-5 DIAGNOSTIC CATEGORIES: RATIONALE AND IM- PLICATIONS FOR PSYCHIATRIC DISORDERS

Speaker: Ruth O'Hara, Ph.D.

SUMMARY:

In DSM 5 dyssomnias such as Restless Legs Syndrome (RLS) and REM Sleep behaviour disorder were both elevated to full diagnostic status. This presentation will provide an overview of the DSM 5 administrative process by which the determination for elevated diagnostic status was evaluated. The rationale and extant data which provided the basis for the new diagnostic status of these disorders will be reviewed. Specifically, data on prevalence; clinical and functional impairment; identified and replicated genetic markers; and pathophysiological basis were all considered for elevating RLS and REM Sleep behaviour disorder to their own diagnostic categories. We will also outline and describe the development of the new criteria for both these disorders. The implications of RLS and REM Sleep behaviour disorder for the development, course, and prognosis of psychiatric illnesses will be discussed.

SYMPOSIUM 64 TRAUMA AND STRESS-RELATED AND DISSO- CIATIVE DISORDERS IN DSM-5

Chair(s): Matthew J. Friedman, M.D., Ph.D., Katharine A. Phillips, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the rationale for the proposed PTSD criteria and why PTSD will no longer be considered an Anxiety Disorder; 2) Understand the rationale for making a diagnosis with the proposed Acute Stress Disorder Criteria; 3) Diagnose the new Dissociative Subtype of PTSD as well as Dissociative Identity Disorder, Dissociative Amnesia, and Depersonalization and Derealization Disorder; and 4) Understand the difference between normal bereavement from the Bereavement-Related Subtype of Adjustment Disorder as well as from Persistent Complex bereavement Disorder.

SUMMARY:

A new chapter will appear in DSM-5 consisting of disorders in which the onset of symptoms has been preceded by a traumatic or stressful event. The rationale for this new category (which contains disorders previously classified as "Anxiety Disorders") will be addressed. This symposium will discuss new criteria for Posttraumatic Stress Disorder, Acute Stress Disorder and the Bereavement-Related Subtype of Adjustment Disorders. Also discussed will be a diagnosis proposed for the Appendix, Persistent Complex Bereavement Disorder. Finally, disorder with dissociative symptoms will be reviewed. These include the Dissociative Subtype of Posttraumatic Stress Disorder as well as the major Dissociative Disorders which will remain in a separate chapter of DSM-5: Dissociative Amnesia, Dissociative Identity Disorder and Depersonalization and Derealization Disorder. A great deal of time will be reserved for questions from the audience.

NO 1**ACUTE STRESS DISORDER IN DSM-5**

Speaker: Robert J. Ursano, M.D.

NO 2**TRAUMA AND STRESSOR-RELATED DISORDERS**

Speaker: Matthew J. Friedman, M.D., Ph.D.

SUMMARY:

The rationale for including a new chapter in DSM-5, consisting of disorders that were preceded by exposure to a traumatic or stressful event will be discussed. This chapter includes PTSD, Acute Stress Disorder, Adjustment Disorders, Reactive Attachment Disorder, Disinhibited Social Engagement Disorder and (for the Appendix) Persistent Complex Bereavement Disorder. The talk will then review the evidence for major revisions in PTSD diagnostic criteria. These include: four (rather than DSM-IV's three) symptom clusters, revision of the A (Stressor) Criterion, addition of a Pre-School Subtype and addition of a Dissociative Subtype.

NO 3**DISSOCIATIVE DISORDERS AND THE DISSOCIATIVE SUBTYPE OF PTSD**

Speaker: Roberto Lewis-Fernandez, M.D.

SUMMARY:

The rationale, research literature, and changes to the Dissociative Disorders and the Dissociative Subtype of PTSD in DSM-5 are presented. Dissociative Identity Disorder will refer to pathological possession and identity fragmentation to make the disorder more applicable cross-culturally. Dissociative Amnesia will include Dissociative Fugue as a subtype, since Fugue is a rare disorder that always involves amnesia but does not always include confused wandering or loss of identity. Depersonalization Disorder will include Derealization as well, since the two often co-occur. Dissociative Disorder NEC will include two new examples featuring acute dissociative reactions. A Dissociative Subtype of PTSD, defined by the presence of depersonalization or derealization in addition to other PTSD symptoms, is now included, based upon new epidemiological and neuroimaging evidence linking it to an early life history of adversity and a combination of frontal activation and limbic inhibition.

NO 4**PERSISTENT COMPLEX BEREAVEMENT DISORDER (PCBD)**

Speaker: Robert Pynoos, M.D., M.P.H.

SUMMARY:

Recent research and clinical observation suggest that a subgroup of bereaved individuals suffers persistent bereavement-related symptoms with significant impairment that warrants consideration of a bereavement-related disorder, independent of other psychiatric conditions. PCBD combines the most empirically supported criteria across theoretical orientations to provide an integrated, multi-faceted Appendix set of diagnostic criteria. This presentation will: 1) present the DSM-5 diagnostic features for the Section 3 "Persistent Complex Bereavement Disorder (PCBD); 2) describe a multi-dimensional model that underlies the diagnostic criteria for PCBD; 3) discuss the empirical basis and rationale for these diagnostic criteria; 4) describe and discuss the traumatic death specifier under PCBD reserved for bereavement due to death by homicide or suicide; and 5) discuss considerations regarding grief, mourning and bereavement in relation to the category of Adjustment Disorders.

SYMPOSIUM 65**ADVERSE EFFECTS OF MODERN ANTIDEPRESSANT TREATMENTS**

Chair: Rajnish Mago, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Summarize the impact of antidepressant adverse effects on patients suffering and nonadherence to antidepressants; 2) Recognize the scope and burden of sexual dysfunctions associated with antidepressants; 3) Implement evidence-based management strategies for antidepressant-associated sexual dysfunctions; 4) Describe the prevalence and management of metabolic adverse effects of adjunctive medications for depressive disorders; and 5) Summarize

recent findings on the pharmacogenetics of adverse effects of medications for depressive disorders.

SUMMARY:

Adverse effects of medications for depressive disorders have a greater effect on patient suffering, non-adherence to treatment, and ultimately on the success of these treatments than is commonly recognized. The literature on the prevalence, identification, and management of adverse effects of medications for depressive disorder was systematically identified and summarized. There is a paucity of research on the methods for identification, assessment, and reporting of adverse effects. In addition, many adverse effects of these medications have not been systematically studied. Sexual dysfunction is one of the most troublesome long-term adverse effects of serotonergic antidepressants. The complex research data on its prevalence, recognition, and management is discussed. Careful evaluation prior to implementing any management of sexual adverse effects of antidepressants is a must. The management strategies include starting treatment with an antidepressant not frequently associated with sexual adverse effects; switching to an antidepressant with lower incidence of these adverse effects; waiting for spontaneous remission; introducing drug holidays or partial drug holidays; possibly scheduling sexual activity around the daily dose of antidepressant; and the use of one of the numerous “antidotes’ or “augmenting” agents depending on the nature of the sexual adverse effect. Second-generation antipsychotics (SGAs) are frequently used as adjuncts in difficult-to-treat depression but may be associated with metabolic adverse events. Less than half of patients are monitored for metabolic syndrome in accordance with consensus guidelines. Weight gain may be associated with leptin, ghrelin, or adiponectin levels. Up to 48.2% of patients treated with antipsychotics may meet criteria for metabolic syndrome. In short-term clinical trials for MDD, mean weight gain for SGAs ranges from 2.0 to 10.8 Kg. Metabolic AEs are dose-related for several SGAs. Some data supports various off-label treatments like metformin, orlistat, topiramate, amantadine, etc. Guideline concordant monitoring for metabolic AEs needs to be practiced universally. Diet, exercise, and switching antipsychotics should be considered first, but pharmacological treatment may be appropriate for some patients. This symposium will also review recent investigations of antidepressant-associated adverse effects, including sexual dysfunction, insomnia, and treatment-associated suicidal thoughts and behaviors. While multiple candidate gene studies have identified associations for a broad range of adverse effects, these have not been replicated convincingly. Genome-wide studies have implicated multiple loci but again have not yielded actionable results. Limitations of existing results will be discussed, as well as next steps for examining antidepressant adverse effects. Results will also be placed in the broader context of pharmacogenetic investigation of non-psychotropic medications.

NO 1

ADVERSE EFFECTS: THE NEGLECTED SIDE OF SUFFERING

Speaker: Rajnish Mago, M.D.

SUMMARY:

Background: Adverse effects (AEs) of antidepressants have a greater effect on patient suffering, non-adherence, and ultimately on the success of treatment than is commonly recognized. Methods: The literature on the prevalence of significant AEs, their effect on nonadherence, and methods for their assessment was systematically reviewed. Results: Very bothersome AEs are reported by 55% of patients on antidepressants. Attempting to avoid specific AEs is the most important factor (49%) in selecting an antidepressant. Before the continuation phase is over, 49% of patients discontinue their antidepressant. AEs are the most common cause of discontinuation (43%). Only 14% of antidepressant clinical trials used a rating scale to identify AEs. An open-ended question fails to identify 66.7% of AEs identified on systematic assessment. Discussion: Research on methods to identify, assess, prevent, and treat AEs has been relatively neglected. Greater attention to AEs is needed to improve adherence.

NO 2

RECOGNITION AND MANAGEMENT OF SEXUAL ADVERSE EFFECTS ASSOCIATED WITH ANTIDEPRESSANTS

Speaker: Richard Balon, M.D.

SUMMARY:

Sexual adverse effects have been reported with almost all antidepressants. Sexual dysfunction in a patient treated with an antidepressant could be due to her/his depression, anxiety, concomitant medical illness and/or medication used to treat this illness, co-occurring substance abuse, and, finally, the antidepressant itself. Thus, careful evaluation prior to implementing any management of sexual adverse effects of antidepressants is a must. The management strategies for sexual adverse effects of antidepressants include starting treatment with an antidepressant not frequently associated with sexual adverse effects; switching to an antidepressant with lower incidence of these adverse effects; waiting for spontaneous remission; introducing drug holidays or partial drug holidays; possibly scheduling sexual activity around the daily dose of antidepressant; and the use of one of the numerous “antidotes’ or “augmenting” agents depending on the nature of the sexual adverse effect.

NO 3

METABOLIC ADVERSE EFFECTS OF ADJUNCTIVE TREATMENTS

Speaker: Michael E. Thase, M.D.

SUMMARY:

Background: Second-generation antipsychotics (SGAs) are frequently used as adjuncts in difficult-to-treat depression but may be associated with metabolic adverse events. Methods: Literature on metabolic AEs was systematically reviewed. Results: Less than half of patients are monitored for metabolic syndrome in accordance with consensus guidelines. Weight gain may be associated with leptin, ghrelin, or adiponectin levels. Up to 48.2% of patients treated with antipsychotics

may meet criteria for metabolic syndrome. In short-term clinical trials for MDD, mean weight gain for SGAs ranges from 2.0 to 10.8 Kg. Metabolic AEs are dose-related for several SGAs. Some data supports various off-label treatments like metformin, orlistat, topiramate, amantadine, etc. Discussion: Guideline concordant monitoring for metabolic AEs needs to be practiced universally. Diet, exercise, and switching anti-psychotics should be considered first, but pharmacological treatment may be appropriate for some patients.

NO 4 PHARMACOGENOMICS OF ANTIDEPRESSANT- ASSOCIATED ADVERSE EFFECTS

Speaker: Roy Perlis, M.D., M.S.

SUMMARY:

Background: To date, most antidepressant pharmacogenomic studies have focused on treatment efficacy. Outside of psychiatry, however, genetic studies of adverse effects have yielded greater success. Method: This symposium will review recent investigations of antidepressant-associated adverse effects, including sexual dysfunction, insomnia, and treatment-associated suicidal thoughts and behaviors. Results: While multiple candidate gene studies have identified associations for a broad range of adverse effects, these have not been replicated convincingly. Genomewide studies have implicated multiple loci but again have not yielded actionable results. Discussion: Limitations of existing results will be discussed, as well as next steps for examining antidepressant adverse effects. Results will also be placed in the broader context of pharmacogenetic investigation of non-psychotropic medications.

SYMPOSIUM 66 CULTURE, COGNITION, VALUES, AND WISDOM

Chair(s): Vijoy K. Varma, M.D., Avdesh Sharma, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how wisdom involves seeing things in the totality, and requires a synthetic ability; 2) Discuss how the cognitive styles in cultures of western (analytic) versus eastern (synthetic) societies influences wisdom; and 3) Identify the link between moral values and social mores and how these can influence the course of wisdom.

SUMMARY:

Right and wrong, true and false, just and unjust, good and bad, lawful and illegal, profitable and unprofitable; there are many ways to dichotomize a decision, a course of action. Wisdom – wise and unwise – goes beyond all of these and straddles these dichotomies. Wisdom involves the ability to see things in the totality, to see what is desirable. A course of action may be right and lawful, but still may be unwise. Wisdom involves seeing things in the totality, and requires a synthetic ability. People differ from one another in cognitive style, from analytic to synthetic. Western cultures tend to be analytic, whereas the traditional societies of the east holistic

and synthetic. A number of things may appear to be right but may still be unwise. Certain things may be just, but implausible. A legal action may give rise to complications in its wake. It may not be worth the cost. Wisdom involves a meta-approach to the problem at hand, to arrive at a course of action. Wisdom is inextricably linked with moral values and social mores. Values largely determine what should be done. However, at times, a course of action may be ignored or left undone, if although morally correct, may create problems. The various aspects of wisdom will be discussed by the presentations in this symposium.

NO 1 CULTURE, COGNITION, VALUES, AND WISDOM

Speaker: Vijoy K. Varma, M.D.

SUMMARY:

Right and wrong, true and false, just and unjust, good and bad, lawful and illegal, profitable and unprofitable; there are many ways to dichotomize a decision, a course of action. Wisdom – wise and unwise – goes beyond all of these and straddles these dichotomies. Wisdom involves the ability to see things in the totality, to see what is desirable. A course of action may be right and lawful, but still may be unwise. Wisdom involves seeing things in the totality, and requires a synthetic ability. People differ from one another in cognitive style, from analytic to synthetic. Western cultures tend to be analytic, whereas the traditional societies of the east holistic and synthetic. A number of things may appear to be right but may still be unwise. Certain things may be just, but implausible. A legal action may give rise to complications in its wake. It may not be worth the cost. Wisdom involves a meta-approach to the problem at hand, to arrive at a course of action.

NO 2 SPIRITUALITY AND VALUES FOR INDIVIDUAL AND COMMUNITY WISDOM

Speaker: Avdesh Sharma, M.D.

SUMMARY:

Wisdom as a concept often gets spoken of at various forums but wisdom as a lived reality requires a framework in the individual and societal context for which spirituality and values provide a strong foundation. Spirituality when understood as 'that pertaining to spirit/soul/consciousness and the various laws that govern it', translates into looking from a higher perspective at human-human or human-environment interaction. It then looks at how matter and consciousness driven matter (life forms) with the interplay of the two (environment) can be a win-win situation for all to thrive. It also looks at personal growth of individuals in the context of societal growth in a manner that provides peace, happiness, prosperity, knowledge, truth and purpose in living for self as well as those around in a sustainable manner. Wisdom does not look at life in a static way but as an ever evolving and growing process.

NO 3 ENHANCING WISDOM THROUGH VIPASSANA MEDITATION

Speaker: Kishore Chandiramani

SUMMARY:

Wisdom has been defined in terms of emotional stability, practical application of knowledge and intelligence, a greater acceptance of things, being positive in the face of adversity and uncertainty, ability for dialectic thinking that promotes reality-orientation, objectivity, capacity for self-transcendence, other-centeredness, empathy, altruism, etc. It is normally seen as innate but also as resulting from richness of life experience. The scientific literature on enhancing wisdom through practice is scant. A wise man can see the reality, both of his inner being and that of the external world, as it is and not just as it appears on the surface. He doesn't feel the need to distort it as he feels able to deal with it. He remains highly alert to the milieu interior and milieu exterior at all time and in spite of that can maintain equanimity. He is not surprised or shocked by anything because he has experienced a lot of things in reality and also at the cognitive and meta-cognitive levels

NO 4 CULTURE, COGNITION, VALUES, AND WISDOM: FROM PHILOSOPHY TO SOCIOLOGY/PSYCHOLOGY AND NOW NEUROBIOLOGY

Speaker: Ajai R. Singh, M.D.

SUMMARY:

From antiquity the province of philosophy, concepts like culture, cognition, values, and wisdom later became the subject matter of sociology/psychology. Neurobiology entered the domain only recently, mainly for heuristic reasons - earlier lack of objective study tools. Since entering, it has contributed substantially. Fascinating evidence and insights are being offered in the neurobiologies of culture, cognition, values and wisdom which the broader visioned psychiatrist cannot ignore. And translational research in psychiatry will have to incorporate in its worldview. It is equally important to synthesize the speculative reflections of philosophers of mind with empirical theories of sociologists, and findings and tests of psychologists. These must combine with neurobiological and imaging studies of neuroscientists to decipher molecular, cellular and systems functioning of the brain in health and disease.

SYMPOSIUM 67 USING GENETICS TO GUIDE PSYCHOTROPIC PHARMACOTHERAPY ACROSS THE LIFESPAN

Discussant: James T. McCracken, M.D.

Chair(s): Erika L. Nurmi, M.D., Ph.D., Daniel J. Mueller, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the importance of pharmacogenetic effects on drug response and adverse events; 2) Understand

how pharmacogenetics can be used to guide treatment algorithms in medicine; 3) Understand the process from pre-clinical exploration to prospective analysis to clinical implementation of pharmacogenetic testing; and 4) Appreciate promising directions for pharmacogenetics in psychiatric practice.;

SUMMARY:

Pharmacogenetic data is currently leveraged across many fields of medicine to streamline treatment algorithms, avoid adverse effects and improve patient outcomes. The understanding of genetic moderators of drug effects and clinical implementation of genetic testing in psychiatry lags behind other disciplines for many of the same reasons that discovering risk loci for psychiatric disease has been daunting; barriers to collecting large treatment populations, genetic and phenotypic heterogeneity, and the complexity of the targeted biological pathways present a challenge. Effect sizes of genetic factors influencing drug response may be substantial, however, and a basic appreciation of relevant pathways exists. In psychiatry, where treatment response is highly variable and poorly understood, and choosing an effective and tolerated medicine is often trial-and-error, pharmacogenetics holds considerable promise for evidence-based treatment matching. This symposium will highlight several promising directions for psychiatric pharmacogenetics across a range of research development stages and patient age groups. While genetic effects are relevant throughout the lifespan, they may be variable based on age, comorbidity, and treatment history and are important to consider in different treatment populations. We will begin with an introduction to the topic of pharmacogenetics. Examples from other fields of medicine where genetic data has been successfully employed to guide clinical practice will provide a window into the possible future benefits for psychiatry. This will be followed by a presentation of pharmacoepidemiology surveys illustrating the clinical importance of considering both drug-gene and drug-drug interactions in psychiatry. The next two speakers will present pre-clinical data that can inform future prospective clinical studies. First, we will examine pharmacogenetic influences on an adverse effect of serotonin reuptake inhibitors (SRIs), accelerated bone loss in the elderly. Data showing that this adverse event may be partially explained by genetic variation in serotonergic signaling will be presented. Next, the impact of genetic variation in drug metabolism and target neurotransmitter systems on SSRI and CBT treatment of anxiety in children will be discussed. The last two speakers will share their experiences implementing genetic testing for compelling variants prospectively and in clinical settings. Prospective studies of genetic variation on lithium response in bipolar adults, incorporating advances in genetics, molecular biology and bioinformatics, will be presented. Finally, the utility of genetic testing for established variants impacting drug pharmacokinetics in a population of patients selected for problematic response or intolerance will be reviewed. A synthesis and discussion will conclude the session. This symposium will illustrate the path from exploration to implementation of pharmacogenetics in psychiatry.

NO 1 THE COMPLEX INTERPLAY BETWEEN GENETICS AND DRUG-DRUG INTERACTIONS ON TREAT- MENT OUTCOMES WITH ANTIDEPRESSANTS AND ANTIPSYCHOTICS

Speaker: Sheldon Preskorn, M.D.

SUMMARY:

Patients permitted in medication registration trials represent a narrow subset of the patients that will receive these drugs once they are approved. Trials are short-term, frequently prohibit polypharmacy, and inadequately represent clinical populations. As the size of the exposed population increases, likelihood of encountering clinically meaningful drug-gene interactions (DGI) and/or drug-drug interactions (DDI) increases. This presentation will focus on DGIs and DDIs in pharmacoepidemiology surveys of antidepressant and antipsychotic therapy. These interactions are common and clinically important; DGIs and DDIs can produce similar effects on clinical outcome. Prescribers must consider both genetic and drug-induced variance amongst patients to more completely understand variable treatment response. These results demonstrate the complex and clinically meaningful interplay between DGIs and DDIs in real world psychiatric practice.

NO 2 GENETIC INFLUENCES ON SSRI AND CBT RE- SPONSE IN PEDIATRIC ANXIETY

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

SUMMARY:

SSRIs and CBT are highly effective therapies for pediatric anxiety; however, heterogeneity in response is poorly understood. Individual variation in drug metabolism and target neurotransmitter systems may play an important role. To address this question, we examined genetic influences on treatment response in the Child/Adolescent Anxiety Multimodal Study (CAMS) of sertraline vs. CBT vs. combination therapy for pediatric anxiety (n=258). Response to both medication and CBT were associated with variation in serotonergic and fear extinction candidates, while SSRI response was also associated with variants affecting drug metabolism and transport. Our study suggests that genetic variation in pharmacokinetic and pharmacodynamic pathways relevant to anxiety therapy may contribute to SSRI and CBT response in children. Our pediatric sample benefits from reduced treatment history, comorbidity, and polypharmacy. These data warrant replication in larger samples and prospective treatment studies.

NO 3 GENETIC VARIATION IN THE SEROTONIN TRANSPORTER AND HTR1B RECEPTOR PRE- DICTS REDUCED BONE FORMATION DURING VENLAFAXINE TREATMENT IN OLDER ADULTS

Speaker: Daniel J. Mueller, M.D., Ph.D.

SUMMARY:

There is evidence for an association between serotonin

reuptake inhibitors (SRIs) and accelerated bone loss. In this pilot study, we examined functional genetic variants in the serotonin transporter and the HTR1B receptor and assessed if these variants predict changes in bone metabolism during SRI treatment. Serum markers of bone formation (P1NP) and resorption (β -CTX) were assayed before and after treatment in 69 older adults (age ≥ 60) participating in a 12-week, open-label trial of the SRI venlafaxine for major depression. Bone formation was significantly reduced, as measured by decrease in P1NP, with administration of venlafaxine in participants with the high-expressing 5HTTLPR genotype and those with the low expressing HTR1B genotype. These preliminary findings indicate that genetic variation in serotonin receptors predicts changes in bone metabolism during SRI use. If replicated, our results may ultimately help to prevent bone fractures in this vulnerable population.

NO 4 TOWARDS CLINICAL APPLICATION OF PHARMA- COGENOMICS IN BIPOLAR DISORDER

Speaker: John R. Kelsoe, M.D.

SUMMARY:

Current treatment of bipolar disorder frequently involves a lengthy trial and error process of medication trials. A pharmacogenomic panel could potentially shorten this process by predicting response to different agents. Lithium, the first and gold standard mood stabilizer, has been the most extensively studied in this regard. We have examined 658 SNPs in 50 candidate genes in a retrospectively assessed sample of 240 bipolar I subjects who were lithium responders and 210 non responders. The strongest associations were seen to multiple SNPs in NRG1 ($p=0.0009$) and CACNG2 ($p=0.0040$). NTRK2 and PDE11A which were associated in an earlier sample remained positive in this extended sample. The association to NTRK2 was also replicated in a prospectively assessed sample (N=77, $p=0.28$). Two ongoing prospective studies of lithium pharmacogenomics will be described, as will a study testing the clinical utility of a pharmacogenomic panel in bipolar disorder.

NO 5 CLINICAL IMPLEMENTATION OF PHARMACOGE- NETICS

Speaker: Deanna L. Kroetz, Ph.D.

SUMMARY:

Implementation of pharmacogenetic principles into drug therapy decision making has been successful within multiple clinical disciplines. Examples include the use of genetic testing for selection of warfarin and 6-mercaptopurine starting doses, and for the choice of clopidogrel and abacavir for anti-platelet and HIV therapy, respectively. In most of these cases, pharmacogenetic selection of dose or drug limits toxicity of the drug. One exception is clopidogrel, where efficacy is determined by genotype. Robust clinical testing and corresponding functional genomics data support all of the current applications of pharmacogenetic implementation. Nonetheless, there are still barriers to adoption of genetic testing. The successes and

challenges associated with clinical implementation of pharmacogenetics will be discussed using examples across drug and disease classes.

NO 6 PRACTICAL IMPLEMENTATION OF PHARMACOGENETICS DATA INTO PSYCHIATRIC CARE

Speaker: Steve Hamilton, M.D., Ph.D.

SUMMARY:

A major hallmark of pharmacologic treatment of psychiatric disorders is the great variability in clinical response to medications as well as the frequency and severity of adverse effects from the same agents. Currently, there are few predictors of drug response or intolerance. We have sought to match DNA polymorphisms known to alter drug metabolism or transport with clinical outcomes in patients selected for problematic response or intolerance in psychiatric outpatients. We have recruited 96 patients and genotyped them for 188 functional variants in 34 drug metabolism and transport genes. Genotype reports providing interpretation from the best available literature were provided to the patients' clinicians and follow-up questionnaires were administered. The reports were found to be helpful, neutral, or unhelpful in guiding treatment decisions in 68%, 18%, and 14% of subjects, respectively. This work provides a platform for prospectively guiding drug treatment in targeted patients.

SYMPOSIUM 68 PSYCHIATRIC PRESCRIBING: MEDICINE, MALPRACTICE, AND MAYHEM

Chair: William Newman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of specific guidelines for appropriate documentation that can help protect providers after negative outcomes; 2) Understand important aspects of off-label prescribing; 3) Discuss key components of medical negligence; 4) Review issues related to split treatment and respondeat superior claims (including supervision of residents or fellows); and 5) Recognize issues related to prescription of potentially addictive medications and their impact on cognition and alleged harm to third parties;

SUMMARY:

According to the American Medical Association, approximately 22 percent of psychiatrists will be sued in their career. Malpractice lawsuits frequently involve prescribed medications. For example, 14 percent of psychiatric malpractice claims specifically allege adverse drug reactions. An additional 38 percent of claims allege incorrect treatment. This panel will address emerging trends regarding malpractice litigation and psychiatric prescribing. Dr. Chelsea Shih will discuss key components of negligence and review issues related to split treatment and respondeat superior claims. Dr. Jason Chapman will address medico-legal aspects of informed consent. In addition, he will review issues related to prescribing potentially

addictive medications, their impact on cognition, and dealing with liability when harm to third parties is alleged (including high profile deaths). Dr. William Newman will explain the origins and impact of black box warnings on prescribing practices and important cases related to off-label prescribing. He will also review 2012 data analyzing the alleged relationship of antidepressants to increased suicidality. Dr. Charles Scott will emphasize important aspects of conducting a forensic analysis of alleged adverse drug reactions in psychiatric malpractice claims. He will provide specific guidelines for physician providers regarding legally appropriate documentation that can be protective to providers after negative outcomes.

NO 1 SPLIT TREATMENT AND RESPONDEAT SUPERIOR CLAIMS

Speaker: Chelsea Shih, M.D.

SUMMARY:

The physician-patient relationship is an evolving bond subject to the external influences of cultural, political, and legal expectations. Specifically, the psychiatrist-patient relationship has witnessed notable changes. Examples include how a psychiatrist's role in treatment of patients has become less therapeutic and more prescriptive. As a result, a significant portion of psychiatrist medical malpractice claims address incorrect treatment and dereliction in provision of care. Dr. Shih will discuss key components of negligence and will review issues related to split treatment and respondeat superior claims.

NO 2 INFORMED CONSENT AND MEDICOLEGAL PITFALLS

Speaker: Jason M. Chapman, D.O.

SUMMARY:

A series of cases decided in the early 1960s ushered in the doctrine of informed consent. Various state courts held that a patient cannot give meaningful consent without first discussing adequate information about the risks of treatment and available treatment alternatives. As the informed consent standard has evolved, new case law has allowed for greater liability attributed to physicians prescribing potentially addictive medications. One example includes malpractice lawsuits alleging harm to third parties injured or killed in motor vehicle accidents. Additionally, Dr. Chapman will explore potential liability in high profile deaths involving prescription drug overdoses.

NO 3 ALLEGED ADVERSE MEDICATION REACTIONS AND MALPRACTICE: A FORENSIC ANALYSIS

Speaker: Charles Scott, M.D.

SUMMARY:

An increasing number of lawsuits focus on allegations that a particular psychiatric medication resulted in the patient becoming suicidal or violent. However, many patients are

prescribed medications because they are at risk for harm to self or others. When a patient taking psychiatric medication exhibits suicidal or aggressive behavior, can the psychiatrist be sued for the very treatment used to minimize such actions? The answer is yes. This presentation will review important aspect for treating providers to consider when prescribing medications that are alleged to contribute to impulsive and harmful behaviors. In addition, important aspects to consider when conducting a forensic analysis of alleged adverse drug reactions in psychiatric malpractice claims with specific guidelines regarding documentation for physician providers will be emphasized.

SYMPOSIUM 69 TRAUMATIC BRAIN INJURY IN THE U.S. MILITARY: FROM ROADSIDE TO BEDSIDE

Chair(s): Brett Schneider, M.D., Scott Moran, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Participants will describe the latest updates on the treatment of traumatically brain-injured patients; 2) Participants will assess the efforts of the US Military to research the neuropathophysiology of TBI, and evaluate the clinical research efforts in the US Military on Traumatic Brain Injury; and 3) Participants will describe the neuropsychiatric effects of TBI including a review of the neuroanatomy involved in TBI, the psychiatric sequelae of TBI, and the psychopharmacology of treatment.

SUMMARY:

Traumatic Brain Injury is the signature wound of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). These unseen injuries lead to many neuropsychiatric sequelae, including physical complaints, memory problems, impulse control deficits, attention deficits, depression and other behavioral health symptoms, and physical symptoms. The US Military has been at the forefront of these issues, in an effort to protect our troops from these injuries and heal them after they occur. In this symposium, leading traumatic brain injury clinicians and researchers from the Walter Reed National Military Medical Center in Bethesda, MD will provide an overview of the US Military's efforts to research traumatic brain injury and its neuroanatomical and neurophysiological basis, the neuropsychiatric sequelae of TBI, and its treatment.

NO 1 CO-OCCURRING DISORDERS WITH COMPLEX TRAUMATIC BRAIN INJURY

Speaker: Jonathan Wolf, M.D.

SUMMARY:

Patients with Traumatic Brain Injury (TBI) may have impairments in a variety of brain processes that impact their susceptibility to substance abuse and amenability to standard treatment modalities. We propose a model of addictions care for patients with TBI that accommodates the impairments that these patients may have in impulse control, social functioning,

emotional regulation, and executive functioning. We present a case series of patients illustrating a novel model of care embedded in an interdisciplinary TBI treatment team, highlighting methods of evaluation and treatment used in military healthcare.

NO 2 TRAUMATIC BRAIN INJURY: RESEARCH EFFORTS

Speaker: Louis French, Psy.D.

SUMMARY:

Dr French will present the latest update of the efforts of the US Military to research the neuropathophysiology of TBI, and present an overview of the clinical research efforts ongoing in the US Military surrounding Traumatic Brain Injury.

NO 3 NEUROPSYCHIATRIC SEQUELAE OF TRAUMATIC BRAIN INJURY

Speaker: David Williamson, M.D.

SUMMARY:

Traumatic Brain Injury (TBI) presents a complex and evolving clinical picture. In addition to sensory and motor deficits, moderate and severe injuries often disrupt more sophisticated brain functions including mood and emotional expression, thinking/judgment, social behavior and impulse control. Behavior problems stemming from these impairments (such as aggression, lability, social impropriety, and intoxication) lead to erosion of relationships and social supports, and can threaten the viability of patients in a community setting. These problems often trigger a referral to behavioral health providers. Dr Williamson will present an overview of the strategies employed in the TBI inpatient program at Walter Reed Hospital to target these challenges. He will discuss the role of pharmacotherapy, multidisciplinary behavioral health interventions, and collaboration with other medical and rehabilitation disciplines in achieving successful outcomes. The presentation will include case vignettes.

SYMPOSIUM 70 THE IMPORTANCE OF DEVELOPMENTAL ISSUES IN PSYCHIATRIC AND PEDIATRIC TRAINING

Discussant: Robert L. Russell, Ph.D.

Chair(s): Robert Friedberg, Ph.D., Melissa Tamas, M.A., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the clinical relevance of pivotal developmental constructs; 2) Recognize the importance of incorporating developmental constructs in residency and fellowship training; 3) Develop a keen alertness to the role of culture and development in child and adult psychiatry; and 4) Appreciate the pivotal nature of developmental theory in pediatric training.

SUMMARY:

This symposium considers the value developmental theory holds for medical training and practice. The first presentation discusses the necessity for incorporating developmental knowledge in psychiatric training and highlights some of the key developmental knowledge salient for understanding the trajectory of normative functioning in childhood, adolescence and adulthood. Friedberg et al.'s presentation explores research that examines the relevance of various developmental variables for clinical outcomes as well as providing clear guidelines to help psychiatrists integrate a developmental perspective into their training and practice. The application of developmental theory to adult psychiatric training and practice is the focus of the second presentation. Khan specifically examines the relationship of developmental considerations to personality development. Further, this presentation demonstrates the way developmental perspectives enhance diagnosis, conceptualization and treatment of adult problems, providing psychiatrists with a more comprehensive understanding of earlier developmental failures which can inhibit healthy personality formation. Psychiatrists using developmental theory gain a fuller understanding of the role that childhood dysfunction plays in shaping the maladaptive personal traits evident in adult psychopathology. The role of culture and development in child psychiatry is considered in the third presentation. Three crucial clinical tasks for child psychiatrists are explicated and Joshi explains how these tasks robustly inform case conceptualization, assessment, and treatment. In the final presentation, developmental theory is considered in relation to pediatric practice. Tamas and Roth show how possessing a solid understanding of the developmental milestones and sequences associated with various ages as well as the different developmental domains that contribute to age expected outcomes, provides the pediatrician with the ability to titrate their interventions so that they can target the specific deficits underlying common emotional and behavioral issues. Russell adds his perspective to the presentations in his role as discussant.

NO 1
THE ROLE OF DEVELOPMENTAL THEORY IN PSYCHIATRIC TRAINING

Speaker: Robert Friedberg, Ph.D.

SUMMARY:

Training psychiatric residents and fellows is a challenging yet compelling task. Faculty must be mindful regarding developing efficient, clinically robust, and effective educational curricula. Developmental variables represent precisely this sort of educational emphasis area. Developmental constructs pervade adult and child psychiatric theory and practice. This presentation highlights the importance of accentuating developmental theory in psychiatric training. Developmental theory incorporates physiological, cognitive, emotional, and social functioning in adults, children, and adolescents. Major developmental theorists and concepts are briefly reviewed. Additionally, recent empirical research demonstrating the relevance of these variables to clinical practice is summarized. Finally,

specific clinical guidelines for bringing this bench science to patients' bedsides are offered. Case examples augment these guidelines.

NO 2
THE ROLE OF DEVELOPMENTAL THEORY IN PSYCHIATRIC TRAINING

Speaker: Nina Pacholec, M.S.

SUMMARY:

Training psychiatric residents and fellows is a challenging yet compelling task. Faculty must be mindful regarding developing efficient, clinically robust, and effective educational curricula. Developmental variables represent precisely this sort of educational emphasis area. Developmental constructs pervade adult and child psychiatric theory and practice. This presentation highlights the importance of accentuating developmental theory in psychiatric training. Developmental theory incorporates physiological, cognitive, emotional, and social functioning in adults, children, and adolescents. Major developmental theorists and concepts are briefly reviewed. Additionally, recent empirical research demonstrating the relevance of these variables to clinical practice is summarized. Finally, specific clinical guidelines for bringing this bench science to patients' bedsides are offered. Case examples augment these guidelines.

NO 3
THE ROLE OF DEVELOPMENTAL THEORY IN PEDIATRIC TRAINING

Speaker: Melissa Tamas, M.A., Ph.D.

SUMMARY:

This presentation examines the utility of developmental theory for pediatric practice. The stigma surrounding mental illness coupled with the scarcity of child psychiatrists contribute to making the pediatrician the first clinician parents approach with disruptive behavior, requiring pediatricians to identify, assess and target some of the more common problems. An understanding of healthy development allows pediatricians to differentiate normative behavior from those requiring intervention. Developmental knowledge can also increase treatment effectiveness, ensuring that interventions are age appropriate and capable of targeting the various maintaining factors. The presentation explores the key developmental milestones, tasks and sequences critical to normal functioning in childhood and adolescence and discuss how impairments in specific domains (cognition, social, emotional) inhibit the attainment of specific age related goals, resulting in emotional and behavioral issues.

NO 4
DEVELOPMENTAL ISSUES FOR ADULT PSYCHIATRIC TRAINING

Speaker: Aftab Khan, M.D.

SUMMARY:

Understanding developmental theories and its role in shaping

the personality of an individual is essential for practice of adult psychiatry. This session focuses on the importance of integrating developmental theories in training psychiatrist not only for them to be able to practice psychodynamic psychotherapy but also more importantly to practice psychodynamically informed psychiatry. It is argued using case examples that without such training one is seriously limited in their understanding of the clinical situation and its management. For example, making a diagnosis of depression with listing all the symptoms is of limited value unless one can ask and explore the more important question of why the person is depressed. Understanding developmental theories in the context of dysfunctional life experiences in childhood which in turn leads to maladaptive personality traits is the only way to understand the patients emotional suffering like having symptoms of depression and anxiety.

NO 5 CULTURE AND DEVELOPMENT IN CHILD PSYCHIATRY

Speaker: Shashank V. Joshi, M.D.

SUMMARY:

This presentation provides an overview of cultural issues and developmental theory, proposing that standard assumptions about developmental trajectories may need reexamination. Child psychiatrists must approach their work under the presumption of multiculturalism, particularly if a broad definition of culture is chosen that is not limited to ethnic or racial makeup, but rather one that embraces the variable values, attitudes, beliefs, and behaviors shared by a people, and that is transmitted between generations. Clinicians should recognize that everyone has a unique culture, and cultural influences are woven into personality like a tapestry. Three clinical tasks include developing a broad knowledge base about cross-cultural variations in child development and childrearing, integrating this knowledge in a developmentally relevant way to make more informed assessments and case formulations, and developing a culturally sensitive therapeutic stance with patients and families.

NO 6 THE ROLE OF DEVELOPMENTAL THEORY IN PEDIATRIC TRAINING

Speaker: Jon Roth, M.D.

SUMMARY:

This presentation examines the utility of developmental theory for pediatric practice. The stigma surrounding mental illness coupled with the scarcity of child psychiatrists contribute to making the pediatrician the first clinician parents approach with disruptive behavior, requiring pediatricians to identify, assess and target some of the more common problems. An understanding of healthy development allows pediatricians to differentiate normative behavior from those requiring intervention. Developmental knowledge can also increase treatment effectiveness, ensuring that interventions are age appropriate and capable of targeting the various maintaining factors. The presentation explores the key developmental milestones, tasks

and sequences critical to normal functioning in childhood and adolescence and discuss how impairments in specific domains (cognition, social, emotional) inhibit the attainment of specific age related goals, resulting in emotional and behavioral issues.

SYMPOSIUM 71 LOOKING TOWARDS DSM-5.1: THE UTILITY OF ASSESSING PERSONALITY FUNCTIONING AND TRAITS IN PERSONALITY DISORDER DIAGNOSIS

Discussant: John M. Oldham, M.D.

Chair(s): Kenneth R. Silk, M.D., Larry Siever, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how to apply the DSM-5 Personality Disorders Types to clinical and research practice; 2) Understand the roles of facets, traits, and domains not only in the diagnosis of personality disorder types, but also in how they impact and facilitate clinical and academic work; and 3) Appreciate the relationship between the DSM-IV Personality Disorders diagnoses and the DSM-5 Personality Disorder types.

SUMMARY:

Major changes in how we diagnose personality disorders are planned for DSM 5. But how will those changes be applied to everyday clinical thinking, clinical practice and biologic research? This symposium will begin to address those issues. We begin with Dr. Skodol who will provide us with an overview of the personality disorders in DSM 5. Then we turn to how the DSM 5 might impact research and clinical work with these patients. First, in order to determine whether there is an impairment in personality functioning, that is how the patient understands and relates to the self and to other people, we must engage the patient in a dialogue and not simply approach the patient with a checklist in mind. Dr. Silk suggests ways to establish this dialogue and explains why this dialogue will be the most productive way to reveal and then help determine the level of personality functioning. Dr. Siever explores the impact that these changes will have upon ongoing research studies as we move from criteria-based to more dimensionally-based diagnoses. While research into the biology of personality disorders has always considered the dimensionality of biologic measures, we do not yet have a strong understanding as to how traits might fit into biological dimensional formulations of the personality disorders. Dr. Koenigsberg notes the conceptual shift to the primacy of personality functioning as an essential part of the diagnosis of a personality disorder. He explores how that change as well as the emphasis on traits, especially when a patient does not fit a specific personality disorder type, might impact how we think about these people clinically. Finally, Dr. Clark presents data that reveals that traits may be able to capture much more specific and relevant behavior about our personality disordered patients than a criterion-based model is able to gather. She will present ways in which traits can best be assessed. Together these presentations provide a broad overview as to

how the changes in DSM 5 will impact the future of clinical practice and research initiatives with personality disordered patients.

**NO 1
DERIVATION AND USE OF THE LEVEL OF PERSONALITY FUNCTIONING SCALE**

Speaker: Donna S. Bender, Ph.D.

**NO 2
PERSONALITY TRAITS IN DSM-5**

**NO 3
DESCRIPTION AND USE OF PERSONALITY DISORDER TYPES IN DSM-5.1**

Speaker: Lee Anna Clark, Ph.D.

SUMMARY:

DSM-5.1 Personality Disorder (PD) includes 6 patterns of personality dysfunction and maladaptive personality traits systematically derived from their DSM-IV counterparts; PD-Trait Specified (TS) is used for all other PD manifestations. For example, DSM-IV schizotypal PD was defined as social/interpersonal deficits marked by discomfort with, and reduced capacity for, close relationships, and cognitive/ perceptual distortions and eccentric behavior. DSM-5 schizotypal personality dysfunction includes, among others, confused self-other boundaries and misinterpretation of others' motives and behaviors, with the traits of suspiciousness, withdrawal, restricted affectivity and psychoticism (e.g., eccentricity). In contrast, one would use PD-TS if the personality dysfunction did not match any—or matched more than one—specific PD (e.g., a profile characterized by anxiety, hostility, withdrawal, and impulsivity). Description and clinical examples of all 6 named PDs and PD-TS are presented.

**NO 4
IMPLICATIONS FOR RESEARCH OF SECTION 3 PROPOSED OF DSM-5 PERSONALITY DISORDER DIAGNOSES**

Speaker: Larry Siever, M.D.

SUMMARY:

In DSM-5 a trait/dimensional diagnostic model, a more limited number of disorders, assessment of levels of personality dysfunction and the inclusion of interpersonal/self-criteria are included in Section 3 for future study. These changes raise the issue of how these concepts could be validated using external validators in research studies. Dimensional formulations of personality disorder have received extensive validation in neurobiologic, longitudinal, and genetic research but the specific current DSM-5 proposal that is grounded in an academic psychology tradition invites further validation studies. The self and interpersonal criteria have received limited validation in longitudinal and neurobiologic research of personality disorders including studies of social cognition and attachment. Rating levels of disorder and psychopathology will permit covariant analysis for differences in severity in future research

projects.

**NO 5
WHAT ARE THE IMPLICATIONS FOR CLINICAL PRACTICE FOR A SHIFT FROM THE DSM-IV MODEL TO A PROPOSED DSM-5.1 MODEL?**

Speaker: Harold W. Koenigsberg, M.D.

SUMMARY:

This presentation examines the extent to which clinical work with personality disorders may be affected by the transition from DSM-IV to a proposed DSM-5.1 model. The natural clustering of individual personality disturbances into commonly encountered personality syndromes is a given, independent of nosology. Nevertheless a classification system prioritizes certain features as salient and this prioritization will shape case conceptualization, treatment-targets, goal-setting with the patient, and course of treatment. Changes in the proposed model that may most directly influence clinical practice include: 1) emphasis upon impairment in self/interpersonal functioning (identity, self-direction, empathy, intimacy) in all the personality disorders, 2) a scale quantifying level of personality functioning, 3) the option to specify one or more of a number of selected personality traits.

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**SYMPOSIUM 72
PATIENT SUICIDE IN RESIDENCY TRAINING**

Discussant: Sidney Zisook, M.D.

Chair(s): Uyen-Khanh Quang-Dang, M.D., M.S., Joan Anzia, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify feelings resident psychiatrists and supervising psychiatrists may have after a patient completes suicide; 2) Demonstrate understanding of a need for improvement in preparing residents for the likelihood of suicide in their career, and in supporting residents who experience patient suicide during training; 3) Demonstrate knowledge of strategies, including video training, used to prepare residents and support them after a patient suicides; 4) Make recommendations to their home training programs on how to improve support for residents who experience patient suicide.

SUMMARY:

According to the Centers for Disease Control and Prevention, in 2009, suicide was ranked as the 10th leading cause of death among persons ages 10 years and older, accounting for 36,891 deaths. Studies estimate that 20-68% of psychiatrists will lose a patient to suicide in their career. A significant number of residents will experience patient suicide during residency training. Unfortunately, open discussions about the feelings and issues raised in response to suicide are rare in training programs and in the literature. This silence may be due to the shame, guilt, fear, confusion, sadness, and other emotions that exist in residents, their colleagues, and supervisors after a patient dies by suicide. We believe this lack of discussion interferes with the use of positive coping strategies by residents,

and that residency training programs need improvement in supporting residents through this difficult experience and preparing them for the likelihood of losing a patient to suicide in their career. Following an introduction (Uyen-Khanh Quang-Dang, MD, MS, PGY-3 at UCSF), two psychiatry residents (Lauren Osborne, MD, PGY-4 at Columbia and Ben Elitzur, MD, Chief Resident at UCSF) will share their experience of having a patient die by suicide. Second, a residency training director (Joan Anzia, MD, Associate Professor of Psychiatry, Residency Training Director and Vice Chair of Education for Psychiatry at Northwestern University Medical Center) will discuss the challenges in educating trainees about the impact of patient suicide. She will show a video of a psychiatrist supervisor (Glenn Gabbard, MD, Clinical Professor of Psychiatry at Baylor College of Medicine) discussing his own experience of patient suicide, with comments by James Lomax, MD, Clinical Professor of Psychiatry and Associate Chair at Baylor College of Medicine. Two attending psychiatrists (Christina Mangurian, MD, Assistant Professor of Clinical Psychiatry and Director of the UCSF/SFGH Public Psychiatry Fellowship and Andrew Booty, MD, Assistant Clinical Professor, UCSF) will then share their experiences of developing a support system for residents who experience patient suicide at their own training programs (Columbia and UCSF). Next, another residency training director (Sidney Zisook, MD, Professor of Psychiatry, Residency Training Director, UCSD) will discuss the collaborative project of making the training video of residents and faculty discussing patient suicide shown earlier and present data from the pilot study of the video in use. Michael Myers, MD, Professor of Clinical Psychiatry, Vice-Chair of Education and Director of Training in the Department of Psychiatry & Behavioral Sciences at SUNY-Downstate Medical Center in Brooklyn, NY, will speak about the effect that patient suicide has on all levels of an academic medical environment. There will be two interspersed breakout sessions to allow for the sharing of experiences with patient suicide among audience participants.

NO 1 RESIDENT EXPERIENCE OF SUICIDE

Speaker: Lauren M. Osborne, M.D.

SUMMARY:

This part of the presentation will focus on a single resident's experience of a patient suicide during residency training. I will give a brief case presentation, and review both formal and informal systems of support instituted by my residency program following this experience. I will conclude with suggestions for training directors on how to support residents through this process.

NO 2 PERSONAL REFLECTION ON A RESIDENT EXPERIENCE OF PATIENT SUICIDE

Speaker: Ben Elitzur, M.D.

SUMMARY:

I will be discussing a case where a patient completed suicide and my reactions that followed. The case involves a patient I

was treating as a third year Resident in an outpatient setting that involved medications and psychotherapy twice weekly. The discussion will focus on coming to terms with patient's autonomy and withholding of information, dealing with the loss of an intimate patient relationship, and how to find a sense of meaning and closure in the aftermath of a patient suicide. The case will also illustrate the difficulty in navigating the need for closure on the part of the Psychiatrist while also respecting the boundaries of the treatment relationship, the needs of the family, and the privacy of the patient's personal information and privacy even after death.

NO 3 COLLATERAL DAMAGE: THE IMPACT OF PATIENT SUICIDE ON THE PSYCHIATRIST

Speaker: James W. Lomax, M.D.

SUMMARY:

Drs. Lomax, Anzia, and Zisook will present material from Collateral Damage: The Impact of Patient Suicide on the Psychiatrist. This video was developed as a discussion stimulus for residents, faculty, and private practitioners in psychiatry to help them with the experience of having a patient complete suicide. The DVD consists of "clinical stories of suicide" that provide information about the subjective experiences of both senior psychiatrists and psychiatrists-in-training for this highly emotional and potentially transformational event in our professional lives. The high likelihood that most psychiatrists will experience suicide in their practice, the different ways to anticipate this experience, and how to help oneself and also to get help at a time of challenge is discussed in detail.

NO 4 PROGRAMS TO SUPPORT RESIDENTS AFTER PATIENT SUICIDE

Speaker: Christina Mangurian, M.D.

SUMMARY:

Dr. Mangurian will describe a program she created at Columbia University to better support residents after patient suicide. This program was published in Academic Psychiatry and involves several components, including: 1) Relief from duties, 2) Direct supervision/support by non-supervising faculty, 3) Direct support by non-supervising residents with similar experience, 4) Practical information (legal, dealing with families), and 5) Other ways to cope. Dr. Mangurian will be encouraging a group discussion about how to create similar support programs for other residency training programs around the country.

NO 5 FACULTY REFLECTIONS: TWO SUICIDE SYMPOSIA FROM THE UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Speaker: Andrew Booty, M.D.

SUMMARY:

I will reflect on half day suicide symposia given at UCSF in

2008 and 2010. I will highlight the content of these different events, including feedback from the residents and what was felt to have worked well and what could be done differently.

NO 6 LOSING A PATIENT TO SUICIDE: THE RIPPLE EFFECT

Speaker: Michael F. Myers, M.D.

SUMMARY:

Dr. Myers will be speaking about the impact of suicide on all levels of psychiatry training, from the resident, to the senior psychiatry attending, and to the academic medical environment. He will be speaking from his experience as a resident who lost patients to suicide as well as a psychiatrist who has treated clinicians, including residents, who have lost a patient to suicide. As part of his presentation, he will show a brief video where he interviews a resident describing her experience of losing a patient to suicide.

SYMPOSIUM 73 ADVANCES IN MEDICAL CARE FOR PATIENTS WITH SCHIZOPHRENIA

Chair: Linda Ganzini, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss screening for hepatitis C and HIV/AIDS with their patients with schizophrenia; 2) Discuss the clinical indications, and the risks and benefits of bariatric surgery with their patients with schizophrenia and morbid obesity; and 3) Discuss everyday strategies to reduce cardiovascular risk factors in patients with serious mental illness.

SUMMARY:

Schizophrenia reduces life expectancy by at least 15 years and the mortality gap—the gap between the age of death for people in the community without mental illness and those with schizophrenia—has increased over recent decades. The many reasons for this early mortality include suicide, drug abuse, homelessness, poverty, unhealthy life styles, adverse effects of medications, poor adherence to chronic disease regimens and delays in receiving medical care. In this symposium, presenters will address new areas of knowledge and innovative approaches to improve medical care among patients with schizophrenia including communicable diseases, obesity, cardiovascular diseases, cancer and end of life care. The role of the psychiatrists in delivering care for patients with comorbid medical and mental illness is highlighted, as well as new models for delivering care in a variety of settings.

NO 1 APPROACHES TO THE MANAGEMENT OF MORBID OBESITY IN PATIENTS WITH SCHIZOPHRENIA

Speaker: Lydia Chwastiak, M.D., M.P.H.

SUMMARY:

This session provides an overview of treatment for obesity among persons with schizophrenia. Behavioral and pharmacologic treatment modalities for weight loss have had modest effects in clinical trials of individuals with serious mental illness—and may be even less helpful to severely obese persons. Bariatric surgery is an effective long-term treatment for severe obesity, but there is limited literature regarding the impact of psychiatric illness on surgical and psychiatric outcomes. Clinical issues related to bariatric surgery (such as altered drug absorption) and ethical concerns (reported increased risk of suicide among patients after bariatric surgery) raise challenging issues for psychiatrists treating patients with schizophrenia who are severely obese.

NO 2 CANCER AND PALLIATIVE CARE IN PATIENTS WITH SCHIZOPHRENIA

Speaker: Linda Ganzini, M.D., M.P.H.

SUMMARY:

Cancer is one of the most common causes of death in persons with schizophrenia. Patients with schizophrenia are less likely to undergo screening for cancer. When cancer develops, patients with schizophrenia are often diagnosed late in the course of treatment, may struggle around making complex decisions and may be less tolerant of cancer treatments. Care at the end of life may be complicated by lack of advance directives, lack of family to deliver care, unfamiliarity of hospice providers in how to care for these patients, and uncertainty around pain management. Innovative approaches to care for patients with schizophrenia and cancer at the end of life are reviewed.

NO 3 EMERGING CLINICAL AND POLICY MODELS OF INTEGRATED SERVICE DELIVERY FOR PATIENTS WITH SCHIZOPHRENIA AND OTHER SEVERE MENTAL ILLNESSES

Speaker: Benjamin Druss, M.D.

SUMMARY:

Dr. Druss will review emerging clinical, research, and policy models for improving health and healthcare in persons with serious mental illness treated in specialty mental health settings.

NO 4 INFECTIONS IN SCHIZOPHRENIA: TUBERCULOSIS, HEPATITIS C, AND HIV/AIDS

Speaker: Oliver Freudenreich, M.D.

SUMMARY:

Tuberculosis, hepatitis C and HIV/AIDS are 3 infections with great public health implications. Dr. Freudenreich's talk will provide an update on the screening, prevention, and treatment of these 3 infections. He will then outline how psychiatrists caring for patients with schizophrenia can work collaboratively

with primary care doctors to identify and successfully treat infected schizophrenia patients.

NO 5 INTERVENTIONS TO IMPROVE CARDIOVASCULAR HEALTH IN PATIENTS WITH SERIOUS MENTAL ILLNESS

Speaker: Gail Daumit, M.D., M.H.S.

SUMMARY:

Persons with serious mental illness have a high burden of modifiable cardiovascular disease risk factors including smoking, obesity, hypertension, diabetes and dyslipidemia. The American Heart Association recently set ambitious strategic Impact Goals to improve the cardiovascular health of all Americans and reduce deaths from cardiovascular disease by 20 percent by 2020. Substantial efforts are underway to meet these goals in the general population. However, successful interventions addressing cardiovascular risk factors for the overall population systematically exclude those with serious mental illness. This population needs tailored interventions to address cognitive and other barriers to behavior change. This session will review the evidence on interventions to reduce cardiovascular risks in patients with serious mental illness. Knowledge gaps will be identified and current studies in the field will be described.

SYMPOSIUM 74 BIPOLAR DISORDERS: 30 YEARS OF PROSPECTIVE FOLLOW-UP

Chair(s): William Coryell, M.D., Hagop S. Akiskal, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To become familiar with the course of the bipolar disorders as reflected in recurrences and resolutions of multiple episode types; and 2) To be acquainted with recent evidence of changes in symptom persistence in bipolar disorder across decades and ages; 3) To review risk factors for switches from major depressive disorder to either bipolar I disorder or bipolar II disorder; and 4) To review characteristic differences between individuals with Major Depressive Disorder, those with Bipolar II Disorder and those with Bipolar I Disorder.

SUMMARY:

As do patients with any serious illness, those with bipolar disorder have a need to know how long their illness is likely to last, whether and when it might recur, how it might evolve over time and what its impact on their lives is likely to be. Answers to these questions derive from studies that describe the course of bipolar illness in general but more particularly from those that consider the prognostic importance of features that vary across individuals with bipolar disorder. These include demographics, symptom quality, phase type, early course of illness, personality, past response to treatment and family history. Because of its sample size, length of follow-up, and thoroughness of both baseline and follow-up assessments,

the CDS is uniquely suited to this task. As have many other studies, it has described times to, and predictors of, remission from index episodes and first recurrences. These data have gone further, though, and have spoken to the predictors of shifts from unipolar to bipolar diagnoses, the timing of recurrences over lengthy periods, long-term illness burden, and the possible evolution of the illness over decades as reflected in changes in cycle length and symptom persistence. This symposium will summarize the results.

NO 1 BIPOLAR I DISORDER: TYPOLOGY AND DURATION OF MOOD EPISODES

Speaker: David Solomon, M.D.

SUMMARY:

This presentation describes the typology of bipolar I mood episodes, that is, the type of different mood episodes that occur over time, and their relative frequency. In addition, the duration of the episodes is described. The results are drawn from 219 patients with bipolar I disorder, who were prospectively followed for up to 25 years with direct interviews every six months or annually, using standardized assessment instruments. The data analytic procedures included mixed-effects grouped time survival models that accounted for correlations among multiple, within-subject mood episodes, and examined the cumulative effects of successive mood episodes. A total of 1208 mood episodes were observed in their entirety, which were classified as follows: major depression 31 % (n = 373), minor depression 13% (n = 157), mania 20% (n = 246), hypomania 10% (n = 126), cycling 17% (n = 210), cycling plus mixed state 8% (n = 94), and mixed 0.2% (n = 2).

NO 2 DEVELOPMENT OF MANIA OR HYPOMANIA IN THE COURSE OF MAJOR DEPRESSIVE DISORDER

Speaker: Jess G. Fiedorowicz, M.D., Ph.D.

SUMMARY:

Mania and hypomania serve as defining features of bipolar disorder; however, these syndromes are often not the initial manifestations of illness. Long-term follow-up studies of individuals with major depression have consistently demonstrated that many ultimately experience periods of mania or hypomania. This development suggests that some individuals with unipolar major depression actually have a bipolar disorder, although the defining features of bipolarity have not yet announced themselves. The potential for misclassification with an accurate history presumably carries considerable clinical relevance because the course of illness and treatments for unipolar depression and bipolar disorders differ. Observational studies with intensive follow-up of well-characterized cohorts are required for the study of this relevant clinical issue. The presentation will review data from such prospective cohorts and highlight contributions from the Collaborative Depression Study.

NO 3 BIPOLAR DISORDERS: THE EFFECTS OF AGE AND TIME

Speaker: William Coryell, M.D.

SUMMARY:

This analysis used the 148 subjects who met the RDC for bipolar I disorder or schizoaffective mania and who completed 20 years of follow-up to determine whether the symptoms of either pole changed in persistence as individuals aged through two decades, whether such changes differed across three age groups, and whether age at onset of illness was independently related to symptom persistence. The proportions of weeks in depressive episodes increased in the youngest two age groups but no such changes emerged for manic symptoms. Earlier ages at onset were associated with greater overall depressive symptoms persistence but not with changes in that persistence over time. The proportion of time ill for both poles tended to correlate across time periods.

NO 4 BIPOLAR II: FROM PRE-CDS NOSOLOGIC ORPHAN TO A TEMPERAMENTAL ENDOPHENOTYPE SUITABLE FOR GENOTYPING

Speaker: Hagop S. Akiskal, M.D.

SUMMARY:

The objective for this presentation is to trace the history of bipolar II and, among others, to highlight the major contributions of CDS to its delineation. The concept of bipolar II was introduced into the psychiatric literature in 1976 based on an NIMH intramural study of mostly women with high suicidality from a familial background intermediate between unipolar and classical bipolar disorder (type I). These patients bore remarkable significance to the German description of *zyklokyrmie* (Hecker, 1877). CDS conducted much of the definitive data-based studies establishing the distinct familial bipolarity including: high achievement, high anxiety, the high specificity of the temperamental dimension of “mood lability” in switching from depression to bipolar II, also highlighted by subthreshold hypomania in progression from unipolar to bipolar II, suicidal tendencies, fluctuating subthreshold course dominated by depression, and psychosocial disability.

SYMPOSIUM 75 ADVANCES IN PHARMACOTHERAPIES FOR SUBSTANCE USE DISORDERS

Discussant: Phil Skolnick, Ph.D.

Chair(s): Ivan D. Montoya, M.D., M.P.H., Phil Skolnick, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the medications and biologic therapeutics that have been recently evaluated in clinical trials for Substance Use Disorders and have shown promising results; 2) Demonstrate knowledge of the safety and efficacy of depot

naltrexone to prevent opioid use relapse among former opioid dependent individuals; 3) Gain knowledge about the use of an implantable formulation of buprenorphine to treat patients with opioid dependence; 4) Learn about the mechanism of action as well as the safety/efficacy of an engineered butyrylcholinesterase to treat cocaine dependence; and 5) Identify medications, such as vigabatrim, to treat cocaine dependence.

SUMMARY:

Approximately 6 million people seek treatment for Substance Use Disorders (SUD) every year in the USA. There are few medications approved by the FDA to treat these disorders and their efficacy is far from optimal. Moreover, there are some SUD, such as stimulant and cannabis dependence, for which no medications have proven safe and effective. Recent advances in the discovery of new molecular targets and compounds as well as biologics are providing an opportunity to discover and develop new treatments for SUDs. Clinical studies reported recently have shown that depot naltrexone, implantable buprenorphine, vigabatrim, and genetically engineered butyrylcholinesterase have shown promising results as pharmacotherapies for opiate (the former two) and cocaine (the latter two) dependence. The purpose of this symposium is to provide an update of the results of clinical studies that have been recently completed, which tested the safety and efficacy of those compounds for the treatment of SUD. It is expected that at the end of the symposium participants will both gain knowledge about these approaches and start planning to use some of these pharmacotherapies in their clinical practice.

NO 1 GENETICALLY-ENGINEERED BUTYRYLCHOLINESTERASE (TV-1380): AN INNOVATIVE APPROACH TO TREATING COCAINE DEPENDENCE

Speaker: Merav Bassan, Ph.D.

SUMMARY:

Cocaine abuse and dependence are problems with devastating medical and social consequences, and currently there is no reliable means to treat cocaine addiction and rescue from cocaine overdose. Human plasma butyrylcholinesterase (BChE) is known to contribute to cocaine hydrolysis and has been considered for use in treating cocaine addiction. Efforts to improve the catalytic efficiency of this enzyme have led to a quadruple mutant fused to recombinant human serum albumin, *Albu-BChE*, which consistently demonstrated its potential therapeutic benefit in a series of pharmacology experiments. *Albu-BChE* shows ability to hydrolyze cocaine with 1000-fold increase in catalytic efficiency as compared to wild-type BChE. The mutant fused BChE prevented signs of cocaine toxicity as well as selectively abolished cocaine-induced “reinstatement” of drug-seeking behavior when administered to rats and monkeys before cocaine challenge. *Albu-BChE* was also evaluated in a proof of principle (PoP) study where

NO 2**BUPRENORPHINE IMPLANTS FOR THE MAINTENANCE TREATMENT OF OPIOID DEPENDENCE***Speaker: Katherine Beebe, Ph.D.***SUMMARY:**

Subdermal buprenorphine hydrochloride/ethylene vinyl acetate implants are an abuse and diversion deterrent formulation designed to deliver constant, low levels of buprenorphine (BPN) for up to 6 months in the treatment of opioid dependence. 287 opioid-dependent adults were treated with double-blind BPN implants, placebo implants, or open-label sublingual BPN. Following removal of the BPN (n=57) or placebo (n=8) from Study 1, subjects received four BPN implants in the opposite arm in Study 2. Treatment with BPN implants was superior to placebo in the percentage of opioid-negative urines ($p < .0001$) and study retention (64% BPN implants, 26% placebo, $p < .0002$), and was non-inferior to sublingual BPN. Patients previously treated with placebo implants or sublingual BPN during the initial 6-month treatment phase further decreased drug use. Treatment was well tolerated in both studies. Results confirm the 12-month safety and efficacy of BPN implants for the treatment of opioid dependence.

NO 3**EXTENDED-RELEASE NALTREXONE FOR PREVENTING RELAPSE TO OPIOID DEPENDENCE DISORDER***Speaker: David Gastfriend, M.D.***SUMMARY:**

Background: Once-monthly extended-release naltrexone (XR-NTX; Vivitrol®) was developed to overcome poor adherence with oral agents in addictive disorders. It is approved in the U.S., Russia and several C.I.S. countries for alcohol and opioid dependence treatment.

Methods: We reviewed all known published, in press or presented studies of XR-NTX formulations.

Results: Studies (N=15) report: efficacy for maintaining abstinence, improving retention, decreasing craving and preventing relapse for as long as 18-months, including in HIV+ and Hepatitis C+ patients; feasibility in commercially insured/employed patients and uninsured/public treatment populations; and promising effectiveness in community outpatient, residential and drug court, jail and parole environments. Results were consistent regardless of manufacturer vs. independent sponsorship. Data indicate good generalizability of findings and the applicability of the agent both in societies that have (U.S.A.) and do not have (Russia)

NO 4**VIGABATRIN FOR TREATMENT OF COCAINE DEPENDENCE***Speaker: Charles W. Gorodetzky, M.D., Ph.D.***SUMMARY:**

Vigabatrin, an irreversible inhibitor of GABA-transaminase (the key enzyme for catabolism of GABA) can block the mani-

festations of cocaine consumption typically seen in animal models.. The increased intracellular GABA is released by a significant excitatory stimulus, making vigabatrin a potentially effective treatment strategy for stimulant dependence. Four clinical trials have been completed in subjects with cocaine and/or methamphetamine dependence. Two open label and one double-blind placebo-controlled study were performed in Mexico. All showed significant positive effects of vigabatrin in achieving a drug free state. In the 9-week double blind trial 14 of 53 (28%) vigabatrin-treated subjects achieved full end-of-trial abstinence versus 4 of 53 (7.5%) placebo-treated subjects ($p < .05$). However, a US double-blind, placebo-controlled trial experienced significant drug non-adherence and did not confirm vigabatrin effectiveness. A second US trial will complete in late 2012.

SYMPOSIUM 76**INTERCONNECTIONS BETWEEN CHILD WELFARE AND MENTAL HEALTH***Chair(s): Dawn Sung, M.D., Andres J. Pumariega, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Consider ways in which early career experiences could inspire trainees to pursue work with the child welfare system; 2) Recognize ways to provide culturally competent mental health services to minority children in the child welfare system; 3) Learn about the important consultative and therapeutic roles that child psychiatrists can serve within child welfare programs; 4) Identify services that address the needs of children in state custody, particularly evidence-based interventions; and 5) Understand effective approaches to building and developing systems of care to deliver more effective mental health services for children in state custody.

SUMMARY:

Children and youth in the child welfare and juvenile justice systems have been well known to have high rates of mental health needs. Many communities are struggling with the challenge of providing adequate mental health services for these high-risk populations, both in terms of access to services as well as evidence-based services appropriate to the complex needs of these populations. In this presentation Dr. Dawn Sung will first discuss her trainee's perspective in working with this population as a resident, sharing case examples from child and adolescent inpatient units at Bellevue Hospital, and explore ways in which more trainees may be encouraged to consider careers working with children in the foster system. Dr. Eugenio Rothe will discuss the additional dimension and challenges of working with minority children in the child welfare system, and ways in which to provide culturally competent mental health care. Dr. Andres Pumariega will discuss the consultative and therapeutic roles that child psychiatrists can serve by discussing the development of the Tennessee Centers of Excellence for Children in State Custody, which provided direct consultative and clinical services and served as a model for system of care development. Dr. Charles Huffine will discuss his work with parent-infant therapy programs by

sharing his work with the Supporting Early Connections program, which is an evidence-based mother infant therapy that was placed in a child dependency court. It not only resulted in sustained collaboration between social service agencies, the mental health system, and courts, but also in excellent clinical results and longterm outcomes for families. Finally, Dr. Irene Sung and Ken Epstein, LCSW will share various strategies for how the San Francisco Department of Public Health has found ways to effectively collaborate with the child welfare system in San Francisco County. They will demonstrate what they have learned from their challenges and successes, and provide examples of how clinicians may build stronger communication and collaboration between agencies within their own communities.

NO 1 CHILD WELFARE AND CHILD MENTAL HEALTH: TRAINEE AND EARLY CAREER PERSPECTIVES

Speaker: Dawn Sung, M.D.

SUMMARY:

As a psychiatry trainee Dr. Dawn Sung will describe her various training experiences working with children and adolescents at Bellevue Hospital who were involved in the child welfare system, and how they influenced her interest in the field of child and adolescent psychiatry. By presenting two cases on the Bellevue Hospital inpatient child psychiatry unit she will demonstrate the many challenges she faced in navigating the foster system, from conflicts within the foster home placement to difficulties working with child welfare agencies. She will also demonstrate how these experiences affected my understanding of the many challenges and barriers facing child psychiatrists. She will then explore possible ways to promote the field in trainees who are interested in working with children in the foster system. By improving their knowledge and validating their frustrations, residents may be less prone to burnout and more encouraged to continue working with this population.

NO 2 MINORITY CHILDREN AND YOUTH IN CHILD WELFARE

Speaker: Eugenio Rothe, M.D.

SUMMARY:

Minority children comprise a significant and growing percentage of children and youth entering the child welfare system. This added dimension presents a number of challenges in providing mental health services to this population. This includes the cultural competence of services for the child, access to same cultural background foster parents (advocated since the early 1980's by the Black Social Workers Association), work on the cultural competence of different race/ethnic foster parents, and therapeutic work to address significant psychopathology encountered in this highly vulnerable population (particularly PTSD and disruptive behavior disorders). Dr. Eugenio Rothe will review the literature on minority children in child welfare, share experiences, and illustrate successful cases from work in multicultural urban (S. Florida) and rural

(NE Tennessee) regions. He will discuss challenges in rural monocultural environments, and highlight ways to promote culturally competent practices.

NO 3 A CONSULTATIVE AND SYSTEMS-BUILDING MODEL FOR CHILDREN IN CHILD WELFARE:10 YEAR EXPERIENCE

Speaker: Andres J. Pumariega, M.D.

SUMMARY:

Children and youth in the child welfare and juvenile justice systems have high rates of mental health needs. Many states struggle with providing adequate access to services as well as evidence-based services appropriate for the complex behavioral and emotional needs of this population. This presentation will review the history and process of the development of the Tennessee Centers of Excellence for Children in State Custody, their evolving function, past and current data on their consultative and clinical activities, and the recent activities in evidence-based practice development that they have catalyzed. The Tennessee COEs (awarded the 2004 APA Silver Achievement Award for Psychiatric Services) have provided direct consultative and clinical services evaluated as highly valuable by stakeholders, but have also fulfilled their promise of serving as a model for system of care development for this very high need population.

NO 4 PARENT-INFANT THERAPY MODELS FOR CHILD WELFARE: A MODEL PROGRAM

Speaker: Charles Huffine, M.D.

SUMMARY:

Many young mothers are emotionally unprepared for having babies, having suffered neglect themselves in their early life, and are at risk for continuing a cycle of poor emotional connections and ill-prepared parents. Various parent-infant therapy programs have been increasingly implemented nationally for the at-risk infants coming to the attention of child welfare, with significant success. This presentation will discuss the "Supporting Early Connections" (SEC) program, which is an evidence-based Mother Infant Therapy conducted by trained specialists at a community mental health center. It was placed in a child dependency court and created a unique collaboration between state Child Protective Services case workers, attorneys and judges, and therapists and volunteer advocates from two innovative programs. This resulted in a sustainable collaboration with substantial clinical improvement, faster permanency, and high rates of reuniting families.

NO 5 COLLABORATIONS BETWEEN MENTAL HEALTH SYSTEMS AND CHILD WELFARE SERVICES: A SAN FRANCISCO PERSPECTIVE, PART I

Speaker: Irene Sung, M.D.

SUMMARY:

Delivering behavioral health services for children and adolescents in the child welfare system requires a system of care with coordination and communication between multiple providers and their respective agencies. Ken Epstein, LCSW, Director of the Children Youth and Family Section of San Francisco's Community Behavioral Health Services and Irene Sung, MD, Chief Medical Officer of the Community Programs Division of San Francisco's Department of Public Health will present the county's collaborative efforts. They have used a model which utilizes systems theory, a trauma informed lens in integrating objectives across systems, developing a common nomenclature, sharing risk and developing service excellence practice parameters. Together they will share examples to discuss challenges and successes, what they have learned from their experiences, and how clinicians, social workers and leaders may use these experiences to better integrate services in their own communities.

NO 6
COLLABORATIONS BETWEEN MENTAL HEALTH SYSTEMS AND CHILD WELFARE SERVICES IN SAN FRANCISCO: WHAT WE HAVE LEARNED, PART II

Speaker: Ken Epstein, M.S.W., L.C.S.W.

SUMMARY:

Delivering behavioral health services for children and adolescents in the child welfare system requires a system of care with coordination and communication between multiple providers and their respective agencies. Ken Epstein, LCSW, Director of the Children Youth and Family Section of San Francisco's Community Behavioral Health Services and Irene Sung, MD, Chief Medical Officer of the Community Programs Division of San Francisco's Department of Public Health will present the county's collaborative efforts. They have used a model which utilizes systems theory, a trauma informed lens in integrating objectives across systems, developing a common nomenclature, sharing risk and developing service excellence practice parameters. Together they will share examples to discuss challenges and successes, what they have learned from their experiences, and how clinicians, social workers and leaders may use these experiences to better integrate services in their own communities.

SYMPOSIUM 77
HEALTH CARE REFORM AND THE ROLE OF THE GERIATRIC PSYCHIATRIST

Discussant: Steven Sharfstein, M.D., M.P.H.

Chair: Benjamin Liptzin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe an ACO and what requirements an organization must meet to participate as an ACO; 2) Describe at least three problems in mental healthcare settings that might be amenable to solutions using Lean production practice methods; 3) Identify at least three key potential roles

for geriatric psychiatrists and ancillary professionals in patient-centered medical homes as part of ACOs.

SUMMARY:

Health care reform and the promotion of Accountable Care Organizations (ACOs) was fueled largely by the need to sustain high quality health care while containing costs and managing risks. In this session, the role of geriatric psychiatrists under health care reform will be explored. First, an ACO will be described and the requirements that an organization must meet to participate as an ACO will be discussed. Then, Lean production practice methods will be reviewed as a way to reduce costs and promote efficiency in mental healthcare settings. Finally, the possible roles for geriatric psychiatrists and allied health professionals in Patient Centered Medical Homes as part of ACOs will be explored and clarified.

NO 1
HOW PRINCIPLES FROM LEAN PRODUCTION PRACTICE METHODS MAY HELP TO PROMOTE EFFICIENCY AND REDUCE HEALTH CARE COSTS

Speaker: Robert P. Roca, M.D.

SUMMARY:

While it is difficult to predict the precise impact of health reform on the psychiatric care of older adults, there is no question that geriatric psychiatrists will be challenged to do more with less. We will have no choice but to figure out how to meet the needs of a rapidly growing elderly population while holding steady – if not reducing – the costs of care. This will put a premium on efforts to trim waste and improve the efficiency and outcomes of our clinical processes. Such efforts can benefit greatly from the use of performance improvement methodologies that were developed in manufacturing and have recently been adapted for use in health care. In this presentation, we will discuss the principles of Lean as they may be applied to health care settings, describe the introduction of Lean into a mental healthcare system, and consider how these methods can help geriatric mental healthcare professionals provide better care in the face of shrinking resources.

NO 2
ROLES OF THE GERIATRIC PSYCHIATRIST IN THE PATIENT-CENTERED MEDICAL HOME

Speaker: Joel Streim, M.D.

SUMMARY:

As health care reform evolves in the USA, it is anticipated that the patient-centered medical home will become more widely adopted as a preferred model for coordinated care. Health services research has clearly demonstrated that integration of mental health services within traditional primary care practices results in better patient engagement, treatment adherence, and clinical outcomes, and these findings are likely to generalize to the medical home as well. Katon and Unutzer recently addressed the role of psychiatric consultation in the medical home and accountable care organizations. This presentation will (1) summarize the evidence for integrating mental health care in primary care, (2) examine the potential role of

the geriatric psychiatrist and the geropsychiatric nurse in the patient-centered medical home, and (3) discuss strategies for integration of geriatric psychiatric care in the medical home model.

NO 3 WHAT IS AN ACCOUNTABLE CARE ORGANIZATION?

Speaker: Helen H. Kyomen, M.D., M.S.

SUMMARY:

According to CMS, accountable care organizations (ACOs) are “groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.” The core principles for all ACOs are as follows: (1) The ACOs are provider-led organizations with a strong base of primary care that is accountable, as a group, for the quality and total per capita costs across the full continuum of care for a set of patients. (2) The ACO payments are linked to quality improvements that also reduce overall costs. (3) The ACOs use reliable and sophisticated performance measurements to support improvement and provide assurance that savings are achieved through improvements in care. Medicare patients who are seen on a fee-for-service basis continue to maintain all of their Medicare rights. In this session, details regarding the history, goals and challenges of ACOs will be explored.

SYMPOSIUM 78 THE FUTURE OF BIPOLAR DISORDER: GENETICS, DIAGNOSIS, AND TREATMENT

Chair(s): Niall Boyce, D.Phil., M.B., Nick Craddock, M.B.B.S., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate an understanding of the current state of knowledge regarding the genetic contribution to bipolar disorder, and of future directions in research; 2) Understand current issues regarding the differential diagnosis of bipolar disorder, to improve clinical diagnostic skills, and to gain knowledge of future biomarker-based diagnostic techniques; 3) Demonstrate a comprehensive knowledge of the pharmacological and non-pharmacological treatment of bipolar disorder, and to understand future developments in treatment.

SUMMARY:

A masterclass in the causes, diagnosis, and treatment of bipolar disorder, this symposium, coinciding with publication of The Lancet’s 2013 Bipolar Disorder series. “Genetics of bipolar disorder”, presented by Professor Nick Craddock of Cardiff University, UK, will summarise the current state of knowledge regarding the genetics of bipolar disorder, putting laboratory findings into clinical context, and looking at future development and application of research. “Diagnostic issues in bipolar disorder”, presented by Professor Mary Phillips of the University of Pittsburgh, will cover the differential diagnosis of bipolar with a focus on distinguishing bipolar from

unipolar depression, as well as borderline personality disorder and ADHD. This presentation will also outline future developments in bipolar disorder such as blood tests, cognitive testing, and imaging. “Management of bipolar disorder: across the course”, presented by Professor John Geddes of Oxford University, includes a guide to pharmacological options tailored to the stage of illness, as well as psychosocial interventions (e.g., joint care plans, education and self-management, management without medication). It also includes a guide to management of inter-episode symptoms.

NO 1 BIPOLAR DISORDER GENETICS FOR THE CLINICIAN

Speaker: Nick Craddock, M.B.B.S., Ph.D.

SUMMARY:

The advent of powerful molecular genetic tools such as genome-wide association studies of single nucleotide polymorphisms and measurement of copy number variation has made a major impact on understanding of common non-psychiatric diseases and is producing replicable findings in psychiatric illnesses, including mood disorders. In bipolar disorder, genes implicated include CACNA1C, the protein product of which is involved in ion channel function, suggesting a key mechanism of importance in the pathogenesis of bipolar disorder. There is evidence for many genes that influence disease risk. In addition to informing understanding of pathogenesis, recent findings provide opportunities to explore the relationship between bipolar disorder and other major psychiatric illnesses. The data suggest overlaps in pathogenesis that will shape future diagnostic classifications. The pace of research is rapid and this presentation will summarize the state of the field for the clinician.

NO 2 DIAGNOSTIC ISSUES IN BIPOLAR DISORDER: CLINICAL AND NEUROIMAGING APPROACHES

Speaker: Mary L. Phillips, M.D.

SUMMARY:

A key area of my research has been to use neuroimaging techniques to study neural circuitry underlying emotion and affect processing, and to develop models of normal emotion processing that can be used to develop diagnostic models for bipolar and other mood disorders. We have shown that individuals with mood disorders can be distinguished by abnormally elevated activity and functional connectivity in neural circuitry important for regulating responses to emotional stimuli. We have also worked to identify risk markers for future mood disorders in at risk children and adolescents. Here, we are focusing on developmental trajectories in emotion regulation circuitry as a first stage toward finding biomarkers that may help identify those who are at highest risk of mood disorders. Emerging findings suggest that the use of traditional clinical, along with neuroimaging, approaches has potential to improve diagnostic accuracy of mood disorders such as bipolar disorder across the lifespan.

NO 3**MANAGEMENT OF BIPOLAR DISORDER:
ACROSS THE COURSE**

Speaker: John R. Geddes, M.D.

SUMMARY:

This presentation gives concise but comprehensive coverage of pharmacological options tailored to stage of bipolar disorder, as well as psychosocial interventions (eg, joint care plans, education and self-management, and management without medication). This presentation concludes with a guide to the emerging field of management of inter-episode symptoms.

SYMPOSIUM 79**EATING DISORDERS UPDATE**

Chair(s): Hans W. Hoek, M.D., Ph.D., B. Timothy Walsh, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) understand the process of developing criteria for the renamed DSM-5 section Feeding and Eating Disorders; 2) diagnose and classify feeding and eating disorders conform the new severity criteria; 3) select the best evidence base treatment for anorexia nervosa, bulimia nervosa and binge eating disorder.

SUMMARY:

Publication of the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders in 2013 will mark one the most anticipated events in the mental health field. The DSM-5 Eating Disorders Work Group recommended several major changes regarding the placement and description of eating disorders. As of the time this abstract was submitted, it appeared likely that these recommendations will be incorporated into DSM-5. This symposium will provide an overview of the evidence base regarding the proposed DSM-5 criteria and the epidemiology, neurobiology and treatment of eating disorders. The development and clinical use of the DSM-5 Feeding and Eating Disorders criteria will be demonstrated on some case histories. Eating disorders do occur most frequently among young females; they are rare among males and therefore often missed. Eating disorders have high mortality rates, especially anorexia nervosa. Most people with eating disorders in the community do not receive treatment at all. Recent research findings and the implications for clinicians will be presented. Evidence based treatment guidelines will be discussed for practitioners. Pharmacological and psychological treatments for bulimia nervosa and binge eating disorder are well-established. The evidence base for the treatment of anorexia nervosa is less solid. New treatment approaches are being developed with encouraging initial findings.

NO 1**EATING DISORDERS IN DSM-5**

Speaker: B. Timothy Walsh, M.D.

SUMMARY:

Objective: To review support for the recommendations of the DSM-5 Eating Disorders Work Group. Methods: A review of the existing literature, work group discussions and examinations in clinical settings resulted in suggested revisions of DSM-IV. Results: Binge Eating Disorder, described in an Appendix in DSM-IV, was recommended to be formally recognized. Because Feeding Disorder of Infancy or Early Childhood has received little clinical or research attention, and because a number of other presentations are not captured by current criteria, the WG recommended that this disorder be renamed Avoidant/Restrictive Food Intake Disorder (ARFID). Finally, the WG recommended that all disorders characterized by a persistent and clinically significant disturbance of eating or eating-related behavior problem be grouped in a DSM-5 section termed Feeding and Eating Disorders. Discussion: Potential (dis)advantages regarding the placement and description of eating disorders in DSM-5 are discussed.

NO 2**EPIDEMIOLOGY OF EATING DISORDERS**

Speaker: Hans W. Hoek, M.D., Ph.D.

SUMMARY:

Objective: To review the epidemiology of eating disorders (EDs) and to compare rates of EDs according to DSM-5 criteria with those with DSM-IV criteria. Methods: We conducted several epidemiological studies in The Netherlands, Finland, Portugal and Curaçao. Special attention was paid to methodological problems affecting the selection of populations under study and the identification of cases. Results: The most common DSM-IV eating disorder both in clinical and community samples has been Eating Disorder Not Otherwise Specified, but will be much less so when DSM-5 criteria are applied. The incidence of anorexia nervosa increased over the past century, but remained stable during the past four decades. The incidence of bulimia nervosa seems to be significantly decreasing. Recent studies confirm previous findings of high mortality rates in the anorexia nervosa population. Discussion: Only a minority of people meeting diagnostic criteria for EDs are seen in mental health care.

NO 3**EATING DISORDERS IN MALES**

Speaker: Anu H. Raevuori, M.D., Ph.D.

SUMMARY:

Objective: To evaluate literature on eating disorders (EDs) and related traits in males. Methods: We conducted studies in Finnish twins in order to examine EDs and muscle dissatisfaction (MD), a key component of body image concern in young males. We also reviewed related literature. Results: Compared to females with EDs, psychiatric and other comorbidity in males is stronger and manifests more heavily in 1st degree relatives. Male-female rate-ratio of anorexia nervosa is found to be 1:4 to 1:12, which imply lifetime prevalence up to 0.6% among males in Western societies. Partial syndromes EDs in males are relatively common, yet major proportion of males with body dissatisfaction and disordered eating develop MD.

Discussion: In males, both EDs and MD appear to be associated with similar type of comorbidity. Compared to the prior version, DSM-5 allows more feasible ED diagnostics in males.

NO 4 ANOREXIA NERVOSA

Speaker: Evelyn Attia, M.D.

SUMMARY:

Introduction: Anorexia nervosa (AN) is a serious psychiatric illness with high rates of morbidity and mortality. Accurate diagnosis is crucial for appropriate evaluation and management. Objective: To introduce the changes to diagnostic criteria for AN included in DSM-5 and discuss latest treatment recommendations. Methods: Review of published studies and clinical reports. Results: The diagnosis of AN has been changed slightly to reflect published data and to include clarifications that should minimize the use of the heterogeneous Eating Disorder Not Otherwise Specified (EDNOS) category. New diagnostic criteria and their implications for identification and management of AN are discussed. Discussion: The DSM-5 Eating Disorders Work Group has made several important changes to diagnostic criteria for AN that should improve case identification, especially among younger patients, males and individuals from non-Western cultures.

NO 5 TREATMENT OF BULIMIA NERVOSA AND BINGE EATING DISORDER

Speaker: James E. Mitchell, M.D.

SUMMARY:

Objective: To review the literature on studies addressing the treatment of bulimia nervosa (BN) and binge eating disorder (BED), which will be a new official diagnosis in DSM-5. Methods: The extant literature will be reviewed including published pharmacotherapy and psychotherapy studies. Results: Both pharmacotherapy and psychotherapy approaches have been developed for the treatment of BN and BED. Discussion: Relative to BN the literature now suggests that structured forms of psychotherapy such as cognitive behavioral therapy are probably superior to medication treatment alone. Medications can be quite helpful in patients who have severe depression at baseline. A new generation of psychotherapy approaches is now evolving. Relative to BED an essential question continues to be whether the primary treatment goal is weight loss, given that many of these patients are overweight or obese, or cessation of binge eating. There has also been an increase in technology-based interventions.

SYMPOSIUM 80 OBSESSIVE-COMPULSIVE AND RELATED DISORDERS IN DSM-5

Discussant: Norman Sartorius, M.A., M.D.

Chair(s): Dan J. Stein, M.D., Ph.D., Katharine A. Phillips, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize conditions that will be included in the DSM-5 chapter on obsessive-compulsive and related disorders; 2) Diagnose newly recognized disorders in the DSM-5 chapter on obsessive-compulsive and related disorders, such as hoarding disorder and excoriation (skin-picking) disorder; 3) Identify ongoing questions about the optimal classification and evaluation of obsessive-compulsive and related disorders.

SUMMARY:

Obsessive-compulsive and related disorders will comprise a new chapter in DSM-5. The chapter will include obsessive-compulsive disorder, body dysmorphic disorder, hoarding disorder, trichotillomania (hair-pulling disorder), excoriation (skin-picking) disorder, substance/medication-induced obsessive-compulsive and related disorders, obsessive-compulsive and related disorders attributable to another medical condition, and obsessive-compulsive and related disorder not elsewhere classified. Obsessive-compulsive and related disorder not elsewhere classified will mention olfactory reference syndrome, criteria for which may be provided in Section 3 (disorders requiring further study), body focused repetitive behavior disorder, and various cultural syndromes. Dr. Phillips will open the symposium by reviewing the construct of obsessive-compulsive and related disorders, and the rationale for including a separate chapter on these prevalent and impairing conditions in DSM-5. Her lecture will also include discussion of body dysmorphic disorder in DSM-5, and of insight as a dimension that cuts across a number of these conditions. Dr. Simpson will review the DSM-5 diagnostic criteria for obsessive-compulsive disorder (OCD). Her lecture will include discussion of a number of issues in the nosology in OCD, including symptom dimensions, and OCD associated with infectious agents. Dr. Mataix-Cols will discuss the rationale for including hoarding disorder as a new condition in DSM-5. His lecture will include discussion of the field survey of the proposed diagnostic criteria and specifiers. Dr. Stein will review the diagnostic criteria for trichotillomania (hair pulling disorder), and the rationale for including excoriation (skin picking) disorder as a new disorder in DSM-5. His presentation will include findings from the DSM-5 field surveys for these two conditions.

NO 1 CHANGES FOR OBSESSIVE-COMPULSIVE AND RELATED DISORDERS IN DSM-5: THE META-STRUCTURE, INSIGHT SPECIFIERS, AND CRITERIA FOR BODY DYSMORPHIC DISORDER

Speaker: Katharine A. Phillips, M.D.

SUMMARY:

This presentation will discuss the DSM-5 chapter of obsessive-compulsive and related disorders, which has not been included in prior editions of DSM. This chapter will include disorders that were classified in other chapters in DSM-IV as well as new disorders that were not included in DSM-IV. The rationale for including this new chapter, and the organization of DSM-5 chapters more broadly, will be discussed. Dr. Phil-

lips will then discuss the dimension of insight, which will be included as a specifier for BDD, OCD, and hoarding disorder. Finally, Dr. Phillips will discuss changes for BDD, a common and impairing disorder that was classified in DSM-IV as a somatoform disorder. In addition to the new insight specifier, changes for BDD include: 1) addition of a criterion indicating the presence of compulsive repetitive behaviors or mental acts that are performed in response to the appearance preoccupations, and 2) addition of a muscle dysmorphia specifier.

NO 2 OBSESSIVE-COMPULSIVE DISORDER IN DSM-5

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

SUMMARY:

This talk will review the DSM-5 diagnostic criteria for obsessive-compulsive disorder (OCD). Changes to the DSM-IV criteria will be highlighted, including the rationale for various specifiers. In addition, key changes to the text will be discussed, including descriptions of associated features that help in making the diagnosis (such as the presence of symptom dimensions and OCD beliefs and cognitions), conditions with which OCD is commonly comorbid, risk and prognostic factors, clinical expression of OCD across the lifespan and the globe, and how to distinguish OCD from other disorders with which it can be confused (e.g., other anxiety disorders, obsessive-compulsive personality disorder, hoarding disorder, body dysmorphic disorder, and delusional disorder).

NO 3 HOARDING DISORDER

Speaker: David Mataix-Cols, Ph.D.

SUMMARY:

Hoarding disorder (HD) is a new diagnostic category that has been proposed for inclusion in the DSM-5 Obsessive-compulsive and related disorders chapter. This talk will review the rationale for such proposal, explore the boundaries of HD with other DSM-5 disorders and discuss the qualitative differences between HD and normative collecting. Finally, the findings of two surveys which tested the reliability, validity, perceived acceptability, clinical utility and stigma associated with the new diagnosis will be summarized and discussed.

NO 4 TRICHOTILLOMANIA (HAIR PULLING DISORDER) AND EXCORIATION (SKIN PICKING) DISORDER

Speaker: Dan J. Stein, M.D., Ph.D.

SUMMARY:

The DSM-5 chapter on Obsessive-Compulsive and Related Disorders will include both Trichotillomania (Hair Pulling Disorder) and Excoriation (Skin Picking) Disorder, conditions that are surprisingly prevalent and impairing. Also, the phrase Body Focused Behavior Disorder, referring to other impairing body focused behaviors, will be noted in Obsessive-Compulsive and Related Disorder: Disorders Not Elsewhere Classi-

fied. Trichotillomania was classified in DSM-IV as an Impulse Control Disorder Not Elsewhere Classified, while Excoriation Disorder was not recognized as an independent diagnostic entity. This presentation will review the questions of how best to classify these conditions, of the most appropriate name for these conditions, and of the optimal diagnostic criteria. Findings from DSM-5 commissioned literature reviews, data analyses, and field surveys will be presented. It is hoped that DSM-5 will help improve the recognition and management of these often overlooked conditions.

SYMPOSIUM 81 DSM-5 BIPOLAR DISORDERS: UPDATE ON REVISED CRITERIA AND THEIR CLINICAL IMPLICATIONS

Discussant: Jan Fawcett, M.D.

Chair(s): Trisha Suppes, M.D., Ph.D., Ellen Frank, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the differences between DSM-IV and DSM-5 criteria for Bipolar Disorders; 2) Identify and diagnosis Bipolar I disorder, Bipolar II disorder, and Bipolar Disorder Not Elsewhere Classified; 3) Recognize the Medical Conditions Associated with Bipolar Disorder; and 4) Diagnosis when evaluating a patient with Bipolar Disorder.

SUMMARY:

This symposium will provide rationale and discussion of implementation for some of the most significant changes to DSM-5 Bipolar Disorders. Dr. Suppes will discuss the change to Criteria A for manic and hypomanic episodes to include the assessment of mood and activity, as well as addressing the decision to maintain hypomania episode criteria at 4 days. Dr. Frank will address the Mixed Features Specifier replacing Mixed Episodes in bipolar disorder (BD). She will address application and rationale for this major change. Dr. DePaulo will discuss the new definition of "Substance-Induced" and "Mood Disorder due to" categories as applied to BD. Dr. Davis will present the implications of DSM-5 revisions on differential diagnosis, the newly organized Not Elsewhere Classified for Bipolar, and review the new short duration hypomania category within NEC. Dr. Fawcett, the Chair of the Mood Disorder Workgroup, will be the discussant, and there will be an opportunity for a panel discussion at the end of the symposium.

NO 1 BIPOLAR AND RELATED DISORDERS: CHANGES TO CRITERIA A AND ISSUES OF DURATION

Speaker: Trisha Suppes, M.D., Ph.D.

SUMMARY:

Dr. Suppes will discuss efforts of the bipolar subcommittee to both decrease false positives and negatives for diagnosis of bipolar disorder (BD). She will focus on the change to Mania and Hypomania Criteria A to include mood AND increases in activity or energy. She will address this change in our conceptualization of BD and implications for implementation.

This talk will also address the lengthy process by which final recommendations included NOT to change the definition of Hypomanic Episode duration from 4 days, maintaining Bipolar II Disorder criteria relatively unchanged. The duration of symptoms to define hypomanic episodes is debated with passionate proponents on all sides. While the initial assignment of a 4-day duration for hypomanic episodes was arbitrary, scientific literature since DSM-IV has shed little light on this issue. Additionally, recent data in support of maintaining a 4-day duration to meet criteria for a hypomanic episode will be reviewed.

NO 2 WHAT HAPPENED TO MIXED EPISODES IN DSM-5?

Speaker: Ellen Frank, Ph.D.

SUMMARY:

Recognizing the frequency with which episodes of bipolar illness are referred to as 'mixed' and, in contrast, the infrequency with which such episodes actually meet the criteria elaborated in DSM-IV, the Mood Disorders Work Group set out to elaborate a set of criteria that are more consistent with the way the term, 'mixed episode,' is used and more consistent with what is found in clinical epidemiologic studies. DSM-5, thus, includes a 'mixed' specifier that allows clinicians to indicate the presence of 2-3 manic/hypomanic symptoms occurring for at least 2-3 days simultaneously with a fully syndromal episode of depression or when a similar number of depressive symptoms are concurrent with a fully syndromal episode of mania or hypomania. This specifier is not limited to lifetime diagnoses of bipolar disorder, but can also be applied to episodes of depression experienced by someone with a lifetime diagnosis of unipolar disorder.

NO 3 MEDICAL CONDITIONS ASSOCIATED WITH BI- POLAR DISORDER AND SUBSTANCE-INDUCED BIPOLAR DISORDER

Speaker: J. Raymond DePaulo, M.D.

SUMMARY:

A significant change proposed for DSM5 is the decision to reconsider the role of antidepressant and ECT associated manias or hypomanias for purposes of differentiating bipolar from unipolar patients. In DSM IV the convention adopted was that a manic or hypomanic episode which occurred only during antidepressant or ECT treatment would not be sufficient for a diagnosis of bipolar disorder, but was categorized as a substance induced manic. While the literature supporting the change was mixed at the time of DSM IV, further studies have been published since then most of which support the notion that patients who become manic or hypomanic during antidepressant or ECT treatment would be more accurately classified as a form of bipolar illness. This change and other smaller changes from DSM IV conventions in this area will be presented.

NO 4 IMPLICATIONS FOR DIFFERENTIAL DIAGNOSIS AND NOT ELSEWHERE CLASSIFIED IN REGARD TO BIPOLAR DISORDER

Speaker: Lori Davis, M.D.

SUMMARY:

A differential diagnosis is the backbone of making the correct diagnosis, especially in regard to Bipolar Disorders. The new DSM-5 criteria are intended to sharpen the differential diagnosis list. The implications of Bipolar Disorder DSM-5 revisions in regard to the differential diagnosis will be presented, especially in regard to differentiating Bipolar Disorders from Anxiety Disorders and Substance Induced Mood Disorders. The diagnosis of Bipolar Disorder, Not Elsewhere Classified (NEC) and the new short duration hypomania category within NEC will be presented.

MAY 21, 2013

SYMPOSIUM 82 MINDFULNESS-BASED STRESS REDUCTION MEDITATION TO PROMOTE RESILIENCY AND TREAT MOOD AND ANXIETY DISORDERS

Discussant: Steven Southwick, M.D.

Chair: Lori Davis, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the principles of mindfulness based stress reduction (MBSR) meditation; 2) Understand the published evidence supporting the use MBSR in the treatment of mood and anxiety disorders; 3) Have a better understanding of the neurobiological underpinnings of meditation, including MBSR practices; and 4) Have increased knowledge of how MBSR meditation promotes resiliency.

SUMMARY:

Philosophical and contemplative traditions teach that "living in the moment" increases happiness. The default mode of humans appears to be that of mind-wandering, which correlates with unhappiness, and with activation in a network of brain areas associated with self-referential processing. Mindfulness Based Stress Reduction (MBSR) meditation is based on a systematic procedure to develop enhanced non-reactive awareness of the moment-to-moment experience of perceptible mental processes. An investigation of brain activity in experienced meditators and matched meditation-naïve controls will be presented (Brewer). The main nodes of the default mode network (medial prefrontal and posterior cingulate cortices) were relatively deactivated in experienced meditators, across all meditation types. Functional connectivity analysis revealed stronger coupling in experienced meditators between brain regions previously implicated in self-monitoring and cognitive control. The findings suggest differences in the default mode network that are consistent with decreased

mind-wandering and self-referential processing. This presentation will discuss the relationship between resiliency and mindfulness by focusing on a number of coping mechanisms, behaviors, and cognitive styles that have been associated with resiliency and that may be enhanced by MBSR (Southwick). These include optimism and positive emotions, capacity to face fear, learning to accept that which cannot be changed, rapid emotional and physiologic recovery from stress, and a focus on altruism and compassion. MBSR promotes coping and accurate thinking, reduces negativity, and shows promise in the treatment of pain, depression, anxiety, and posttraumatic stress disorder which will be reviewed in this symposium (Davis).

NO 1 MINDFULNESS-BASED STRESS REDUCTION IN THE TREATMENT OF MOOD AND ANXIETY DISORDERS

Speaker: Lori Davis, M.D.

SUMMARY:

This presentation will discuss the principles of Mindfulness Based Stress Reduction (MBSR) meditation, the clinical implications of MBSR, and include a current review of the evidence based research findings in the treatment of mood and anxiety disorders. Results from a clinical pilot study of MBSR in the treatment of posttraumatic stress disorder and the methods for an ongoing multisite randomized controlled trial of MBSR for PTSD will be presented. A discussion of the clinical applications and directions for future research will be included.

NO 2 POSSIBLE NEURAL MECHANISMS OF MEDITATION

Speaker: Judson Brewer, M.D., Ph.D.

SUMMARY:

This presentation will provide the details and findings of an investigation of brain activity in experienced meditators and matched meditation-naïve controls while they performed several different meditations. The study found that the main nodes of the default mode network (medial prefrontal and posterior cingulate cortices) were relatively deactivated in experienced meditators, across all meditation types. Further, functional connectivity analysis revealed stronger coupling in experienced meditators between the posterior cingulate, dorsal anterior cingulate and dorsolateral prefrontal cortices (regions previously implicated in self-monitoring and cognitive control), both at baseline and during meditation. Our findings demonstrate differences in the default mode network that are consistent with decreased mind-wandering and self-referential processing. As such, they provide a new understanding of possible neural mechanisms of meditation.

NO 3 RESILIENCY AND MINDFULNESS

Speaker: Steven Southwick, M.D.

SUMMARY:

Resiliency to stress is defined as the ability to cope with and adapt well to stress and adversity. Although there is no one universal definition of resiliency, it is generally understood as the ability to bounce back from hardship and trauma. This presentation will discuss the relationship between resiliency and mindfulness by focusing on a number of coping mechanisms, behaviors, and cognitive styles that have been associated with resiliency and that may be enhanced by mindfulness. These include optimism and positive emotions, capacity to face fear, learning to accept that which cannot be changed, rapid emotional and physical recovery from stress and in some cases, a focus on altruism and compassion. The clinical implications of mindfulness and factors of resiliency in the recovery of individuals following traumatic life events will be discussed.

SYMPOSIUM 83 MILITARY POSTTRAUMATIC STRESS DISORDER AND ITS COMPLEX COMORBIDITIES: ADVANCES IN DIAGNOSIS AND TREATMENT

Discussant: Elaine Peskind, M.D.

Chair(s): Murray A. Raskind, M.D., Elaine Peskind, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To treat combat PTSD in Iraq and Afghanistan war Veterans; 2) To deliver more effective smoking cessation treatment to Veterans with PTSD; 3) To recognize the brain structure, function and neuropathologic concomitants of repeated blast and blunt trauma mild traumatic brain injury (mTBI).;

SUMMARY:

Posttraumatic stress disorder (PTSD) following participation in military combat operations is demanding increased national attention with the return of millions of American Service Members and Veterans from deployments to the conflicts in Iraq and Afghanistan. As psychiatrists and other mental health providers evaluate and attempt to treat combat operations PTSD in these patients, it has become apparent that having PTSD as their only behavioral disorder is the exception. Rather, PTSD is usually accompanied by multiple comorbidities. Prominent among these are blast concussion mild traumatic brain injury (mTBI) with persistent postconcussive behavioral and somatic symptoms, and substance use disorders. The latter often result from attempts to "self medicate" PTSD re experiencing and hyperarousal symptoms particularly trauma nightmares, sleep disruption and daytime hypervigilance. Difficulties extrapolating pharmacologic and service delivery treatment approaches developed in civilian PTSD to combat operations PTSD complicate treatment planning for these service members and Veterans. Controversy continues as to whether persistent postconcussive symptoms in combatants who sustained blast mTBI reflect persistent structural and functional brain abnormalities or are functions of comorbid PTSD and depression. Finally, there is a great concern that Veterans exposed to blast mTBIs are at increased risk for developing chronic traumatic encephalopathy,

a tauopathy dementia increasingly diagnosed in professional football players and other contact sport athletes who have experienced multiple concussions. This symposium will present recent research findings that demonstrate: (1) substantial efficacy of the alpha-1 AR antagonist prazosin for trauma nightmares, sleep disturbance, overall PTSD and global function in combat soldiers returned from Iraq and Afghanistan; (2) chronic structural and functional brain abnormalities in blast mTBI in Iraq and Afghanistan soldiers that are not attributable to PTSD; (3) delivery of smoking cessation to Veterans with chronic PTSD by their mental health provider doubles smoking quit rate; and (4) neuropathologic evidence of tauopathy that is consistent with early chronic traumatic encephalopathy in military Veterans who have experienced multiple blunt or blast trauma mTBIs.

**NO 1
PRAZOSIN: AN EFFECTIVE TREATMENT FOR
COMBAT PTSD IN ACTIVE-DUTY SOLDIERS
RETURNED FROM IRAQ AND AFGHANISTAN**

Speaker: Murray A. Raskind, M.D.

SUMMARY:

We conducted a 15-week randomized, parallel, double-blind, placebo-controlled trial of the alpha-1 adrenoreceptor antagonist prazosin for PTSD nightmares, sleep quality, global function and total PTSD symptoms in active duty soldiers following combat deployments to Iraq and Afghanistan. 67 soldiers (65 active duty at Joint Base Lewis-McChord and 2 recently discharged Veterans) were randomized to prazosin or placebo for 15 weeks. Drug was titrated over 6 weeks to a possible maximum dose of 5 mg midmorning and 20 mg at bedtime for male soldiers and 2 mg midmorning and 10 mg at bedtime for female soldiers. Prazosin subjects improved significantly more than placebo subjects in trauma nightmares, sleep quality, global function, total CAPS score and the CAPS reexperiencing and hyperarousal symptom clusters. Prazosin was well tolerated and blood pressure changes over time did not differ between groups. Prazosin is effective and well tolerated for combat related PTSD.

**NO 2
ARE PERSISTENT POSTCONCUSSIVE SYMPTOMS
FOLLOWING BLAST MTBI ATTRIBUTABLE
TO COMORBID PTSD OR NEUROIMAGING
DETECTABLE BRAIN ABNORMALITIES**

Speaker: Eric C. Petrie, M.D., M.S.

SUMMARY:

34 Blast-mTBI Veterans and 18 Iraq and Afghanistan deployed Veterans without blast mTBI underwent magnetic resonance DTI and MPF mapping; [18F]FDG-PET imaging of CMRglu; structured clinical assessments of blast exposure, psychiatric diagnoses, and PTSD symptoms; neurologic evaluations; self-report scales of postconcussive symptoms, combat exposure, depression, sleep quality and alcohol use. Blast-mTBI Veterans exhibited reduced fractional anisotropy in the corpus callosum; reduced MPF in subgyral, longitudinal, and cortical/subcortical white matter tracts and gray matter/

white matter border regions; reduced CMRglu in parietal, somatosensory, and visual cortices; and higher scores on measures of PCS, PTSD, combat exposure, depression, sleep disturbance and alcohol use.

**NO 3
NEW TREATMENT APPROACHES TO TOBACCO
AND ALCOHOL USE DISORDERS**

Speaker: Andrew J. Saxon, M.D.

SUMMARY:

Problematic alcohol and tobacco use are prevalent among military members and Veterans and frequently co-occur with PTSD. VA data indicate that 20% of 6523 Veterans of the Iraq/Afghanistan Wars entering outpatient PTSD program between 2004 and 2006 had alcohol abuse or dependence. Among military members deployed to Iraq 58.3% of males and 51.2% of females used tobacco during deployment. A majority indicated an intention to stop smoking upon returning from deployment. A longitudinal study of 48,304 military members showed deployment as a risk factor for ex-smokers to resume smoking. Veterans with PTSD who smoke often use tobacco in an attempt to cope with psychiatric symptoms. For Veterans who have PTSD and also smoke tobacco, integrating care for smoking cessation with PTSD treatment improves tobacco quit rates for and could serve as a model for treatment of other substance use disorders co-occurring with PTSD.

**NO 4
NEUROPATHOLOGIC SEQUELAE OF MILD
TRAUMATIC BRAIN INJURY**

Speaker: Ann McKee, M.D.

SUMMARY:

Repetitive blunt impact and blast mTBI experienced by military personnel are risk factors for chronic traumatic encephalopathy (CTE). It is characterized clinically by behavioral and personality abnormalities, loss of attention and concentration, impulsivity, irritability, suicidality, depression and short term memory loss in early stages. In early CTE, there are prominent perivascular foci of phosphorylated tau protein at the depths of the cortical sulci and in subpial regions. These initial localized phosphorylated tau abnormalities spread to involve widespread regions of cerebral cortex, medial temporal lobe, deep nuclei and brainstem. Deposition of beta amyloid, most commonly as diffuse plaques, occurs in fewer than half the cases and is significantly associated with age. Most instances of CTE are characterized by abnormal deposition of TDP-43 protein. Postmortem exam of 5 Iraq and Afghanistan Veterans with a history of mTBIs revealed the presence of tauopathy consistent with CTE.

SYMPOSIUM 84 SUICIDE AND THE GOLDEN GATE BRIDGE

Chair: Mel Blaustein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the nature of suicide and especially bridge suicide; 2) Explain myths and misconceptions about suicide; and 3) Discuss the most effective suicide deterrents.

SUMMARY:

The Golden Gate Bridge is one of the most beautiful yet lethal structures in the world. Since its construction in 1937 over 1,500 individuals have committed suicide at this iconic site--a rate of two deaths per month. In 2004 the Psychiatric Foundation of Northern California (the 501(c)(3) arm of the Northern California Psychiatric Society) organized a drive with mental health workers, family members, the press and the general public to demand a barrier on the bridge. The following year the Bridge Board approved engineering and environmental studies and three years ago approved barrier construction (but without funding). In 2009 this panel presented an APA Presidential Symposium exploring public attitudes, misconceptions and myths about suicide, the allure of the bridge and the effectiveness of suicide deterrents. We will look at these issues again in depth, but update our efforts. Our distinguished panel will include: two family members whose adolescent children committed suicide, two psychiatric suicide experts, the director of San Francisco Suicide Prevention, plus the former Marin County Coroner and the CEO and former chief engineer of the Golden Gate Bridge.

NO 1 A HISTORY OF GOLDEN GATE BRIDGE SUICIDE BARRIER CAMPAIGNS

Speaker: Eve Meyer, M.S.W.

SUMMARY:

Eve Meyer, the Executive Director of San Francisco Suicide Prevention for over 20 years, will discuss the history of the Golden Gate Bridge suicide barrier campaigns. She will comment about the suicide prevention community's response.

NO 2 PERSPECTIVE FROM A FAMILY MEMBER

Speaker: John Brooks

SUMMARY:

John Brooks is a bank media financier whose 17-year old daughter committed suicide from the Golden Gate Bridge in 2008. He will talk about that experience.

NO 3 SUICIDE DETERRENENTS

Speaker: Anne Fleming, M.D.

SUMMARY:

Anne Fleming, MD is an Associate Clinical Professor of Psychiatry at University of California, San Francisco and works on the consultation liaison team at San Francisco General Hospital. She lost a physician classmate to bridge suicide in 2004. She will present an examination of suicide deterrents and focus specifically on the Golden Gate Bridge.

NO 4 A FORMER CORONER REPORTS ON BRIDGE SUICIDE

Speaker: Ken Holmes

SUMMARY:

Ken Holmes, the Marin County Coroner from 1975-2010, will present demographics on bridge suicide over the years. He will also talk about the investigative process and the meeting with families after the deaths.

NO 5 PERSPECTIVE FROM A FAMILY MEMBER

Speaker: Mary Zaboltny

SUMMARY:

Mary Zaboltny is an artist whose 18-year old son committed suicide from the Golden Gate Bridge in 2005. She will reflect on that experience.

NO 6 CONSTRUCTION OF A SUICIDE BARRIER

Speaker: Denis Mulligan

SUMMARY:

Denis Mulligan, CEO and former Chief Engineer of the Golden Gate Bridge, will discuss the engineering and architectural aspects of building a barrier on the Golden Gate Bridge. He will analyze design models and address the implementation of the approved metal mesh net.

SYMPOSIUM 85 DSM-5: CASES THAT CLARIFY THE NEW NO- MENCLATURE

Chair(s): John W. Barnhill, M.D., Robert Haskell, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize some of the pivotal changes between DSM-IV and DSM 5; 2) Become more adept at using the DSM-5 to identify diagnoses; 3) Understand ways in which DSM-5 is a useful tool to better understand our patients; and 4) Recognize some of the diagnostic ambiguities that persist, both in DSM-5 and the field of psychiatry.

SUMMARY:

This symposium is intended to clarify ways in which DSM-5 can be used in the creation of psychiatric diagnoses. Each presentation will conform to the following structure: a brief

outline of a case, followed by the discussion of an initial differential diagnosis. Additional clinical information will then be provided, and the presenters will conclude with more definitive diagnoses. Each of the cases will refer to diagnoses that have been viewed as controversial and/or have been significantly reframed between DS-IV and DSM-5. Specific topics will include the “grief exclusion” of depression, eating disorders, cognitive decline, somatic symptoms, and psychiatric disorders induced by medications and/or medical illnesses. Throughout this symposium, the presenters will highlight changes made in DSM-5 as well as practical ways that the new diagnostic categories can be used.

NO 1 WHAT IS ARFID? AND OTHER IMPORTANT QUESTIONS FOR THE 21ST-CENTURY PSYCHIA- TRIST

Speaker: Evelyn Attia, M.D.

SUMMARY:

DSM5 has introduced clarifications and changes to the list of Feeding and Eating Disorder Diagnoses. The category of Feeding and Eating Disorders includes Avoidant-Restrictive Food Intake Disorder (ARFID), a disorder characterized by food restriction and/or nutritional deficiency without the fear of fat or body image distortions that are typical of anorexia and bulimia nervosa. This case-based presentation will review the current evidence base regarding the presentation and management of ARFID.

NO 2 SUBSTANCE USE DISORDERS

Speaker: Raymond Raad, M.D., M.P.H.

SUMMARY:

There have been a number of changes to the criteria for substance use disorders from DSM-IV to DSM-5. A case with substance use disorders will be presented, along with a discussion of how to use DSM-5 to make accurate diagnoses and differential diagnoses.

NO 3 COMORBID BIPOLAR DISORDER, COCAINE AND CANNABIS DEPENDENCE, HIV INFECTION

Speaker: Stephen J. Ferrando, M.D.

SUMMARY:

Dr. Ferrando will discuss the complex differential diagnosis involved in assessing an HIV-positive patient with history of both depressive and manic episodes, cognitive impairment and concurrent substance abuse. The discussion involves careful psychiatric and medical history, assessment of neurocognitive function in the setting of HIV and mood disorder, assessment of substance abuse severity and investigation of acute and chronic medical issues, such as adherence to HIV medication, systemic illness and CNS comorbidities, including HIV-associated dementia.

NO 4

“DOCTOR, NO ONE HAS AN ANSWER FOR WHAT’S WRONG WITH ME. CAN YOU HELP ME?” : THE NEW NOMENCLATURE OF SOMATIC SYMPTOM AND RELATED DISORDERS IN DSM- 5

Speaker: Anna Lopatin Dickerman, B.A., M.D.

SUMMARY:

In DSM-5, the category of somatoform disorders will now be replaced by Somatic Symptom Disorder and other related illnesses. The hallmark of such disorders is the presence of somatic symptoms along with abnormal or maladaptive thoughts, feelings, and behaviors. The new diagnostic criteria have been streamlined with the goal of reducing overlap among the disorders as previously defined in DSM-IV. This should result in increased clarity and less problematic clinical usage. Notably, the new nomenclature of DSM-5 places less emphasis upon the absence of medical explanation for somatic symptoms. This better allows for an appreciation of the complex interface between psychiatry and medicine, in which somatizing patients may or may not have an actual co-morbid diagnosed medical condition. Furthermore, there are no longer any arbitrary high symptom counts needed to make somatic symptom diagnoses. Therefore, DSM-5 classification in this area now better accounts for existing empirical evidence.

NO 5

LATE-LIFE DEPRESSION AND MILD NEURO- COGNITIVE DISORDER

Speaker: George S. Alexopoulos, M.D.

SUMMARY:

The differential diagnosis of older patients with major depression and mild cognitive impairment poses four questions: 1) Is depression a response to social and functional limitations imposed by cognitive deficits (DSM V: adjustment disorder with depressed mood)? 2) Is cognitive dysfunction part of the depression itself (DSM V: major depressive disorder, single episode)? 3) Is cognitive impairment an early stage neurocognitive disorder (DSM V: minor neurocognitive disorder) unmasked by depression (DSM V: major depressive disorder, single episode)? 4) Are both depressive and cognitive symptoms due to a neurological event (“vascular depression”) (DSM V: Depressive disorder associated with another medical condition).

SYMPOSIUM 86

MATERNAL STRESS IN PREGNANCY: CLINICAL AND NEURODEVELOPMENTAL IMPLICATIONS

Chair: Elizabeth Fitelson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify clinical features and epidemiology of antenatal mood and anxiety disorders as they relate to our understanding of pathological antenatal stress; 2) Under-

stand the current research associating markers of maternal stress in pregnancy with postpartum mood, changes in fetal neurobehavior and child development; and 3) Recognize how the research elucidating the downstream effects of maternal stress on mother and child may inform clinical decision-making around mood and anxiety disorders in pregnancy.

SUMMARY:

The issue of maternal stress in pregnancy and how it affects the mother, fetus, and developing child is an emerging and complicated field for both researchers and clinicians. While there is accumulating human and animal data suggesting that maternal prenatal stress has significant impact on fetal and infant neurobehavioral development, it is difficult to differentiate these effects from those of postnatal environmental factors and to distinguish them definitively from familial genetic traits. Both clinicians and researchers struggle with the goal of finding a valid and reliable definition of antenatal stress and the specification of what level has a negative influence on development. Moreover, clinicians must often weigh two categories of risk to the developing fetus: those of clinically significant stress, such as untreated maternal depression and anxiety, versus treatment with psychotropic medications. This symposium presents current research findings on maternal stress and its implications for fetal and infant development, and explores the clinical implications of this information for the management of perinatal psychiatric illness. Topics covered include clinical features and management of prenatal mood and anxiety disorders, as well as recent findings regarding maternal mood and HPA axis regulation, fetal neurobehavior and newborn/child brain development (including newborn MRI assessment) in relation to prenatal maternal stress and variation in the serotonin transporter gene.

NO 1 ANTENATAL MATERNAL STRESS IN THE CLINICAL SETTING

Speaker: Kristin L. Wesley, M.D.

SUMMARY:

Human and animal research alike suggest that maternal stress in pregnancy has a significant impact on fetal and infant neurobehavioral development, but in the treatment setting it is unclear what the clinical correlates of antenatal stress may be. This presentation will discuss clinical features and epidemiology of mood and anxiety disorders in pregnancy and how these disorders correlate to our understanding of maternal stress. A representative clinical case will be presented to highlight the research questions relevant to clinical decision-making. For example, what levels of prenatal depression and anxiety have a negative impact on perinatal neurobehavioral development? How does one compare the effects of the untreated illness on the developing fetus to the effects of medication treatment? How can the impact of prenatal stress on the developing fetus be distinguished from genetic influence and the effects of the postnatal environment?

NO 2 PLACENTAL CORTICOTROPIN-RELEASING HORMONE PREDICTS POSTPARTUM DEPRESSIVE SYMPTOMS

Speaker: Laura Glynn, Ph.D.

SUMMARY:

Successful and cost effective therapies exist, but the inability to detect and diagnose postpartum depression (PPD) constitutes a significant impediment to provision of care. Relatively little is known about the etiology of PPD. However, accumulating evidence suggests that corticotropin-releasing hormone (CRH) may play a role. The purpose of the present study was to investigate whether placental CRH (pCRH) is a marker of risk for postpartum mood disturbance. Pregnant women (N=197) were assessed five times during pregnancy and at 3-months postpartum. Women who exhibited PPD symptoms were characterized by elevated levels of CRH (from 23 to 31 weeks) and exhibited accelerated trajectories of pCRH across gestation. These findings are consistent with the broader view that HPA and placental axis dysfunction plays a role in depressive episodes during the perinatal period.

NO 3 FETAL EXPOSURE TO STRESS AND STRESS PEPTIDES PROGRAMS HUMAN FETAL, INFANT, AND CHILD BEHAVIOR

Speaker: Curt Sandman, Ph.D.

SUMMARY:

Two separate cohorts of two hundred subjects each and with identical prenatal procedures were evaluated as mother/fetal dyads as early as 12 weeks gestation with measures of biological and psychosocial stress. Subjects entered our current project at 6-8 years of age to examine consequences of prenatal exposures to biological and psychosocial stress on cognition and brain structure. We found that fetal exposure to elevated levels of maternal depression and stress was associated with impaired cognitive performance and decreased brain volume. These effects support previous findings suggesting that prenatal exposures, even within normal physiological limits exert programming influences on the nervous system. (Supported by awards HD28413, NS41298, HD51852)

NO 4 MATERNAL MOOD AND GENETIC VARIABILITY: FETAL NEUROBEHAVIOR AND NEWBORN BRAIN DEVELOPMENT FROM MRI

Speaker: Catherine Monk, Ph.D.

SUMMARY:

Identification of biological processes that mediate the associations between maternal prenatal stress and infant outcomes, as well as others that may alter brain development prior to birth, are central to increased knowledge, clinical decision making, and improved intervention for optimizing children's trajectories. In this presentation, we discuss data from two on-

going projects that (1) examine variation in gene expression in the placenta, maternal leukocytes, and fetal blood associated with maternal distress and (2) maternal prenatal mood and variation in the infant's genetic background for the serotonin transporter related to fetal neurobehavior and infant brain development from newborn MRI assessments.

**NO 5
TREATING ANTENATAL MOOD AND ANXIETY
DISORDERS: PRINCIPLES OF MANAGEMENT**

Speaker: Lucy Hutner, M.D.

SUMMARY:

Approximately one in eight women suffer with depression during pregnancy; anxiety disorders are at least as common. These disorders, as markers as pathological stress, often require difficult management decisions during pregnancy. Often, women with these disorders are untreated or undertreated due to fears about treatment risks, stigma, and the lack of available resources. This talk will outline the principals of management and treatment options for clinicians and patients currently faced with these decisions.

**NO 6
IS THE RESEARCH ON PRENATAL STRESS ABLE
TO GUIDE CLINICAL DECISIONS FOR TREAT-
MENT?**

Speaker: Elizabeth Fitelson, M.D.

SUMMARY:

Although much of the research on perinatal mood and anxiety disorders has focused on the risks of treatment, the long-term clinical implications and neurodevelopmental risks of untreated antenatal stress are becoming more clear. However, there remain many unanswered questions about both treatment effects and untreated illness in pregnancy, and clinicians and patients are left with the continued dilemma of making real-world decisions in the face of these uncertainties. This talk will bring together the current data about antenatal stress and pharmacologic treatment to help clarify how the research can guide clinical decisions and what we still need to learn.

**SYMPOSIUM 87
PERSPECTIVES ON GOOD PSYCHIATRIC MAN-
AGEMENT**

Chair(s): John Gunderson, M.D., Paul Links, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Encourage familiarity and training in treatment of BPD with Good Psychiatric Management; 2) Increase awareness of the effectiveness of good case management in treating BPD; 3) Describe what and how basic case management can be learned; and 4) Understand how GPM differs from other empirically-validated therapies for BPD.

SUMMARY:

Good Psychiatric Management (GPM) is an empirically validated treatment for BPD (McMain et al. 2009) that establishes a case-management (as opposed to individual psychotherapy) model for treatment that can be used by non-BPD specialists. This symposium will review the scientific data about its effectiveness (McMain), and the processes and sustainability of improvements (Links). It will then describe the methods developed for attaining competence in GPM, including workshops and a manual (Gunderson) and report the data about the effectiveness of this training (Keuroghlian). Finally, the similarities and differences of GPM from Dialectical Behavior Therapy (DBT) and Mentalization-based Therapy (MBT) will be described (Choi-Kain).

**NO 1
INTEGRATING GENERAL PSYCHIATRIC MAN-
AGEMENT WITH DIALECTICAL BEHAVIORAL
THERAPY AND MENTALIZATION-BASED TREAT-
MENT**

Speaker: Lois W. Choi-Kain, M.D.

SUMMARY:

Mentalization Based Treatment (MBT) and Dialectical Behavioral Therapy (DBT) are two of the most recognized evidence based treatments (EBTs) for borderline personality disorder (BPD). Despite the clear efficacy of these treatments, they have remained limited in their accessibility to the public. General Psychiatric Management (GPM) is a less specialized general psychiatric approach to case management of BPD founded in a well-developed formulation of the psychopathology of the disorder, rather than a highly specified technical psychotherapeutic procedure, requiring less training and treatment resources than other EBTs. This symposium will discuss using GPM and a standard approach to treating BPD, upon which EBTs such as DBT and MBT can be layered if patients need more treatment. Convergences and divergences among these three practical clinical approaches to BPD will be reviewed and recommendations for informed integration of approaches will be described.

**NO 2
OUTCOME OF DIALECTICAL BEHAVIOR THERA-
PY AND GENERAL PSYCHIATRIC MANAGEMENT
FOR PATIENTS DIAGNOSED WITH BORDERLINE
PERSONALITY DISORDER**

Speaker: Shelley McMain, Ph.D.

SUMMARY:

Findings from a randomized controlled trial that evaluated the effectiveness of Dialectical Behavior Therapy (DBT) for borderline personality disorder (BPD) will be presented. One-hundred and eighty patients were assigned to one-year of DBT or General Psychiatric Management (GPM), a comprehensive approach consisting of psychodynamic psychotherapy, case management, and pharmacotherapy. There were no significant between-group differences on outcomes at the end of the one-year treatment and two years postdischarge.

Patients showed significant changes across a wide range of outcomes including suicidal and non-suicidal self-injurious behaviors, health care utilization, general symptom distress, and borderline psychopathology. Over the follow-up phase, the original treatment effects did not diminish for participants in either group. This is the largest psychotherapy outcome study of BPD, and the largest study of DBT carried out independent from the developer of this approach.

NO 3 THE EFFECT OF ATTENDING A GOOD PSYCHIATRIC MANAGEMENT WORKSHOP ON NEGATIVE ATTITUDES TOWARD PATIENTS WITH BORDERLINE PERSONALITY DISORDER

Speaker: Alex S. Keuroghlian, M.D., M.Sc.

SUMMARY:

Objective: The goal of this study is to evaluate the effect of attending a GPM workshop on negative attitudes towards BPD patients. Method: Negative attitudes were assessed among clinicians with self-reports obtained before and after one 8-hour GPM workshop combining lectures with case vignettes. Results: After attending the workshop, participants were significantly less likely to report 1) that they would prefer to avoid caring for a BPD patient if they had a choice and 2) that the prognosis for BPD treatment is hopeless. Preliminary results also show a near-significant decrease in participants' dislike of BPD patients and increase in the feeling that they can make a positive difference in the lives of BPD patients. Conclusions: Attending a one-day GPM workshop appears to decrease negative feelings and beliefs among clinicians regarding patients with BPD and the prognosis for BPD treatment. Results from other workshops will be used to compare results and participant demographics.

NO 4 TRAINING IN GOOD PSYCHIATRIC MANAGEMENT

Speaker: John Gunderson, M.D.

SUMMARY:

Competence in general psychiatric management for borderline patients has traditionally been acquired by many years of trial-and-error experience in hospitals, partial hospitals or outpatient clinics. Now a handbook offers a condensed "how to" didactic description of key Good Psychiatric Management (GPM) interventions (Gunderson & Links, unpublished). This handbook contains descriptions of the most common clinical problems and how they should be managed. Two training methods are used to facilitate acquisition of competence in GPM. The first is a series of case reports interrupted by decision points that invite clinicians to consider 3 to 5 alternative responses. The merits of each response is then rated as Good, Acceptable or Poor, each then being given a critical discussion. The second is videotaped interactions between clinicians and borderline patients that vividly illustrate good GPM interventions. GPM training can be introduced by workshops.

SYMPOSIUM 88 DSM-5 AND CULTURE: THE SUPPLEMENTARY MODULES FOR THE CULTURAL FORMULATION INTERVIEW IN DSM-5

Discussant: Laurence J. Kirmayer, M.D.

Chair(s): Devon Hinton, M.D., Ph.D., Ladson Hinton, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about how to sensitively assess patients with psychiatric disorders from other cultures; 2) Learn about a set of modules that were developed for DSM-5 that will help to guide cultural sensitive assessment of psychiatric disorders; and 3) Learn about clinical and research applications of modules that were developed for DSM-5 that aim to help to guide cultural sensitive assessment of psychiatric disorders.

SUMMARY:

An interview (the Cultural Formulation Interview, or CFI) was developed for the DSM-5 that aims to help culturally sensitive assessment of persons with psychiatric disorders. The Supplementary Modules complement the CFI and allow for more in-depth investigation. The CFI and Supplementary Modules are considered key means to increase culturally sensitive assessment of psychiatric disorders. The CFI contains a number of assessment domains that include cultural identity, explanatory model of illness, level of functioning, social network, psychosocial stressors; spirituality, morality, and religion; patient-clinician relationship; coping and health seeking. The Supplementary Modules assess each of the domains in more detail, and the supplementary modules includes modules that are specifically designed for special populations: school age children and adolescents; immigrants and refugees; and older adults; and care givers. The current session is designed to give a sense of how these modules interphase with the CFI, their clinical utility, and the particular structure of some of the modules.

NO 1 THE CULTURAL FORMULATION INTERVIEW SUPPLEMENTARY MODULE FOR IMMIGRANTS AND REFUGEES: ENHANCING CLINICAL CARE DURING TRANSITION AND RESETTLEMENT

Speaker: James Boehnlein, M.D.

SUMMARY:

For immigrants and refugees, migration and resettlement present many challenges that affect mental health. It is essential for clinicians to have practical tools to assess variables that enhance accurate diagnosis and effective treatment. The supplementary module for Immigrants and Refugees in the Cultural Formulation Interview (CFI) allows clinicians to maximize these clinical goals. This supplementary module allows clinicians to efficiently assess the most important variables of migration and resettlement that influence mental health, such as pre-migration difficulties, exposure to violence

and persecution, migration-related losses, resettlement in the new country, and future expectations. Using specific clinical examples, this presentation will highlight the most important elements of this CFI supplementary module that contribute to better clinical care. Ample time will be allotted for audience discussion and input.

NO 2 CONDUCTING A COMPREHENSIVE CULTURAL ASSESSMENT USING DSM-5

Speaker: Roberto Lewis-Fernandez, M.D.

SUMMARY:

The inclusion of the Outline for Cultural Formulation (OCF) in DSM-IV provided a template for cultural assessment during a mental health evaluation. However, its outline format has not helped clinicians formulate specific questions for patient care or researchers pursue studies with a standard interview. In response, the DSM-5 Cultural Issues Subgroup operationalized the OCF into several patient-centered tools. The Cultural Formulation Interview (CFI) is a 16-item questionnaire, which can be used in routine clinical practice with any patient in any clinical setting. Cases requiring in-depth cultural assessment are guided by 12 supplementary modules, which expand on each domain of the CFI and provide additional questions to assess youth, older adults, and immigrants and refugees. A module for caregivers and an Informant version of the CFI gather collateral information. This talk will review these tools and illustrate how to use them together in different clinical situations.

NO 3 CULTURAL IDENTITY MODULE FROM AN INTER- NATIONAL PERSPECTIVE

Speaker: Hans G. Rohlof, M.D.

SUMMARY:

Cultural Identity is a quite complex phenomenon. Yet it is of great importance in psychiatric diagnosis and treatment, since it influences idioms of illness, treatment seeking patterns, and treatment attitude. In The Netherlands there is a long experience with a Cultural Interview in which questions about identity play a major role (Rohlof et al, 2009). Cultural identity seemed to be the most important item to be discussed in team meetings (Groen, 2009). In 2012, for the DSM-5, an international group constructed a new interview about cultural identity alone: the Cultural Identity Module. Extensive discussions with experts from all over the world resulted in a new text. Similarities and differences with the Dutch interview, and why they were made, will be discussed. The new module is a sophisticated new instrument, with which the complicated nature of cultural identity can be described much better.

NO 4 THE EXPLANATORY MODULE AND THE COPING AND HELP-SEEKING MODULE: A DEMONSTRATION OF CLINICAL UTILITY

Speaker: Devon Hinton, M.D., Ph.D.

SUMMARY:

To supplement the CFI, there is a supplementary module that aims to further explore patients' understanding of their presenting problem (The Explanatory Module) and a supplementary module that further explores the patients' attempts at coping and help-seeking in respect to the presenting problem (The Coping and Help-Seeking Module). The two modules are complementary in that how the patient seeks to cope and seek for treatment further illustrates the patient's understanding of the problem, i.e., the patient's explanatory model. This talk describes the explanatory module and coping help-seeking modules, and illustrates the clinical utility of these two modules by using them to explore a common presenting complaint among Cambodian refugees.

NO 5 USE OF THE CULTURAL FORMULATION INTER- VIEW AND SUPPLEMENTARY MODULES WITH OLDER ADULTS

Speaker: Ladson Hinton, M.D.

SUMMARY:

The older adult population in the US is large and increasingly culturally diverse. This presentation will examine aging-related changes (e.g. increased prevalence of functional and cognitive impairment, involvement of one or more caregivers) that may complicate the cultural assessment of older adults. The informant version of the CFI and two supplementary modules, one for caregivers and one for older adults, are important tools that can be used to augment the CFI and tailor cultural assessment to better address the needs and situations of older adults. This specific aims of this talk are to 1) discuss general considerations for use of the CFI in older adult populations, 2) highlight the clinical utility of the informant version of the CFI, the caregiver supplementary module and the older adult supplementary modules, 3) present case vignettes to illustrate the clinical utility of CFI and supplementary modules in older adults.

SYMPOSIUM 89 TREATMENT OUTCOMES, STIGMA, AND SOCIAL SUPPORT IN DEPRESSION: FINDINGS FROM A MULTI-ETHNIC, MIXED-METHODS, LONGITUDI- NAL STUDY

Discussants: Jeanne Miranda, Ph.D., Sigrid K. Madrigal, B.A.

Chair(s): Elizabeth Bromley, M.D., Ph.D., Kenneth Wells, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the challenges patients with depression may face in disclosing their diagnosis and treatment to family members, friends, and co-workers; 2) Identify the attributes of the patient's social network that may impact depression treatment engagement and depression outcomes; and 3)

Understand the elements of a resiliency-based approach to depression treatment and its potential role in countering mental health stigma.

SUMMARY:

Individuals are embedded in networks of social relationships and systems of support that influence their health behavior and provide resources for help seeking. We present findings from a major longitudinal study of patient experience in depression. We use unique interview and social network data from a large sample of Latinos, African Americans and whites enrolled in a study of depression treatment in primary care. We contextualize 10-year follow up data on depression outcomes with data from three waves of semi-structured interviews and a social network survey. Both the interview and the social network survey query patient experience of depression, attitudes of social network members toward depression, treatment experiences, positive and negative life events and symptoms. We review the findings and their implications for depression treatment and community-engaged strategies for building resiliency. Data come from Partners in Care, a group-level randomized controlled trial of practice-initiated quality improvement (QI) programs for depression. First, we present an overview of 10-year outcome data on depressive symptoms and quality of life, including differences between Latino, African American and white subjects. Second, we present qualitative data that summarize the challenges subjects face in managing depressive symptoms in their social contexts. These data describe experiences of depression stigma, the risks of disclosure of depression and treatment and the strategies subjects develop to compensate for deficiencies in their systems of support. Next we look at social network survey data that reveal the attributes of the social network that shape responses to depression. We present results that link network composition, network structure and care seeking behaviors across 4 subject attributes: ethnicity, gender, current diagnosis of depression and current treatment for depression. We describe network features that correlate with subjects' willingness to disclose depression and the prevalence of stigma. Then, we provide an extended example of the value of a mixed-method approach by examining the role of romantic partners in depression, treatment, and coping. Finally, we describe subjects' health care experiences, presenting findings that demonstrate the impact of the QI intervention on psychiatric medication use and help-seeking behaviors. Finally, two discussants, an academic researcher and a community member, discuss the implications of the findings for community resiliency and depression treatment. The two review what a resiliency perspective on these data could provide, such as identifying and validating social and communal strengths and informing interventions that teach caregivers and communities to counter stigma. Then, discussants consider the options for moving "beyond CBT" toward a future in which depression treatment addresses the needs of the individual as well as the social network and community context in which the individual lives.

NO 1

DEPRESSION STIGMA IN SOCIAL CONTEXT

Speaker: Elizabeth Bromley, M.D., Ph.D.

SUMMARY:

Despite growing awareness of the neurobiological nature of mental illness, individuals with depression still face considerable stigma. We review findings from interviews with subjects with depression that explore symptoms, help-seeking, and coping. An exploratory analysis of a random sample (n= 40) showed a high prevalence of hostility within subjects' social networks toward depression treatment. In a second sample (n=46; interviews=137) selected purposively according to the degree of stigma within the network and the subject's likelihood to disclose depression treatment, we used narrative analysis to understand the dynamics that influence low v. high disclosure and low v. high stigma. Results demonstrate that disclosure can have negative consequences, even in social contexts with little stigma; very few subjects with depression narrate a coherent concept of the illness; and events within the family unrelated to stigma lead many subjects to hide their symptoms and/or treatment.

NO 2

ASSOCIATION OF NETWORK STRUCTURE AND COMPOSITION WITH SUPPORT-SEEKING BEHAVIORS

Speaker: Harold D. Green Jr., M.S., Ph.D.

SUMMARY:

We present results that link network composition, network structure and support seeking behaviors across key descriptive features of respondents: ethnicity, gender, current depression, and depression treatment. Network composition (e.g., proportion of friends or relatives) and network structure (e.g., size, number of isolates) were related to support seeking, though these relationships varied. Across our four features, network composition and structure were related to a respondent's likelihood of approaching a network member to talk, to get information or advice, or to get 'other' types of support such as money, rides, etc. That network structure and composition impact an individual's likelihood of seeking support, and that these differ depending on whether respondents are Hispanic, male, female, depressed (or not), or in treatment (or not) is important information for use in designing network-based depression interventions.

NO 3

THE ROLE OF ROMANTIC RELATIONSHIPS IN DEPRESSION TREATMENT

Speaker: David P. Kennedy, Ph.D.

SUMMARY:

This presentation provides an extended example of insights generated through this mixed-methods approach by examining the role that romantic partners play in depression, treatment, and coping with stress. First, we discuss the mixed methods study design that includes multiple waves of qualitative inter-

views and social network interviews with participants of the Partners in Care Quality Improvement intervention. We then illustrate the qualitative analysis process through an exploration of the role that romantic partners play in narratives of recent stressful events, acute episodes of depression, and treatment experiences. We also explore the role of romantic partners in the social networks of the same respondents and compare these findings with qualitative results. Our findings illustrate the important and complicated role that romantic partners play -- both positively and negatively -- in the treatment of depression and on-going coping with stress and symptoms of depression.

NO 4 EXPERIENCES WITH TREATMENTS FOR DEPRESSION: A MIXED-METHODS DESIGN

Speaker: Adriana Izquierdo, M.D.

SUMMARY:

We use a mixed-methods study design to understand better the factors associated with subjects' use of psychiatric medications. Quantitative analysis revealed significantly higher rates of antidepressant use at long-term PIC follow-up among Latinos in the QI-intervention group, relative to non-Latino white and African-American subjects. We then analyzed qualitative data collected at long-term follow-up to generate hypotheses rooted in grounded theory to explain our quantitative findings. Major themes relevant to Latinos' experiences with antidepressants included the impact of family knowledge about depression and its treatments, and the impact of family support, experienced as family members' observations of the medications' benefits on subjects' mood and functioning. Our findings may inform the design of culturally-appropriate mental health interventions for depressed Latinos that leverage existing social networks to reinforce medication adherence and improve depression outcomes.

SYMPOSIUM 90 PSYCHONEUROIMMUNOLOGY: CLINICAL APPLICATION OF AN EMERGING FIELD IN MEDICINE

CHAIR: DANA SHAW, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Become familiar with the emerging paradigm of psychoneuroimmunology; 2) Recognize the role of neurotransmitters, cytokines, and hormones as chemical mediators of one interconnected supersystem; 3) Consider the relevance of biomarkers for neuro, endocrine, and immune function; and 4) Explore the utility of biomarker assessments to guide treatment decisions.

SUMMARY:

Psychoneuroimmunology, the convergence of the fields of psychiatry, neurology, immunology, and endocrinology, is one of the most exciting and rapidly advancing areas of medical science. With the intent to gain a more complete understand-

ing of the complexities of human health and disease by considering classically defined systems as a single, interconnected supersystem, the emerging field is empowering clinicians with an expanded perspective for addressing today's most challenging health concerns, notably within the field of mental health. A particularly intriguing area of this evolving paradigm is a growing body of evidence supporting the use of biomarkers to effectively assess neuro, endocrine, and immune function. These discoveries are setting the stage for a practice model that combines traditional psychiatric evaluations with biomarker assessments that may lead to more effectively targeted treatment strategies. Recent research in the field describes the impact of inflammatory processes on mental health, with a particular focus on inflammation and mood disorders. Psychoneuroimmunology provides a framework for how inflammation and its biochemical mediators impact neurological function. For example, the production of pro-inflammatory cytokines due to infection and other immunological processes influences central and peripheral serotonin synthesis, potentially impacting serotonergic pathways regulating mood, fear response, and sleep quality. Assessing for the presence of inflammation may be an important consideration in the effective management of mood disorders. This symposium will introduce the emerging paradigm of psychoneuroimmunology, exploring its roots and recent discoveries. Participants will identify how the nervous, endocrine, and immune systems are interconnected through their chemical messengers. Evidence exploring the use of neuro, endocrine, and immune biomarkers to manage mental health concerns will be reviewed.

NO 1 HISTORY AND OVERVIEW OF THE NEURO ENDOIMMUNE SUPERSYSTEM

Speaker: Dana Shaw, M.D.

SUMMARY:

The communication between the nervous, endocrine and immune systems has implications for many mental health disease states. The connection between inflammation and psychiatric conditions has become well-established through decades of research. A growing appreciation of the cross-talk between the nervous, immune, and endocrine systems has shown that all systems are dependent upon the function of the other; therefore a thorough assessment of nervous system function should not ignore the possibility of inflammation and endocrine-driven neuropsychiatric symptoms. This presentation will provide an overview of currently recognized connections between immune & endocrine function and mental health.

NO 2 TO TEST OR NOT TO TEST: THE USE OF NEURO, ENDOCRINE, AND IMMUNE BIOMARKERS AND LABORATORY-BASED TESTING IN CLINICAL PSYCHIATRIC PRACTICE

Speaker: David Scheiderer, M.B.A., M.D.

SUMMARY:

The goal of this presentation is to provide health care professionals the necessary tactics to identify and employ currently available tests designed to expand our treatment options with the aim of improving patient care, clinical outcomes, and general health. Describe and discuss the emerging trends in the use of diagnostic laboratory tests with an emphasis on imaging techniques, genetic testing, and examination of body fluid analytes such as serum, plasma, saliva, urine, or cerebrospinal fluid.

NO 3**CASE STUDY PRESENTATION: BIOMARKERS AND INTEGRATIVE INTERVENTIONS FOR ENHANCING NERVOUS, ENDOCRINE, AND IMMUNE HEALTH OUTCOMES**

Speaker: Elizabeth Stuller, M.D.

SUMMARY:

Applying the science behind the nervous, endocrine and immune system communication empowers the clinician not only with additional laboratory assessments, but also a broader selection of therapeutic interventions. Classical interventions such as psychotropic medications are reviewed, along with complementary and alternative therapies such as nutritional supplementation, dietary guidance, and targeted amino acid therapies for enhanced patient outcomes.

SYMPOSIUM 91**GETTING STARTED WITH ELECTRONIC HEALTH RECORDS IN YOUR PRACTICE**

Chair(s): Lori Simon, M.D., Daniel J. Balog, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the functions and components needed for EHRs used by psychiatrists; 2) Have a better awareness of the major issues involved with the use of EHRs; 3) Have a greater understanding of the applicability of the government's Meaningful Use/government incentive program for psychiatry EHRs; 4) Be able to develop a cost/benefit analysis for your practice to determine whether the use of an EHR makes sense; and 5) Identify the steps required to prepare for, select, and implement an EHR in your practice.

SUMMARY:

There is a growing recognition of the importance of using computers within healthcare, particularly with regard to patient care. However, many psychiatrists, especially those in solo or small group practice settings, continue to use computers in a very limited way. This symposium will provide psychiatrists with in-depth information on the functions needed for a psychiatry EHR, as well as how to go about selecting and implementing an EHR for their practice. The material will be related to a case study of a typical private practice to help the audience better understand the material being presented. The main issues involving the use of EHRs, including security, privacy, data sharing, interoperability, and usability will also be

discussed, along with an analysis of the potential costs and benefits for a practice. In addition, detailed information on the government's meaningful use/incentive program as it applies to psychiatry EHRs will be presented.

NO 1**ELECTRONIC HEALTH RECORDS: HISTORY, FUNCTIONS, AND COSTS**

Speaker: Lori Simon, M.D.

SUMMARY:

1) A brief review of the agenda. 2) An overview of the history of automation in healthcare will be given in order to provide a perspective on how the current environment in which EHRs are developed and implemented evolved, including further insight into the problems that currently exist in that environment. 3) An indepth discussion of the functions that typically comprise an EHR for psychiatrists. For each function, it will be indicated in which of the 3 major practice settings, specifically inpatient units, private solo/small group practice, and/or outpatient clinics the function would be most applicable, as well as the degree of importance for that setting. Emphasis will be placed on the private solo/small group practice setting. 4) A detailed discussion will be provided on the costs involved in installing an EHR in the private solo/small group practice setting.

NO 2**MAJOR ISSUES: SECURITY, PRIVACY/AUTHORIZATION, AND DATA SHARING/INTEROPERABILITY**

Speaker: Steven R Daviss, M.D.

SUMMARY:

Security --> It is imperative that patient data remain safe from both destruction and accessibility by those people not authorized to do so. This is of particular importance for psychiatry notes and data stored remotely, as is now commonly done. Privacy/Authorization --> EHRs must provide functionality which allows patients to specifically authorize who can access their data. Given the many types of data and numbers of potential providers, this can be quite a complex and challenging task. 3) Data Sharing/Interoperability --> In order to optimally use patient data, it is important that it be accessible outside of the EHR. One important vehicle for doing so has been the establishment of health information exchanges (HIEs) across the country. How to maximize this effort while ensuring the security and confidentiality of the data is a major challenge.

NO 3**USABILITY AND BENEFITS**

Speaker: Edward Pontius, M.D.

SUMMARY:

1) Usability is key to successful EHR introduction. Design, functionality, performance and reliability can come together to create an EHR that supports clinical work seamlessly with a minimum of attention and concern- good usability- or it

can delay, obstruct, frustrate and endanger the clinical work. We will explore factors that contribute to usability and report the most recent experience of psychiatric colleagues across the country with the usability of their EHR's. 2) Benefits of EHR implementation will be explored. EHR implementation improves the ability of the psychiatrist to collect, organize and appreciate patient data, to learn from patient experience over time, and to bring new evidence-based insights to the benefit of the patient. EHR implementation can also largely free psychiatrists from the role of scribes for patient history, and enable patients to take a more active, collaborative role in their own assessment and treatment.

NO 4 MEANINGFUL USE AND THE MEDICARE/MEDICAID ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAMS

Speaker: Robert M. Plovnick, M.D., M.S.

SUMMARY:

This presentation will include an overview of the federal EHR incentive programs, including to whom the program applies; the mechanism for participation; the associated financial incentives and penalties; and an overview of the "meaningful use" of EHRs that must be demonstrated in order to fulfill the requirements of the program.

NO 5 SELECTING AND IMPLEMENTING AN ELECTRONIC HEALTH RECORDS FOR YOUR PRACTICE

Speaker: Roger Duda, M.D.

SUMMARY:

Selecting an electronic health record can appear to be a challenging task. This presentation will discuss the process a provider should consider in choosing an EHR. Topics to be addressed will be EHR use concerns, process of selecting an EHR, and real world positive and negative experiences. At the end of the presentation, a provider should have an understanding of how to approach the process of selecting an EHR. Implementation of an EHR involves several important tasks, including customization, testing, training, preparation of documentation, inputting of existing patient data into the EHR and converting data that may be stored in an existing computer system. In addition, the successful interoperability of any computer systems that need to interact with the EHR needs to be assured. This topic will address all of these tasks and stress the importance of performing them in a thorough manner.

NO 6 RESOURCES FOR ELECTRONIC HEALTH RECORDS

Speaker: Daniel J. Balog, M.D.

SUMMARY:

1) A comprehensive list of primarily online additional resources

for all of the topics presented in this symposium will be compiled and categorized. The list that is currently in the EHR section of the APA website will be updated with this new material. During the symposium, an overview of the contents of the list will be given and the audience will be referred to the website to access it.

SYMPOSIUM 92 DELUSIONS AND VIOLENCE POST-MACARTHUR VIOLENCE RISK ASSESSMENT STUDY

Chair(s): Jeremy W. Coid, M.B., M.D., Simone Ullrich, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the difference between predictive and causal models in research into violence and psychosis; 2) Identify patients at risk of future violence due their delusions; and 3) Formulate goals of treatment for patients with delusions at risk of future violence.

SUMMARY:

For many psychiatrists, the findings of Appelbaum et al (2000) that delusions do not increase the overall risk of violence in persons with mental illness in the year after discharge from hospitalization were surprising. Several large epidemiological studies have subsequently questioned any direct association between violence and psychosis. This symposium presents new findings from four different datasets whose findings point in the same direction - delusions are strongly associated with violence. However, these studies include people in the community, patients, and prisoners who were acutely psychotic, and untreated for their delusions. These studies therefore do not conflict with the original ground breaking findings of the McArthur Violence Risk Assessment Study but emphasize the importance of identifying delusional beliefs in our patients, recognizing specific affective responses to these beliefs, especially anger, and then targeting interventions on these affective responses if the aim is to prevent future violence.

NO 1 ANGER DUE TO DELUSIONS MEDIATES THE RELATIONSHIP WITH SERIOUS VIOLENCE

Speaker: Jeremy W. Coid, M.B., M.D.

SUMMARY:

Background: Previous research has failed to confirm associations between delusions and violence. Objectives: To investigate whether violence is associated with delusions and affect due to delusions in first episode psychosis. Method: 458 first episode patients in East London, UK, interviewed with the SCAN, MADS, and MacArthur classification violence severity scale. Violent behavior reported by patients when experiencing symptoms. Results: A small number of uncommon delusions showed direct pathways to minor violence. Highly prevalent delusions demonstrated pathways to serious violence but were mediated by anger due to the delusional beliefs. Other affects due to delusions such as fear, anxiety,

and elation showed no associations. Conclusions: Anger due to delusions explains the relationship between violence and acute psychosis among patients in first episodes. Treatment and risk management should focus on reducing the anger due to delusions and not solely on changing delusional beliefs.

**NO 2
DELUSIONS AND VIOLENCE IN THE GENERAL POPULATION: FINDINGS FROM THE 2007 HOUSEHOLD SURVEY OF ADULTS IN ENGLAND**

Speaker: Constantinos Kallis, Ph.D.

SUMMARY:

Background: Psychosis may exist along a spectrum within the general population. Psychotic symptoms may be associated with violence. Objective: To investigate whether certain symptoms are associated with violence. Method: cross-sectional survey 7377 male and female adults 16-75 years in households in England 2007. Self-reported violence and standardized measures of psychiatric morbidity including PSQ. Results: Violence in past 5 years, multiple incidents, and police involvement were associated with psychotic symptoms. Victims were more often family members, or close friends. After stratifying according to mental health treatment/no treatment in past year paranoid delusions showed strong associations with any violence, multiple incidents, victim injury, perpetrator injury, police involvement, but with fewer effects from other symptoms. Conclusions: Paranoid delusions in the general population show strong associations with violence. This effect is absent if treatment has been received.

**NO 3
DELUSIONS, NEGATIVE AFFECT, AND VIOLENCE: NEW FINDINGS FROM THE MACARTHUR VIOLENCE RISK ASSESSMENT STUDY**

Speaker: Simone Ullrich, Ph.D.

SUMMARY:

Background: Pathways from delusions to violence are complex and findings inconsistent. Recent research suggests anger due to delusions is a key factor. Objective: Replication of finding using the MacArthur Violence Risk Assessment Study. Method: Affect related to delusions and serious violent incidents were assessed for two months prior to admission in 328 patients reporting delusions. Results: No significant main effects on violence were found for the 15 delusions and violent outcome. Anger due to delusions, terror, and anxiety were significantly associated with violence but confounded by trait anger. The pattern of association differed between anger, anxiety, and terror. Conclusions: There is an indirect pathway between delusions and violence and anger due to delusions has an important role. Terror and anxiety appear to be relevant moderators with a different pathway. This shows the relevance of close temporal proximity between symptoms and violence when establishing associations.

**NO 4
UNTREATED DELUSIONS AMONG RELEASED PRISONERS WITH SCHIZOPHRENIA AND VIOLENCE**

Speaker: Robert Keers, Ph.D.

SUMMARY:

Background: Psychosis is a risk factor for violence at population level but its role in violence in released prisoners is controversial. Objectives: We look at whether schizophrenia or specific delusions increases risk of violent re-offending and if treatment modifies this. Method: Data was used from a prospective longitudinal study of released prisoners followed up for 5 years in the community; 1,279 no psychosis and 215 with schizophrenia. Results: Untreated diagnosis of schizophrenia during imprisonment was associated with violent offences. Those treated both in prison and after were at a significantly reduced risk of violence compared to non-psychotics. Symptoms in prison and after showed untreated individuals with psychosis were more likely to experience persecutory delusions associated with violent re-offending on release. Conclusions: Psychiatric treatment in prison and following release were associated with reduced rates of violent recidivism in prisoners with psychosis.

**SYMPOSIUM 93
HUMAN SEX TRAFFICKING: THE REALITIES AND CHALLENGES OF THIS NATIONAL AND INTERNATIONAL TRAGEDY**

Discussant: Silvia W. Olarte, M.D.

Chair: Stacy Drury, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the international incidence and etiology of human sex trafficking; 2) Understand the neurobiological and psychological factors that create challenges facing those that have been trafficked as they struggle to recover from their traumatic experiences; 3) Improve the ability of individuals to recognize, provide mental health treatment, and access legal resources for women and children who are survivors of international and domestic human trafficking; and 4) Increase awareness about the multi-faceted tragedy of human trafficking and the fact that it is the fastest growing crime against humanity across the globe;

SUMMARY:

Today human trafficking of women, children and men is one of the fastest growing crimes against humanity across the globe. In the United States the average age of entry into sex trafficking is 9 and it is estimated that over 100,000 children age 9-19 are current victims of sex trafficking annually in the United States. However this is not a problem limited to the United States and the international statistics are even more frightening. The "high profit" margin associated with selling children and women for sex across the globe, the limited legal resources and punishments for those that do traffic children, and the subversive and traumatic nature of this process repre-

sent huge barriers to eliminating this horrific process. Individuals sold into human trafficking are subjected to repeated physical violations, abuse, forced substance use, starvation, psychological trauma, and exposure to sexually transmitted diseases- which often kill them. High rates of psychiatric disorders and unprecedented rates of suicide are found in victims of human trafficking. Perhaps most disturbing is that about half of these children are sold into slavery from someone they know. This symposium brings to light the current facts surrounding human sex trafficking across the globe. Presentations will begin with an overview of current estimates and etiology of global sex trafficking and the historical foundation from which sex trafficking developed. Next an introduction into the neurobiology and psychological factors associated with early trauma and disrupted attachment relationships and how these contribute to the challenges facing these children once brought into the sex trade, and why it is often so challenging to get them to leave. Next Kara Van De Caar will discuss the legal issues, both nationally and internationally, facing those working with human trafficking survivors and current efforts to alter the criminal system to more effectively fight this growing tragedy. Dr. Patricia Ordorica will discuss the growing evidence based research directed at treating the mental health conditions associated with human sex trafficking. Lastly, internationally known human rights advocate, Dr. Sunitha Krishnan (participation to be confirmed) will present her experiences with saving children from sex trafficking internationally through her organization Prajwala. (In the event Dr. Krishnan is unable to attend, portions of her acclaimed TED talk will be shown and Dr. Leah Dickstein will present about recognizing early trauma in all patients.) A discussion will follow with all participants as well as Dr. Leah Dickstein and Dr. Silvia Olarte.

**NO 1
ACROSS ALL BORDERS: A LEGAL PERSPECTIVE
ON HUMAN TRAFFICKING**

Speaker: Kara Van de Carr, J.D.

SUMMARY:

Ms. Van de Carr, J.D. attorney and founder of Eden House a safe house for women survivors of human trafficking and a former diplomat to Jamaica where she was confronted with the victims of international sex trafficking for the first time will present an overview of the US government response to the problem of international human trafficking as well as the trafficking of minors for purposes of sexual exploitation. As the largest demand country in the world for human trafficking services, the United States has a huge number of human trafficking victims within its borders. Ms. Van De Carr will also discuss how the law defines human trafficking, how to recognize victims, (particularly domestic victims who are often difficult to identify), as well as services available in the United States to international and domestic survivors of the sex trade.

**NO 2
FROM VICTIM TO SURVIVOR: RECOVERY FROM
HUMAN SEX TRAFFICKING: EVIDENCE-BASED,
TRAUMA-INFORMED APPROACHES**

Speaker: Patricia I. Ordorica, M.D.

SUMMARY:

There is growing evidence-based research emerging for treating mental health conditions experienced by victims of human sex trafficking, an alarming world-wide epidemic. Victims of human sex trafficking are commonly found to suffer from Post-Traumatic Stress Disorder, Substance Use Disorders, and Anxiety and Mood Disorders, including Major Depressive Disorder, Panic Disorder, Obsessive Compulsive Disorder, Generalized Anxiety Disorder, and Dissociative Disorders. Trauma-informed services will be highlighted as an essential component of a victim's recovery.

NO 3

**SEEING PAST THEIR COVER: LOOKING FOR
SURVIVORS OF EARLY ABUSE IN OUR PA-
TIENTS AND UNDERSTANDING ITS IMPACT ON
TREATMENT**

Speaker: Leah J. Dickstein, M.A., M.D.

SUMMARY:

Dr. Leah Dickstein will discuss the need to explore early trauma in patients across all age ranges. Recognizing that many individuals currently suffering with mental illness have a history of early life trauma that they often do not disclose it is important to explore this in each patient. Given the known treatment implications for those exposed to early life trauma, particularly sexual and physical abuse, it is critical to address this issue in our patients as we decide the best treatment plan

SYMPOSIUM 94

**CANNABIS-USE AND YOUTH: UPDATES ON
RISK, ASSESSMENT, AND TREATMENT**

Discussant: Paula D. Riggs, M.D.

Chair(s): Geetha Subramaniam, M.D., Kevin M. Gray, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the neurocognitive effects of Cannabis use on youth; 2) Identify and provide brief interventions for Cannabis misusing youth; 3) Demonstrate knowledge of evidence-based psychosocial treatments for their cannabis abusing youth patients; and 4) Demonstrate knowledge of and incorporate evidence-based pharmacological treatments for their cannabis abusing youth patients.

SUMMARY:

According to 2011 findings from the Monitoring the Future Survey, marijuana use has continued to rise among teens for the past four years, with approximately 30% of 8th, 10th and 12th graders combined reporting past year use in 2011. Data from the latest Treatment Episode Data Set (TEDS, 2009) indicates that marijuana is the primary substance of abuse (72%) among youth ages 15 to 17 admitted to publicly-funded substance use disorder (SUD) treatment programs. It is therefore essential that healthcare professionals, especially

mental health experts, become familiar with recent updates on the research on a) the effect of cannabis use on the developing adolescent brain and b) how to identify youth that have developed problem use; and gain expertise in providing brief or specialized treatments which could be integrated into psychiatric practices. In this symposium, the speakers will cover the continuum of translational research ranging from clinical neuroscience to assessment and treatments, to provide the audience a succinct, yet comprehensive overview of recent research findings and their implications for adoption into clinical practice. Dr. Krista Listahl will review the literature and recent findings on the impact on chronic cannabis use on the developing adolescent brain and resultant consequences in young adulthood. Dr. John Knight will review guidelines for screening and brief intervention (SBI) in pediatric office setting in addition to presenting results from a recently completed SBI trial that recruited cannabis and alcohol misusing teens in the US and Czech Republic. Dr. Kevin Gray will review the scientific literature on pharmacological treatments for cannabis dependence including the recently published double-blind placebo controlled study using N-Acetyl-cysteine in youth and discuss potential applications for youth. Dr. Emily Tanner-Smith will provide an overview of available evidence-based treatments for youth with substance abuse (predominantly cannabis abuse) and review the results of a recently published meta-analysis of controlled treatment trials for youth with SUD. Dr. Paula Riggs will serve as a discussant and discuss strategies to incorporate these research findings into psychiatric clinical practices. Geetha Subramaniam will serve as a moderator for a Question and Answer Session.

NO 1 EFFECTIVENESS OF OUTPATIENT TREATMENT FOR ADOLESCENT SUBSTANCE ABUSE

Speaker: Emily Tanner-Smith, Ph.D.

SUMMARY:

THIS PRESENTATION WILL PROVIDE AN OVERVIEW OF EVIDENCE-BASED OUTPATIENT TREATMENTS FOR YOUTH WITH SUBSTANCE USE DISORDERS, PARTICULARLY TREATMENTS AVAILABLE FOR YOUTH WITH CANNABIS USE DISORDERS. THE PRESENTATION WILL FOCUS ON FINDINGS FROM A RECENTLY PUBLISHED META-ANALYSIS OF 45 CONTROLLED STUDIES, WHICH INDICATED THAT FAMILY THERAPY PROGRAMS WERE MORE EFFECTIVE THAN THEIR COMPARISON CONDITIONS. AN ANALYSIS OF 311 PRE-POST EFFECT SIZES MEASURING CHANGES IN SUBSTANCE USE ALSO INDICATED THAT THE GREATEST IMPROVEMENTS WERE SHOWN IN FAMILY THERAPY AND MIXED GROUP COUNSELING PROGRAMS. ADDITIONAL FINDINGS WILL BE DISCUSSED FOR ANALYSES RESTRICTED TO CANNABIS USE OUTCOMES, AND RESTRICTED TO YOUTH SELECTED FOR TREATMENT DUE TO THEIR CANNABIS ABUSE. THE PRESENTATION WILL CONCLUDE WITH SUMMARY STATEMENTS ABOUT THE CURRENT EVIDENCE BASE FOR OUTPATIENT SUBSTANCE ABUSE TREATMENT FOR YOUTH WITH SUBSTANCE USE DISORDERS, AND MORE SPECIFICALLY

FOR YOUTH WITH CANNABIS USE DISORDERS.

NO 2 NEUROCOGNITIVE EFFECTS OF CANNABIS USE ON YOUTH

Speaker: Krista Listahl, Ph.D.

SUMMARY:

CANNABIS IS THE MOST COMMONLY USED ILLICIT DRUG, WITH 42% OF 12TH GRADERS USING MJ IN THEIR LIFETIME. ADOLESCENCE IS A DYNAMIC TIME THAT INVOLVES SIGNIFICANT NEURODEVELOPMENTAL CHANGES IN BOTH GRAY AND WHITE MATTER. THEREFORE, DRUG EXPOSURE DURING THESE YEARS IS OF PARTICULAR CONCERN. IN THIS PRESENTATION, WE PROVIDE AN OVERVIEW OF THE NEUROCOGNITIVE CHANGES ASSOCIATED WITH CANNABIS USE IN TEENS AND EMERGING ADULTS. THUS FAR, STUDIES CONDUCTED IN ADOLESCENTS WITH MINIMAL PSYCHIATRIC COMORBIDITIES HAVE SUGGESTED SUBTLE COGNITIVE DEFICITS ASSOCIATED WITH ADOLESCENT CANNABIS USE, INCLUDING PROCESSING SPEED, ATTENTION, MEMORY, AND EXECUTIVE FUNCTIONING. NEUROIMAGING STUDIES HAVE REVEALED ABNORMAL PREFRONTAL CORTEX (PFC), HIPPOCAMPAL, AMYGDALA, AND CEREBELLAR VOLUMES IN CANNABIS-USING TEEN. ABNORMAL BRAIN FUNCTION AND WHITE MATTER INTEGRITY HAVE ALSO BEEN REPORTED IN CANNABIS-USING YOUTH. POTENTIAL CLINICAL AND PUBLIC HEALTH IMPLICATIONS WILL BE DISCUSSED IN LIGHT OF THESE FINDINGS.

NO 3 PHARMACOLOGICAL TREATMENTS FOR CANNABIS USE DISORDERS: APPLICATIONS FOR YOUTH

Speaker: Kevin M. Gray, M.D.

SUMMARY:

While significant advances have been made in psychosocial treatment research on cannabis use disorders, effect sizes are small to modest, and the majority of patients fail to achieve sustained periods of abstinence. A potential avenue to enhance outcomes is the development of pharmacological interventions to complement psychosocial treatments. This strategy has yielded success in other areas of addiction treatment (e.g., naltrexone in alcohol dependence, buprenorphine in opioid dependence, etc.), but research targeting cannabis dependence is very limited. Most of this work has focused on adult cannabis users, yielding mixed results. A recent encouraging study demonstrated superior abstinence outcomes with N-acetylcysteine, compared to placebo, when added to psychosocial treatment in cannabis dependent adolescents. This presentation will include an overview of pharmacotherapy studies and provide guidance on incorporating findings into clinical practice with adolescent patients.

NO 4**SCREENING, ASSESSMENT, AND BRIEF INTERVENTION FOR CANNABIS MISUSE IN PEDIATRIC OFFICE SETTINGS***Speaker: John R. Knight, M.D.***SUMMARY:**

MEDICAL PROFESSIONAL ORGANIZATIONS RECOMMEND THAT PEDIATRICIANS SCREEN ALL ADOLESCENT PATIENTS FOR SUBSTANCE USE YEARLY AS PART OF ROUTINE CARE, BUT LESS THAN HALF OF PEDIATRICIANS REPORT DOING SO. REASONS INCLUDE LACK OF: TIME, TRAINING IN MANAGING POSITIVE SCREENS, AND TREATMENT RESOURCES. INVESTIGATORS AT BOSTON CHILDREN'S HOSPITAL DEVELOPED A COMPUTER PROGRAM DESIGNED TO OVERCOME THESE BARRIERS, INCREASE THE RATE OF PHYSICIAN COUNSELING, AND THEREBY TO LOWER CANNABIS USAGE IN THE MONTHS FOLLOWING THE VISIT. ADOLESCENTS SELF-ADMINISTER THE SCREEN BEFORE THE MEDICAL VISIT; THE COMPUTER GIVES THEM INSTANT FEEDBACK AND INFORMATION ABOUT THE NEGATIVE HEALTH EFFECTS OF SUBSTANCE ABUSE AND SENDS A REPORT TO THE DOCTOR WITH THE RESULTS OF THE SCREEN, LEVEL OF RISK, AND SUGGESTED TALKING POINTS FOR A 2-3 MINUTE DISCUSSION. THIS SYSTEM HAD PROMISING EFFECTS ON REDUCING CANNABIS USE IN A NEW ENGLAND POPULATION OF ADOLESCENTS AND LARGE, SIGNIFICANT EFFECTS ON CANNABIS USE IN THE CZECH REPUBLIC

SYMPOSIUM 95**DIVERGENT INTERNATIONAL GUIDELINES FOR THE PHARMACOLOGIC TREATMENT OF BORDERLINE PERSONALITY DISORDER***Discussant: John M. Oldham, M.D.***CHAIR(S): THEO INGENHOVEN, M.D., PH.D., KENNETH R. SILK, M.D.****EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Appreciate that varying points of agreement and disagreement in recommended pharmacologic treatment and indications for that treatment for borderline personality disorder across different countries; 2) Understand that there has been in general a shift from the use of antidepressants to atypical antipsychotics and mood stabilizers; and 3) Appreciate that we have better evidence for psychological treatment than for pharmacologic treatment for patients with borderline personality disorder.

SUMMARY:

In the last decade, several Guidelines were published on diagnosis and treatment of patients with personality disorders. First, the APA Practice Guideline on the Treatment of Borderline Personality Disorder was published in 2001 (and sealed up in 2005). More recently, three West European countries

independently developed an own treatment guideline for personality disorders, published in the Netherlands (2008), Germany (2009) and Great Britain (2009). Moreover, efforts to make new guidelines for Australia will be finished soon (2012/2013). Psychiatric management whenever necessary, and extended psychotherapy whenever possible, reflect the major recommendations of these subsequent guidelines. Pharmacologic treatment is not the treatment of first choice in (borderline) personality disorder, unless pharmacotherapy can focus on a clear comorbid Axis I disorder. However, in clinical practice, patients with (borderline) personality disorder often use medication and poly pharmacy seems more the rule than the exception. Although results of the growing number of placebo-controlled clinical trials and meta-analyses converge with respect to specific symptomatic outcome domains, the international clinical guidelines clearly diverge in their algorithms and practical recommendations. In this series of presentations personality disorders will be presented from this specific perspective, each of them covering an American, West European or Australian guideline. International consensus can help to gap these different perspectives from over the world.

NO 1**GROWING OLD TOGETHER? DRUG ALGORITHMS IN THE APA PRACTICE GUIDELINES ON THE TREATMENT OF BORDERLINE PERSONALITY DISORDER: 2001 AND BEYOND***Speaker: Kenneth R. Silk, M.D.***SUMMARY:**

The 2001 APA Guidelines for the Treatment of Patients with Borderline Personality Disorder revealed greater evidence for psychotherapeutic than for psychopharmacologic treatment. It emphasized treatment with SSRIs for 2 of the 3 "subtypes" of BPD. Since 2001, Cochrane reviews, meta-analyses, and other systematic reviews emphasize mood stabilizers and atypical antipsychotics as the pharmacologic classes with the most support for effectiveness in BPD. SSRIs appear effective primarily for BPD patients in a co-morbid major depressive episode but show little effectiveness for chronic depression, dysthymia or impulsivity. There is a need for multi-center systematic studies with larger N's before explicit pharmacologic recommendations can be strongly supported. Not only do we need to update the APA Guidelines, but if the proposed DSM 5 changes in personality disorder diagnoses become realized, this need to restudy and reformulate the pharmacologic guidelines will become even stronger.

NO 2**DEUTSCHE GRÜNDLICHKEIT? THE GERMAN GUIDELINES AND COCHRANE META-ANALYSES***Speaker: Klaus Lieb, M.D.***SUMMARY:**

We recently published a Cochrane Collaboration systematic review and meta-analysis of pharmacotherapy for Borderline Personality Disorder (BPD) in which we included 28 primary randomized controlled studies testing antipsychotics, mood

stabilisers, antidepressants and omega-3 fatty acids. The findings and an update in 2012 indicate promising results for an amelioration of both BPD core symptoms (anger, impulsivity) and associated general pathology, but not overall severity by lamotrigine, topiramate, valproic acid and aripiprazol, whereas no evidence was found for an efficacy of SSRIs. The findings underline a syndrome-target treatment approach as suggested by the guideline of the German Association for Psychiatry and Psychotherapy. Further research is needed to replicate study results and to conduct studies that are more close to clinical practice, e.g. investigating treatment effects in the presence of distinct comorbidities.

NO 3 TILT AT DUTCH WINDMILLS? DUTCH ALGORITHMS AND SYMPTOM DOMAIN-SPECIFIC META-ANALYSES

Speaker: Theo Ingenhoven, M.D., Ph.D.

SUMMARY:

In order to develop Multi-disciplinary Guidelines for the Treatment of Personality Disorders in the Netherlands, we conducted a systematic review of studies using antipsychotics, antidepressants and mood stabilizers in patients with severe personality disorders. Symptom specific pharmacological treatment algorithms for borderline and/or schizotypal personality disorder were redefined for cognitive perceptual symptoms, impulsive behavioral discontrol and affective dysregulation (subdomains: anxiety, depressed mood, anger, mood lability). Recently, we validated our algorithms by conducting a series of meta-analyses on placebo controlled randomized clinical trials. Our results validate the Dutch guideline, and seriously questions the APA Practice Guideline for the Treatment of Patients with Borderline Personality Disorder. Recent research findings and clinical implications will be discussed.

NO 4 THE RATIONALE FOR THE NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE (NICE) GUIDELINE FOR THE TREATMENT OF BORDERLINE PERSONALITY DISORDER

Speaker: Peter Tyrer, M.D.

SUMMARY:

The principal recommendation of the NICE guideline for the pharmacologic treatment of borderline personality with regard is unequivocal: 'drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder (for example, repeated self-harm, marked emotional instability, risk-taking behaviour and transient psychotic symptoms)'. This is further developed by additional clinical recommendations: (a) antipsychotic drugs should not be used for the medium- and long-term treatment of borderline personality disorder, (b) drug treatment may be considered in the overall treatment of comorbid conditions, and (c) short-term use of sedative medication may be considered cautiously as part of the overall treatment plan for people with borderline personality disorder in a crisis. The reasons for this decision are the poor quality of

most drugs trials, their tiny numbers, and influence of pharmaceutical companies.

NO 5 AUSTRALIAN CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF BORDERLINE PERSONALITY DISORDER

Speaker: Andrew M. Chanen, M.B.B.S., Ph.D.

SUMMARY:

In January 2011 the Australian National Health and Medical Research Council commissioned the production of an Australian clinical practice guideline for the management of borderline personality disorder. This was developed using the novel ADAPTE methodology. Rather than developing a guideline de novo, relevant clinical questions were adapted from NICE guideline 78: Borderline personality disorder: treatment and management. Despite using similar methodologies, the recommendations in these two guidelines have clinically important differences, especially for the use of pharmacotherapy in BPD. The Australian guideline is due for final approval and publication in early 2013.

SYMPOSIUM 96 THE REVISED ADJUSTMENT DISORDER DIAGNOSIS FOR DSM-5 AND ICD-11: ADDITIONS, DELETIONS, COMPARISONS

Chair(s): James J. Strain, M.D., Andreas Maercker, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the comparison of the new DSM-5 and the ICD-11 changes to the diagnosis of Adjustment Disorder. Rationale for the changes made and explanations for the differences between DSM-5 and ICD-11; 2) Explain and justify the elimination of the bereavement disclaimer as a criteria for the diagnosis of Adjustment Disorder; 3) Explain and justify the addition of the new sub-type: Adjustment Disorder with Acute Stress Disorder/Post Traumatic Stress Disorder sub-type; 4) Explain and justify the addition of the new sub-type: Adjustment Disorder with Prolonged Bereavement sub-type; and 5) Understand the evidence for Adjustment Disorders qualifying for a regular diagnostic category rather than a sub-threshold status;

SUMMARY:

The Adjustment Disorders (AD) are one of the most frequently used diagnosis in the psychiatric taxonomy. It is the most frequently diagnosed mental disorder in the military. The AD will be under a stress related genre which will include: PTSD, ASD, AD and Dissociation Disorder. Until now AD has been regarded as a sub-threshold diagnosis, with very subjective and limited criteria on which to make the diagnosis. By and large, the diagnosis has problems with both reliability and validity. In addition to the requirement for a reaction beyond that expected from the stressor, the subject should display:

1) alteration in functioning, e.g., work, school, relationships and/or 2) significant distress. The ICD-11 requires both, while DSM-5 requires only one. Is there evidence to justify this difference. These criteria are very subjective making research on this common diagnosis difficult because of the lack of a more objective check list..ICD-11 may add more of the stress related symptoms, e.g., avoidance, intrusion (preoccupation), failure to recover. What is the evidence for this? Data do show that for the major depressive disorders (MDD), patients with bereavement have similar symptoms to those with MDD and therefore that work group recommended that the disclaimer for bereavement be eliminated. This is one of the reasons for eliminating the disclaimer for bereavement in the criteria for AD. If the bereavement disclaimer was eliminated it would be possible to register those patients with bereavement requiring treatment to be registered under their own sub-type and study how their bereavement progressed or resolved. (This subtype required the stressor bereavement be at least 12 months in contrast to the three months of the other subtypes. This would avoid “medicalizing” normal grief. Furthermore, treatment for bereavement could be employed with this AD sub group to understand if it was effective for them. In addition, it could be observed how many of this cohort would go on to have chronic grief and or prolonged bereavement. To further the attempt to study the AD it was proposed that a sub-type for Acute Stress Disorder (ASD)/Post Traumatic Stress Disorder (PTSD) be included. Since this would include those patients that did not have all the criteria for ASD or PTSD and who had experienced a non-traumatic or traumatic stressor, their diagnostic trajectory could be studied to see if they progressed on to the full blown diagnoses. In addition, it could be ascertained if the specific treatments for ASD and PTSD might be effective for this AD sub group. Finally, it has been proposed that sufficient data exist to justify that the AD should be removed from the sub-threshold status to a full fledged psychiatric diagnosis. The data supporting this claim will be presented and discussed.

NO 1 THE REVISED ADJUSTMENT DISORDER DIAGNOSIS FOR THE DSM-5 AND ICD-11: ADDITIONS, DELETIONS, COMPARISONS

Speaker: James J. Strain, M.D.

SUMMARY:

The Adjustment Disorders (AD) are one of the most frequently used diagnosis in the psychiatric taxonomy. It is the most frequently diagnosed mental disorder in the military. The AD will be under a stress related genre which will include: PTSD, ASD, AD and Dissociation Disorder. Until now AD has been regarded as a sub-threshold diagnosis, with very subjective and limited criteria on which to make the diagnosis. By and large, the diagnosis has problems with both reliability and validity. In addition to the requirement for a reaction beyond that expected from the stressor, the subject should display: 1) alteration in functioning, e.g., work, school, relationships and/or 2) significant distress. The ICD-11 requires both, while DSM-5 requires only one. Is there evidence to justify this difference. These criteria are very subjective making research

on this common diagnosis difficult because of the lack of a more objective check list..ICD-11 may add more of the stress related symptoms, e.

NO 2 ADJUSTMENT DISORDER: CHANGES FOR ICD-11

Speaker: Andreas Maercker, M.D., Ph.D.

SUMMARY:

The changes for ICD-11 will be presented along with a rationale for the decisions behind these changes. Since the Adjustment Disorders are a stress related disorder, common reactions to stress as well as new research findings were instrumental to the development of changes suggested for the ICD-11 volume. Furthermore, comparisons with DSM-5 will be made as attempts were made to harmonize the two taxonomies.

NO 3 PROPOSED ADJUSTMENT DISORDER SUBTYPE ACUTE STRESS DISORDER/POSTTRAUMATIC STRESS DISORDER

Speaker: Matthew J. Friedman, M.D., Ph.D.

SUMMARY:

Acute Stress Disorder(ASD)/Post Traumatic Stress Disorder (PTSD) Adjustment Disorder Sub type is designed to capture that segment of the Adjustment Disorders that have ASD or PTSD features but miss one of more of the required symptoms for the full diagnosis. Inclusion of this sub-type is based on substantial research showing that individuals with sub-syndromal PTSD exhibit significantly more clinical distress and functional impairment than non-affected individuals, but significantly less than those with full PTSD. This will also promote research to determine whether current treatments for ASD and PTSD are effective for sub-syndromal patients. Also the neurobiology of the subtype can be compared with that of full ASD or PTSD. Finally, it can be studied if sub-typed individuals develop full PTSD/ASD, remain static as a subtype, or resolve in time and/or with treatment. It provides an opportunity to study in greater depth a subset of the Adjustment Disorders heretofore not possible.

NO 4 COMMENTS ON THE PROPOSED SUBTYPE OF ADJUSTMENT DISORDER FOR PROLONGED OR COMPLICATED BEREAVEMENT

Speaker: M. Katherine Shear, M.D.

SUMMARY:

I would discuss removal of the bereavement exclusion, rather than inclusion of the CG category in the adjustment disorder section. This is a very interesting idea - probably better place for people struggling with grief but not yet diagnosable with chronic grief , rather than the V-code. This would be a similar strategy and similar to the ASD/PTSD sub-type that the DSM-5 work group has proposed. We definitely need

a place for bereavement care earlier than 12 months. Just today I saw a woman whose son - her favorite child - died in a tragic accident a month ago. She is someone who has some long-standing issues and is, in my opinion, at risk for developing complicated grief. Should I turn her away because there are people wrestling idea - probably better place for people struggling with grief but not yet diagnosable with chronic grief, rather than the V-code. This would be a similar strategy and similar to the ASD/PTSD sub-type that the DSM-5 work group has proposed.

NO 5 ADJUSTMENT DISORDER: THE CASE FOR FULL SYNDROMAL STATUS IN DSM-5

Speaker: Patricia Casey, M.D.

SUMMARY:

This talk will present data from a longitudinal study carried out in liaison psychiatry on a sample of over 300 subjects. The diagnosis was based on the SCAN interview and also made independently using DSM-IV. Analysis of data was carried out using both methods of diagnosis. The results indicate that adjustment disorder and major depression show no differences in the severity of social functioning and suicidal ideation. Additionally the severity of depressive symptom reaches "case-ness" level in both conditions. There were some differences with regard to specific biological symptoms. The impact of adjustment disorder on social functioning and symptoms is such that adjustment disorder should no longer be regarded as a subsyndrome and should be accorded full syndromal status. This will facilitate further study of adjustment disorder.

SYMPOSIUM 97 EATING DISORDERS: SOUP TO NUTS

Chair: Ken Weiner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the latest understanding of the roles of temperament, genetics, family and environment on the development, maintenance and treatment of eating disorders; 2) Identify the medical problems associated with severe restricting and purging, and their treatment; 3) Review the current evidence base and rationale for psychopharmacologic treatment of eating disorders; and 4) Understand how Acceptance and Commitment Therapy and Cognitive Remediation Therapy are being used to effectively treat eating disorders.

SUMMARY:

The presentation "eating disorders: soup to nuts" will include an overview of four important topics in the treatment of eating disorders, including: new understandings and recent updates in the treatment of eating disorders; medical complications of severe restricting and purging; the art and science of psychopharmacology for eating disorders and co-morbid conditions; and acceptance and commitment therapy and cognitive remediation therapy in the treatment of eating disorders. Dr. Ken Weiner will talk about the most recent understandings

about effects of temperament, genetics, family and environment on the development and maintenance of eating disorders. Dr. Celeste Wiser will thoroughly review the medical complications of eating disorders including the most common medical problems related to anorexia nervosa and starvation, as compared to complications associated with purging frequency and mode in bulimia nervosa. Dr. Anna Vinter will review the evidence base for effective medication to treat eating disorders and talk about strategies for treating the illness and their frequently co-morbid conditions. Dr. Emmett Bishop will discuss how two newer therapeutic techniques effectively address specific components of eating disorders. Acceptance and commitment therapy targets major maintaining factors of eating disorders and moves the focus of treatment away from changing cognitions and onto how to live a valued life, and cognitive remediation therapy addresses, among other things, the inflexibility in thinking that is a manifestation of the psychology of eating disordered patients.

NO 1 NEW UNDERSTANDINGS AND RECENT UP- DATES IN EATING DISORDERS

Speaker: Ken Weiner, M.D.

SUMMARY:

Paradigms have shifted substantially within the subspecialty of eating disorders and clinicians must review recent research and receive continuing education to stay current on new progress in the field and to provide the best care for patients. Dr. Ken Weiner will talk about the most recent understandings and developments about effects of temperament, genetics, family and environment on the development and maintenance of eating disorders. He will review the recent research in the field and discuss implications, as well as provide insight based on his more than 25 years in the treatment of eating disorders. Dr. Ken Weiner is the co-founder of Eating Recovery Center in Denver, Colorado; is recognized as a national expert in treating eating disorders; and lectures extensively in the United States.

NO 2 MEDICAL COMPLICATIONS OF SEVERE RE- STRICTING AND PURGING

Speaker: Celeste Wiser, M.D., M.S.

SUMMARY:

Most medical problems in Anorexia Nervosa are related to starvation, while in Bulimia Nervosa medical complications are related to purging frequency and mode. Medical instability can be critical in both the starving and refeeding states, and a protocol is recommended for monitoring and treating these severe cases. Dr. Celeste Wiser will thoroughly review the medical complications of eating disorders and provide practical resources for responding to the most common indicators seen in this patient population. Dr. Celeste Wiser is the Medical Director of Summit Eating Disorders and Outreach Program in Sacramento, California, specializing in the treatment of children, adolescents and adults with eating disorders and co-morbid psychiatric and medical disorders.

NO 3 THE ART AND SCIENCE OF PSYCHOPHARMACOLOGY FOR EATING DISORDERS AND COMORBID CONDITIONS

Speaker: Anna Vinter, M.D.

SUMMARY:

The search for effective medication to treat Anorexia Nervosa has been disappointingly elusive. There is slightly more evidence to guide treatment of Bulimia Nervosa and Binge-Eating Disorder, but treatment still requires as much art as science. Dr. Anna Vinter will review the evidence base and talk about strategies for treating eating disorders and their frequently co-morbid conditions. Medications discussed will include antidepressants, mood stabilizers and antipsychotics, and treatment recommendations will be presented for Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorder. Dr. Anna Vinter is an Attending Psychiatrist for Summit Eating Disorders and Outreach Program in Sacramento, California, specializing in working with patients in the Partial Hospitalization and Intensive Outpatient Programs.

NO 4 BEYOND CBT: ACCEPTANCE AND COMMITMENT THERAPY AND COGNITIVE REMEDIATION THERAPY FOR THE TREATMENT OF EATING DISORDERS

Speaker: Emmett Bishop Jr., M.D.

SUMMARY:

Dr. Emmett Bishop will discuss how two newer therapeutic techniques effectively address specific components of eating disorders. Acceptance and Commitment Therapy targets major maintaining factors of eating disorders and moves the focus of treatment away from changing cognitions and onto how to live a valued life. Cognitive Remediation Therapy addresses, among other things, the inflexibility in thinking that is a manifestation of the psychobiology of eating disordered patients. These therapeutic techniques have proven to be effective in working with this complex patient population, and can especially be effective in working with patients where traditional therapeutic techniques have failed. Dr. Emmett Bishop has more than 30 years experience treating eating disorders and is the co-founder of Eating Recovery Center in Denver, Colorado.

SYMPOSIUM 98 ADVANCES IN AUTISM SPECTRUM DISORDER RESEARCH

Chair(s): Joseph Biederman, M.D., Gagan Joshi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the utility of a unique profile on the Child Behavior Checklist for screening for autism spectrum disorders.;2) Identify the comorbidity of bipolar disorder and

autism spectrum disorder in youth, and understand the very severe psychopathologic state that it represents.;3) Gain knowledge about the preliminary results of pilot simulation studies of autism spectrum disorders in driving and work behavior.;

SUMMARY:

This symposium will present new data on research in autism spectrum disorders (ASDs). Dr. Biederman's study evaluated the properties of a profile of the Child Behavior Checklist (CBCL) in discriminating children with ASD (N=65) from psychiatrically referred youth (N=83) (IQ>70). Stepwise logistic regression was used to identify those scales that best predicted ASD when compared with the non-ASD comparison group. Receiver operating characteristic curves examined the ability of the significant predictor T-scores to identify ASD subjects versus non-ASD subjects. Withdrawn Behavior, Social Problems, and Thought Problems T-scores were the best independent predictors of ASD status (area under the curve 0.86). Dr Joshi's study evaluated the concurrent and discriminant validity of a DSM-based structured diagnostic interview for the assessment of ASDs in clinically referred populations. Concurrent validity was examined through the agreement of the structured interview with the clinician diagnosis of ASD and with the Social Responsiveness Scale (SRS) in a clinically referred population (N=123). Discriminant validity was examined by addressing the specificity of the structured diagnostic interview in a large sample of psychiatry clinic referred youth with ADHD (N=1563). 94% of the clinician diagnosed subjects with ASD had a positive diagnosis of ASD on the structured interview, 97% of the clinician and structured interview diagnosed ASD subjects screened positive for ASD on the SRS and 96% of the clinician diagnosed and SRS screened positive ASD subjects also had a positive diagnosis of ASD on the structured interview. 11% of the ADHD subjects (172/1563) had a positive diagnosis of ASD on the structured interview leading to a conservative estimate of 89% specificity. Results suggest high sensitivity and specificity of the DSM-based structured diagnostic interview for assessing ASD in referred populations. Dr Wozniak examined the clinical and familial correlates of bipolar (BP)-I disorder when it occurs with ASD comorbidity. Using data from a large family study of youth with BP- I disorder (BP-I; probands N=157; relatives N=487), youth with ADHD without BP-I (probands N=162; relatives N=511) and age and sex matched controls without BP-I or ADHD (probands N=136; relatives N=411). 30% of the BP-I probands met criteria for ASD. The phenotypic and familial correlates of BP-I were similar in youth with and without ASD comorbidity. Dr. Fried will present data from two laboratory simulation paradigm studies that examined work and driving performances in individuals with ASD. Significant differences were found in the performance of adults with ASD when compared to group matched controls. For work, this included difficulty completing unstructured tasks and limited insight into actual work performance. For driving, individuals with ASD had higher levels of physiologically measured anxiety and atypical gaze patterns during aspects of the simulation.

NO 1**A UNIQUE PROFILE OF THE CHILD BEHAVIOR CHECKLIST CLINICAL SCALES HELPS IDENTIFY AUTISM SPECTRUM DISORDER IN CLINICALLY REFERRED YOUTH**

Speaker: Joseph Biederman, M.D.

SUMMARY:

Objective: To evaluate a unique profile of the CBCL to identify children with autism spectrum disorders (ASD). Methods: Scales of the CBCL were compared between children (IQ>70) with ASD (N=65) and without ASD (N=83). Step-wise logistic regression identified those scales most predictive of ASD. AUC was used to examine the ability of the significant predictor T-scores to identify ASD subjects versus non-ASD subjects. Results: Withdrawn Behavior, Social Problems, and Thought Problems T-scores were the best independent predictors of ASD status. The Withdrawn+Social Problems+Thought Problems T-scores yielded an AUC of 0.86, indicating an 86% chance that a randomly selected sample of ASD subjects will have abnormal scores on these scales than a randomly selected sample of non-ASD subjects. Conclusions: These findings suggest that a new CBCL-ASD profile could serve as a rapid and cost-effective screening of ASD.

NO 2**A DSM-BASED STRUCTURED DIAGNOSTIC INSTRUMENT (DSM-SDI) FOR RAPID ASSESSMENT OF AUTISM SPECTRUM DISORDERS IN CLINICALLY REFERRED POPULATIONS**

Speaker: Gagan Joshi, M.D.

SUMMARY:

Objective: To evaluate the concurrent and discriminant validity of a DSM-based structured diagnostic interview (DSM-SDI) for the assessment of ASD. Methods: We examined the agreement of the DSM-SDI with the clinician diagnosis and with the Social Responsiveness Scale (SRS) in subjects with ASD (N=123). Results: 94% of the clinician diagnosed subjects with ASD had a positive diagnosis of ASD on the DSM-SDI. 97% of the clinician and DSM-SDI diagnosed ASD subjects screened positive for ASD on the SRS. 96% of the clinician diagnosed and SRS screen positive ASD subjects also had a positive diagnosis of ASD on the DSM-SDI. 11% of the ADHD subjects had a positive diagnosis of ASD on the DSM-SDI leading to an estimate of 89% specificity. Positive and negative predictive values were 40% and 99.8% respectively. Conclusions: Results suggest high sensitivity and specificity of the DSM-SDI for assessing ASD, suggesting it could serve as a useful diagnostic-aid for the assessment of ASD.

NO 3**EXAMINING THE COMORBIDITY OF BIPOLAR DISORDER AND AUTISM SPECTRUM DISORDER**

Speaker: Janet Wozniak, M.D.

SUMMARY:

Objective: We examined the clinical and familial correlates of BPD co-occurring with and without ASD comorbidity in a population of youth with BPD. Method: Clinical correlates and familial risk was assessed from a large family study of youth with bipolar I disorder (BPD-I; probands N=157; relatives N=487). Findings in BPD-I youth were compared with those of youth with ADHD without BPD-I (probands N=162; relatives N=511) and Controls (probands N=136; relatives N=411). Subjects were assessed using structured diagnostic interviews as well as a range of measures assessing dimensions of functioning. Results: 30% of the BPD-I probands met criteria for ASD. Age at onset of BPD was significantly earlier in the presence of ASD (4.7 ± 2.9 vs. 6.3 ± 3.7 years; $p=0.01$). The phenotypic and familial correlates of BPD were similar in youth with and without ASD comorbidity. Conclusion: A clinically significant minority of youth with BPD-I suffers from comorbid ASD.

NO 4**THE IMPACT OF AUTISM SPECTRUM DISORDER: ADULTS IN THE WORKPLACE AND ON THE ROAD**

Speaker: Ronna Fried, Ed.D.

SUMMARY:

Background: Limited research exists on the reasons for the low number of adults with ASD who are gainfully employed or who have driver's licenses. Methods: In 2 pilot studies, we analyzed data from young adults with ASD in both work and driving simulation paradigms. The work simulation assessed observable and self-reported behavior and task performance in a 10-hour day. The driving simulation was a 40-minute route designed to include a variety of road situations. Results: In both simulations, we found significant differences in performance of adults with ASD when compared to controls, and individuals with ADHD. For work, this included difficulty completing unstructured tasks and limited insight into actual work performance. Individuals with ASD had higher levels of physiologically measured anxiety and atypical gaze patterns while driving. Conclusions: Both studies show that understanding work and driving performance in adults with ASD has high clinical and public health relevance.

SYMPOSIUM 99**CONTEMPORARY ISSUES IN SPORTS PSYCHIATRY: A GLOBAL PERSPECTIVE**

Chair: Antonia L. Baum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the scope of psychiatric issues encountered in the athletic arena; 2) Recognize cross cultural issues that arise in the field of sports psychiatry; 3) Recognize exercise addiction, and distinguish it from healthy athletic training; 4) Diagnose depression in the athlete, and will have some guidelines for the treatment of depression in the athlete; and 5) Understand what performance enhancement is for the

athlete, and will learn some strategies for implementing this.

SUMMARY:

The international community of sports psychiatrists have come together to write a textbook on contemporary issues in sports psychiatry from a global perspective. Several areas will be highlighted to further the understanding of some of the unique considerations when working with athletes. These include an overview of the cross cultural issues encountered in the athletic arena, some of which have been illustrated recently in the London summer Olympic games, and will again be seen in the upcoming Sochi winter Olympic games. Another important area in the field of sports psychiatry to be presented is the various ways that exercise addiction presents, and how it can be distinguished from healthy athletic involvement, and how one can address this in treatment. There will be a presentation on the assessment of depression in the athlete, with some guidance on the treatment of this entity in the athletic arena. Performance enhancement will also be addressed, an area where sports psychiatrists are frequently called upon for help.

NO 1 DEPRESSION IN ATHLETES

Speaker: David Baron, M.D.

SUMMARY:

Depression in athletes is a condition that has gone largely unnoticed as medical attention has traditionally focused on their physical health. Previous studies have suggested that the prevalence of depression in athletes is approximately the same as it is in the general population, yet the attitudes and life circumstances of athletes can make diagnosing and treating depression difficult. Athletes may view seeking help for depression as a sign of weakness, anticipate ridicule from coaches and teammates, and avoid pharmacological therapy for fear of performance-degrading side effects. The Baron Depression Screener is a useful diagnostic tool to help psychiatrists diagnose depression in athletes. Careful attention must be given to depression in athletic sub-populations such as young athletes, female athletes, injured athletes, and retired athletes.

NO 2 EXERCISE ADDICTION: THE DARK SIDE OF SPORTS AND EXERCISE

Speaker: Tamas Kurimay, M.D., Ph.D.

SUMMARY:

An optimal level of regular physical activity is one of the most important factors of the maintenance of physical and mental health. Too much exercise can sometimes have as many adverse effects on one's health as too little. Recent research shows that excessive physical activity should be recognized as exercise addiction and categorized among the behavioral addictions. Similarly to other addictive behaviors, exercise addiction can also be described by mood modification, satiety, tolerance, withdrawal symptoms, personal conflict, and relapse. The purpose of the presentation of our international working team is to emerge some key questions in the synthe-

ses of the current knowledge of symptomology and diagnosis of exercise addiction. We present some available epidemiological data, too. We pinpoint some useful diagnostic tools in light of etiological models. We will demonstrate exercise addiction through a case.

NO 3 PERFORMANCE ENHANCEMENT AND THE SPORT PSYCHIATRIST

Speaker: Michael Lardon, M.D.

SUMMARY:

The practice of medicine is aimed at restoring an individual's normal function from various pathologic states. In sport psychiatry we are not only focused on restoring unhealthy athletes to normal mental health but we seek to help the athlete find optimal mental health and by doing so optimize competitive performance. This is accomplished by utilizing principles of general psychiatry and integrating them with the principles of performance enhancement. This lecture will look in more detail at the fundamental principles and techniques of performance enhancement. This lecture will be divided into four sub-sections: 1) motivation and goal setting 2) managing cognition and emotion in the competitive environment 3) mental imagery and attention focus and 4) positive psychology and athletic zone experience.

SYMPOSIUM 100 BIPOLAR DISORDER: SPECIAL TOPICS

Discussant: Robert Post, M.D.

Chair: Michael Gitlin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the data in support of the efficacy of psychotherapy as an adjunctive treatment of bipolar disorder; 2) Be aware of the potential uses of pharmacogenomics in the future diagnosis and treatment of bipolar disorder; 3) Understand the factors underlying the functional impairment of bipolar disorder; and 4) Identify the avenues for recognizing the prodromal symptoms of bipolar disorder and know about the preliminary work in early intervention.

SUMMARY:

Beyond the classic aspects of bipolar disorder- such as its natural history and optimal pharmacotherapy- a number of other, less commonly explored topics are of great current interest and will be even more so in the future. This symposium will review a number of these topics. One area focuses on whether we can improve our ability to identify the onset of the disorder and recurrences sooner than we do currently and intervene during this earlier time frame to avoid some of the serious disruptions that occur from full episodes. Another area reflects the increasing awareness of the functional impairment associated with bipolar disorder. Much of the current research in this area has explored the correlates of functional impairment in bipolar disorder: why do bipolar patients who are euthymic still have poor role function and impoverished re-

relationships? Pharmacogenomics is a new and future oriented topic in bipolar disorder. What role will it have in the future? And finally, in this era of biology and psychopharmacology, what is the place of psychotherapy? And what are the data demonstrating the efficacy of adjunctive psychotherapy of bipolar disorder? There are now over 20 randomized trials on the role of adjunctive family, cognitive-behavioral, interpersonal and group therapy, which point to utilizing specific psychosocial strategies at different points in the illness or prodromal periods.

NO 1 THE DIFFICULT LIVES OF BIPOLAR INDIVIDUALS: CONTRIBUTORS TO FUNCTIONAL OUTCOME

Speaker: Michael Gitlin, M.D.

SUMMARY:

Although outcome in bipolar disorder is typically measured by symptoms and episodes, functional outcome may be more important. Bipolar disorder is characterized by significant functional impairment in all domains of function. Although a greater number of mood episodes correlates with more functional impairment, it is also clear that many euthymic bipolar patients show significant functional impairment. The exact causes of this functional impairment are still unclear. Contributors to this impairment probably include depressive symptoms, including mild depression, cognitive impairment, personality pathology and comorbid disorders.

NO 2 BIPOLAR DISORDER: THE NEED FOR EARLY DETECTION AND INTERVENTION

Speaker: Michael Bauer, M.D., Ph.D.

SUMMARY:

There is a need to clarify whether early detection of at-risk states for the development of bipolar disorders is possible and, if so, which early intervention strategies are most appropriate. If it is possible to reliably identify individuals at true risk for bipolar disorder, the next question to be answered is how early detection initiatives that presently are mostly realized within research projects could be established pragmatically within clinical settings in the health care system. When symptom severity, distress and impairment are sufficiently significant to initiate treatment in people who are considered having at-risk-BD, psychotherapeutic interventions are a reasonable starting point. While current evidence for their effectiveness in this special population is much limited, ongoing studies aim to clarify whether symptomatology can be decreased, psychosocial function preserved, and conversion to manifest BD be postponed and/or prevented.

NO 3 PHARMACOGENOMICS IN BIPOLAR DISORDER

Speaker: Mark Frye, M.D.

SUMMARY:

A meta-analysis of SLC6A4 and antidepressant induced mania (AIM+) reported differences in estimated genetic effects. The purpose of this study was to rigorously define the AIM+ phenotype for subsequent genomic analyses. Bipolar (BP) I or II disorder subjects were enrolled. AIM+ was defined as within 60 days of starting/changing dose of antidepressant. Mood stabilizer, BP I vs II, rapid cycling at time of AIM/AIHM, episodes of AIM/AIHM with medication, and ethnicity were assessed. A case (AIM+) control (AIM-) matched design was constructed. 784 subjects were enrolled (15% with history of AIM+). The majority were female (65%), BP I (91.5%), on SSRI (75%) and 37.7% rapid cyclers. No significant difference was found with anxiety, eating, or substance abuse disorders. AIM+ had a higher rate of lifetime ADD (33% vs 23%). Preliminary analysis did not reveal an s allele / AIM association. This early analysis emphasizes the importance of phenotype assessment prior to genomic analysis.

NO 4 PSYCHOSOCIAL INTERVENTIONS FOR BIPOLAR DISORDER: CORE STRATEGIES AND CURRENT EVIDENCE

Speaker: David J. Miklowitz, Ph.D.

SUMMARY:

There has been a substantial increase in the number of randomized trials testing the effects of adjunctive psychosocial interventions for bipolar disorder. This talk will review several models of psychosocial intervention that have a strong evidence base: cognitive behavioral therapy, family focused treatment, interpersonal and social rhythm therapy, and group psychoeducation. These treatment models have a number of similarities as well as important differences. A smaller body of literature examines the effects of psychosocial intervention on youth with bipolar disorder or at risk for this condition. Clinical strategies that have been found to be effective across age ranges will be highlighted. Finally, the interface between psychosocial and pharmacological treatment will be examined.

SYMPOSIUM 101 SEXUAL DISORDERS AND SEXUAL HEALTH IN ICD-11: PARALLELS AND CONTRASTS WITH DSM-5

Chair(s): Jack Drescher, M.D., Peggy Cohen-Kettenis, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) recognize similarities and differences between the DSM-5 and ICD-11 revision processes; 2) identify controversies surrounding inclusion of paraphilia diagnoses in both the DSM and the ICD; 3) describe the clinical, research, public health, and human rights concerns that support the removal of psychological and behavioral disorders associated with sexual orientation in the ICD; and 4) identify controversies surrounding inclusion of gender diagnoses in both the DSM and the ICD.

SUMMARY:

The World Health Organization (WHO) is revising the International Classification of Diseases (ICD), with publication of ICD-11 planned for 2015. Since the release of ICD-10 over 20 years ago, there have been major advances in research and social understanding related to sexual disorders and sexual health-including gender identity and sexual orientation-that are being considered in ICD-11 development. This symposium will begin by outlining key aspects of the ICD revision process, which differs from DSM in that ICD encompasses all of health and not just mental disorders, offering the possibility of a more integrative view of sexuality in the context of health and service needs. The presentations will focus on suggested revisions for the ICD's sex and gender diagnoses, specifically addressing the paraphilias, psychological and behavioral disorders associated with sexual development and orientation (i.e., ego-dystonic sexual orientation), the gender identity disorders (i.e., transsexualism), and "Factors Influencing Health Status and Contact with Health Services" (equivalent to V codes in DSM-IV). In the area of paraphilic disorders, WHO and APA have used different criteria for revision and inclusion of categories, resulting in substantially different categories and significantly different definitions. Specifically, WHO does not view paraphilic patterns of arousal that involve entirely consensual or solitary behaviors as public health issues, and their presence in the classification raises international human rights concerns. Similarly, the Working Group has proposed eliminating the ICD-10 categories on "Psychological and behavioral disorders associated with sexual development and orientation" entirely, based on lack of evidence regarding the validity and clinical utility of these categories as well as an international human rights perspective. In the area of gender identity, the ICD-11 Working Group has proposed renaming the categories Gender Incongruence of Adolescence and Adulthood and Gender Incongruence of Childhood and moving these categories out of the ICD-11 chapter on mental and behavioral disorders, thereby eliminating the need for distress and impairment as criteria. Finally, a new set of codes related to sexual counseling is intended to increase access to health care for sexual problems and difficulties that are not mental disorders, which may cause distress and, if not appropriately attended, can evolve into more consequential disorders.

NO 1**PSYCHOSEXUAL DEVELOPMENT AND SEXUAL ORIENTATION IN THE INTERNATIONAL CLASSIFICATION OF DISEASE**

Speaker: Susan Cochran, Ph.D.

SUMMARY:

Over the last half century, mental health classification systems, including the DSM and the International Classification of Disease (ICD), have gradually removed diagnostic categories that once treated homosexuality per se as a mental disorder. These changes reflect both emerging cultural and political perspectives and, more importantly from the standpoint of diagnostic nosology, the lack of empirical evidence to support pathologizing variations in sexual orientation expression.

Nevertheless, unlike the 1987 DSM-III-R and subsequent DSM editions, the ICD-10 has until now retained diagnostic categories that imply the existence of mental disorders uniquely linked to sexual orientation expression. This presentation reviews the sparse evidence for these putative disorders from the standpoint of their validity and clinical utility, as well as their intersection with human rights concerns in an international context. The presentation also offers a rationale for their removal.

NO 2**FROM GENDER IDENTITY DISORDERS TO GENDER INCONGRUENCE, FROM MENTAL DISORDER TO SOMETHING ELSE: PROPOSED REVISIONS TO ICD-11**

Speaker: Jack Drescher, M.D.

SUMMARY:

The ICD-11 Working Group on Sexual Disorders and Sexual Health has recommended (1) changing Transsexualism to Gender Incongruence (GI) of Adolescence and Adulthood and Gender Identity Disorder of Childhood to Gender Incongruence of Childhood; and (2) moving the GI diagnoses out of ICD's mental and behavioral disorders chapter, to either a separate chapter containing no other entities or a chapter on gender and sexual health. Consequently, distress and impairment are no longer required as diagnostic criteria. This proposal reflects evolving medical and cultural views of gender and gender transition. Historically, classification of gender diagnoses as mental disorders was based more on earlier social attitudes than available scientific evidence. None of the current treatments prescribed for the condition could be construed as conventional mental health treatments, given that standard approaches today involve changing the body and social role rather than changing the individual's mind.

NO 3**INTRODUCING A SEXUAL HEALTH COUNSELING SECTION IN ICD-11**

Speaker: Alain Giami, Ph.D.

SUMMARY:

The chapter on "Factors Influencing Health Status and Contact with Health Services" is the place in the ICD for issues that may be appropriate foci of treatment but are not disorders or diseases (equivalent to V codes in DSM-IV). In the ICD-10, some sexual health categories are found in the chapter on Mental and Behavioral Disorders, while others are classified in other disease chapters (e.g., of the endocrine or genitourinary system), or in relation to pregnancy, childbirth and the puerperium, sexual and family violence, and other areas. The creation of a new set of categories related to sexual health counseling will be useful in integrating these areas in clinical practice, but also when the main problem is lack of sexual education and knowledge. This will increase access to health care for problems and difficulties that are not mental disorders, which may cause distress, and which, if not appropriately attended, can evolve into more consequential disorders.

NO 4 PARAPHILIAS IN DSM-5 COMPARED WITH ICD-11

Speaker: Richard B. Krueger, M.D.

SUMMARY:

There has been significant controversy concerning the revision of the paraphilias in DSM-5 and considerable criticism of these disorders in ICD-10. This section of the symposium will contrast the different criteria for revision established by the American Psychiatric Association and by the World Health Organization. There has been significant controversy concerning the revision of the paraphilias in DSM-5 and considerable criticism of these disorders at an international level in relation to ICD-10. This section of the symposium will contrast the different criteria for revision established by the American Psychiatric Association and by the World Health Organization and the different processes for each. Specifically, WHO does not view paraphilic patterns of arousal that involve the World Health Organization and the different processes for each. These differences have resulted in significantly different definitions, which will be described in detail and contrasted. Implications of these differences will be suggested.

NO 5 PUBLIC HEALTH, CLINICAL UTILITY, AND AN INTEGRATIVE VIEW OF SEXUAL HEALTH IN ICD-11

Speaker: Geoffrey M. Reed, Ph.D.

SUMMARY:

WHO is revising the ICD, with publication of ICD-11 planned for 2015. ICD is used by WHO's 194 Member States, including the US, as the basic unit of clinical information for health reporting, treatment selection and reimbursement, outcomes evaluation, health policy, and resource allocation. Since the approval of ICD-10 over 20 years ago, there have been major advances in research and social understanding related to sexual disorders and sexual health, including gender identity and sexual orientation, that must be considered in developing ICD-11. This presentation will outline key aspects of the ICD revision process, based on principles of clinical utility, global applicability and human rights, within the context of WHO's mission of attainment by all peoples of the highest possible level of health. In contrast to DSM, ICD encompasses all of health and not just mental disorders, offering the possibility of a more integrative view of sexuality in the context of health and service needs.

SYMPOSIUM 102 UPDATE ON TOURETTE'S DISORDER: DOES ONE SIZE FIT ALL?

Chair(s): Cathy L. Budman, M.D., Erica Greenberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the clinical phenomenology, differential

diagnosis, natural history, epidemiology, treatment, and basic neurobiology of Tourette's Disorder (TD) across the lifespan; 2) Identify the common psychiatric comorbidities in TD, their treatment, and how these conditions may evolve through the life cycle; 3) Recognize the clinical significance and complexities of genetics and of clinical phenotypes in TD; 4) Identify non-pharmacological strategies for treatment of tics and psychiatric comorbidities in TD for both children and adults; and 5) Recognize the clinical presentation of TD and associated psychiatric comorbidities in an adult; identify and prioritize current treatment options and intervention strategies.

SUMMARY:

Tourette's Disorder (TD) is characterized by the childhood onset of multiple motor and/or phonic tics of at least one-year duration, and is commonly associated with additional psychiatric disorders. Although typically improved, tics often persist into adulthood. This symposium addresses the complex diagnostic and treatment challenges for pursuing wellness across the lifespan in those with TD, and examines the mounting evidence, and clinical implications for its heterogeneous phenotypes. Presentations by an expert panel of child and adult psychiatrists cover clinically relevant topics about TD as it unfolds over the life cycle. First, an updated overview of TD highlights recent phenomenology, epidemiology, natural history findings and tic treatments with particular attention to adults with TD. Next, a developmental perspective guides a systematic examination of TD's common psychiatric comorbidities and their evidence-based treatments across the lifespan. Focus then shifts to a presentation of the latest genetics findings for TD, including implications of putative genetic and environmental contributors to genotypic and phenotypic heterogeneity. Keeping in mind such biological and psychological complexity, the next lecture focuses on cutting edge non-pharmacological treatments that may effectively target tics in both children and adults. The symposium will conclude with a case presentation of an adult with TD, followed by a full panel discussion and audience Q&A.

NO 1 OVERVIEW OF TOURETTE'S DISORDER ACROSS THE LIFESPAN

Speaker: Cathy L. Budman, M.D.

SUMMARY:

Tourette's Disorder (TD) is characterized by childhood onset of waxing/waning tics that peak by puberty, and decrease by early adulthood. Objective longitudinal outcome assessment reveals that most adults have persistent tics (Pappert et al. 2003); tics first emerging in adulthood should prompt a search for secondary causes. The adult TD phenotype characterized by facial, neck, and truncal tics is usually accompanied by psychiatric comorbidities (Jankovic et al. 2010). Persistent tic severity and coexisting psychiatric disorders in adulthood are associated with increased psychosocial difficulties and reduced quality of life (Eddy et al. 2011). Adults with chronic tic disorder (CTD) report social or public avoidance and experience discrimination resulting from tics. Improved clinical surveillance for tics and co-existing psychiatric disorders

across the lifespan, coupled with appropriate psychosocial, educational, and vocational interventions is needed for enduring wellness in TD.

NO 2 PSYCHIATRIC COMORBIDITIES IN TOURETTE'S DISORDER

Speaker: Barbara Coffey, M.D., M.S.

SUMMARY:

Tourette's Disorder (TD) is often associated with marked impairment, disability and reduced quality of life. Although many patients experience attenuation of tic symptoms by puberty, many older adolescents continue to experience disabling tics well into adulthood. The majority of referred TD patients also meet criteria for a comorbid psychiatric disorder, such as OCD, ADHD, mood and non-OCD anxiety disorders. Even when tics attenuate in adolescence, comorbid disorders tend to persist. Recent data suggests that clinically referred TD patients are at high risk for depression in young adulthood. The decision to treat requires comprehensive evaluation to ascertain severity of comorbidity. Disentangling tic and comorbid symptoms is the first step in establishment of treatment targets. Recent and novel treatments will be emphasized.

NO 3 GENETICS AND CLINICAL PHENOTYPES OF TOURETTE'S DISORDER

Speaker: Carol Mathews, M.D.

SUMMARY:

Recent estimates indicate that Tourette's Disorder (TD) may occur in up to 1:300 individuals. Among clinical samples, Obsessive Compulsive Disorder (OCD) and Attention Deficit Hyperactivity Disorder (ADHD) co-occur with TD at high rates. This lecture will discuss recent findings indicating that tics, OCD, and ADHD share both genetic and/or environmental influences, and that the phenotypic expressions of TD susceptibility genes may encompass more than tics. An overview of TD genetic studies to date, including the most recent results from the genome-wide associations study (GWAS) will be presented. The potential effects of candidate genes, alone or in combination with other genes may contribute to the varying clinical subtypes of TD. Rapidly progressing etiological studies will ultimately have a direct impact on TD diagnosis, prognosis, and treatment.

NO 4 NONPHARMACOLOGICAL TREATMENTS OF TIC DISORDERS

Speaker: John T. Walkup, M.D.

SUMMARY:

Studies demonstrate the efficacy of a behavioral approach in reducing tic severity and impairment across the lifespan. In the first published study, 126 children (ages 9-17) with a chronic tic disorder were randomized (1:1) to a comprehensive behavioral treatment that included competing response training and

a functional intervention vs. supportive therapy (Piacentini et al. 2010). Of those randomized to the behavioral intervention, 53% were much or very much improved as compared to 18% in the control condition. A large study in adults (N=122; ages 16-69) using the same methodology was recently published (Wilhelm et al. 2012). Overall 38% adults were considered responders to behavioral treatment, and 6% responded to control treatment. The treatment was well tolerated in both studies, and tic worsening was not observed. The efficacy of behavioral treatments in reducing tic severity fundamentally changes the approach to patients with tic disorders.

NO 5 CASE PRESENTATION OF AN ADULT WITH TOURETTE'S DISORDER

Speaker: Erica Greenberg, M.D.

SUMMARY:

A case of an adult with Tourette's Disorder will be presented. The case will include the patient's background history, and any previous evaluations/treatments he has received. Attention to potential pitfalls in accurate diagnosis and intervention will be emphasized. Additionally, effective strategies for improved recognition of symptoms, accurate diagnosis, and effective treatment of tics and/or psychiatric comorbidities in an adult with TD will be discussed using a biopsychosocial model. Input from the panel of experts, and the audience, will be invited. The symposium will conclude with a general Q&A.

SYMPOSIUM 103 SCHEMA THERAPY: AN INTEGRATIVE APPROACH TO CHALLENGING AND DIFFICULT TREATMENT POPULATIONS

Discussant: Poul Perris, M.D.

Chair(s): Heather M. Fretwell, M.D., Neele Reiss, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the major underlying concepts of Schema Therapy. These include but are not limited to: core emotional needs, schemas (such as Defectiveness, Unrelenting Standards), schema modes (such as Innate Child Modes, Maladaptive Coping Modes), limited reparenting: validation, limit setting and empathic confrontation; 2) Recognize schema mode activation in patients with personality disorders and treatment-resistant Axis I disorders, and identify patients who are likely to benefit from schema therapy; and 3) Describe the evidence base of schema therapy for a variety of personality disorders, as utilized in individual sessions; group sessions; intensive outpatient settings; and inpatient settings.

SUMMARY:

Schema Therapy (ST) is an evidence-based psychotherapy for the treatment of challenging and difficult disorders, in particular personality disorders and an increasing number of Axis I disorders. The goals of ST reach beyond teaching behavioral skills to include the fundamental work of personality

change. This series of presentations by international experts will start with a description of the ST model by its developer, Jeffrey Young, and how Young and associates developed a variety of innovative approaches to address the inherent challenges when treating patients with personality disorders and treatment-resistant depression. The series will continue with Arnoud Arntz, a professor of psychology at the University of Maastricht, The Netherlands, who specializes in psychotherapy research and is the permanent scientific advisor to the International Society of Schema Therapy (ISST). He will present landmark studies in the growing evidence base for ST, including some investigations in brain activity changes before and after ST. Joan Farrell, Research and Training director for the center for BPD Treatment and Research – IU School of Medicine – Midtown CMHC and her partner Ida Shaw, Director the Schema Therapy Institute Midwest in Indianapolis, are acknowledged as world experts in the use of the group format to deliver ST and will describe their approach and its proven effectiveness. The current president for the ISST, Wendy Behary, has given lectures and workshops around the globe on the use of ST in the treatment of narcissistic personality disorder, and will share how the unique components of ST result in treatment successes for NPD. Eelco Muste represents the prestigious De Viersprong Institute in The Netherlands, which is a key center for personality disorder research. He will describe the results of a ST multidisciplinary team intervention for combined cluster B and C disorders in both inpatient and intensive outpatient formats. The last presentation will preview future directions for the field, and is given by Neele Reiss, an active researcher and lecturer from the Mainz Institute for Schema Therapy. Poul Perris, our discussant, is a past president of the ISST and director of the Swedish Institute for CBT and Schema Therapy.

NO 1 THE UNIQUE SCHEMA THERAPY MODEL AND ITS DEVELOPMENT

Speaker: Jeffrey Young, Ph.D.

SUMMARY:

ST is an integrative treatment with roots in Cognitive Therapy, psychodynamic psychotherapy, gestalt therapy, learning theory, and developmental psychology. This approach involves decreasing the intensity of maladaptive schemas that trigger emotional and action states referred to as modes. Schemas are psychological constructs which result from interactions of unmet core childhood needs, innate temperament, and early environment. When schemas are triggered, intense “states” occur that are described in ST as “modes,” and account for the emotional reactivity and unstable relationships seen in many patients with personality disorders. Schema therapy addresses and seeks to correct the underlying schemas by utilizing cognitive, experiential, and behavioral pattern-breaking strategies. The goal of ST is to change schemas and modes so that patients can change dysfunctional life patterns and get their core needs met in an adaptive manner outside of therapy.

NO 2

AN INTERNATIONAL OVERVIEW OF THE EMPIRICAL EVIDENCE FOR SCHEMA THERAPY

Speaker: Arnoud Arntz, Ph.D.

SUMMARY:

This presentation reviews the international studies to evaluate two main areas of Schema Therapy (ST) 1) the psychometric properties of the questionnaires to measure ST concepts and 2) those to evaluate the psychotherapeutic effectiveness of ST. The outcome studies conducted have evaluated the effectiveness of individual and/or group ST in 1) reducing the clinical symptoms of disorders, 2) global severity of psychiatric symptoms, 3) interpersonal and occupational functioning and 4) quality of life. Patient and therapist satisfaction and cost-effectiveness have also been measured in the BPD studies. Most outcome studies have been conducted with Borderline Personality disorder, followed by Cluster C PDs, treatment-resistant depression, eating disorder and Post-traumatic Stress disorder. The main finding is that outpatient ST is a highly effective and safe treatment for BPD.

NO 3

FUTURE DEVELOPMENTS IN SCHEMA THERAPY

Speaker: Neele Reiss, Ph.D.

SUMMARY:

Schema Therapy (ST) was developed by J. Young to treat all personality disorders (PDS) and difficult interactional patterns. Trials for populations other than BPD such as cluster C PDs and forensic patients are under way. Furthermore pilot studies on BPD patients have demonstrated that a combination of individual and group ST may be effective in the inpatient setting for patients who cannot be maintained safely in the community (Reiss et al, submitted). In the future, dismantling studies will be needed to understand the active ingredients of ST as well as the mechanisms of change underlying the used techniques. The dosage needed to elicit change needs to be determined for different disorders and severity levels. Finally, if a “limited reparenting” therapeutic relationship proves to be important, future studies will have to research why this element is crucial in working with patients with difficult interpersonal patterns.

NO 4

GROUP SCHEMA THERAPY: CATALYZING THE TREATMENT OF PERSONALITY DISORDERS

Speaker: Joan Farrell, Ph.D.

SUMMARY:

This presentation describes Group Schema Therapy (GST) for the treatment of Personality Disorder patients. GST integrates cognitive, experiential, and behavioral pattern-breaking intervention in a cohesive group culture, with active direction from a co-therapist pair. These interventions facilitate increased awareness and produce changes in early maladaptive schemas and modes at the emotional as well as and cognitive levels. In this close analogue of the family of origin, group acceptance and validation can correct schemas of defectiveness and shame that are common in BPD patients. GST

interventions like group imagery rescripting and mode role plays provide corrective emotional experiences that fill gaps in emotional learning and heal residual effects of trauma. As Dr. Arntz described, GST demonstrated large treatment effects for patients with Borderline Personality Disorder in a RCT and pilot studies in three countries.

NO 5 SCHEMA THERAPY FOR CLUSTER B AND C PERSONALITY DISORDERS

Speaker: Eelco Muste, Ph.D.

SUMMARY:

This presentation describes the Schema Therapy (ST) Program at De Viersprong Halsteren in the Netherlands, a psychotherapy center for the treatment of personality disorders, and its preliminary evaluation. The program adapted the ST model developed for outpatient individual psychotherapy for use with groups in an inpatient and day hospital setting implemented by a multidisciplinary therapy team (psychotherapists, creative therapists – drama, art, music, nonverbal- and sociotherapists) (Muste et al, 2009). Healthy interactions that are absent in patients' home environments can be fostered in therapy groups. This intensive group program provides many opportunities for maladaptive schemas and modes to be identified, their triggers understood and healthier modes developed. A number of open-trial pilot studies demonstrate significant treatment effects in reduced psychiatric symptoms at treatment and maintained at one-year follow-up (Timman et al, 2006).

NO 6 SCHEMA THERAPY FOR NARCISSISM: EM- PATHIC CONFRONTATION, LIMIT-SETTING, AND LEVERAGE

Speaker: Wendy Behary, L.C.S.W.

SUMMARY:

Schema Therapy offers strategies for weakening the suggested maladaptive coping modes of the narcissist. The therapist, in a limited and adaptive re-parenting role, empathically confronts challenging emotional states and self-defeating behaviors ("schema modes"). Setting limits and facilitating emotion-focused experiences, such as imagery, allows access to the lonely and vulnerable parts of the narcissist's personality. Links between maladaptive coping modes, early experiences, and current life patterns are identified. Attuned focus on the therapy relationship offers healthy modeling for reorganizing emotional belief systems, and for generalizing therapist-patient interpersonal experiences to current life experiences. The narcissist learns to dispose of (automatic) deeply entrenched life patterns in exchange for getting their core needs met.

SYMPOSIUM 104 THE CHANGING FACE OF SUICIDE: ASSESS- MENT, TREATMENT, EPIDEMIOLOGY, CULTURAL ISSUES, AND THE EMERGING PROBLEM OF SUICIDE TERRORISM

Discussant: Walid Sarhan, M.D.

Chair(s): David V. Sheehan, M.B.A., M.D., Ossama T. Osman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Assess suicidality more effectively in clinical settings in ways that will protect the patient and improve medico-legal protection; 2) Understand the need for cultural sensitivity in suicide assessment and the epidemiology of suicide; 3) identify the strengths and limitations of the suicidality rating scales used in research studies and in clinical practice; 4) Identify which medications are not approved to treat suicidality and the data supporting the anti-suicidality properties of any psychiatric medications; 5) Enhance understanding of the contribution of psychiatric disorders to suicide terrorism.;

SUMMARY:

The face of suicide is changing. Long cherished views of suicide and its assessment are undergoing revision. Once thought to be mainly a complication of depression, suicide risk is now known to be elevated in a wide range of neuro-psychiatric disorders. There is evidence that suicidality may have a genetic component. The roles of age, culture and religion in modifying suicide are receiving renewed attention. Suicide attacks are used with increasing frequency as a weapon of terrorism. Although the academic literature on terrorism minimizes the possibility that suicide attackers might have antecedent suicidal ideation or behavior, scholars are beginning to explore the possibility that suicidality does play a role in the path to becoming a suicide attacker. There are questions about the effectiveness of current treatments for suicidality. Antidepressants, once the mainstay of treatment, actually increase suicidality in people under 25 and only improve suicidality compared to placebo in people over age 65. Conversely other medications not formally classified as antidepressants (e.g. lithium and clozapine) appear to lower suicidal symptoms. These changes and revisions in our understanding of suicide and suicidality have led to calls for more sophisticated methods of assessment of suicide and improved treatments. Recognition of the increased risk of suicidality in children and adolescents taking antidepressants have galvanized regulatory agencies, in particular, into insisting on more systematic assessment of the range of suicidal ideations, self-harm and suicidal behaviors and led to calls for the adoption of universal standards in suicide assessment in research. One result has been the development of new assessment interviews and scales to capture these domains of suicidality with greater precision and reproducibility. Suicidality is the most important condition associated with mortality in psychiatry. As such it merits more attention and investment than it currently receives.

Understanding suicidality and anti-suicidality mechanisms of action and having a good animal model for suicidality could lead to the future development of medications that target suicidality more specifically.

All these changing perspectives will be discussed in this symposium. The speakers will challenge and stimulate the audi-

ence to rethink cherished views on suicidality.

NO 1 THE CHANGING FACE OF SUICIDE ASSESSMENT AND TREATMENT

Speaker: David V. Sheehan, M.B.A., M.D.

SUMMARY:

The finding that antidepressants are associated with an increased risk of suicidality triggered an interest in the systematic assessment of suicidality as an adverse event. This led to tighter definitions and guidelines for the implementation of suicide ideation and behavior categories in clinical research (C-CASA Coding system). If medications can increase the risk of suicidality, it should be possible to develop medications with specific anti-suicide properties. There is interest in developing rating scales sensitive in detecting an anti-suicidal efficacy signal. Some scales may be useful in documenting suicidal adverse events; others useful in detecting an anti-suicidal efficacy signal and some may meet both objectives. Several groups have shown an interest in searching for drugs and mechanisms that may be promising as anti-suicide treatments. This presentation updates the status of rating scales, treatments and mechanisms that are currently under study to meet these objectives.

NO 2 EMERGING ISSUES IN THE EPIDEMIOLOGY OF SUICIDE

Speaker: Christer Allgulander, Ph.D.

SUMMARY:

Although most of those who commit suicide have not seen a psychiatrist, and although most of those who attempt suicide survive without repeated attempts, the traditional view based on Eli Robin's pivotal study is that suicide is a consequence of a brain disorder, particularly depression. Identifying and treating depression with SSRIs/SNRIs probably account for the >30% reduction in suicides in Sweden over the last two decades. Yet, suicides are now seen in relation to the social consequences of the financial crisis in the last three years. Also, the aging of western societies brings late-life suicides, particularly in men, and increasingly a desire for assisted suicide in the very old. For this, physicians have to develop guidelines that are legally based such as in the Netherlands. This presentation is based on recent trends in the epidemiology of suicide. It will bring attention to the emerging new suicides that ask unprecedented questions to physicians.

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NO 4 CULTURAL ISSUES IN SUICIDE

Speaker: Ossama T. Osman, M.D.

SUMMARY:

The cultural dimensions to suicide has been gaining interest. Ethnic groups differ in rates of suicidal behaviors, the context within which it occurs, and the associated help-seeking behavior. Therefore, suicide can be better understood after considering the relevant socio-cultural attitudes and sensitivities. In the context of the Arab Cultures there are several important risk and protective factors for suicidal behavior which are important to consider when conducting suicide assessments or interventions. For example, the roles of religion (religious differences in views of suicide, the afterlife, the role of the extended family; the interpretations of distress, and the impact of stigma. In summary, this presentation will discuss the cultural context of suicidal behavior with its implications for research, practice, and education. The different concepts will be demonstrated with an example from the Arab Population in the Middle East.

NO 5 SUICIDE TERRORISM: A CRITICAL ASSESSMENT OF EVIDENCE

Speaker: Ivan S. Sheehan, Ph.D.

SUMMARY:

Individuals who commit acts of suicide terrorism are believed to do so for religious, cultural, strategic, political, or sociological reasons or because they are driven by revenge, love, hate, despair, or a desire for attention. Whether suicide terrorists suffer from psychiatric disorders, exhibit clinical signs of suicidality, or are otherwise without mental illness and motivated by purely strategic, religious, or political agendas is a matter of contention. This presentation will critically assess the prevailing wisdom, based on anecdotal evidence, that suicide terrorists are normal and without psychopathology. The presentation will also review current rates of suicide terrorist incidents and address the empirical evidence and limitations of evidence suggesting low rates of psychiatric disorders among suicide terrorists. The presentation will outline a systematic evidence-based approach to collecting reproducible data on the contribution of mental illness to suicide terrorist acts.

SYMPOSIUM 105 NEW PERSPECTIVES ON THE INTERPERSONAL DIMENSION IN THE PERSONALITY DISORDERS

Discussant: Antonia S. New, M.D.

Chair: Larry Siever, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Evaluate clinicians as to the latest advances in understanding of neurobiology of interpersonal impairment in personality disorders; 2) Demonstrate knowledge of current treatment possibilities for interpersonal impairment in personality disorders; and 3) To update clinicians of the newest advances in genetics of interpersonal impairment in personality disorders.

SUMMARY:

Personality disorders are defined in terms of disturbances of interpersonal behavior and processing as well as self-regulation. New perspectives from a variety of research approaches have enriched our understanding of the underpinnings involved in the interpersonal disturbances in the personality disorders and their relation to other specific dimensions/trait disturbances and underlying etiologic factors. Interpersonal disturbances in the personality disorders appear to emerge in part from deficits in interpersonal processing, appreciation of social cues and inappropriate modulation of interpersonal behavior including disinhibition of social and interpersonally aversive behavior, poor regulation of emotions and cognitive processes in the context of relationships, and excessive constriction or avoidance of facilitatory social behaviors. A focus on these underlying disturbances from neurobiologic, behavioral, and social psychological perspectives can help clarify the underlying nature of these social interpersonal impairments which is key to effective clinical management. In this symposium, Siever will introduce an evolving conception of interpersonal disturbance in personality disorders as being rooted in neurobiologic vulnerabilities that interact with less than optimal nurturing environments. Critical neurocircuitry and modulators of these vulnerabilities as well as environmental/developmental influences will be discussed. Stanley will present data regarding the opioid system in relation to interpersonal disturbances in borderline personality disorder which may contribute to self destructive behaviors in the context of interpersonal disappointments. Choi-Kain will discuss the interpersonal dimension expressed in attachment deficits that appear to be familially transmitted suggesting both genetic and environmental influences. Perez-Rodriguez will discuss candidate genes in the opioid and oxytocin systems that appear to influence the development of maladaptative adjustment strategies and how social processing differences detected through the MASC might influence this impairment. Fonagy will discuss results of research on normal infant development including longitudinal studies of social development and neurobiologic studies in adults and their implications for treatment in the context of faulty mentalizing systems enabling individuals to develop reliable structures for interpersonal understanding and communication necessary for effective psychological

therapy. Antonia New will discuss these presentations and define potential new directions for research.

NO 1 INTRODUCTION

Speaker: Larry Siever, M.D.

SUMMARY:

Interpersonal difficulties in personality disorders may be based in specific vulnerabilities in empathy, interpersonal cue processing, appropriate behavioral responses, and capacity to mentalize the intentions of others rather than nonspecific impairment. Primitive limbic systems relying on shared representations of others' intentions in a more reactive/reflexive system rather than cortical systems involving explicit mental state attributions regarding the mental states, of the other person may dominate. Neuropeptides may modulate these neural systems shifting them from more reflective or resonant modes to more analytic representations of others. As these networks mature in relation to specific psychosocial environments, specific vulnerabilities in empathy and interpersonal capacities may emerge. Understanding of these structural and functional pathologies is critical for both the pharmacological and the psychosocial management and treatment of the personality disorders.

NO 2 BORDERLINE PERSONALITY DISORDER SEEN IN THE CONTEXT OF LIFESPAN DEVELOPMENT: IMPLICATIONS FOR EARLY INTERVENTION

Speaker: Peter Fonagy, Ph.D.

SUMMARY:

The presentation will review recent longitudinal studies of child development which have borderline personality disorder or borderline features as endpoints, with particular reference to issues of genetic vulnerability and social cognition. Broadly, findings are consistent with a model of development where the constitutional predisposition creates a vulnerability to different forms of social adversity, with a final common pathway emerging as dysfunctional self- and interpersonal representations in adolescence. The neural mechanisms underpinning these processes will be explored. The implications in relation to early intervention and opportunities for pre-emptive psychiatric treatment will be discussed.

NO 3 ATTACHMENT AND INTERPERSONAL DISTURBANCE IN BORDERLINE PERSONALITY DISORDER

Speaker: Lois W. Choi-Kain, M.D.

SUMMARY:

The empirical and clinical associations between attachment instability and borderline personality disorder (BPD) have provided an important conceptual framework for understanding how the multidimensional features of the disorder interrelate. Evidence from a number of recent family studies suggests

both that BPD is highly heritable and that the multifaceted symptoms are transmitted together as a unitary liability rather than as multiple independent liabilities towards affective, behavioral, and interpersonal instability. While attachment status between parents and children are shown to be concordant, limited evidence of the heritability of attachment exists. This presentation will report findings on the familiarity of attachment and other measures of interpersonal instability in relation to the broader syndrome of BPD. Possible underlying neurobiological mechanisms and implications for treatment and further research will be discussed.

NO 4 NEUROPEPTIDE ABNORMALITIES IN BORDERLINE PERSONALITY DISORDER: GENETIC AND BEHAVIORAL FINDINGS RELATED TO INTERPERSONAL DYSFUNCTION

Speaker: M. Mercedes Perez-Rodriguez, M.D., Ph.D.

SUMMARY:

Borderline personality disorder is characterized by affective instability, impulsivity, identity diffusion, and interpersonal dysfunction. Impulsive, suicidal, and self-injurious behaviors are commonly triggered by interpersonal conflicts, perceived rejection and loss. This may be interpreted as a dysfunction in the attachment and affiliative system. Neuropeptides, including the opioids, oxytocin, and vasopressin, play a key role in the attachment and affiliative behaviors, and thus may be abnormal in borderline personality disorder. I will discuss candidate genes in the opioid and oxytocin systems that appear to influence the development of maladaptive social adjustment strategies. I will also discuss how social processing differences detected through the Movie for the Assessment of Social Cognition (MASC) might influence impairments in interpersonal functioning in patients with personality disorders.

NO 5 INTERPERSONAL DYSFUNCTION, SELF-HARM, AND THE OPIOIDS IN BORDERLINE PERSONALITY DISORDER

Speaker: Barbara Stanley, Ph.D.

SUMMARY:

Interpersonal dysfunction is a hallmark of borderline personality disorder. This interpersonal dysfunction is manifest both directly through difficulties in developing and maintaining relationships and indirectly as seen in precipitants to self-injurious behaviors—suicidal and non-suicidal self injury. We have demonstrated that individuals with borderline personality disorder are much more likely to cite interpersonal reasons for engaging in self-harm behaviors and for increases in suicide ideation. Interestingly, feeling neglected is a particularly strong indicator for increased suicidality in borderline personality disorder. The opioid system is implicated both in relation to interpersonal disturbances in borderline personality disorder and in self-injurious behaviors. This presentation will discuss patterns of suicidality in the borderline population and findings linking opioid dysfunction to self-harm. Potential novel interventions based on these results will be discussed.

SYMPOSIUM 106 HEDONIC EATING, ADDICTION, AND OBESITY

Discussant: Charles P. O'Brien, M.D., Ph.D.

Chair(s): Nicole Avena, Ph.D., Mark S. Gold, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the behavioral and neurochemical evidence of overlaps between ingestion of highly palatable foods and other addictions; 2) Understand how overlaps between excessive palatable food intake and addiction may contribute to the current obesity epidemic and its associated health concerns; and 3) Learn about new areas of research that are focused on both better understanding and assessing the symptoms of addiction and the development of treatment approaches that address addictive aspects of palatable foods.

SUMMARY:

The increase in the incidence of obesity, along with the convenient availability of highly-palatable, calorically-dense foods, has led some to suggest that hedonic hyperphagia may be a cause of increased body weight. It is well known that overeating of palatable food can have powerful effects on brain reward systems, however, it is debated whether excessive intake of palatable food can produce signs of dependence like those seen in response to drugs of abuse. In recent years, the study of addiction has broadened to include a number of behavioral addictions in addition to drug and alcohol dependence. Studies investigating the possibility of addiction to palatable foods in humans provide evidence for a construct of addictive overeating that may help researchers and clinicians to better understand and treat both obesity and certain eating disorders. In addition, hedonically-driven eating can lead to excessive intake of sugar-rich, but nutritiously-poor foods, which has prompted studies investigating the potentially harmful effects of certain ingredients contained in many highly-palatable foods. This discussion will highlight current research and policy issues regarding excessive intake of highly-palatable food, non-drug addiction, hedonic overeating and the insects between excessive food intake and addiction.

NO 1 EVIDENCE OF ADDICTIVE EATING IN HUMANS

Speaker: Ashley N. Gearhardt, Ph.D.

SUMMARY:

Evidence is steadily growing for the role of an addictive process in problematic eating behaviors. The proposed presentation will discuss the use of the Yale Food Addiction Scale (YFAS) to assess addictive eating and the relationship between this measure and disordered eating, reward-related neural activation, and population-based eating problems.

NO 2 IS FAST FOOD ADDICTIVE?

Speaker: Robert H. Lustig, M.D.

SUMMARY:

We will examine whether the nutrients present in fast food, the characteristics of fast food consumers, or the presentation and packaging of fast food may encourage substance dependence, as defined by the American Psychiatric Association. The majority of fast food meals are accompanied by a soda, which increases the sugar content 10-fold. Caffeine is a “model” substance of dependence; coffee drinks are driving the recent increase in fast food sales. Limited evidence suggests that the high fat and salt content of fast food may increase addictive potential. Obesity is characterized by resistance to insulin, leptin and other hormonal signals that would normally control appetite and limit reward. Neuroimaging studies in obese subjects provide evidence of altered reward and tolerance. Stress and dieting may sensitize an individual to reward. These findings support the role of fast food as a potentially addictive substance that is most likely to create dependence in vulnerable populations.

NO 3**SOCIAL AND POLICY IMPLICATIONS**

Speaker: Kelly Brownell, Ph.D.

SUMMARY:

There are likely to be significant social and policy implications from the growing body of science on food and addiction. This work could help alter national discourse about diet, nutrition, and obesity by shifting attention from the personal failing of individuals to the properties of the foods being marketed to the population as a whole. The work is likely to affect legislators working on obesity prevention, particularly with respect to the protection of children. Whether government has the authority to intervene in ways the food industry formulates and markets its foods is an important and legally nuanced topic. The same is true of legal approaches to product liability. This presentation will discuss how the available research bears on these matters.

NO 4**SUBSTANCE AND NON-SUBSTANCE ADDICTIONS: WHERE DO EATING-RELATED BEHAVIORS FIT IN THE DSM?**

Speaker: Marc N. Potenza, M.D., Ph.D.

SUMMARY:

Given the prevalence, impact and heterogeneity of obesity, it is important to understand clinically relevant distinguishing features. We used brain imaging and psychiatric and other clinical assessments to characterize lean and obese individuals with and without binge eating disorder (BED). Obese and lean individuals showed differences in the neural correlates of stress and favorite-food cue responses. Food craving responses in obese but not lean individuals was related to neural activations and measures of insulin resistance. Obese individuals with and without BED showed differences in the neural correlates of cognitive control and reward processing, with BED showing greater similarities to substance and non-substance addictions during reward anticipation. Obesity, and particularly BED, appears to share neurobiological and clinical

features with addictions. Prevention and treatment implications will be discussed.

SYMPOSIUM 107**FOSTERING RESILIENCE AND EMPOWERMENT IN WOMEN AFFECTED BY GENDER-BASED VIOLENCE AND POVERTY ACROSS THE GLOBE**

Discussants: Leah J. Dickstein, M.A., M.D., Patricia I. Ordorica, M.D.

Chair: Christina T. Khan, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the epidemiology of gender-based violence in sub-Saharan Africa and worldwide and factors associated with its occurrence; 2) Identify components of interventions for women’s empowerment that have been effective in low-income populations; 3) Discuss the role of collaboration and relational connection as well as financial support and skill development in empowerment of women living in poverty; 4) Discuss the mutual benefits to women involved in collaborative partnerships that empower women around the globe.

SUMMARY:

Across the globe, women are disproportionately affected by poverty and gender-based violence (GBV). Myriad factors contribute to the serious and widespread public health problem posed by GBV and poverty including disparities in access to education and employment. Strategies such as education and microfinance have been implemented to try to ameliorate the subjugation of women through an empowerment model. In this symposium, we will review the literature on GBV and income disparity. We will discuss interventions geared toward empowering women and fostering resilience that have been undertaken in low-income communities. We will identify important components of a human rights-based approach to women’s empowerment and discuss interventions in which we have been involved in sub-Saharan Africa.

NO 1**APPROACHING THE PROBLEM OF GENDER-BASED VIOLENCE IN SUB-SAHARAN AFRICA FROM A DEVELOPMENT AND EMPOWERMENT PERSPECTIVE**

Speaker: Mary Kay Smith, M.D.

SUMMARY:

There are a number of cultural, economic, and societal factors involved in the development and continuation of gender-based violence experienced by many women living in rural sub-Saharan Africa. Nonetheless, some men and women are beginning to more closely examine the costs and benefits of continuing these physically and emotionally abusive practices, thereby examining the roles that traditional beliefs, customs, and poverty play in gender-based violence. This presentation will review the literature on gender-based violence in several regions of Sub-Saharan Africa and will more closely exam-

ine the perspectives of individuals living in northern Zambia. The author will draw upon her experience collaborating with Zambian women to develop and run an annual conference focused on empowering women through a variety of educational approaches. The importance of involving women living in rural areas, community leaders from more urban settings, and (to a more limited degree) men will be explored

NO 2 FOSTERING RESILIENCE BY “HELPING THE HELPERS” WITH A COLLABORATIVE BUSINESS MODEL

Speaker: P. Lynn Ouellette, M.D.

SUMMARY:

This presentation will discuss the work with different groups of Kenyan women that grew as an important intervention originally begun by volunteering with AIDs orphans. Providing mentoring and consultation to allied health providers has become an integral part of “helping the helpers” and fostering their skills, professional development and a sense of increased value, self worth and empowerment in their everyday work. Also presented will be a collaborative business model developed with groups of women from profound poverty which has been a true exchange of culture and ideas, fostering mutual connection and respect, and leading to empowerment and resilience thus allowing the development of a sustainable market for these women to support their families.

NO 3 GENDER-BASED VIOLENCE AND INTERVENTIONS FOR WOMEN’S EMPOWERMENT: CULTURAL CONSIDERATIONS

Speaker: Christina T. Khan, M.D., Ph.D.

SUMMARY:

Gender-based violence is an important public health problem worldwide. Structural and economic factors complicate interventions for women and recovery from violence. This presentation will focus on educational interventions for women’s empowerment within a culturally-sensitive framework. The literature on women’s empowerment and skills building for low-income women will be reviewed. The author will discuss cultural considerations when designing and implementing educational interventions for gender-based violence in non-Western populations, drawing from work in Africa and Latin America.

SYMPOSIUM 108 DEPRESSIVE DISORDERS AND COMORBIDITY: 30 YEARS OF PROSPECTIVE FOLLOW-UP

Discussant: Robert M. A. Hirschfeld, M.D.

Chair: Martin B. Keller, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Diagnose and treat difficult to treat depressed pa-

tients by identifying clinical variables and subsyndromal states that predict the probability of future recovery, recurrence, and chronicity; 2) Understand the need and enhance their ability to identify the presence of substance use in depressed patients and build diagnostic and treatment skills for substance use in this population; and 3) Measure levels of anxiety severity in depressed patients and use the data to predict better or worse outcomes of the clinical course of major depression and the probability of suicidal behavior.

SUMMARY:

This symposium will provide evidence based clinical management recommendations resulting from over 30 years of prospective follow-up interviews of almost 1000 inpatients and outpatients with mood disorders. The findings are from the NIMH Psychobiology of Depression study, known as the Collaborative Depression Study; the longest and most comprehensive study ever done on mood disorder in the history of mental health research. Highlights will be presented from approximately 300 peer reviewed research manuscripts on multiple dimensions of patients suffering from depressive disorders with and without co-morbid substance use disorders and a spectrum of levels of severity of coexisting anxiety symptoms and disorders. There will be an emphasis on effect on treatment strategies of the cumulative probabilities of recovery and recurrence over time and predictors thereof, of major depression. The symposium will trace the evolution of the paradigm shift from when mood disorders were most often thought to be acute single episode diseases which were likely to fully recover when properly treated to moderate to severe mood disorders, often chronic and likely to recur without long term treatment management. Implications for the clinical management of these disorders are presented based on findings about the dimensional analysis of symptom severity and the predominance of symptoms below the threshold for major depressive disorder, which is the predominant state experienced after patients no longer meet full DSM criteria for a mood disorder. Changes in psychosocial impairment associated with step wise changes in symptom severity are reviewed, revealing the importance of resolution of residual symptoms for achieving true episode recovery. Findings will suggest that clinicians treating major depression should assess and treat comorbid alcoholism to achieve optimal outcome of the depressive disorder along with the importance of proper management of alcoholism. The significant frequency of anxiety symptoms will be shown to be related to poor outcomes of the depressive disorders and to be significantly correlated with suicide attempts and completion; leading to the addition of an anxiety severity rating across mood disorders in the DSM V.

NO 1 ALCOHOL PROBLEMS IN PATIENTS WITH AFFECTIVE DISORDERS

Speaker: Deborah Hasin, Ph.D.

SUMMARY:

Prior to the Clinical Depression Study (CDS), little information existed on the relationship of alcohol disorders and major

affective syndromes diagnosed with standardized criteria and procedures. Using two, five and ten-year follow-ups, we prospectively examined the association between these disorders. We found that the time-varying status of alcohol disorders affected the course of depression, particularly the likelihood of relapse. The CDS findings influenced subsequent research, including a large prospective study of patients dependent on alcohol, cocaine and/or heroin. This study confirmed the conclusion that the course of affective and substance use disorders are intertwined to a substantial extent. Clinical implications drawn from the CDS and subsequent research suggest that positive outcomes are better achieved when clinicians treating major depression also assess and treat comorbid alcohol problems. Evidence-based procedures for this are briefly presented.

NO 2 CLINICAL COURSE AND OUTCOME OF UNIPOLAR MAJOR DEPRESSION

Speaker: Robert Boland, M.D.

SUMMARY:

The CDS was the first study to observe the longitudinal course of Unipolar Major Depression prospectively using a clear and consistent methodology and specific diagnostic criteria. This presentation reviews the information garnered from the 30 years of study on time to recovery, time to recurrence and predictors thereof, and demonstrates how this information has helped to answer some of the most fundamental questions about Major Depressive Disorder, including how to approach patients at different points in their illness, patients with comorbid dysthymia and patients with substantial social and/or occupational dysfunction.

NO 3 THE LONG-TERM COURSE OF UNIPOLAR MAJOR DEPRESSIVE DISORDER: THE VALUE OF A DIMENSIONAL APPROACH

Speaker: Lewis Judd, M.D.

SUMMARY:

A dimensional paradigm provides a new perspective for understanding the long-term course of major depressive disorder (MDD). Our CDS studies have shown that during up to 31 years of systematic follow-up, patients with MDD typically fluctuate among levels of depressive symptom severity, mostly below the diagnostic threshold for major depressive episodes (MDEs). They are symptomatic during a mean of 55% of weeks during long-term follow-up: 15% at the diagnostic threshold for MDE, 24% at the threshold for minor depression, and 16% of weeks with subsyndromal depressive symptoms. There is a significant increment in global psychosocial disability with each increase in depressive symptom severity. The presence of on-going residual subsyndromal depressive symptoms after MDE resolution, although meeting the consensus definition of MDE recovery, is associated with significantly higher risk for rapid relapse than asymptomatic recovery.

NO 4 THE ROLE OF ANXIETY SEVERITY IN THE OUTCOME OF MOOD DISORDERS

Speaker: Jan Fawcett, M.D.

SUMMARY:

The CDS data has highlighted the role of anxiety severity as a mediator of outcome in major affective disorders. In 1983, CDS data showed the frequency of the occurrence/severity of anxiety in major affective disorders. Later, data from the CDS showed that anxiety severity was a correlate of suicide up to one year as opposed to standard risk factors such as hopelessness, past of recent suicidal behavior, and severity of suicidal ideation which were long term correlates up to ten years later. Subsequent analyses from the CDS have shown that anxiety severity predicts poor outcome up to 20 years follow-up. This presentation will review these studies and other studies that have also shown anxiety severity as a correlate of poor outcomes and suicide in major affective disorders.

SYMPOSIUM 109 COMMUNITY PARTNERS IN CARE: RESULTS FROM A COMMUNITY-PARTNERED, COMPARATIVENESS EFFECTIVE STUDY TO IMPROVE OUTCOMES FOR DEPRESSION IN LOS ANGELES

Chair: Bowen Chung, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn 6 and 12 month patient outcomes and cost-effectiveness from Community Partners in Care (CPIC), a community partnered, comparative effectiveness study to improve patient depression outcomes; 2) Understand how two approaches to implementing an evidence-based, collaborative depression care model in two under-resourced, minority communities impacted rates of provider participation in training; 3) Acquire knowledge about factors associated with successful training and implementation of cognitive behavioral therapy with non-licensed depression care providers; 4) Grasp knowledge about the baseline data from Community Partners in Care on patient substance use; and 5) Appreciate a community member's perspective on partnering with academic research partners on a depression care study improve patient outcomes in two, African American and Latino communities in LA.

SUMMARY:

Our symposium will present study data from Community Partners in Care (CPIC), a Community Partnered Participatory Research (CPPR) study to address racial disparities in depression. Depression continues to be the largest cause of adult disability in the U.S. with racial disparities in access, quality, and outcomes. Although there are a number of evidence-based approaches to improve depression outcomes (medications, cognitive behavioral therapy, collaborative models to implement depression care), little is known about how to disseminate evidence-based approaches to deliver depression care to under-resourced, minority communities. CPIC used CPPR to design, implement and analyze a randomized,

comparative effectiveness trial to disseminate evidence-based, depression QI programs in two under-resourced communities: South Los Angeles and Hollywood. Both interventions had the same QI tools. CPPR is a manualized form of community-based participatory research, recommended to engage and to build trust with minority communities around research. Clients were nested within programs randomized to one of two intervention conditions: Community Engagement and Planning (CEP), community network development and activation intervention around QI goals, and Resources for Services (RS), a more standard technical assistance “disease management” model. Effectiveness of these approaches was measured on depression, health, and services use using data from telephone surveys of both the 1018 adult clients interviewed at baseline, at 6-month, and 12-month follow-up. Of 1,018 depressed clients, 57% were female, 87% Latino and or African American, 43.6% had less than high school education, 73.7% had income below federal poverty, 20% were working and 54.1% were uninsured. The percentage with 12-month depressive disorder was 61.9%, while 39.3% had substance abuse and 54.7% multiple chronic conditions. Over half had multiple risks for homelessness. There were no significant differences in baseline variables by intervention status. There 95 participating programs in CPIC from different sectors: 18 mental health, 20 substance use, 17 primary care, 10 homeless serving agencies, social community services (e.g. churches, senior centers). CPIC trained 312 providers, 258 in CEP and 54 in RS, in the different components of collaborative care. In our symposia, we include presentations on: 1) a summary of CPIC 6 and 12 months client outcomes data, cost-effectiveness and cost-savings data; 2) a baseline summary of CPIC client substance use and services use; 3) factors associated with successful implementation and training of cognitive behavioral therapy for depression in both licensed and non-licensed (e.g. substance use counselors) providers; 4) the impact differential impact of RS and CEP on rates of provider participation in training training; and 5) a community member’s perspective on participating on the impact of this study on her community.

NO 1 SIX-MONTH CLIENT OUTCOMES FROM COMMUNITY PARTNERS IN CARE

Speaker: Kenneth Wells, M.D., M.P.H.

SUMMARY:

We present 6-month client outcomes from CPIC. Linear and logistic regression was conducted, adjusted for baseline variables, sex, ≥3 chronic conditions, education, race/ethnicity, income < federal poverty, past year alcohol abuse or use of illicit drugs, and 12-month depressive disorder on data from 1018 adults interviewed at baseline and at 6-months to detect differences between RS and CEP. Analyses showed CEP relative to RS significantly ($p < .05$) improved the primary outcome, mental health-related quality of life (MCS-12) (44.1% v. 51.4%); improved physical functioning and increased activity levels (18.7% v. 12.8%); reduced hospitalizations for alcohol, drug, mental health overall, (5.8% v. 10.5%). Our approach is effective approach at engaging under-resourced minority com-

munities to implement strategies leading to improvements in mental well-being, facilitate health, and decrease hospitalizations and specialty mental health medication visits.

NO 2 EXPLORATORY STUDY OF CBT TRAINING UPTAKE AMONG COMMUNITY PROVIDERS

Speaker: Victoria Ngo, Ph.D.

SUMMARY:

With the rise in pressure to employ evidence-based practices (EBPs), understanding factors associated with successful training and implementation of EBPs is important. Using a mixed methods approach, baseline survey and training data from 72 providers who participated in CBT training from the CEP condition and 1-year follow-up qualitative interviews with 30 providers receiving CBT support (full support, partial support, standard technical assistance) were used to explore factors associated with training participation and implementation. Those receiving full support were more likely to report benefits of training and continued implementation of CBT. Participation barriers included clinician workload and training burden. Facilitators appeared to be related to supportive agency environment, community engagement of research staff/project, and flexibility of the training program. Results provide insight into potential factors related to training participation and implementation of EBPs.

NO 3 HOW CAN SUBSTANCE ABUSE SERVICE AGENCIES PREPARE FOR THE AFFORDABLE CARE ACT? IMPLICATIONS FOR BEHAVIORAL HEALTH HOME IN FINDINGS FROM COMMUNITY PARTNERS IN CARE (CPIC)

Speaker: Evelyn Chang, M.D.

SUMMARY:

Little data about service utilization exists to guide behavioral health home development for patients with co-occurring disorders (COD), who use services across multiple sectors. We present baseline client survey data analysis from CPIC to describe demographics and services utilization in the past six months. Nearly half ($n=407$, 48.5%) had co-morbid substance use disorder (SUD). Of those, most ($n=323$, 79.4%) were receiving SUD treatment. Overall, 46.0% had any health insurance. Most (77.7%) had incomes under the federal poverty level. Clients with co-morbid SUD were more likely than those without SUD to: have depression (61.3% vs 53.8%); be in transitional housing (21.3% vs 3.8%); visit the ER (59.1% vs 46.7%); be admitted (23.0% vs 7.9%); have more outpatient MH visits (70.4% vs 50.6%) and fewer PC visits (54.8 vs 74.9%). A medical home created for those with COD must address underlying SUD, MH, and psychosocial problems.

NO 4 COMMUNITY-PARTNERED PARTICIPATORY RESEARCH'S APPLICATION IN COMMUNITY PARTNERS IN CARE

Speaker: Felica Jones

SUMMARY:

We present a community member's perspective on participation in a Community Partnered Participatory Research Study (CPPR). The community member will share the CPPR model and how it was applied to developing the partnership between academic researchers and partners from diverse agencies in two under-resourced, minority communities: South Los Angeles and Hollywood-Metro. A description of the underlying principles of partnership: respect, equal power-sharing, transparency, and active participation by community members in all parts of the research process from study development, design, measurement development, sampling, study implementation, data collection, data analysis, and manuscript preparation. Additionally, we will share how community conferences are a tool for both engagement around research as well as dissemination of research results. And last, she will share what the study and partnership has meant to the local community.

SYMPOSIUM 110 IMPLICATIONS OF SPIRITUAL EXPERIENCES TO THE UNDERSTANDING OF MIND-BRAIN RELATIONSHIP

Discussant: James W. Lomax, M.D.

Chair: Alexander Moreira-Almeida, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To recognize the importance of different positions on the nature of the interrelationship of the brain and the mind and their clinical and research implications; 2) To identify historical and philosophical contributions to the current neuroscientific debate about the nature of mind; 3) To recognize the implications of empirical research on spiritual experiences for the understanding of mind-brain relationship; 4) To identify the clinical, research, and philosophical implications of these findings; and 5) To recognize remaining challenges in need of further empirical study and philosophical reflection in understanding the mind-brain relationship.

SUMMARY:

Although psychiatry is among the professions most centrally related to the relationship of mind and brain, there has been lack of reflection by mental health professionals on this crucial subject (1,2). Different positions taken on the nature of the interrelationship of the brain and the mind have produced very dissimilar clinical and research approaches (2,3,4,5). In addition, centuries old controversies on mind-body relationships have been based on observation of a narrow range of phenomena, often contaminated by several theoretical and methodological biases (2,5). This symposium explores how some of these disagreements can be resolved by rigorous investigation of spiritual experiences. Although spirituality has increasingly been recognized as an important topic in psychiatry, the implications of spiritual experiences for the mind-brain problem has been neglected. Applying contemporary research

methods to meditation, mystical and near-death experiences may provide a badly needed broadening and diversification of the empirical base needed to advance our understanding of the mind-body problem. In this interdisciplinary symposium 5 researchers from three countries will integrate different approaches (philosophical, historical, neurobiological, phenomenological, epidemiological, and clinical) to address the major clinical, research and theoretical implications of this challenging subject. A common theme is that both scientific rigor and humility are needed in order to understand the mechanisms underlying spiritual experiences, and human experience as a whole.

NO 1 METAPHORS AND ANALOGIES AS (PSEUDO) EXPLANATIONS OF MENTAL PHENOMENA: A CRITIQUE OF CONTEMPORARY MATERIALISM IN COGNITIVE NEUROSCIENCE

Speaker: Saulo Araujo, Ph.D.

SUMMARY:

Materialism is as old as philosophy itself. In its most general sense, it is a metaphysical thesis according to which matter is the ultimate foundation of reality, i.e., everything that exists is material and can be materially explained. However, since there are several conceptions of matter, different forms of materialism emerged over time. The objective of this study is to analyze a kind of materialism present in contemporary philosophy and neuroscience, which argues for a brain-based explanation of consciousness and mental phenomena in general, promising for a near future the long-awaited solution to the mind-brain problem. However, a closer look at this new form of materialism reveals that, rather than a scientific explanation of these phenomena, it offers a series of metaphors and analogies that have been renewed since the eighteenth century. Thus, we conclude that this new form of materialism seems to be closer to scientific ideologies than science itself.

NO 2 DISTINGUISHING MAGICAL THINKING AND MA- TURE SPIRITUALITY IN MIND-BRAIN RESEARCH

Speaker: C. Robert Cloninger, M.D., Ph.D.

SUMMARY:

A major impediment to understanding spiritual experiences is the need to distinguish genuine spiritual phenomena from fraud and magical thinking. Recent research on spiritual phenomena have screened large number of claimants to exclude with mental disorders and other individuals who accepted money for services. An additional precaution is the standardized assessment of personality with rigorous validity analysis. The Temperament and Character Inventory (TCI) is particularly useful for this purpose because it includes a measure of spirituality, the Self-Transcendence (ST) Scale. The spirituality subscale of ST includes paranormal experiences such as ESP among its items. Prior empirical research will be reviewed that shows that when high ST is combined with low Self-directedness (SD), subjects can be characterized as schizotypal. However, when high ST is combined with high SD, individuals

have a personality profile indicating positive well-being and mature spirituality.

NO 3 THE NEUROBIOLOGICAL CORRELATES OF SPIRITUAL EXPERIENCES

Speaker: Andrew Newberg, M.D.

SUMMARY:

There has been growing interest in the study of spiritual practices and experiences using neuroscientific techniques such as functional brain imaging. Spiritual practices include a myriad of different approaches and contain a number of cognitive, emotional, and sensorial elements. This paper reviews the current literature on the neurobiological correlates of spiritual experiences in an attempt to integrate their neuropsychological, neurophysiological, and psychotherapeutic aspects. Spiritual experiences likely involve a number of brain structures including the frontal, parietal, and temporal lobes, limbic system, and hypothalamus. Neurotransmitters involved likely include the opioid, serotonergic, GABA, and dopaminergic systems. Studies have shown that spiritual practices can be both beneficial and detrimental. Determining the neurobiological correlates of spiritual experiences is essential for understanding how they relate to specific psychological states and conditions.

NO 4 DO NEAR-DEATH EXPERIENCES AND AP- PROACHING DEATH EXPERIENCES EXTEND OUR UNDERSTANDING OF HUMAN CON- SCIOUSNESS?

Speaker: Peter Fenwick, M.D.

SUMMARY:

Recent studies on near death experiences precipitated by cardiac arrest raise questions about the nature of consciousness. These seem to arise at the time when all brain function ceases, suggesting a possible continuation of consciousness after death, and that mind and brain are separate. An understanding of the mental states of the dying is now recognized as an important part of palliative care. Both the dying and their caregivers may experience phenomena which suggest also a continuation of consciousness after death and that we do not yet fully understand the process of dying. Their occurrence helps the grieving of the relatives who see them.

NO 5 RESEARCH ON POSSESSION/TRANCE/MEDI- UMSHIP AND THE MIND-BRAIN RELATIONSHIP

Speaker: Alexander Moreira-Almeida, M.D., Ph.D.

SUMMARY:

Possession, trance and mediumship (PTM) are widespread experiences that involve alterations in consciousness. Since the 19th Century there is a substantial, but neglected tradition of scientific research about PTM and its implications for the nature of mind. These investigations performed by high level

researchers were seminal in the development of concepts such as dissociation and subliminal mind. This presentation will review current empirical studies investigating these experiences. Findings show that most of these experiences are not related to mental disorders and some criteria to assess their clinical significance will be presented. Studies investigating the origins, the sources, of mediumistic communications suggest that fraud, hallucination, and unconscious mind activity may explain much but not all the observed data. These data have implications for our understanding of mind and its relationship with the body.

SYMPOSIUM 111 AUTISM AND SOCIAL COMMUNICATION IN DSM-5

Chair: Bryan H. King, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the rationale for changes to the diagnosis of autism and related conditions in the DSM-5; 2) Understand the new criteria for Autism Spectrum Disorder and the principles governing their application; and 3) Understand how social communication, speech, and language disorders may present in individuals who do not have autism.

SUMMARY:

Neurodevelopmental disorders (ND) have their onset in infancy or early childhood and cause life-long impairments in cognitive and behavioral functions. Diagnostic criteria for these disorders must be sensitive to age and developmental stage, as symptom expression frequently changes as children grow and develop, and the criteria also must be sensitive to gender and cultural differences in symptom manifestations. In addition, the diagnostic criteria must serve adult patients, in whom early childhood histories may be lacking, while retaining diagnostic integrity by requiring evidence of onset in infancy or early childhood. The ND Workgroup was charged with considering all of these factors as they deliberated over recommendations for changes that would improve diagnostic sensitivity and specificity for the ND diagnostic criteria and text descriptions in DSM-5. The symposium will provide an overview of how the diagnostic criteria for Autistic Disorder have changed over time, present the rationale and criteria in DSM-5, and highlight areas that will need ongoing attention as the autism spectrum continues to be elaborated. Particular attention will be given to the importance of specifiers in the diagnosis of Autism Spectrum Disorder, potential gaps that exist with respect to appreciating how autism presents in females and in the elderly, and a broader treatment of social communication, language, and speech disorders in children.

NO 1 THE RATIONALE FOR SPECIFIERS IN AUTISM SPECTRUM DISORDER DIAGNOSIS

Speaker: Gillian Baird, M.D.

SUMMARY:

This presentation will describe the work group recommendation that a full description of the individual should be made as part of the ASD diagnostic process using specifiers. The specifiers will be outlined. This recommendation follows the recognition that co-existing medical, mental, neurodevelopmental and functional conditions are common in ASD, that the presence of ASD may not be obvious in the first year of life and recognition may be accompanied by stasis or regression of skills and that the functional impact for the individual of any neurodevelopmental disorder in general and of ASD in particular varies depending on the severity of the condition, any co-existing condition and their intellectual ability.

NO 2**TRYING TO UNDERSTAND THE WHOLE SPECTRUM: THE NEED FOR MORE RESEARCH ON ASD IN FEMALES AND THE ELDERLY**

Speaker: Francesca Happé, Ph.D.

SUMMARY:

One explicit aim of DSM-5 was to recognize differences in presentation of conditions such as Autism Spectrum Disorder by age, gender and cultural group. This presentation will consider some outstanding questions regarding ASD in females and the trajectory of ASD into old age. Is the high ratio of males to females diagnosed with autism and related disorders in part a reflection of masculine stereotypes? How is IQ related to diagnosis of autism across the sexes? What do we know about old age in those with ASD, and why might it be essential to know more? This talk will present some new data from population-based cohorts, and some key questions based on the literature to date.

NO 3**AUTISM SPECTRUM DISORDER**

Speaker: Bryan H. King, M.D.

SUMMARY:

From the earliest descriptions of autism, the field has wrestled with the questions of how inclusive a net to cast, and how bright to define the boundaries around not only who is in and who is not, but whether the autism spectrum is made up of discreet entities or is continuous. These discussions have been particularly salient with respect to the application of categorical diagnoses within the autism spectrum in the DSM. The diagnoses of Asperger disorder, and of Pervasive Developmental Disorder NOS have not only grown dramatically but have seemingly also been used to capture dimensional or severity characteristics in affected individuals. This presentation will review the history of the diagnosis of autism, the new criteria for Autism Spectrum Disorder in DSM-5, and the principles the neurodevelopmental workgroup intended for the application of the new criteria set.

NO 4**SOCIAL COMMUNICATION, LANGUAGE, AND SPEECH DISORDERS IN YOUNG CHILDREN**

Speaker: Amy Wetherby, Ph.D.

SUMMARY:

The diagnostic classifications for Communication Disorders in the new revisions of the DSM-5 are organized into Social Communication, Language, and Speech Disorders. Distinctions between these diagnostic categories and differentiation from Autism Spectrum Disorder will be presented. Video vignettes will be used to highlight differences between young children with Communication Disorders and Autism Spectrum Disorder.

SYMPOSIUM 112**PSYCHOTROPIC MEDICATIONS IN PATIENTS WITH PACEMAKERS AND DEFIBRILLATORS**

Discussants: Margo C. Funk, M.A., M.D., Archana Broj-mohun, M.D.

Chair(s): Archana Brojmohun, M.D., Margo C. Funk, M.A., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the impact of the QTc and its prolongation in patients with pacemakers and defibrillators; 2) Be familiar with the numerous psychotropic and other medications that can cause prolongation of the QTc and potentially cause Torsade de Pointes; 3) Be informed of the use of alternatives to QTc prolonging medications in the acutely medically ill patient; and 4) Conclude that pacemakers and defibrillators are not necessarily protective from Torsade de Pointes and that caution is required.

SUMMARY:

Background: Consultation liaison (CL) psychiatrists are frequently asked to recommend treatment with psychotropic drugs (PTDs) for hospitalized patients with implanted cardiac rhythm management devices (CRMDs) i.e. permanent pacemakers (PPMs), implantable cardiac defibrillators (ICDs) and cardiac resynchronization therapies (CRTs). Many PTDs can prolong ventricular repolarization, thereby increasing the risk of serious arrhythmia such as Torsade de Pointes (TdP). While many practitioners feel that the CRMD offers protection against TdP, emerging evidence suggests otherwise. **Objective:** Using the clinical vignette of a young woman with a pacemaker who developed life-threatening TdP in the course of prolonged delirium and medical illness, we illustrate the need to understand and predict the risk profile of patients with CRMDs in whom PTDs are being used. **Method:** We review the basic operative principles of CRMDs as well as the pathogenesis of drug-induced TdP. **Conclusion:** Evidence suggests that physicians should not rely on CRMDs to protect against dysrhythmia when prescribing torsadogenic medications; rather, the presence of a CRMD should serve as a marker of increased cardiac risk. CL psychiatrists should also consider the morbidity of repeated ICD shocks, including the potential for creating a pro-arrhythmic state, and the risk of acute stress reactions and post-traumatic stress disorder. Based on available evidence and clinical experience, we offer a treatment

algorithm to help guide CL teams in choosing and monitoring PTD use in this patient population.

**NO 1
CLINICAL VIGNETTE: TORSADE DE POINTES IN
A PATIENT WITH A PACEMAKER**

Speaker: Archana Brojmohun, M.D.

SUMMARY:

The author will present the case of a delirious patient with a pacemaker who developed Torsade de Pointes following the administration of QTc prolonging medications including psychotropics. This clinical vignette will serve to introduce the topic of the symposium.

**NO 2
BASICS OF CARDIOLOGY FOR PSYCHIATRISTS**

Speaker: Junyang Lou, M.D., Ph.D.

SUMMARY:

In this part of the presentation, the author will discuss the QTc; its calculation; its significance in patients with pacemakers and defibrillators. The author will also discuss the indication for those devices as well as the basics of their functioning and what the psychiatrist needs to know.

**NO 3
THE USE OF PSYCHOTROPIC MEDICATIONS IN
THE ACUTE SETTING IN PATIENTS WITH PACE-
MAKERS AND DEFIBRILLATORS**

Speaker: Margo C. Funk, M.A., M.D.

SUMMARY:

The author will review the safe treatment of the acutely ill patient with a pacemaker or defibrillator in the medical setting, especially patients with delirium. This will include the safe use of psychotropics as well as alternatives to the use of psychotropic medications when those are contraindicated. In addition, the author will present a proposed algorithm for psychiatrists when evaluating patients with pacemakers and defibrillators.

**SYMPOSIUM 113
BRINGING THE UNIFORM OUT OF THE CLOSET:
ARTISTIC AND CLINICAL PERSPECTIVES OF
GAY MILITARY LIFE BEFORE AND AFTER “DON’T
ASK, DON’T TELL”**

Discussant: Donald R. Bramer, B.S.

Chair: Eric Yarbrough, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the policy changes that have occurred in the military regarding LGBT members from a personal, professional, and artistic viewpoint; 2) Understand how military practices have further instilled internalized homophobia in their service members; 3) Identify and treat common presenting

problems by those who have experienced trauma as it pertains to being LGBT and serving in the military; and 4) Identify ways in which the United States' policies regarding LGBT members of the military are different when compared to other countries and their LGBT members.

SUMMARY:

“Don’t Ask Don’t Tell” was a United States policy that ended in September of 2011. While instated and even after, it has had negative effects on homosexuals serving in the military. Mental health care workers need to understand how this policy has affected both those serving as well as their families. This presentation will explore the effects of DADT from several viewpoints. Service members' stories will be shared through a photojournalism project of photos and oral interviews with service members affected by the military's ban on homosexuals serving. This constitutes an ethnographic record of these service members' stories that is a window into the broader mental health concerns of the population. A professional narrative will help attendees understand how policy changes came about and explain ways to identify and treat lasting scars. Other discussants will share personal accounts as well as contrast our military to those in other countries.

**NO 1
DISCUSSION: MENTAL HEALTH EFFECTS OF
“DON’T ASK, DON’T TELL”**

Speaker: Mary E. Barber, M.D.

SUMMARY:

Psychiatry has had a long relationship with the military and homosexuality. Prior to 1973, psychiatrists helped the military screen out gays and lesbians from service. Following the removal of homosexuality from the DSM, this was no longer the case, and in 1990 the APA issued a statement against discrimination in the workplace, including the military, on the basis of sexual identity. Don't Ask Don't Tell put military psychiatrists and service members needing mental health treatment in a difficult position, and was a constant source of psychological stress on those serving.

**NO 2
GAYS IN THE MILITARY: HOW AMERICA
THANKED ME**

Speaker: Vincent Cianni, M.F.A.

SUMMARY:

Gays in the Military: How America Thanked Me is a visual and audio investigation into the effects and aftermath of the military's ban on lives and careers of LGBT service members from WWII veterans to recent enlistees and active duty personnel. The project combines photographs, text and audio recounting their experiences of discrimination, harassment and civil and human rights abuses. Even though Don't Ask, Don't Tell, implemented during the Clinton administration in 1993, has recently been repealed, there have been considerable effects from the ban on homosexuality in the military over the years. The photographer discusses his project of taking photographs and conducting interviews of military veterans and service

members affected by the ban on gays and lesbians serving in the military, either before or after the enactment of the Don't Ask, Don't Tell policy and after its repeal. He reviews the history of the ban and presents excerpts from the interviews.

NO 3 FROM OTHER PARTS OF THE WORLD

Speaker: Øyvind Erik D. Jensen, M.D.

SUMMARY:

This portion of the presentation will focus on gays and lesbians serving in the armed forces in other parts of the world. The presenter is a currently serving military psychiatrist in the Norwegian Defence Medical Services, with deployments in Kosovo and Afghanistan. Norway has allowed gays and lesbians to serve in the armed forces since 1977.

NO 4 CHANGING THE POLICIES: AN INSIDER'S VIEW

Speaker: Elspeth C. Ritchie, M.D., M.P.H.

SUMMARY:

This portion of the presentation will focus on how "Don't Ask Don't Tell" was viewed and changed from within the military. It will briefly cover the evolution of Don't Ask; Don't Tell from the perspective of a military psychiatrist. Personal vignettes from Korea, Somalis and Iraq will be shared.

SYMPOSIUM 114 BEFORE IT'S TOO LATE: MOVING TOWARD A PREVENTATIVE MODEL IN PSYCHIATRY BY BUILDING RESILIENCY THROUGHOUT THE LIFESPAN

Chair: Sarah Richards Kim, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify modifiable risk factors for the development of psychiatric illness during the prenatal, postnatal, early childhood, latency, and adolescent stages of development; 2) Recognize the impact of treating mental illness in parents on the mental well-being of their children during different stages of the child's development from the prenatal to adolescent periods; 3) Appreciate the importance of treating mental illness in parents, not only to reduce the burden of disease in the adult patient, but also to build resiliency in the child.; and 4) Understand the necessity of an individual risk/benefit assessment in treatment decisions of pregnant and lactating women, which accounts not only for the risks of treatment, but also the risks of non-treatment.

SUMMARY:

Adult psychiatry is largely practiced in a reactionary fashion. The origins of psychopathology are often traced to early life experiences, but few adult psychiatrists consider themselves equipped to modify these experiences. However, a growing literature suggests that treating illness in mothers and fathers

improves the mental health of their children. As healthcare reform shifts toward a preventative model promoting wellness, identifying modifiable risk factors for psychiatric illness will be critical to the day to day work of psychiatrists. Risk factors for the development of psychopathology during childhood have been identified in large cohort studies. The growing field of perinatal psychiatry bridges the gap between child and adult psychiatry, with possibilities for intervention occurring earlier than ever before. Many clinicians are unsure how to treat women during pregnancy, fearing adverse effects on the fetus; however evidence suggests that under-treating during pregnancy also carries risks to the developing child. How we treat postpartum depression in mothers affects attachment, crucial for the mental health of the developing infant. Treating depressed mothers of depressed children in latency and adolescence increases remission rates in the children. Involving families in the treatment of depressed adolescents with chronic physical illness improves psychiatric outcomes over treating the adolescents alone. In this symposium, speakers will highlight potential points of intervention in adults and the impact on the development of mental illness and wellness in their children.

NO 1 PRENATAL, POSTNATAL, AND EARLY CHILD- HOOD RISKS: THE GENERATION R STUDY

Speaker: Frank Verhulst, M.D., Ph.D.

SUMMARY:

Environmental factors, in interplay with genetic factors, play an important role in the emergence of psychopathology. It is widely accepted that even prenatal and other early life experiences may be important determinants of later psychopathology. The GenerationR (R for Rotterdam) study is a longitudinal population based cohort in which children are followed-up from fetal life forward, with data available up to age 5 years. Intrauterine exposures including those of maternal depression, anxiety, smoking, SSRI, nutrition, and cannabis were studied in relation to fetal growth and later child problems. Also influences such as family functioning, breast feeding, paternal psychopathology, harsh parenting, socioeconomic differences, and TV viewing on child development were studied. A cumulative risk model suggests that as genetic, perinatal, and environmental risk factors accumulate, the child is at progressively greater risk, despite the small impact any single factor is likely to have.

NO 2 SSRI TREATMENT OF DEPRESSION DURING PREGNANCY

Speaker: Katherine Wisner, M.D., M.S.

SUMMARY:

Are SSRI safe to use during pregnancy? The word safe has no operational definition in this context. The establishment of any exposure as harmless presents the impossible task of proving no effect on an infinite number of reproductive & developmental outcomes throughout the exposed offspring's lifespan. The author will summarize clinical & epidemiologic

studies that estimate a subset of reproductive risks in SSRI-treated women. New data from in offspring exposed in utero to SSRI, Major Depressive Disorder, or Neither will be presented: 1) growth parameters (weight, length, head circumference) and, 2) Bayley Mental and Psychomotor Development Indices & Behavioral Rating Scale, across the first year of life. The author will synthesize the research into clinically relevant information for risk-benefit decision making. From population-level data, the physician must communicate the nature and probability of the risks of treatment and of disease exacerbation.

Data: NIMH R01 MH60335

NO 3 EVALUATION AND TREATMENT OF MOTHER-INFANT ATTACHMENT ON A PERINATAL PSYCHIATRY INPATIENT UNIT

Speaker: Samantha Meltzer-Brody, M.D.

SUMMARY:

Introduction: The University of North Carolina at Chapel Hill opened a new Perinatal Psychiatry Inpatient Unit (PPIU) in 2011 to provide state of the art care for women suffering from severe perinatal psychiatric illness. The PPIU is the first of its kind in the US and encourages extensive interaction between mother and baby to promote attachment during this critical time period. Objective: To describe symptom change from admission to discharge via assessment batteries. Mood, anxiety, trauma history, mania, social support, and mother-infant attachment are assessed. Results: We describe data from the first year of the PPIU. There was clinically and statistically significant symptom improvement observed in all domains, with a focus on mother-infant bonding. Conclusion: The UNC PPIU was developed to provide intensive psychiatric care in a safe and supportive setting. Specialized interventions appropriate for the perinatal period have been developed and demonstrate excellent response.

NO 4 TREATING DEPRESSED MOTHERS AND HELPING THEIR CHILDREN (AGES 7-17): RESULTS FROM CLINICAL TRIALS

Speaker: Myrna Weissman, Ph.D.

SUMMARY:

The offspring of depressed, as compared to non depressed, parents have high-rates of major depression. These problems begin early and are recurrent through their lifetime. Results from several clinical trials using pharmacotherapy or psychotherapy show that a high percent of children of depressed mothers are also in an episode at the time the mother comes for treatment. These studies also show that mother's remission from depression is associated with the child's improvement. The more rapid the mother's remission, the sooner the child recovers. The implication of these findings for identification, clinical care and personalized treatment will be discussed.

NO 5 FAMILY INTERVENTIONS IN TREATING MENTAL ILLNESS IN ADOLESCENTS WITH CHRONIC MEDICAL ILLNESS

Speaker: Eva Szigethy, M.D., Ph.D.

SUMMARY:

Youth with physical illness have high rates of depression (DEP) which is associated with poor medical outcomes. Inflammatory bowel disease (IBD) has been shown to have high rates of DEP and poor quality of life (QoL). Parents of youth with IBD have been shown to have increased rates of psychological distress and poor communication, factors that can even further negatively impact the child's emotional and physical disease course. This presentation will summarize results of a randomized trial comparing cognitive behavioral therapy (CBT) to supportive therapy (ST) in 224 depressed youth ages 9-17 with IBD with emphasis on how addition of parent sessions to child sessions impacted outcomes at 3 months. Both therapies were effective in improving DEP, IBD, and QoL in the youth and distress in parents. The addition of parental sessions further enhanced outcomes. These findings show the importance of integrating family-based therapy in the treatment of pediatric chronic physical illness.

SYMPOSIUM 115 APPROACHES TO TREATING REFRACTORY OBSESSIVE-COMPULSIVE DISORDER ACROSS THE LIFESPAN

Chair: Jerry Halverson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand some of the controversies in diagnosis and treatment of OCD in children and be able to discuss treatment approaches for patient and family system; 2) Understand the use of cognitive behavioral therapy in OCD and identify strategies for working with more difficult to treat presentations of OCD; 3) Understand the evidence base for medications in OCD and be able to construct a medication treatment plan for OCD based on previous medication trials; 4) Understand the rationale for combining medications and psychotherapy in the treatment of difficult to treat OCD; and 5) Understand the use of neurocircuit-based treatments in difficult to treat OCD and be able to understand the current evidence base.

SUMMARY:

Obsessive-compulsive disorder (OCD) is an anxiety disorder in which people have unwanted and repeated thoughts, feelings, ideas, sensations (obsessions), or behaviors that make them feel driven to do something (compulsions). In many cases it may be highly refractory and difficult to treat with standard interventions. Research on OCD continues to expand and there are now many approaches to treatments that were not as well known when the APA treatment guidelines were published in 2007. This symposium will have many of the top researchers in the field of OCD treatment discuss treatment

of difficult to treat OCD throughout the lifespan. S. Evelyn Stewart, MD will discuss the diagnosis of OCD in pediatric populations as well as treatment approaches that address both the patient and the family system. Bradley Riemann, PhD will discuss the use of cognitive behavioral therapy in OCD and give practical clinical recommendations on how to adjust the therapy for the more difficult to treat populations. Darin Dougherty, MD will present the evidence base and a practical approach to using medications in OCD, with an emphasis on the more difficult to treat presentations. Jerry Halverson, MD will discuss the combination of medication and psychotherapy in the treatment of OCD at the more intensive outpatient and residential levels of care. Finally, Benjamin Greenberg MD, PhD will present data on neurocircuit based treatments of refractory OCD such as rTMS, deep brain stimulation and neuroablative surgeries. There will be time for discussion and Q/A.

NO 1 FAMILY FUNCTIONING AND INTENSIVE TREATMENT IN PEDIATRIC OCD

Speaker: S. Evelyn Stewart, M.D.

SUMMARY:

OCD is a common illness affecting patients & family members. This study examines OCD-related family 95% OCD-affected families completed a validated OCD OFF Scale. 6 GF-CBT participants completed measures of OCD, impact and family functioning at pre, mid, and post-treatment. Statistical significance was defined by $p < 0.05$. Among subjects completing the OFF during worst OCD, youth and parents reported similar family impairment ($p > 0.05$). Fathers reported less daily OCD-related social ($p = 0.02$) and work performance ($p < 0.001$) impacts and lower emotional impact ($p = 0.001$) compared to mothers. Among GF-CBT participants, OCD severity decreased by 17.6% ($p = 0.03$) at midpoint and by 31.4% ($p = 0.02$) at post-treatment. All measures decreased (non-significantly) between pre & post-treatment. Family functioning impairment is common in Pediatric OCD. Piloting a GF-CBT approach demonstrated success.

NO 2 CRITICAL ADJUSTMENTS OF CBT MODELS IN TREATMENT OF REFRACTORY OCD

Speaker: Bradley Riemann, Ph.D.

SUMMARY:

Cognitive-behavioral therapy (CBT) has been found to be effective in treating obsessive-compulsive disorder (OCD) either as a stand-alone treatment or in combination with medication. However, some individuals with OCD do not respond to standard CBT treatment protocols. This talk will focus on reasons why standard protocols are insufficient for some (e.g., severity, comorbidity, lack of insight) and ways to adjust CBT treatment models to produce effects in nonresponders. The later will focus on dose of treatment as well as issues such as the graduated nature of exposure. Research data will be utilized throughout the presentation.

NO 3 PHARMACOTHERAPY APPROACHES TO TREATING REFRACTORY OBSESSIVE-COMPULSIVE DISORDER

Speaker: Darin D. Dougherty, M.D., M.Sc.

SUMMARY:

This presentation will focus on pharmacological approaches to treating obsessive compulsive disorder (OCD) if patients are nonresponsive to first line pharmacotherapy approaches (namely serotonin reuptake inhibitors [SRIs]). Approaches discussed will include both alternative monotherapy and SRI augmentation strategies. This will include discussions regarding the efficacy of serotonin-norepinephrine reuptake inhibitors and monoamine oxidase inhibitors as monotherapy and SRI augmentation with neuroleptics. The presentation will conclude with new directions in OCD pharmacotherapy, including treatment with glutamatergic agents. At the end of the presentation, participants should have a solid understanding of the current state of pharmacological treatment of OCD.

NO 4 RESIDENTIAL TREATMENT: COMBINING MEDICATIONS, EXPOSURES, AND MILLIEU THERAPY FOR OPTIMAL TREATMENT OF REFRACTORY OCD

Speaker: Jerry Halverson, M.D.

SUMMARY:

This presentation will discuss the combination of medications and Cognitive Behavioral Therapy/ Exposure Response Prevention for treatment of refractory OCD in adults. Data and rationale for combining medications and psychotherapy in refractory OCD will be presented and discussed. Finally, I will discuss the application of combined approaches in vivo at the residential and partial hospitalization level of care and will present case examples and treatment efficacy data.

NO 5 NEUROCIRCUIT-BASED TREATMENTS FOR OCD

Speaker: Benjamin Greenberg, M.D., Ph.D.

SUMMARY:

Surgical ablation and deep brain stimulation (DBS), are used only in the small subset of individuals with chronic, disabling, and treatment-intractable illness. Stereotactic lesions and DBS differ in their onset of action, and carry different risks and burdens. These procedures are intended to modulate prefrontal cortex-basal ganglia-thalamic circuitry implicated in OCD. Data are mainly open-label, though small studies have used sham-controlled DBS. And sham gamma knife lesions were compared to actual ablation in the first controlled trial of ablation in psychiatry. Across procedures, meaningful benefit appeared in 30-60%. The longstanding clinical impression that behavioral therapy becomes more effective after surgery continues. It is hoped that better delineation of brain and behavioral mechanisms underlying therapeutic benefit will also guide less invasive treatments, e.g. rTMS, first used in OCD

15 years ago, but still early in development for the illness.

SYMPOSIUM 116 HIV, STD, AND RELATED MEDICAL COMORBIDITIES

Chair: Marshall Forstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of complex relationship between immunological, endocrinological, and psychological systems; 2) Demonstrate knowledge of HCV and HIV viral interactions and their corresponding medication interaction; 3) Demonstrate knowledge of HIV-related cardiovascular concerns, including hyperlipidemia, inflammation, and interaction of cardiac meds with ARV's; and 4) Demonstrate knowledge of gastrointestinal issues that cause emotional distress and/or result from drug interactions.

SUMMARY:

Infection with HIV and progression to AIDS is associated with a number of co-occurring systemic medical complications and illnesses, all of which can be a significant source of distress and suffering for persons with HIV/AIDS. These complications may include HCV, metabolic changes, cardiovascular problems, endocrine abnormalities, and gastrointestinal issues. These disorders may be associated with HIV infection, or alternatively complications related to treatment with antiretroviral medications. HIV infection is also commonly associated with Hepatitis C. The symposium on is not intended to provide a lengthy discourse on each topic addressed, but rather a general overview that will provide psychiatric clinicians with a basic working knowledge of co-morbid medical conditions and enhance their understanding of associated psychiatric conditions and psychological distress. Presentations included in the larger symposium would include: 1) Interactions between psychiatric illness, STDs, and HIV, 2) the complex relationship between immunological, endocrinological, and psychological systems, 3) HCV and HIV viral interactions and their corresponding medication interaction; and 4) HIV-related cardiovascular concerns, including hyperlipidemia, inflammation, and interaction of cardiac meds with ARV's.

NO 1 ENDOCRINE ABNORMALITIES IN HIV INFECTION

Speaker: Marshall Forstein, M.D.

SUMMARY:

A number of endocrine abnormalities develop in patients with HIV infection, including diabetes, insulin resistance, dyslipidemia, and lipodystrophy, thyroid disorders, hypogonadism, and sexual dysfunction. Psychiatric symptoms and syndromes are common in patients with endocrine disorders. Depression is most frequent, but anxiety, hypomania/mania, psychosis, and cognitive dysfunction are all common. This 20 minute presentation will address endocrine the manifestations and how treatment can help patients achieve a better quality of life.

NO 2 CARDIOVASCULAR RISK AND HIV

Speaker: Francisco Fernandez, M.D.

SUMMARY:

People with HIV have a higher risk for cardiovascular disease. Cardiovascular disease (CVD) can be associated with HIV infection, opportunistic infections, use of antiretroviral drugs, or with classic risk factors (such as smoking or age). Psychiatric disorders and CVD also coexist. Mood and anxiety disorders in particular have been linked to heart disease, particularly anxiety or depression. The treatment of psychiatric disorders in patients with CVD/HIV can be challenging because of the cardiovascular side effects of many psychotropic medications as well as the potential of multiple drug-drug interactions. During this presentation faculty will provide an overview of CVD and HIV and review recommended treatment interventions and precautions.

NO 3 INTERACTIONS BETWEEN PSYCHIATRIC ILLNESS, STDS, AND HIV

Speaker: Marc Safran, M.D., M.P.A.

SUMMARY:

This 20 minute presentation will provide an overview of common STDs that psychiatrists should be aware of, as well as why they may be relevant in the context of psychiatric treatment. Clinical and public health issues related to interactions between psychiatric illness, STDs, and HIV will be explored. Implications for psychiatrists treating persons with HIV will be considered.

NO 4 HEPATITIS C AND HIV COINFECTION

Speaker: Antoine Douaihy, M.D.

SUMMARY:

The increasing health care crisis of co-infection with hepatitis C virus (HCV) and HIV has recently attracted the attention of research in the areas of psychiatric and neurocognitive complications related to co-infection. The preliminary data suggest that HIV/HCV co-infection has neurocognitive and psychiatric effects. This presentation will review the findings of what is known about the neurocognitive and psychiatric aspects of HIV/HCV co-infection and discuss the clinical implications and challenges in working with co-infected persons.

SYMPOSIUM 117 NEW FRONTIERS IN PLACEBO EFFECTS

Chair(s): Devdutt Nayak, M.D., Eric D. Peselow, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify psychosocial circumstances in understanding placebo effects in Psychiatry; 2) Elaborate biological and psychological basis of enhancing beneficial effects of Place-

bos; 3) Recognize controversies in Ethical use of placebos in Research and Clinical Practice; 4) Describe role of therapeutic relationship in Psychosomatic Medicine; and 5) Identify the impact of Placebo research in evaluating robustness of medications and psychotherapy in Clinical Psychiatry;

SUMMARY:

Trickery or treatment? Bane or boon to research? Adding depth to our knowledge or an embarrassment to psychiatry as a neuroscience? Placebo effects are fascinating, intriguing, but remain controversial. In this symposium, we will explore the new concepts of placebo effects from biological, psychological, ethical research and clinical practice perspectives. Belief and expectations are fundamental to the biological effects of placebos. They appear to activate qualitatively different physiological systems such as opioid circuitry, learning circuits, and expectancy and reward networks. Loss of prefrontal executive circuits (as in Alzheimer's Disease, ADHD, Schizophrenia) reduces placebo effectiveness. Analgesics and anti-anxiety drugs are much less effective in 'hidden' administration. Verbal and nonverbal communications including words, gestures, and demeanors can mediate and modulate the intensity of placebo responses. Searching for 'the meaning' in the psychotherapeutic encounter can enhance unconscious healing through exploring life experiences in the social and cultural context. Active ingredients of any effective psychotherapy appears to be faith, belief, trust, hope AND relationship. Double-blinded clinical trials remain the best scientific method to evaluate efficacy of the interventions but placebos have become a "nuisance" to statisticians in analyzing their confounding effects. Meta-analyses of placebo responses in mental disorders show a 60% response in major depression, 53% in GAD, and 23% in OCD and schizophrenia. All psychotherapies appear to be 'empirically validated' but show only modest superiority or equivalence over other psychotherapies, none directly related to their unique technique. FDA, AMA, and WHO have contrasting positions on use of placebo. Placebo opponents argue that ethical obligations to a single subject override the benefits to science and society and even minor discomfort of symptoms does not justify the use of placebo. The informed consent issue remains problematic and was intensely debated in suicidal and schizophrenic patients. This is a uniquely vulnerable population who cannot make a truly informed decision to participate in research. Can use of placebo pill ever be ethically justified in clinical practice? All therapeutic approaches may be equally efficacious and have common factors. All effective therapists appear confident, communicate clearly, and express concerns and empathy. The most reliable source of a strong placebo effect is a doctor. Purely placebo responding patients are nonexistent but it is possible to hone your skills as a placebo effect enhancing practitioner. The professionals need to acquaint themselves with the new concepts of placebo effects.

NO 1 NEUROBIOLOGICAL PERSPECTIVES OF PLACEBOS

Speaker: Ramakrishna R. Veluri, M.D.

SUMMARY:

The brain is the primary site where placebo response takes place via different mechanisms -conditioning, learning and anticipation of reward. Placebo response can produce modulation of release of different neuro transmitters, changes in HPA, endocrine systems, immune suppression and regulate the release of polypeptides. The Opioid, Dopamine and Serotonergic are the three major neuro transmitter systems involved in the placebo response. Factors such as stress, motivation, mood and cognition will influence the extent of placebo response as well as prior priming the patient with the medications. Genetic variability may also play a role. Prefrontal neurocircuitry is the key brain structure involved in inducing the placebo responses and damage to this circuitry affects placebo effects in patients with Alzheimer's dementia, Schizophrenia ADHD and OCD.

NO 2 PSYCHOLOGY OF PLACEBO EFFECTS

Speaker: John Naliyath, M.D.

SUMMARY:

Placebo effects are known since antiquity. "The cure itself is a certain leaf, but in addition to the drug there is a certain charm, which if someone chants when he makes use of it, the medicine altogether restores him to health, but without the charm there is no profit from the leaf"- Plato Hope, faith, anxiety reduction, expectations, search for meaning, are some of the mechanisms contributing to placebo effects. Studies suggest that the material aspects of pills influence patient's perception and response. Psychoanalytic thinking has given us insight into developmental psychology and the genesis of mind-body activity which can lead to unconscious healing and even the placebo effects. Early childhood experiences are very important in shaping the way we think about healing, Psychologist have proposed that early care givers are 'hidden regulators' of infant's somatic activities and modulates infant's level of ANS arousal and future emotional well being.

NO 3 PLACEBOS IN RESEARCH CLINICAL TRIALS

Speaker: Noshin Chowdhury, M.D.

SUMMARY:

Clinical trials remain the best scientific method to evaluate efficacy of new therapeutic interventions. The placebo arm is considered as "nuisance" in analyzing confounding non specific effects. Meta-analytic research of placebo responses in psychiatric disorders show about 60 % response in Major Depression, 50 % response rate in GAD, and only 20% response in OCD and Schizophrenia. Sham ECT Meta-analytic research estimates a placebo response upwards of 40 %. All bona fide psychotherapies appear to be efficacious over "inactive" comparators but are more or less equal when compared with one another. It is very difficult to design blinded studies in this crucial and sensitive area as therapist knows what treatment is being delivered.

NO 4**PLACEBOS POSE ETHICAL DILEMMAS**

Speaker: Vicky Chodha, M.D.

SUMMARY:

NIMH statistics clearly show the need for research in mental disorders but the ethical problems pose a clear hazard in using placebo in clinical research and everyday practice as well. Bioethical experts have deliberated on the issues of informed consent in conducting research in mentally ill people. Others have questioned placebo strategies asking, can placebo be distinguished from non-specific effect? The burden of the proof should be on the researcher and not subjects. FDA considers placebos as the 'gold standard' of research. Using placebos in suicidal patients have raised thorny legal and ethical questions. Some have argued that placebo pills be used as "cures." The concept of 'deception' needs to be addressed. Other issues in everyday practice are ethics of "off label" use and adequate disclosure of side effects.

NO 5**ENHANCING PLACEBO RESPONSE IN CLINICAL PRACTICE**

Speaker: Devdutt Nayak, M.D.

SUMMARY:

Some practitioners are known to consistently elicit more positive responses via their communications and "bedside manners", regardless of the techniques of their particular therapy itself. They have something in common: Healing setting, Are empathic listeners and good communicators. Active listening coupled with inaction contributes to a placebo response. Confidences, enthusiasm, willingness to reassure, hope promotion, and appropriate touching is important elements of positive communication style. Placebo enhancement often occurs in the context of seeking patient participation in health decision making, mutually shared belief system between the doctor and the patient and a willingness to adapt medical goals to patient's values and needs. A person coming to psychiatrist also brings significant distress and inability to cope BUT it also creates a state of heightened suggestibility to benefit from the recommended intervention and restores morale.

SYMPOSIUM 118**A PRIMER ON PREVENTION IN PSYCHIATRY**

Chair(s): Ruth Shim, M.D., M.P.H., Michael T. Compton, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define and provide medical and psychiatric examples of universal, selective, and indicated preventive interventions; 2) List 5 risk factors for suicide that can be incorporated into routine psychiatric interviews; and 3) Describe 3 universal preventive interventions developed to reduce the incidence of alcohol and/or drug abuse and dependence.

SUMMARY:

In recent decades, psychiatrists, psychologists, preventionists, and allied professionals have learned a great deal about risk and protective factors related to mental illnesses, as well as the development of evidence-based interventions addressing such factors and disorders. Prevention has been the mainstay of the field of public health; however, this population-based approach is now being embraced by the general health sector and is becoming more widely accepted in the mental health field. Both general medicine and psychiatry are primarily involved in individual-level treatment, but with widespread prevalence of chronic medical and psychiatric illness, and an increasing aging population, there has been growing recognition of the importance of a population-based prevention approach. Psychiatrists and other mental health professionals should adopt a "prevention-minded" approach to clinical practice. This session will provide psychiatrists with an overview of prevention principles and how they can be applied in psychiatric practice. The presenters are members of the Prevention Committee of the Group for the Advancement of Psychiatry (GAP) and will draw from their work in the American Psychiatric Publishing book, *Clinical Manual of Prevention in Mental Health*.

NO 1**INTRODUCTION TO PREVENTION PRINCIPLES**

Speaker: Ruth Shim, M.D., M.P.H.

SUMMARY:

Dr. Shim will discuss classifications of prevention, the concepts of risk and protective factors, the justification for an increasing focus on prevention in psychiatry, recommendations for enhancing training in prevention, and the ways that prevention can be incorporated into integrated care settings.

NO 2**CONSIDERING SCHIZOPHRENIA FROM A PREVENTION PERSPECTIVE**

Speaker: Michael T. Compton, M.D., M.P.H.

SUMMARY:

Dr. Compton will discuss the epidemiology of schizophrenia, including the onset, phenomenology, and course, and define and describe risk factors and risk markers for schizophrenia. This presentation will examine primary, secondary, and tertiary prevention of schizophrenia and consider universal, selective, and indicated preventive interventions efforts. Practical, specific applications of prevention principles to schizophrenia will be considered.

NO 3**SUICIDE PREVENTION**

Speaker: Frederick Langheim, M.D., Ph.D.

SUMMARY:

Dr. Langheim will discuss the epidemiology of suicidal behavior, and risk/protective factors for suicide. In addition, up to date primary, secondary, and tertiary prevention of suicidal behavior will be examined, with emphasis on universal, selec-

tive, and indicated suicide preventive interventions. This presentation will provide specific suicide prevention advice that practitioners can apply to their interactions with patients.

NO 4 SUBSTANCE ABUSE PREVENTION

Speaker: Rebecca Powers, M.D., M.P.H.

SUMMARY:

Dr. Powers will present on the risk and protective factors associated with alcohol abuse/dependence and substance abuse/dependence, and will also discuss the various issues that complicate the effective prevention of substance use disorders. In addition, universal, selective, and indicated preventive interventions will also be discussed. The presentation will highlight specific strategies for mental health professionals on preventive interventions and relapse prevention in patients with alcohol and substance use disorders.

NO 5 APPLYING PREVENTION PRINCIPLES IN PSYCHIATRIC PRACTICE

Speaker: Christopher Oleskey, M.D., M.P.H.

SUMMARY:

Dr. Oleskey will present eight prevention principles that mental health professionals should consider in their efforts to become prevention-minded mental health professionals. These principles will summarize key concepts of the overall symposium and will discuss the importance of epidemiology and risk and protective factors, the feasibility of applying evidence-based preventive interventions in a clinical setting, and the overall role of mental health professionals in mental health promotion and mental illness prevention.

SYMPOSIUM 119 PEDIATRIC BIPOLAR DISORDER IN ITS HISTORICAL PERSPECTIVE: AN EXAMINATION OF REASONS FOR ITS CONTROVERSIAL STATUS

Chair: Edmund C. Levin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Better understand the multiple factors which have led to the diagnosis of Pediatric Bipolar Disorder being surrounded by controversy; 2) Appreciate that the style of conceptualizing the reasons for symptom development may strongly influence the assigned diagnosis; 3) Improve patient care by understanding more the importance of performing comprehensive diagnostic evaluations which include a focus on attachment problems and trauma histories; 4) Appreciate that the effects of early trauma (Adverse Childhood Experiences) are both physical and mental and may endure across the entirety of the life cycle; and 5) Appreciate that rates of diagnosis of Pediatric Bipolar Disorder vary internationally and consider reasons for this aspect of the controversy.

SUMMARY:

An editorial in the *AJP* describes Pediatric Bipolar Disorder (PBD) as “notoriously controversial” (Ghaemi & Martin, 2007). The rise in PBD has drawn comment in the psychiatric literature and public media. Part of the controversy has centered on two differing constructs of PBD being used—“narrow” and “broad phenotype” PBD. To mitigate against a perceived over-diagnosis especially of broad phenotype PBD, a new diagnosis has been proposed, Disruptive Mood Dysregulation Disorder (DMDD). Both diagnoses have been criticized as each fails to consider contextual factors in children’s lives. In particular PBD research has been criticized for not giving due consideration to traditional aspects of child psychiatry, namely: attachment, trauma, neglect and family dynamic factors (e.g. McLennan, 2005). Increasingly, research in adult cohorts has highlighted the role of relational trauma in childhood to a wide range of physical and psychiatric morbidities across the lifespan (Felitti et al., 2002). Child psychiatric problems are best understood in a biopsychosocial framework centered on developmental history and the context of a child’s life (Carlson & Meyer, 2006). In a similar manner, trends and shifts in research and practice in psychiatry can be better understood in a historical and socially dynamic context. Psychiatry straddles the diverse field of the sciences and humanities. It is susceptible to historical, social and economic forces that may engender paradigm shifts. It has been argued that psychiatry has moved in recent decades from an over-emphasis on psychosocial contextual factors, i.e., as in “brainless psychiatry,” to a current over-emphasis on biological factors centered within the child, or “mindless psychiatry.” This symposium examines the emergence of PBD as a widespread diagnosis, at least within the USA, over the past two decades with an eye to factors engendering a paradigm shift within psychiatry and society over the same time period. One Australian and three American Child and Adolescent Psychiatrists, aware from their practices and from the lay and professional media of the controversy surrounding PBD, attempt to understand the complex reasons for this. Their presentations address: 1. A review of the PBD and DMDD literature finds a relative absence of attachment theory and minimal examination of abuse and developmental trauma. Additionally, it reveals that clinical practice and diagnosing rates vary markedly internationally. 2. The failure of structured research child psychiatric interviews to reliably describe bipolar phenomenology in childhood is documented. Ways to enhance reliability and validity are recommended. 3. The fates of certain historic diagnostic and treatment approaches are reviewed. While some yielded great benefits, others proved over time to be only fads. 4. Finally, a child psychiatrist documents that a geriatric clinic population can be differentiated on the basis of the presence or not of an early trauma history.

NO 1 PEDIATRIC BIPOLAR DISORDER OR DYSPHORIC MOOD DYSREGULATION DISORDER: BUT WHERE’S THE TRAUMA? ARE ATTACHMENT AND TRAUMA CONSIDERED IN PBD AND DMDD?

Speaker: Peter Parry, M.B.B.S.

SUMMARY:

Objective: A major criticism of the validity of Pediatric Bipolar Disorder (PBD) has been that children exhibiting such emotional and behavioral dysregulation are better understood from an attachment theory and developmental trauma perspective. Another is that research into PBD has overlooked these factors. Dysphoric Mood Dysregulation Disorder (DMDD) has been proposed for DSM5 mainly to mitigate overdiagnosis of PBD. This presentation will examine to what extent the literature on PBD and now DMDD considers attachment and trauma factors. Paradigmatic considerations will be discussed as to why phenomenological factors are emphasized in research apparently at the expense of contextual factors. International variation in the diagnosis of PBD is marked. Although some epidemiological studies show higher rates similar to some USA studies, rates of diagnosis in clinical practice, particularly of pre-pubertal PBD, remain generally low outside North America.

NO 2**IN THE MIND OF THE BEHOLDER: DIAGNOSING BIPOLAR DISORDER IN CHILDHOOD WITH A STRUCTURED PSYCHIATRIC INTERVIEW**

Speaker: Stuart Kaplan, M.D.

SUMMARY:

The objective of this paper is to discuss the failure to reach a consensus about the appearance of bipolar disorder in children as a cautionary reminder that the structured psychiatric interview cannot, itself, validate a diagnosis. The loss of general agreement about this diagnosis in childhood is most prominently marked by the proposed DSM-5 diagnosis of Severe Mood Dysregulation Disorder. The author finds that one of the reasons for the controversy relates to the problems stemming from the use of the structured psychiatric interview. He concludes that such use has failed to provide a coherent clinical description of bipolar disorder in childhood and techniques from social psychological research might be helpful in resolving the problem.

NO 3**PARADIGM SHIFT: THE EVOLUTION OF THE CONCEPT OF DEPRESSION, RELATED DISORDERS, AND THE RISE OF THE DIAGNOSIS OF PEDIATRIC BIPOLAR DISORDER**

Speaker: Stuart Bair, M.D.

SUMMARY:

The objective of this paper is to develop an historical perspective on diagnostic and therapeutic paradigms of mood disorders and associated comorbidities and to highlight their advantages, limitations, sometimes serendipitous discoveries and to consider the ultimate benefit of each in light of the current controversy about pediatric bipolar disorder. To do so, the author considers: a) the changing concept of depression in childhood from psychoanalytic to biochemical; what is lost, what is gained? B)The schizophrenogenic mother,the refrigerator mother, double bind theory (i.e. blame mom); what is the role of dynamic interactions in symptom formation? C)

Cade's discovery of the use of lithium for manic depressive disorder;why are the response rates so different for children? d)the Feingold diet forADHD;what is the contribution of environmental factors? e)Bradley's discovery of the use of amphetamine for Hyperkinetic Disorder;where does ADHD fit in?

NO 4**DEVELOPMENTAL TRAUMA DISORDER IS NOT JUST FOR KIDS: MENTAL AND PHYSICAL CONSEQUENCES OF EARLY TRAUMA IN A GERIATRIC POPULATION**

Speaker: Edmund C. Levin, M.D.

SUMMARY:

The objective of this paper is to understand the pervasive and persistent consequences of early chronic trauma as it effects both the physical and psychologic spheres. Emphasized is the importance of having a familiarity with Developmental Trauma Disorder and the Adverse Childhood Experiences (ACE) Study. While providing consultation to a geriatric clinic, the author discovered that two groups of referrals were made to him: One was characterized by histories of early chronic trauma (ACE) and one was not. The group without a trauma history was older but tended to be generally more physically and mentally healthy. However there were within this group a higher percentage of patients with dementia, usually diagnosed as due to Alzheimer's. The group associated with significant early chronic trauma histories was younger and had more diagnoses relating to physical illness. The fewer dementias in this group tended to be not Alzheimer's but secondary to addictions and general poor self care.

SYMPOSIUM 120**REFUGEES AND EXILES: MENTAL HEALTH IMPLICATIONS, REPATRIATION, AND INTEGRATION**

Discussant: Andres J. Pumariega, M.D.

Chair(s): Rama Rao Gogineni, M.D., Driss Moussaoui, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the socio-political context of refugees and their implications for mental health; 2) Learn the impact of stress, trauma on the psychic functioning of refugees and exiles;3) Understand the role of loss, grief, assimilation, acceptance in refugees; and 4) Learn ways of addressing socio-cultural and treatment aspects of helping refugees and exiles.

SUMMARY:

Number of refugees and displaced people in today's world is about 25-50 million. Refugees represent a variety of cultures, races and nations ,from about 40 current world wide conflicts. In the recent conflicts in Kosovo and the genocide in Rwanda show the difficulties faced by international organizations in trying to protect civilians. Risk factors that may predispose refugees and asylum seekers to psychiatric symptoms and disorders include: exposure to war, state-sponsored violence

and oppression, including torture, internment in refugee camps, human trafficking, physical displacement outside one's home country, loss of family members and prolonged separation, the stress of adapting to a new culture, low socioeconomic status, and unemployment. Stressors of refugees include separation from family and community; an unwelcome host community; prolonged or severe suffering prior to exile; being elderly or adolescent; lacking knowledge of the host language and loss of socioeconomic status. The 4 presentations will illustrate the complexity, socio-cultural, psychiatric aspects of 4 different groups. Afghan refugees in Pakistan show 70% PTSD or trauma related syndromes aggravated by floods, poverty, suicidal bomb blasts etc., Kosovar and Bosnian refugees manifest PTSD with hyperarousal and numbing. "New Pittsburghers" refugees from Bhutan, Nepal, Myanmar etc. were helped by supportive resettlement efforts by psychiatry. Cuban exiles from South Florida reported frequent thoughts related to their losses, separations, and psychology of "forced departure". Points to consider when treating asylum-seekers or refugees: Bear in mind that the patient may be extremely anxious about the security of personal information. Issues of trust may be problematic; use organizations such as Human Rights Watch. Studies have shown a high prevalence of depression, post-traumatic stress disorder (PTSD), panic attacks, somatization, and traumatic brain injuries in refugees. Psychotherapy for refugees should not be restricted to symptom reduction but can be extended to include improvement in their human relationships and life functioning. The training of qualified mental health practitioners for psychotherapy and counseling of refugees is a necessary prerequisite of any refugee mental health program.

NO 1 AFGHAN REFUGEE CRISES: A RAY OF HOPE

Speaker: Khalid A. Mufti, M.D.

SUMMARY:

40 years of recurring trauma, torture and destruction of socioeconomic infrastructure to Afghans during the on going war has led them to take refuge in very large numbers in Pakistan, mostly in the border areas including Peshawar, Pakistan. Various estimates in cross sectional studies showed 40 to 70 % PTSD and other trauma related syndromes. This may not be looked as fiction and is based on the real world experiences as well. Mental Health is currently aggravated by terrorism (suicidal bomb blasts), violence, poverty, floods, frequent internal displacement in Pakistan have added criminal activities in refugees. As a result the psychiatric morbidity including suicide in women and children has shown a rapid increase. Different types of torture and trauma witnessed differently by males and females. HORIZON, a local based NGO, skilled in Disaster Mental Health has distinguished itself as the fore runner organisation providing sustainable treatment and support refugee Afghans.

NO 2 EMOTIONAL NUMBING IN EASTERN EUROPEAN REFUGEES DIAGNOSED WITH PTSD

Speaker: Aida Mihajlovic, M.D., M.Sc.

SUMMARY:

In the advent of conflict worldwide, there are a growing number of refugees with PTSD. Due to a significant increase in Eastern European refugees, it is important to account for heterogeneity within PTSD in this population. An important symptom of chronic PTSD is numbing of general responsiveness. Interestingly, there is both hyperarousal yet blunted emotional affect. In a follow-up to our 2005 study of Bosnian refugees, our new study explores if emotional blunting is applicable to other European refugees with PTSD. Subjects rated their reactions to pleasant imagery using Lang's Looking at Pictures test. The results of this study showed that PTSD numbing is seen primarily with positive stimuli. According to the Department of Homeland Security, 56,384 refugees were admitted to the U.S. in 2011; therefore, screening and identifying the core symptoms of PTSD is essential for optimal treatment of this patient population.

NO 3 HISTORICAL TRAUMA, LOSSES, AND SEPARATIONS: A PILOT STUDY TO EVALUATE THE PSYCHOLOGICAL PROBLEMS OF EXILES

Speaker: Eugenio Rothe, M.D.

SUMMARY:

Exile represents a specific type of migration which is frequently traumatic and characterized by a forced departure from the country of origin with no possibility of return. There is a scarcity in the psychiatric literature with regard to the mental health of exiles and the psychiatric symptoms that accompany these losses. Methods: A sample of 240 adult Cuban exiles residing in Miami, Florida was interviewed using the Historical Trauma Questionnaire (Whitbeck et al., 2004). The instrument was designed to measure this condition in Native-Americans and it was translated into Spanish and adapted, taking into account the historical and cultural characteristics of Cuban exiles that reside in South Florida. Results: More than 60% of the sample reported frequent thoughts related to the emotional losses and family separations resulting from the experience of emigration and exile. Conclusions: The psychological consequences of the experience of exile have not been properly studied.

NO 4 RESETTLEMENT, PRIMARY CARE, AND PSYCHIATRY: THE VIEW FROM PITTSBURGH

Speaker: Kenneth Thompson, M.D.

SUMMARY:

The Squirrel Hill Health Center, a federally qualified health center, was established to serve religious and ethnic minority populations, with a special focus on "new Pittsburghers". Over the past few years, as the US and Pittsburgh have

experienced a largely unrecognized influx of refugees, exiles and economic refugees, the clinic has focused on these ‘new Pittsburghers’ providing them with integrated medical and psychiatric care. The challenges and rewards associated with each population- Latinos, Iranians, Burmese and Nepali Bhutanese- have been substantial. This presentation will describe the experience of working with traumatized, displaced people and explore the roles that psychiatry and psychiatrists might take in supporting their resettlement

SYMPOSIUM 121

CULTURE AND DSM-5: CHANGES TO DISORDER CRITERIA AND TEXT

Discussant: David Kupfer, M.D.

Chair: Roberto Lewis-Fernandez, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the reasons why cultural variation was incorporated into DSM-5 and the process that was followed to achieve this goal; 2) Describe the changes to the Anxiety Disorders text and criteria to make DSM-5 more culturally sensitive and valid across cultures, focusing on Panic Disorder and Social Anxiety Disorder; 3) Describe the revisions of the Feeding and Eating Disorders in DSM-5 that encompass a broader range of culturally diverse illness presentations, focusing on Anorexia Nervosa; 4) Describe the culture-related changes to the Dissociative Disorders and the Trauma- and Stressor-Related Disorders, focusing on PTSD, Dissociative Identity Disorder, and DD Not Elsewhere Classified; and 5) Discuss the role of cultural factors in overall personality development and within each of the six personality disorder types included in the new classification schema;

SUMMARY:

Specific symptoms and other nosological characteristics (e.g., duration) of psychiatric disorders show substantial cultural variation. DSM-IV-TR has been criticized for over-specifying the criteria of some disorders, resulting in excessive use of Not Otherwise Specified diagnoses and artifactually elevated rates of comorbidity. The DSM-5 revision process addressed this limitation in several ways. An important component of this process involved enhancing the cross-cultural validity of disorder criteria and textual description by incorporating available data on cross-cultural variability of disorder presentation. This is expected to reduce apparent comorbidity and the overuse of Not Elsewhere Classified diagnoses by helping clinicians identify the specified disorder that best fits the patient's symptoms, while at the same time allowing for cultural variation. This symposium presents the work of several DSM-5 Work Groups and of the Study Group on Gender and Culture, focusing on changes to DSM-5 intended to enhance validity of disorder characterization. Presenters are members or advisors of the Study Group as well as the Work Groups on the Anxiety, Obsessive-Compulsive, Posttraumatic, and Dissociative Disorders, and the Eating and Personality Disorders. The presentation on the Anxiety Disorders will highlight changes to the descriptions of Panic Attack, Panic Disorder, and Social

Anxiety Disorder. These changes include a broader spectrum of panic symptoms, cultural aspects of the identification of unexpected vs. expected panic attacks, and alternative presentations of social anxiety involving fear of offending others as opposed to concern over humiliation and embarrassment. The talk on Eating Disorders will discuss the cultural embeddedness of the criteria for Anorexia Nervosa and changes to these criteria intended to include culturally diverse presentations, for example, the absence of ‘‘fat phobia’’ as a prominent symptom in certain cultural settings. The presentation on the Dissociative and Trauma- and Stressor-Related Disorders will focus on changes to Dissociative Identity Disorder, involving the incorporation of language on pathological possession into the definition of the Disorder and the addition of a specifier for presentations of DID with prominent pseudoneurological symptoms, common cross-culturally. New examples of Dissociative Disorder Not Elsewhere Classified will also be discussed; these describe syndromes of acute dissociative pathology, included in ICD-10, but under-emphasized in DSM-IV-TR. Finally, the talk on Personality Disorders will elaborate on the impact of cultural factors on personality development and the development of personality psychopathology. The importance of the referential value of cultural norms in the evaluation of personality states and traits will also be discussed. These changes to the Manual will be discussed by the Chair of the DSM-5 revision process.

NO 1

CULTURE-RELATED CHANGES TO DSM-5: PROCESS AND RATIONALE

Speaker: Roberto Lewis-Fernandez, M.D.

SUMMARY:

Specific symptoms and other nosological characteristics (e.g., duration) of psychiatric disorders show substantial cultural variation. This may help explain why DSM-IV-TR diagnoses map only partially onto their putative biological substrates. It is more likely that these biological domains constitute dimensional vulnerability factors that pattern disorder expression more generally (e.g., mood dysregulation), and that specific syndromes arise from the interaction of this general vulnerability with other factors, including contextual elements such as culturally patterned illness expressions. This talk will discuss the process by which cultural variation was incorporated into DSM-5. Specific goals included reducing artifactually elevated comorbidity and excessive use of Not Elsewhere Classified diagnoses. Recommendations will be made for how to include evaluation of cultural and contextual factors affecting disorder presentation in the diagnostic process.

NO 2

CULTURE-RELATED CHANGES TO THE CRITERIA AND TEXT IN THE ANXIETY DISORDERS IN DSM-5

Speaker: Devon Hinton, M.D., Ph.D.

SUMMARY:

This talk describes some of the proposed changes in the anxiety disorders criteria and text in DSM-5 that aim to make

the DSM more culturally sensitive and cross-culturally valid. Examples include the DSM-5's discussing a broader spectrum of panic attacks symptoms, allowing panic attack onset from a baseline state of anxiety, specifying in a certain way the "expectedness" of panic attacks in panic disorder, and describing the cultural shaping of panic disorder: culturally defined cues of panic attacks and associated catastrophic cognitions. Other examples include the DSM-5's specifying that social phobia may include fear of offending others, a fear that is found in many cultures (e.g., in Japan, those with Taijin Kyofusho fearing that they emit an offending odor) and DSM-5's specifying that in the phobia disorders that the fear is inappropriate and out of proportion to real danger from the vantage point of the individual's specific cultural context.

NO 3 FEEDING AND EATING DISORDERS IN DSM-5: REVISED CRITERIA BETTER ENCOMPASS CULTURAL DIVERSITY

Speaker: Anne E. Becker, M.D., Ph.D.

SUMMARY:

Eating disorders present unique diagnostic across diverse cultural settings, partly because of the dimensionality of certain core symptoms and their relativity to local social norms. Cross-national and historical data also demonstrate the cultural variability of concerns with "fatness," a core feature of anorexia nervosa (AN). For example, a clinical presentation termed "non-fat phobic anorexia nervosa" has been well-documented among the Hong Kong Chinese but was not captured by DSM-IV criteria for AN, despite striking similarities. Eating disorders frequently remain unrecognized in clinical settings in the US, where deeply concerning ethnic disparities in treatment access have also been reported. This presentation will describe revisions in DSM-5 criteria for the feeding and eating disorders that will potentially encompass a greater range of culturally diverse presentations and thereby enhance their clinical utility in identifying patients who can benefit from treatment.

NO 4 CULTURE AND THE DSM-5 DISSOCIATIVE, TRAUMA-RELATED, AND STRESSOR-RELATED DISORDERS

Speaker: Roberto Lewis-Fernandez, M.D.

SUMMARY:

Changes enhancing the cultural validity of DSM-5 Dissociative and Trauma- and Stressor-Related Disorders are discussed. Revisions to Dissociative Identity Disorder include language on pathological possession and addition of a specifier for pseudoneurological symptoms. DD Not Elsewhere Classified has been augmented with two examples of Atypical, mixed, or other presentations that do not meet full criteria. Both describe acute dissociative pathology, which is included in ICD-10 but under-emphasized in DSM-IV-TR. PTSD will be highlighted among the Trauma- and Stressor-Related Disorders, including criterial changes to the avoidance cluster symptom threshold and the description of trauma-related maladaptive

cognitions and nightmares. Textual changes include discussion of cultural variation in conditional probability of PTSD and of contextual and interpretive factors affecting disorder severity. These revisions aim to enhance the cross-cultural validity and clinical utility of DSM-5.

NO 5 THE PLACE OF PERSONALITY, PERSONALITY DISORDERS, AND CULTURE IN DSM-5

Speaker: Renato D. Alarcon, M.D., M.P.H.

SUMMARY:

The DSM-5 Personality and Personality Disorders (PDs) Work Group devoted a significant time of their deliberations to the proposal of a trait-based system for the definition and diagnostic criteria of the disorders. Against such background, this presentation will elaborate on the impact and the role of cultural factors in the process of personality development and on its clinical transition to the psychopathological domain. The acceptance of a general statement pointing out the referential value of cultural norms may be considered the essential (and perhaps, only) cultural component in this group of conditions. Individual comments on cultural considerations and suggestions made in connection with each of the six PD types included in the new classification will be presented. The need for specific training issues will be discussed. The presentation will end with a list of needs and prospects related to the topic and its inclusion in future versions of the diagnostic Manual.

SYMPOSIUM 122 INTEGRATIVE MEDICINE IN PSYCHIATRY

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

Chair: Lila E. Massoumi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the current data on efficacy and safety for: omega-3 fatty acids, N-acetyl cysteine, S-adenosyl methionine, inositol, kava and melatonin, in treating psychiatric disorders; 2) Distinguish between herbs that are likely to cause adverse medication interactions and those which are not; and 3) Describe an integrative medicine approach to mitigating adverse effects from psychiatric medications via the utilization of herbs, nutrients, and the hormone melatonin.

SUMMARY:

This symposium reviews the current evidence for a range of nutrients, herbal medicines, and other complementary treatments with evolving evidence in the treatment of psychiatric disorders. In addition, it covers a range of critical clinical considerations, such as potential medication interactions, safety and supplement quality issues, and prescriptive advice. Specific nutraceuticals covered in the first part of the symposium include: omega-3, N-acetyl cysteine, S-adenosyl methionine, inositol, kava, and melatonin. The second part of the symposium begins with discussion on the commonly used herbal medicines and their potential adverse or augmenting interactions with medications, and suggests directions for

monitoring and safe administration. The symposium concludes by describing the use of herbs and nutrients to mitigate common side effects of psychotropic medications.

NO 1 N-ACETYL CYSTEINE, OMEGA-3, AND KAVA: LATEST EVIDENCE AND CLINICAL APPLICATIONS FOR AFFECTIVE DISORDERS

Speaker: Jerome Sarris, M.H.Sc., Ph.D.

SUMMARY:

This presentation reviews the current evidence of 3 nutraceuticals with evolving evidence in the treatment of affective disorders: N-acetyl cysteine (NAC), omega-3, and kava, covering 1) The latest research on NAC, an endogenous glutamate-modulating antioxidant, revealing efficacy in a range of psychiatric illnesses, including affective disorders; 2) Our recent meta-analysis of adjunctive omega-3 RCTs in bipolar disorder (five pooled datasets; n=291). For bipolar depression, a significant effect was found in favor of omega-3 ($p=0.029$; $d=0.34$). On the outcome of mania, no significant result was found; 3) A 6-week RCT using standardized kava tablets versus placebo for 75 patients with GAD. Results revealed a significant reduction in HAMA-rated anxiety for the kava group compared to the placebo group with a moderate effect size ($p=0.046$, $d=0.62$). Within the kava group, GABA transporter polymorphisms rs2601126 ($p=0.046$) and rs2697153 ($p=0.02$) were associated with HAMA reduction.

NO 2 INOSITOL, MELATONIN, AND SAM-E: UPDATE AND APPLICATIONS IN PSYCHIATRY

Speaker: David Mischoulon, M.D., Ph.D.

SUMMARY:

This presentation will cover 3 popular nutraceuticals used in psychiatry. Inositol is a polyol carbohydrate used to treat major depressive disorder, bipolar disorder, obsessive compulsive disorder, and panic disorder. Melatonin is a hormone manufactured in the pineal gland, involved in regulating circadian rhythms. Melatonin is popular among people who wish to reset their circadian clocks upon traveling across time zones. It is also used for treating sleep disorders, and has shown promising evidence in children. S-adenosyl methionine (SAME) is a methyl donor used primarily as an antidepressant, with demonstrated efficacy in more than 45 randomized trials, both as monotherapy and more recently as adjunctive therapy for antidepressant partial responders. We will review indications, efficacy, and safety of these compounds, as well as recommended dosing. We will also present findings from a recently completed study of SAME versus escitalopram in major depressive disorder.

NO 3 HERBS AND MEDICATION INTERACTIONS

Speaker: Patricia L. Gerbarg, M.D.

SUMMARY:

The use of herbs by patients taking medication is on the rise and many individuals do not tell their doctors about the supplements they are taking. Physicians need to understand the potential interactions between herbal and prescription medications. Patients are more willing to discuss their use of herbs with physicians who show that they are knowledgeable and interested. Open communication is essential for patient safety as well as for optimal outcomes. It is important for physicians to be able to distinguish between herbs that are likely to cause adverse medication interactions and those which are not. Commonly used herbal medicines, potential adverse or augmenting interactions with prescription medications, effects on CYP3A4 enzyme systems and p-glycoprotein, and the use of routine monitoring to reduce the risk of unwanted effects will be discussed. The quality and applicability of in vitro CYP3A4 testing in assessing potential herb-drug interactions will also be addressed.

NO 4 HERBS AND NUTRIENTS TO COUNTERACT MEDICATION SIDE EFFECTS

Speaker: Richard Brown, M.D.

SUMMARY:

Herbs, nutrients, hormones, and mind-body practices can be used to counteract medication side effects. These relatively safe treatments can mitigate adverse effects from anxiolytics, antidepressants, mood stabilizers, and anti-psychotics. Treatments discussed will include hormones (eg. Melatonin), herbs (eg. Amrit Kalash, butcher's broom, huperzine, lemon balm, *Lepidium meyenii* (Maca), *Panax ginseng*, passionflower, *Rhodiola rosea*, *Rhododendrum caucasicum*), nutrients (eg. N-Acetyl cysteine, B vitamins, picamilon, S-adenosylmethionine, shark liver oil), aniracetam, and Coherence Breathing. CAM approaches to side effects, such as physical and mental fatigue, sedation, insomnia, sexual dysfunction, hepatic dysfunction, constipation, weight gain, tremor, akathisia, restless leg syndrome, Parkinsonian symptoms, cognitive and memory problems, hematological disorders, and hair loss will be discussed. Risks, benefits, and guidelines for safe administration of CAM will be presented.

MAY 22, 2013

SYMPOSIUM 123 NEAR TRUTHS, TRUTHS, AND UNTRUTHS: MYTHBUSTERS 2

Chair(s): Philip R. Muskin, M.A., M.D., Sparsha Reddy, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the stresses that contribute to surprising "pathological" behavior by medical/surgical house staff; 2) Explore and understand how professionals can balance work and home life in a manner that is fulfilling and successful; 3) Investigate and learn the clinical data that supports or does

not support using SSRI medications at higher than approved doses; and 4) Understand the impact of psychological interventions for cancer patients and review the data on the impact of those interventions on quality of life and overall survival.

SUMMARY:

Near Truths, Truths, and Untruths is a continuation of the Mythbusters symposium at the 2012 APA meeting. The goal of this series of symposia is to focus on common issues we think are true, beliefs that we hope are true, and experiences we find ourselves at a loss to explain. Investigating the data that support or refute the “truths” will lead us to a greater understanding of what we do, why we do it, and how to change it, should we choose to do so. This year the symposium will include biological and psychological “truths.” Robert Boland will present: “The use of high dose SSRIs for depression: mythical treatment or good clinical judgment?” When patients do not achieve an adequate response to an antidepressant, what data supports a dose increase to a suprathreshold dose? He will review the data asking the question, “Is the problem in our treatment, or in the data?” Philip Muskin will present: “Why do house staff sometimes act like borderlines?” The sometimes puzzling and sometimes distressing behavior of medical/surgical house staff resembles the behavior seen in patients with borderline personality disorder. Yet the individuals are not borderline. Reviewing data on the stresses and abuses of medical training he will look at the etiology of these behaviors and present a methodology for resolution. Sparsha Reddy will present: “Healthy mind, healthy body? Can healing the mind heal cancer?” She will review the proposed pathophysiology of the mind-body connection as it pertains to people with cancer. While psychological interventions logically can help people cope more adequately with their illness, can these interventions also extend their survival? She will review the data, the myths, and expose the truths. Linda Worley will present: “Why can’t women still have it all?” The on-going tension between a balanced career and life is not a gender issue; it is a universal human struggle. Are there role models in our profession or is such a balance a myth? What family-friendly policies exist and how can we incorporate them into our professional lives?

NO 1 HAVING A SUCCESSFUL CAREER AND A FAMILY: IMPOSSIBLE DREAM OR ACHIEVABLE?

Speaker: Linda L. M. Worley, M.D.

SUMMARY:

A 2012 Atlantic article, claiming that ‘women still can’t have it all’ ([1http://www.theatlantic.com/magazine/archive/2012/07/why-women-still-cant-have-it-all/309020/](http://www.theatlantic.com/magazine/archive/2012/07/why-women-still-cant-have-it-all/309020/)) set off a robust debate. Career-life balance isn’t a just a gender issue, it’s a universal human struggle. Even within psychiatry, highly visible role models esteemed for both career and life-balance are rare. Most academic healthcare institutions operate from a career first, family second perspective and see their best and brightest talent departing in record numbers as they begin having children. Thankfully, innovative businesses are discovering that family friendly policies enable them to recruit and

retain the best talent, which increases their overall success and productivity. This presentation will discuss the tensions and offer solutions. Given enough drive and determination, it IS possible to have both a wonderful career and a happy family. The secrets to achieving this elusive life balance will be revealed!

NO 2 HEALTHY MIND, HEALTHY BODY? CAN HEALING THE MIND HEAL CANCER?

Speaker: Sparsha Reddy, M.D.

SUMMARY:

The term “psycho-oncology” calls attention to the obvious interconnectedness between the mind or “the psyche,” and the body or the cancer. There have been several studies looking at the impact these two elements have on each other. This presentation will focus on the effects of psychological interventions in people with a wide array of cancers. It will also briefly review some of the proposed pathophysiology of the mind-body connection as it pertains to people with cancer. It makes intuitive sense that providing intensive supportive interventions will likely help people with cancer cope better with their illness. But can these interventions also extend their survival? Ultimately, this presentation will attempt to answer that very question.

NO 3 THE USE OF HIGH DOSE SSRIS FOR DEPRESSION: MYTHICAL TREATMENT OR GOOD CLINICAL JUDGMENT?

Speaker: Robert Boland, M.D.

SUMMARY:

When depressed patients do not respond to an SSRI at the recommended dose, most clinicians will increase the dose to a high therapeutic or even dose. This is despite considerable evidence, both basic and clinical, suggesting that these antidepressants have a relatively flat dose-response curve. The weight of clinical evidence suggests that high dosing of SSRIs does not increase the chance of response but that it does substantially increase the risk of negative effects. This evidence is not new: most of the studies bearing on this subject were done decades ago. Such mismatches between what happens in the lab and what happens in the clinic are not unusual, and should be taken seriously. How should this be interpreted: is the problem in our treatment, or in the data? In attempting to answer this question, we will review the original data, and consider more recent studies both from clinical trials and basic science to help try and resolve this mismatch.

NO 4 WHY DO HOUSE STAFF ACT LIKE PATIENTS WITH BORDERLINE PERSONALITY DISORDER?

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

SUMMARY:

Medical illness and hospitalization impose intense psychological strain on patients. Regression, which accompanies hospitalization, requires patients to cope with fears of abandonment, castration, and death. Much of the work of the psychiatrist seeing medically ill patients surrounds the regressive pull of the medical illness and the patient's adaptive/maladaptive coping. Physicians are vulnerable to similar stress. Long work hours, the tremendous level of responsibility, the chaotic environment of the hospital, and the abuse which medical students and residents experience contribute to create a particular form of what in other settings is seen as "psychopathology." Seemingly odd behaviors directed at patients and sometimes at the psychiatric consultant are reminiscent of behaviors more typically seen in patients with certain types of personality disorders. This presentation will discuss the some of the causes and some solutions to what is mystifying behavior.

SYMPOSIUM 124**UPDATE ON PRESCRIPTION OPIOID ABUSE AND TREATMENT OPTIONS FOR THE PSYCHIATRIST**

Chair: Wilson M. Compton, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the current epidemiological trends in prescription drug abuse, and get a realistic feel for the extent of the problem; 2) Understand specific diagnostic and treatment options for patients with chronic pain and co-occurring psychiatric disorders including addiction; 3) Obtain a greater understanding of the role of new medication treatments, and of integrative treatment models used to treat acute pain and addiction concurrently; and 4) Obtain a greater understanding of behavioral treatment options, and how they may be integrated with medication management.

SUMMARY:

Opioid analgesics are among the most powerful treatments available to relieve human suffering from various disease processes. However, they have equally powerful potential adverse effects including addiction. This creates a quandary for physicians, psychiatrists, and psychologists caring for patients with remote or current histories of substance abuse or current opioid maintenance therapy, and the need for analgesia for relief of acute or chronic pain conditions, including pain from malignant and non-malignant origins. Empirical evidence for treating these patients is limited, but useful experience has been gained. This symposium will present this experience and recent research findings that may open new pathways of care that both reduce addiction and under-treatment of pain in this population. Specifically definitions of many of the terms commonly used in the care of these patients will be discussed, so that the various specialists required to care for these complex patients can communicate more effectively. The different types of pain will be discussed including the specific management concerns of patients presenting with a wide variety of

addiction histories. Conversely, how each of these addiction histories should be considered by the clinician in setting a patient specific treatment plan will be explored. A significant number of patients with opioid dependence beginning buprenorphine detoxification or maintenance treatment also report chronic pain. Integrated treatment models are effective for treating medical comorbidities; however, better models of care for chronic pain and co-occurring addiction are needed. For example, with regard to pharmacological treatments, what are the advantages and disadvantages of buprenorphine used to treat acute pain and addiction concurrently? New studies are showing results of improved pain relief when the patient is detoxified from opioids, in these situations of hyperalgesia depot naltrexone may be of lasting value. In addition to these pharmacological approaches, what are the common features of integrated treatments for both chronic pain and opioid addiction? Specifically, given the shortage of empirically-based protocols in therapies for persisting pain, this session will also highlight the role of acute pain among those in treatment for opioid addiction and ways to improve the efficacy and effectiveness of combined treatment, including behavioral, physiological, emotional reactivity and cognitive restructuring.

NO 1**PRESCRIPTION DRUG ABUSE IN THE UNITED STATES**

Speaker: Wilson M. Compton, M.D.

SUMMARY:

The extent of analgesic, sedative and stimulant prescription drug abuse in the USA is staggering, with approximately 6.1 million Americans, ages 12+ reporting non-medical use of psychotherapeutics in any given month during 2011. Among 12th graders, 8-10% report Vicodin, 4-5% OxyContin, 8-9% amphetamine, 6-8% sedatives and 5-7% methylphenidate abuse in each of the past several years. Complications of prescription drug abuse include addiction to the substances, treatment admissions, as well as morbidity and mortality. Of note, recent data from CDC documents that rates of mortality associated with use of prescription-type opioids increased more than 3 fold over the past 20 years and now exceeds mortality from motor vehicle accidents in many jurisdictions. Overall, the challenge is for physicians to monitor prescribing practices in order to maximize benefits while simultaneously reducing the risk of diversion, abuse and addiction.

NO 2**OVERVIEW OF THE TREATMENT OF ACUTE AND CHRONIC PAIN IN THE PATIENT WITH A HISTORY OF ADDICTION**

Speaker: Sean Mackey, M.D., Ph.D.

SUMMARY:

This session will describe the necessity of obtaining a history of substance of abuse (including alcohol and tobacco) from all patients. The need to categorize the patient as in long term recovery, recent recovery, or active using will be emphasized. The need to discuss options with the patient are discussed. From this background, a plan of treatment can be developed.

The need to adequately treat the patients pain will then be discussed. The need for higher than normal doses in some cases will be explained.

NO 3 DISCONTINUING OPIOIDS AMONG PATIENTS WITH ONGOING PAIN

Speaker: Ian Carroll, M.D., M.S.

SUMMARY:

Patients with pain continue and discontinue opioid medications for a variety of reasons. We will discuss the factors that contribute to persistent opioid use among patients with pain, and the difficulties that they face in trying to wean themselves off of these medications. In particular we will further discuss the role that non-pain factors have in promoting ongoing opioid use, and how we can increase awareness of these factors among our patients. In addition we will explore the murky area spanning the long distance between appropriate medical use and obvious addiction, and discuss strategies for improving wellness and harm reduction in patients who don't meet criteria for "opioid dependence" or "opioid addiction".

NO 4 INTEGRATING BUPRENORPHINE INTO OFFICE- BASED PRACTICE

Speaker: David A. Fiellin, M.D.

SUMMARY:

Office-based treatment of opioid dependence with buprenorphine is provided to an estimated 300,000 patients annually. The goal of this talk will be to provide practical information on the use of buprenorphine in office-based practice. The talk will cover the rationale for buprenorphine, its unique pharmacology, the logistics of office-based practice and address some of the common scenarios addressed by those who offer this treatment.

NO 5 INJECTABLE NALTREXONE FOR THE TREAT- MENT OF OPIOID AND ALCOHOL DEPENDENCE

Speaker: Lynn E. Fiellin, M.D.

SUMMARY:

Injectable naltrexone, a mu-opioid antagonist, is increasingly being used to treat both opioid and alcohol dependence. The goal of this talk will be to provide information and guidance on how to use injectable naltrexone to treat these disorders and to review the most current literature on the studies examining the efficacy and side effects of this medication.

NO 6 COGNITIVE BEHAVIORAL TREATMENT FOR CO- OCCURRING CHRONIC PAIN AND OPIOID DE- PENDENCE

Speaker: Declan Barry, Ph.D.

SUMMARY:

Co-occurring chronic pain and opioid dependence (POD) is prevalent and associated with deleterious treatment outcomes in patients entering opioid agonist maintenance treatment (OMT). OMT may decrease non-prescribed opioid use in patients with POD, but continued problematic opioid use may persist, especially if pain is not addressed successfully, and strategies for managing chronic pain during OMT have not been systematically evaluated. This presentation will describe studies regarding (a) the treatment needs of patients with POD, (b) providers' experiences treating these patients, (c) the development of integrated cognitive behavioral therapy (CBT for POD) for treating the dual, interrelated problems of chronic pain and opioid dependence during OMT with methadone or buprenorphine, and (d) findings from pilot studies and randomized clinical trials that have examined the feasibility, acceptability, and initial efficacy of CBT for POD in opioid treatment program and office-based settings.

SYMPOSIUM 125 MANAGEMENT OF THE NONCOGNITIVE SIGNS AND SYMPTOMS OF DEMENTIAS/MAJOR NEU- ROCOGNITIVE DISORDERS: DILEMMA OR OP- PORTUNITY?

Discussant: Soo Borson, M.D.

Chair: Helen H. Kyomen, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the neurobiologic principles associated with the affective and behavioral outcomes of dementia using neural stem cell and neurogenesis models; 2) Target pharmacologic and other somatic interventions for specific patterns of acute and chronic behavioral disturbances in dementia patients, and consider novel treatments when usual treatments are intolerable, ineffective or lose effectiveness; and 3) Optimize the use of positive communication, behavioral strategies, and milieu management in interactions with dementia patients with neuropsychiatric symptoms.

SUMMARY:

Over 80% of patients with dementias/major neurocognitive disorders (Mnd) exhibit behavioral and psychological symptoms over the course of the illness. Such neuropsychiatric symptoms of dementias/Mnd are often complex, difficult to manage and adversely impact patients, caregivers, and healthcare, financial and social systems. This symposium will focus on the neurobiology, identification, evaluation and management of specific patterns of noncognitive disturbances in patients with dementias/Mnd from neuropsychiatric, geropsychiatric and behavioral perspectives. Commonly used multidisciplinary treatments as well as novel interventions will be explored as options to enhance dementia patient care and outcomes.

**NO 1
NEURAL STEM CELLS AND NEUROGENESIS IN
DEMENTIAS/MAJOR NEUROCOGNITIVE DIS-
ORDERS: ASSOCIATION WITH AFFECTIVE AND
BEHAVIORAL OUTCOMES**

Speaker: Daniel G. Herrera, M.D., Ph.D.

SUMMARY:

Neurogenesis is primarily a developmental process that involves the proliferation, migration, and differentiation into neurons of primordial central nervous system stem cells. Neurogenesis continues in the adult mammalian brain, particularly in the olfactory bulb and the hippocampus. Extensive research suggests that marked decreased hippocampal volume, as observed in certain neurodegenerative disorders, is associated with learning and memory deficits and mood dysregulation. Changes in such conditions have been partially attributed to neurogenesis. Review of the literature and recent research will be presented to examine the rationale and potential role of targeting neurogenesis as a treatment for the affective and behavioral dysfunctions that are highly associated with dementias/major neurocognitive disorders (Mnd). However, most dementias/Mnd have diverse clinical presentations and diffuse pathologies with unclear etiologies, and thus present challenging cellular therapeutic goals.

**NO 2
MANAGEMENT OF THE BEHAVIORAL AND
PSYCHOLOGICAL SYMPTOMS OF DEMENTIAS/
MAJOR NEUROCOGNITIVE DISORDERS: THE
USUAL AND THE NOVEL**

Speaker: Helen H. Kyomen, M.D., M.S.

SUMMARY:

Usual treatments for the noncognitive signs and symptoms of dementias/major neurocognitive disorders (NCSSD/Mnd) can be effective if the cause of the disturbance is identified correctly, and multidisciplinary interventions are selected and provided with an integrated plan. Conditions that may be associated with NCSSD/Mnd and which respond to fairly specific interventions include pain/discomfort, delirium, psychosis, mania, depression, apathy, anxiety, abnormal behavior and resistiveness. Usual pharmacologic interventions often involve psychiatric drugs such as antipsychotics, mood stabilizers, antidepressants and sedative/hypnotics. Other novel treatments may include the use of cognitive enhancers, nutritional supplements, aromatherapy, hormonal therapy, electroconvulsive therapy, light therapy, and cardiovascular agents. In this session, a framework for the evaluation and treatment of NCSSD/Mnd will be presented, incorporating commonly used and novel alternative interventions.

**NO 3
NONPHARMACOLOGICAL INTERVENTIONS FOR
THE NEUROPSYCHIATRIC SYMPTOMS OF DE-
MENTIA**

Speaker: Daniel D. Sewell, M.D.

SUMMARY:

Nonpharmacological interventions (NPIs) for behavioral symptoms in individuals living with dementia offer many advantages and are sometimes the only interventions needed. Compared to medications, NPIs have a favorable risk-benefit ratio and are often much less costly. NPIs are also relatively easy for both professional and family caregivers to learn and apply. NPIs fall into three categories: effective communication; optimal environments and meaningful activities. Use of NPIs helps to achieve the maintenance of function, enjoyment, reduction of problem behaviors and improved quality of life for the individuals living with dementia and their caregivers. Effective application of NPIs requires: individualization; partnering and respect; consistency and routinization; planning for success; and flexibility and creativity. This session will provide keys to effective communication; describe characteristics of optimal environments and present guidelines for successful activities.

**SYMPOSIUM 126
BRAIN, MIND, AND BEHAVIOR: BIOLOGICAL
CONNECTIONS**

Chair: Amresh K. Shrivastava, M.D., M.R.C.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define complexity of interrelationship between brain, mind and behavior; 2) Understand neurohormonal and neuroimmunological effect of brain development; and 3) Understand pharmacological interventions for psychosomatic illness.

SUMMARY:

The theme of Brain mind and behavior has been a challenging one for scholars since a long time when we use to hear discussions about 'mindless brain' and 'brainless mind'. It has been a long journey in the research in the field of biological psychiatry and neurosciences to come to some consensus. That behavior is multidisciplinary as proposed by biopsychosocial model. However the key aspect of underrating 'mind' from biological perspective has still been left out. Current research has made strong argument about behavior being biologically determined, however very few areas have been systematically studied, most important limitation in the research exploring behavior is lack of biological studies explaining behavior in a person who is not having a mental illness. The ethical limitations are major roadblocks in this regard, which remains dissuasive, more so because of increasing human right concerns. It may never be possible to explore biology of normal behavior. The second limitation in this area of exploring the complexity, even where definite psychopathological conditions exist, is lack of studies during the transition to pathology. Findings of biological changes in established illness are not the same because these illnesses progress slowly. Research in the field of understanding dimensions and matrices of 'minds' has also been highly neglected. There has been limited effort to take a newer direction of biological research to find out brain mind connections. Field of genetics and epigenetics have added some value in understand-

ing brain and behavior with newer insight; however it is too premature to draw any definite or near benefit conclusion to explicitly make a statement about how environment unfolds misty of neurobiology.

NO 1 CORTISOL AND COGNITION IN MAJOR DEPRESSION

Speaker: Alan F. Schatzberg, M.D.

SUMMARY:

In recent years, attention has been paid to the role excessive activity of the hypothalamic-pituitary-adrenal axis may play in the cognitive deficits in depression. Cortisol-synthesized in and released from the adrenal-crosses the blood brain barrier where it binds with low affinity to a glucocorticoid receptor (GR) that is widely distributed throughout the cortex. The hormone may facilitate or impair memory-depending on cortisol concentrations. We present data on a series of studies conducted in healthy controls as well as in endogenous major depressives with or without psychosis. Our total sample is over 150 subjects. Cortisol levels were assessed hourly from 6pm to 9am and were significantly elevated in delusional depressives compared to the other two groups between 6pm and 4 am. Patients with delusional depression demonstrated the greatest deficits in cognitive functioning. Memory performance correlated significantly and negatively with cortisol levels even in healthy controls.

NO 2 THE LINK BETWEEN STRESS AND DEPRESSION

Speaker: Gustavo E. Tafet, M.D., Ph.D.

SUMMARY:

The role of stress in the origin and development of depression has been extensively studied and demonstrated. In this regard, it plays a critical role at the psychological level, where it participates in the development of cognitive vulnerability which predisposes to develop depressive symptoms. Regarding the psycho-neuro-endocrinological perspective, it produces dysregulation of the HPA axis, with the resulting increase in CRF and cortisol levels, and an array of neurobiological consequences, including alterations in neurotransmitter systems, such as 5HT neurotransmission, and neurotrophin mediated neuroplasticity. In recent years, an extensive body of research contributed to better understand the underlying mechanisms that link stress with depression. Therefore we propose an integrative view which take into account these contributions, and therefore to introduce possible strategies aimed at more effective approaches in the clinical practice, including both the therapeutic and

NO 3 INSULIN, DIABETES, AND THE BRAIN: OPPORTUNITIES FOR UNDERSTANDING DISEASE PATHOETIOLOGY IN SEVERE MENTAL ILLNESS AND GENUINELY NOVEL DRUG DISCOVERY

Speaker: Roger S. McIntyre, M.D.

SUMMARY:

Contemporary disease models in psychiatry posit abnormalities in cellular function, synaptic connections, and neural substrates. Similar observations have also been documented in preclinical and clinical models of metabolic disorders. Descriptive and interventional research indicate that insulin dysregulation as well as alterations in the inflammatory milieu, modulate both neuronal and glial function under normal and pathophysiological conditions. Emerging evidence also indicates that modulating metabolic and inflammatory systems is capable of mitigating dimensions of psychopathology. This presentation will review the scientific background and conceptual framework, present emerging preclinical and clinical data empirically supporting the metabolic/CNS interface, and will provide a review of preliminary treatment approaches for treating psychiatric disorders with metabolic/inflammatory-based treatments.

NO 4 NEUROIMMUNE FUNCTION IN DEPRESSION AND SUICIDE

Speaker: Ghanshyam N. Pandey, Ph.D.

SUMMARY:

The observed immunological disturbance in depression and suicide is based on the observation that the levels of the proinflammatory cytokines are increased in the plasma of depressed patients. However, it is not clear whether similar changes in cytokines are also present in brains of depressed and suicidal subjects. We have studied the levels of the proinflammatory cytokines in plasma and postmortem brain of depressed and suicidal subjects and observed that the protein and the gene expression levels of proinflammatory cytokines IL-1?, IL-6, and TNF-? are significantly increased in the plasma and lymphocytes of depressed patients compared with normal subjects. The protein and gene expression levels of IL-1?, IL-6, and TNF-? were also significantly increased in the prefrontal cortex of suicidal subjects compared with normal control subjects. These studies demonstrate that the suggested immunological dysfunction in depression and suicide may be related to changes in cytokines levels.

NO 5 PATHWAY OF DEVELOPMENT OF PSYCHOSIS AMONG CANNABIS-ABUSING INDIVIDUALS: TOWARD A MODEL FOR TRAJECTORY

Speaker: Amresh K. Shrivastava, M.D., M.R.C.

SUMMARY:

Cannabis has been implicated as a risk factor for the development of schizophrenia, however, the exact biological mechanisms remain unclear. Cannabis use is common amongst individuals who are Ultra High Risk (UHR) and those who have already developed psychosis. Interestingly, it has also been reported that 15% of cannabis users who do not fit into these two categories experience acute psychotic symptoms. Though both, neurobiological basis of development of schizophrenia and related psychosis and brain changes due to

cannabis are well known yet the pathway of cannabis causing psychosis is not well understood. Studies do point out that cannabis affects cognition, neurochemistry, neurophysiology, neurotransmission as well as brain development., there is very little information available to explain why and how some individuals develop psychosis and others do not..

NO 6 RECENT ADVANCES IN PSYCHOPHARMACOL- OGY OF PSYCHOSOMATIC MEDICINE

Speaker: Amarendra N. Singh, D.P.M., M.D.

SUMMARY:

The art and science of psychopharmacological treatment of psychosomatic disorders has expanded greatly in the past two decades. Novel drugs of an exciting nature, alternative uses of existing drugs, combination strategies and specialized needs of patients have brought sophistication and enhances therapeutic sciences. Psychopharmacological advances in psychosomatic medicine have been in the following areas: (1) anxiety disorders, (2) eating disorders, (3) major depression, (4) primary insomnia, (5) migraine (6) management of somatization. This paper describes recent advances of psychopharmacotherapies in appropriate psychosomatic disorders and avoids including the older psychopharmacological agents, which are rarely used at the present tie in spite of their popularity in the past. The ultimate goal of psychopharmacological management remains to bring optimal benefit to patients with minimal adverse reaction, which will enhance quality of care markedly.

SYMPOSIUM 127 SUCCESSFUL AGING

Chair: Ipsit Vahia, M.B.B.S., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize how successful aging has been studied empirically, including definitions and models of successful aging; 2) Appreciate the associations between age, emotion, spirituality, resilience and biology; 3) Recognize the potential for successful aging as a measure of clinical outcomes; and 4) Understand neurobiological factors that impact the potential for resilience and successful aging.

SUMMARY:

The past decade has witnessed considerable progress in the study of successful aging. There is consensus among researchers that successful aging is best conceptualized as a multidimensional entity that encompasses cognition, emotion, positive psychological traits and subjective perception of successful aging, in addition to physical health. However, the role of psychiatry in promoting successful aging remains poorly defined. Recent literature suggests that a diverse range of intrinsic and extrinsic factors, both biological as well as non-biological can impact the potential for successful aging. The six presentations in this session will aim to capture the diversity and complexity of this topic and the current literature.

Three of the talks (by Drs. Nemeroff, O'Hara and Wolkowitz) will focus on biological determinants of successful aging and resilience and will include data that suggest potential biomarkers to guide future clinical and research work on this area. Dr. Blazer will discuss the role of spirituality n successful aging, while Dr Sachdev will focus on centenarians and discuss successful aging in the context of successful aging. Dr. Vahia will focus on successful aging as a clinical entity and discuss how chronic medical and psychiatric illness can impact potential for aging successfully. The session will conclude with an interactive panel discussion on the role of psychiatry in promoting successful aging.

NO 1 SPIRITUALITY AND SUCCESSFUL AGING

Speaker: Dan Blazer II, M.D., Ph.D.

SUMMARY:

Both empirical and experiential evidence support the association between spirituality and physical/emotional well-being in the elderly. Empirical studies of religiosity/spirituality (R/S) have established a positive association with many specific health outcomes, such as depression and survival. Religious activities have been especially demonstrated to have positive effects, private religious practices less so. Emerging evidence also supports the association of faith communities which facilitate spiritual formation, attachment and good health outcomes including stress reduction and coping methods. In addition, faith communities also provide practical support such as physical care and assistance with challenges such as transportation and finances. Critics have emerged and their critiques have ranged from the political/philosophical to the methodological. To understand the association between R/S and successful aging, consideration of these challenges is essential

NO 2 THE CENTENARIAN AS A MODEL OF SUCCESS- FUL AGING

Speaker: Perminder Sachdev, M.B.B.S., M.D., Ph.D.

SUMMARY:

Individuals over the age of 90 are the fastest growing proportion of the population. Assumptions based on findings from younger old groups are not necessarily true for centenarians. Contrary to estimates in the past that all 100-year-olds would be demented, rates of dementia amongst centenarians show substantial variation, ranging from 16% to 70%, with many remaining non-demented, suggesting high brain reserve. The Sydney Centenarian Study and other similar population-based studies show that while these individuals have significant cognitive and functional impairments, they demonstrate an ability to view life with optimism. The majority continue to live independently in the community. This positive health outcome can be attributed to personality characteristics, lifestyle factors and genetics. Many centenarians have been able to successfully compress morbidity well into the ninth and tenth decades of their lives. Centenarians may therefore be regarded as models of successful aging.

NO 3 FROM SADNESS TO SENESCENCE: CELLULAR EFFECTS OF PSYCHIATRIC ILLNESS

Speaker: Owen Wolkowitz, M.D.

SUMMARY:

Serious mental illnesses are often associated with comorbid medical disease and with premature mortality, raising the possibility of accelerated biological aging. Studies are now examining this possibility in several psychiatric conditions. An emerging theme is that at least some patients with these disorders have signs of accelerated cellular aging, defined by shortened leukocyte telomeres and altered activity of the telomere-lengthening enzyme, telomerase. Shortened telomeres are frequently associated with increased risk of medical illness and premature mortality, providing a possible nexus between these mental illnesses and their medical comorbidities. Mechanistic studies suggest that chronic inflammation and oxidative stress, often reported in these mental illnesses, play a role in telomere shortening and accelerated aging. Clarification of accelerated biological aging in psychiatric conditions should lead to novel therapeutic targets for these illnesses as well as comorbidity.

NO 4 THE BIOLOGY OF RESILIENCE

Speaker: Ruth O'Hara, Ph.D.

SUMMARY:

Resilience is defined as the ability to maintain stable levels of psychological functioning when exposed to stressful events. Investigators suggest resilience is an important component of successful aging. The serotonin transporter polymorphism short (s) allele is a genetic risk factor associated with psychopathological response to stress, dysregulated HPA function, and lower levels of resilience. We report on a longitudinal follow-up of 100 healthy, older adults, in which we investigated the relationship among the s allele, HPA function, and resilience, measured by the Connor-Davidson Resilience Scale, and their impact on cognition and affect. S allele carriers with lower levels of resilience had increased waking cortisol and exhibited greater cognitive decline, increased levels of anxiety and depressive symptoms and poorer self-report ratings of successful aging. We discuss the implications of these findings for biological mechanisms of resilience and models of successful aging.

NO 5 PERSONALIZED MEDICINE: AGING AND PSY- CHIATRY

Speaker: Charles Nemeroff, M.D., Ph.D.

SUMMARY:

The central tenet of personalized medicine is the premise that an individual's unique physiological characteristics play a major role in disease vulnerability and in response to specific therapies. These physiological characteristics are determined

by genetic and environmental determinants. The role of genetic polymorphisms of specific candidate genes, epigenetic mechanisms, microRNAs and gene-environment interactions in personalized medicine will be described. Also the emerging role of functional brain imaging in identifying markers of disease vulnerability and an individual's response to treatment will be discussed. The importance of the interaction of genetic factors and the environment will be highlighted by the literature on the impact of child abuse and neglect and its interaction with vulnerability of genes in increasing risk for PTSD and mood disorders. The impact of these factors on the development of comorbid medical/psychiatric disorders in the elderly will be reviewed.

NO 6 SUCCESSFUL AGING IN THE CONTEXT OF CHRONIC MEDICAL AND PSYCHIATRIC ILLNESS

Speaker: Ipsit Vahia, M.B.B.S., M.D.

SUMMARY:

This presentation will first review empirical models of successful aging and summarize findings on how domains of successful aging may interact with each other. The presenter will then review existing literature on successful aging among older adults infected with HIV (as an example of chronic medical illness) and among older adults with schizophrenia (as an example of chronic psychiatric illness). This talk will also include new data on how domains of successful aging interact in older adults coping with these clinical conditions. The last part of the presentation will focus on whether patterns of successful aging in clinical populations differ from those in healthy older adults, and whether a dimension-based approach to successful aging can help identify targets to optimize the potential for successful aging

SYMPOSIUM 128 CHOOSING THE RIGHT TREATMENT FOR SUB- STANCE ABUSE

Chair(s): Herbert D. Kleber, M.D., Adam Bisaga, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Be familiar with the various approaches in the clinical development of new cocaine dependence pharmacotherapies and have a greater awareness of the recent research findings particularly medications that may be used clinically; 2) Recognize the clinical signs and symptoms associated with abuse of sedative-hypnotic or stimulant medications, be familiar with the strategies to manage patients, and recognize potential risks and benefits of prescribing these medications; 3) Be acquainted with the major types of empirically supported behavioral treatments for substance abuse, the potential for combining behavioral and pharmacologic approaches, and understand the clinical obstacles encountered in delivery of these treatments; and 4) Understand the problem of opioid abuse among chronic pain patients, know the screening tools and risk stratification strategies to reduce the likelihood of abuse.

SUMMARY:

Substance abuse/dependence remains a major public health problem with financial costs and important implications for health and the criminal justice system. Shifts continue to occur in cost, purity, and geographic spread of various agents. The fastest growing problem is prescription opioid and stimulant abuse, while cocaine and heroin remain endemic, methamphetamine decreases, marijuana has higher potency, and marijuana use has lower age of onset. The symposium combines current scientific knowledge with the most efficacious treatments for all of these agents and includes a separate presentation on comorbid pain. Emphasis is on office based approaches, and presentations include discussion of both pharmacologic and psychologic treatment methods. The speakers are nationally recognized experts in the field of focus on practical and cutting edge treatments.

NO 1**CHOOSING THE RIGHT TREATMENT FOR COCAINE DEPENDENCE**

Speaker: Adam Bisaga, M.D.

SUMMARY:

Cocaine dependence remains severe health problem, with no commonly accepted pharmacotherapies. Strategies to enhance rather than block the dopaminergic neurotransmission have proven effective to induce abstinence in cocaine-using individuals. Medications such as d-amphetamine and modafinil are the most promising. Practical and safety concerns involved in prescribing psychostimulant medications to cocaine users will be discussed. Other pharmacological strategies, such as medications that enhance GABA-ergic neurotransmission have potential as abstinence-maintenance treatments. A recent trial showed a combination of d-amphetamine and topiramate to be effective in producing abstinence. Strategies to prevent cocaine from entering the brain are also being developed and results with a "cocaine vaccine" are promising. A combination of pharmacological, possibly more than one medication, as well as behavioral interventions will likely be required for patients to achieve and maintain abstinence.

NO 2**TREATMENT OF CHRONIC PAIN AND OPIOID DEPENDENCE: ROLE FOR OPIOID AGONISTS AND ANTAGONISTS**

Speaker: Maria A. Sullivan, M.D., Ph.D.

SUMMARY:

Prescription opioid abuse has reached epidemic proportions in the U.S. Clinicians face the significant challenge of maintaining therapeutic access to opioids for legitimate analgesic use while minimizing the potential for opioid abuse and diversion. Addiction in pain patients is often more difficult to identify than in illicit substance users. Screening and risk stratification, universal precautions, identification of aberrant behaviors, and adherence monitoring techniques will be considered. We will discuss treatment options for patients with opioid dependence and chronic pain, including abuse-deterrent formula-

tions, as well as risks and benefits of long-acting opioids (e.g. buprenorphine, methadone). The role for opioid antagonist maintenance with long-acting naltrexone (Vivitrol) in cases of opioid abuse and hyperalgesia will be examined. Advantages and disadvantages of various pharmacologic choices for treating opioid dependence in chronic pain patients will be summarized.

NO 3**DETECTING AND MANAGING PRESCRIPTION SEDATIVE-HYPNOTIC AND STIMULANT ABUSE**

Speaker: John J. Mariani, M.D.

SUMMARY:

Despite extensive clinical experience, concerns about overprescribing, abuse liability, and the behavioral safety of sedative-hypnotics and stimulants still remain. While these medications are effective treatments for psychiatric disorders, specifically sedative-hypnotic agents for anxiety disorders and stimulants for attention-deficit/hyperactivity disorder, both classes of medication have a significant risk of abuse and the incidence of nonprescribed use is substantial. An overview of the strategies to detect and manage abuse of these controlled substances will be provided. Special attention will be focused on the complex clinical issues that arise when prescribing these agents stimulants in the presence of co-occurring substance use disorders.

NO 4**COMBINING MEDICATIONS AND PSYCHOSOCIAL INTERVENTIONS IN THE TREATMENT OF SUBSTANCE ABUSE**

Speaker: Edward Nunes, M.D.

SUMMARY:

Several types of psychosocial-behavioral interventions, including cognitive behavioral skill-building approaches (e.g., relapse prevention, community reinforcement approach, contingency management, motivational enhancement therapy, and 12-Step facilitation), have been studied for use either alone or in combination with medications for treatment of substance abuse. Such interventions have served as means of helping patients to achieve abstinence, encouraging lifestyle change, and promoting compliance with medications. An overview of these models and a brief review of findings in treatment outcome research will be provided. Obstacles encountered in the delivery of these approaches, the clinical implication of integrating such models, and the efforts to generalize research findings to community settings will be addressed.

NO 5**CHOOSING TREATMENT FOR CANNABIS DEPENDENCE**

Speaker: Herbert D. Kleber, M.D.

SUMMARY:

Cannabis is the most widely used illicit drug in the United States with 10% ending up dependent. Underlying psycho-

pathology increases this risk and in others marijuana use may increase risk of depression and psychosis. Heavy chronic cannabis use can lead to a characteristic withdrawal syndrome, especially with current THC levels averaging 7-10%. Such symptoms may hinder ability to reduce or cease use. Various psychotherapeutic treatment approaches have been efficacious but no one type of psychotherapy has been found to be superior and relapse rates are high. Efficacy of pharmacologic interventions has had only limited trials. Agonist and antagonist therapies have shown promise, e.g., dronabinol (oral THC), as well as combined pharmacotherapies (such as dronabinol and lofexidine). A recent adolescent study combining n-acetyl cystine with contingency management showed promising results as did “phone therapy” An overall review with treatment implications will be presented.

SYMPOSIUM 129 FIRST STEPS IN HELPING PATIENTS WITH FIRST-EPIISODE PSYCHOSIS

Chair: Bruce M. Cohen, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the importance of early intervention and effective engagement in producing better outcomes in life-long psychiatric illness; 2) Understand how the choice of specific targeted treatments, provided within a community setting, can positively affect symptom and social outcome; 3) Understand standard, state of the art, as well as innovative approaches to care, including the use of mobile devices to help manage data and encourage care.

SUMMARY:

This symposium brings together leaders in community and military psychiatry to discuss the importance of early intervention in producing better outcomes for life-long psychiatric illnesses, especially for those who have experienced a first episode of psychosis. Specifically, given what is known about the link between early and sustained treatment and rehabilitation, we will address what kind of effective outreach and programs can be offered to make engagement more likely and more successful. Among the topics we will explore: clinical and environmental obstacles in engaging patients and their families in research at the time of their first psychiatric hospitalization and how modern technology can allow us to define a patient's health trajectory, determine the nature of intervention required and achieve a higher definition, more contemporaneous view of population health. Having multiple inputs and experiences: Hospital based, community based, patient feedback, VA programs, commercial interests, makes this symposium especially rich in information and ideas.

NO 1 CHALLENGES IN ENGAGING FIRST-ADMISSION PATIENTS AND THEIR FAMILY MEMBERS IN LONG-TERM OUTCOMES RESEARCH

Speaker: Evelyn Bromet, Ph.D.

SUMMARY:

There are a number of clinical and environmental obstacles in engaging patients and their families in research at the time of their first psychiatric hospitalization. This is particularly true when research is conducted in non-academic clinical settings. This talk focuses specifically on the environmental challenges encountered by the Suffolk County Mental Health Project as we recruited, engaged, and followed a group of participants over a 20 year period. Some challenges were presented to us; other challenges were created by us. In the end, the key to resolving most of the challenges was maintaining a respect and trust.

NO 2 TWO-YEAR STABILITY OF DIAGNOSIS IN FIRST- EPISODE PSYCHOSIS: THE IMPORTANCE OF CLOSE OBSERVATION EARLY IN THE COURSE OF THE CONDITION

Speaker: Mauricio Tohen, D.P.H., M.D.

SUMMARY:

Establishing the proper diagnosis early on is paramount for intervention selection in first episode psychosis. However, clinicians should keep in mind that early in the course of a psychotic condition symptoms may change. Affective symptoms not present at onset may later appear which would require changes in intervention selection. Early in the course of a first episode of psychosis, patients must be closely follow in order to determine if intervention changes are needed.

NO 3 AN UPDATE ON U.S. DEPARTMENT OF VETER- ANS AFFAIRS PROGRAMS FOR ENGAGING AND TREATING VETERANS WITH PSYCHOTIC DISOR- DERS

Speaker: Lisa B. Dixon, M.D., M.P.H.

SUMMARY:

The Veterans Health Administration has aggressively pursued the identification, assessment, treatment and rehabilitation of veterans who experience a first episode psychosis. This has included the traditional treatment venues delivered on inpatient units, outpatient clinics, as well as more remote setting that use telemental health technology to bring the specialty providers to the veterans in rural and very rural parts of the country. A major initiative to enhance engagement with veterans that experience a psychotic episode is the use of peer counselors, these are veterans with mental illnesses that have undergone a rigorous 6 month training program in counseling that are hired as employees to assist the mental health providers. We have found that this strategy increases the likelihood that veterans will adhere to a rehabilitation program that ultimately aims for independent living and employment.

NO 4 OUTREACH AND ENGAGEMENT IN A COMMU- NITY PSYCHIATRY PROGRAM

Speaker: Dost Ongur, M.D., Ph.D.

SUMMARY:

Community psychiatry programs continue to evolve and can serve as a key element in supporting the lives and the treatment and rehabilitation opportunities and decisions of people with psychiatric disorders. There is increasing recognition that engaging the members of a community setting in a conversation about their own goals and perceived needs from the program leads to improved outcomes. In this segment, we will discuss our current programs designed to engage and serve the members of a community program, Waverley Place, and our efforts to systematically collect information from member on their needs and get their advice on how to improve our program offerings. A special focus in this effort is on successfully engaging patients early in treatment, particularly those experiencing a first episode of illness, and we will review what we have learned from our own experiences and the experiences of the members of our program.

NO 5**BIG DATA AND MOBILE DEVICES TO AMPLIFY CARE DELIVERY**

Speaker: Trishan Panch, M.B.B.S., M.P.H.

SUMMARY:

Is it possible to design a technology enabled intelligent system to better engage and empower patients and their families in their care? We will discuss approaches to developing clinical rules engines to deliver care plans to patients in a form that they can understand and interact with. We describe how, based on patient interaction with care plans, how it is possible to define their health trajectory, determine the nature and timing of intervention required and achieve a higher definition, more contemporaneous view of population health. This discussion will frame a practical approach to using technology to address the challenges of supporting patients with long term mental health problems in the community.

SYMPOSIUM 130**HIV - RELATED NEUROCOGNITIVE DISORDERS**

Chair: Karl Goodkin, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the diagnostic and treatment approaches to neuropsychiatric disorders in people with HIV/AIDS.;2) Understand the pathophysiology of HIV-1 associated neurocognitive disorders (including asymptomatic neurocognitive impairment).;3) Describe psychopharmacological treatment (including drug interactions) for neurocognitive complications.;4) Understand the impact and potential benefits of early antiretroviral treatment (ART) on neurocognitive dysfunction.;

SUMMARY:

Advances in the treatment of the human immunodeficiency virus (HIV) have dramatically improved survival rates over the past 10 years. As life expectancy increases, however, more

and more clinicians are likely to encounter neuropsychiatric manifestations of HIV disease. Some patients present may with cognitive deficits due to an HIV-triggered neurotoxic cascade in the central nervous system, while others might present with a spectrum of psychiatric disorders during the course of their illness. These disorders can adversely influence the progression of HIV disease, lead to noncompliance with prescribed medication and treatment and, if missed, can lead to irreversible damage. As quality of life becomes a more central consideration in the management of HIV as a chronic illness, better awareness of these neuropsychiatric manifestations is paramount. During this symposium participants will receive an up-to-date medical review (including the most recent advances in antiretroviral therapy), discuss the assessment and diagnosis of neuropsychiatric disorders, and identify the most current and effective psychopharmacologic treatment options.

NO 1**NEUROPSYCHIATRIC OVERVIEW**

Speaker: Lawrence M. McGlynn, M.D.

NO 2**NEUROCOGNITIVE DECLINE**

Speaker: Karl Goodkin, M.D., Ph.D.

NO 3**PSYCHOPHARMACOLOGY**

Speaker: Stephen J. Ferrando, M.D.

NO 4**WHEN TO START ANTIRETROVIRAL THERAPY: A SWINGING PENDULUM?**

Speaker: Peter W. Hunt, M.D.

SYMPOSIUM 131**FOUND IN TRANSLATION: CHALLENGES AND OPPORTUNITIES IN TRANSLATING MENTAL HEALTH CARE INTO A CHINESE CONTEXT**

Discussant: Francis Lu, M.D.

Chair(s): Justin Chen, M.D., Robert M. Rohrbaugh, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the profound influence of culture on psychiatric diagnosis and treatment; 2) Provide examples of specific cultural challenges that act as barriers to providing mental health care to Chinese patients in both China and the U.S.; and 3) Describe opportunities for utilizing a Chinese cultural perspective for expanding Western understanding of psychiatric diagnosis and treatment.

SUMMARY:

Western frameworks for conceptualizing, diagnosing, and treating mental illness have assumed dominance throughout much of the world. The globalization of a Western "disease model" of psychiatry holds great promise for reducing morbid-

ity and mortality, improving access to evidence-based care in developing countries, and reducing stigma and maltreatment related to traditional conceptions of psychiatric illness. Yet practitioners of psychiatry in non-Western cultural contexts are frequently confronted with unique clinical challenges that reflect deep-seated variations in everything from societal norms regarding acceptable behavior to fundamental explanatory models of what it means to be ill. China's rapid modernization, in combination with increasing immigration from China to the US, have allowed for increased clinical experience with the unique issues that arise when these two cultures come together within a psychiatric clinical setting. This symposium will draw on the clinical experiences of the presenters, all of whom have worked with Chinese psychiatric patients in either China or the US, to highlight some of these issues of "translation" – both in terms of challenges presented, as well as opportunities for expanding understanding on both sides. Topics to be discussed include: Traditional Chinese conceptions of mental illness; challenges in the application of DSM/ICD diagnoses in Chinese populations in the US; challenges in integrating psychotherapy into mainstream mental health care in China; perceptions of psychiatry among Chinese medical students; and multicultural discourse studies as a means for understanding the meaning and experience of psychiatric illness.

NO 1 TRADITIONAL CHINESE CONCEPTIONS OF MENTAL ILLNESS

Speaker: Justin Chen, M.D.

SUMMARY:

The concepts of "kuang" and "dian" (roughly corresponding to mania and depression) have been documented in China since at least the 8th century BCE. Similarly, ancient Chinese texts describe illnesses that resemble what might now be called panic, delirium, globus hystericus, and malingering. Although some of the traditional Chinese terms are still in use today, these do not necessarily map neatly onto modern psychiatric diagnoses. This talk will review the literature related to traditional Chinese conceptions of mental illness, as well as provide a brief general overview of the contrasts between Chinese and Western conceptions of illness and treatment.

NO 2 PERCEPTIONS OF PSYCHIATRY AMONG CHI- NESE MEDICAL STUDENTS

Speaker: Zhening Liu, M.D., Ph.D.

SUMMARY:

Despite a tremendous shortage of psychiatrists in China, recruitment of Chinese medical students into psychiatry remains suboptimal. Students face significant barriers related to the perceived status of psychiatry in China, including medical school curricula which devote little time to psychiatric issues during the preclinical years, and a lack of clinical clerkship rotations similar to other medical specialties. These curricular barriers lead to a paucity of experience with patients with psychiatric illness and minimal contact with psychiatrist role models. In addition, Chinese students must overcome the

cultural stigma of being associated with psychiatric illness. Students' families often discourage medical students from entering the field. This presentation, given by the director of medical student education at Xiangya School of Medicine, will describe some of the methods utilized to attempt to overcome the barriers that medical students face in choosing a career in psychiatry.

NO 3 PSYCHOTHERAPY IN MENTAL HEALTH CARE IN CHINA: A CROSS-CULTURAL ADVENTURE

Speaker: Jianyin Qiu

SUMMARY:

Although indigenous forms of psychotherapy have arguably existed in China for centuries, what is commonly referred to as psychotherapy today was introduced from the West. Since the founding of the People's Republic of China in 1949, the development of psychotherapy in China can be divided into four stages. In particular, the past two decades have seen tremendous expansions in both the clinical practice of psychotherapy as well as the development of large-scale training programs. Several challenges remain for integrating psychotherapy into mainstream mental health services, including practice regulation, research capacity, and cultural barriers. This discussion will highlight examples from the presenter's own experience as a psychiatrist who specialized in psychotherapy at the Shanghai Mental Health Center to discuss the pitfalls and opportunities for implementing psychotherapy into routine mental health care in China.

NO 4 MULTICULTURAL DISCOURSE STUDIES AS A MEANS FOR UNDERSTANDING THE MEANING AND EXPERIENCE OF PSYCHIATRIC ILLNESS

Speaker: Jose Saporta, M.D.

SUMMARY:

Bringing Western psychology, psychiatry, and psychodynamic psychotherapy to non-Western cultures is an opportunity for dialogue and creative synthesis - or for a repetition of a monologue of the Western voice. Whereas Western psychology, psychiatry and psychodynamic theory are rooted in Western worldviews and modes of discourse, the history of Chinese thought has been different in important ways still evident in contemporary Chinese discourse. Cultural discourses play an important role in constructing meaning and shaping the experience of psychiatric illness. Dominant Western perspectives have tended to marginalize and suppress non-Western forms of discourse. This discussion will present a model from Chinese discourse studies which allows for flexible use of and dialogue between Western and non-Western/local perspectives and discourses when addressing psychological distress in non-Western cultures.

NO 5 CHALLENGES IN THE APPLICATION OF DSM/ ICD DIAGNOSES IN CHINESE POPULATIONS IN THE UNITED STATES

Speaker: Albert Yeung, M.D.

SUMMARY:

In European and North American cultures, depression is a well-accepted psychiatric syndrome characterized by specific affective, cognitive, behavioral, and somatic symptoms. In many non-European cultures, including Nigerian, Chinese, Canadian Eskimo, Japanese, and Southeast Asian, equivalent concepts of depressive disorders are not found. Studies exploring illness beliefs of depressed Chinese Americans with a low degree of acculturation have shown that many of them were unaware of, or unfamiliar with the concept of major depressive disorder (MDD). Based on data collected in Boston at a community health center serving mostly Chinese American patients, this presentation will discuss illness beliefs of depressed Chinese Americans, and the challenges clinicians face in communicating with them about their depression.

SYMPOSIUM 132 IMMIGRATION AND ITS ADVERSITIES: MENTAL ILLNESS, DETENTION, AND DEPORTATION

Discussant: Carissa Caban-Aleman, M.D.

Chair(s): Daniel B. Martinez, M.D., Rupinder Legha, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the basic legal issues associated with immigration, including the detention and asylum processes; 2) Recognize the unique legal challenges faced by immigrants with mental illness who may also lack competency; 3) Identify the unique role psychiatrists can play as consultants to immigrants and their legal teams and as advocates for immigrants who are seeking asylum or have been detained; and 4) Identify opportunities for advocacy--for detained immigrants and, in particular, for detained immigrants with mental illness--within the American Psychiatric Association and beyond.

SUMMARY:

Every year, the United States Immigration and Customs Enforcement (ICE) detains and deports hundreds of thousands of immigrants. As "non-citizens," detainees do not have a right to court-appointed lawyer and must provide counsel at their own expense. As a result a significant portion have no lawyer present during immigration proceedings. Since detained immigrants bear the burden of proof, regarding justification for asylum, the lack of guaranteed representation can be pivotal. Detained immigrants with mental disabilities face additional challenges in advancing their legal rights and providing credible information regarding their defense. However, there are few safeguards and regulations in place to protect detained immigrants with mental competency issues. As the largest settler of refugees, the United States admits tens of thousands of these immigrants who are unwilling to return to their country

of origin, due to a "well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion." Those seeking asylum also bear the burden of proof in providing evidence to substantiate their claims of persecution, but many have significant trauma histories that can undermine testimony and credibility. They are also responsible for funding their own legal counsel, which has proven to be a significant factor in determining outcomes. Detained immigrants and refugees seeking asylum face a complex legal process, and mental illness can play a significant role in their outcomes. By working with clients and lawyers as a medical consultant and educator, psychiatrists can make a significant contribution. The purpose of this symposium is to outline the legal process involved with detainment, deportation, and seeking asylum and to illustrate the critical role that psychiatrists can play as consultants to immigrants and legal teams alike.

NO 1 TRAUMA IN ASYLUM SEEKERS: HOW MENTAL HEALTH PROFESSIONALS CAN PROVIDE CRITICAL EXPERTISE

Speaker: Karen Musalo, J.D.

SUMMARY:

Individuals seeking asylum often have experienced persecution or been witness to atrocities inflicted on family, friends or members of their community. As is well-recognized, the experience of such events can lead to posttraumatic stress disorder (PTSD). PTSD can impact an individual's emotional affect and ability to recall detail, and can lead to judges finding the person not worthy of belief. Over the years, attorneys have turned to mental health experts as a means of educating judges and explaining why behavior that might otherwise be interpreted as indicative of mendacity actually show the opposite. The collaboration between lawyers and mental health professionals often can make the difference between a case that is granted, and one that is denied. This presentation will focus on the legal requirements of asylum, and the particular elements which most benefit from the expert evaluation of a mental health professional.

NO 2 WORKING WITH ATTORNEYS TO SAVE LIVES: CLINICAN + ATTORNEY = DYNAMIC DUO

Speaker: Jillian M. Tuck, J.D.

SUMMARY:

When doctors and lawyers work together to save lives, their impact is extraordinary. Over the past decade, Physicians for Human Rights statistics have shown that when doctors and lawyers work together with asylum seekers and others fleeing human rights violations, a full 90% are saved from returning to the country of persecution. The collaboration between doctors and lawyers is not easy, however. They are trained in different ways, often have different goals, and they generally approach working with clients from very different perspectives. Best practices for doctor -attorney collaborations are not hard to implement, but require clear and frequent communication,

patience, and respect for each other's areas of expertise. This presentation will provide tips for effective communication, including definition of roles, chronology of collaboration, and explanation of what constitutes an effective medical-legal affidavit.

**NO 3
ASYLUM SEEKERS AND PSYCHIATRIC EVALUATIONS: A JOINT COLLABORATION AT YALE**

Speaker: Howard Zonana, M.D.

SUMMARY:

This presentation will explore the challenges of asylum law and the role for forensic psychiatrists, based on the 20-year collaboration between the Yale Law and Psychiatry Program and the Yale Immigration Legal Services Clinic. We will present the demographic and diagnostic profile of asylum seekers and the ethical and clinical issues that emerged in the cohort. Finally, we will present a model for legal-psychiatric collaboration, identifying necessary resources and the barriers and challenges in this work.

**NO 4
FORENSIC PSYCHIATRISTS WITHOUT BORDERS: ASSISTING WITH REFUGEE APPLICATIONS**

Speaker: Maya Prabhu, LL.B., M.D.

SUMMARY:

This presentation will explore the challenges of forensic psychiatric evaluations of refugees who are seeking resettlement based on our 2 year collaboration with the Iraqi Refugee Assistance Project and Yale Law School. We will consider the diagnostic and technical challenges of telepsychiatry, ethical considerations of overseas field work, cross-cultural complexities and considerations in client and attorney interface.

**NO 5
FRANCO-GONZALEZ V. HOLDER: THE FIGHT TO ESTABLISH A RIGHT TO COUNSEL FOR IMMIGRATION DETAINEES WITH SERIOUS MENTAL DISORDERS**

Speaker: Talia Inlender, J.D.

SUMMARY:

On March 31, 2010, Jose Antonio Franco-Gonzalez, a man with the cognitive level of a young child, was released from custody after languishing for nearly five years in an immigration detention with no lawyer and no open removal proceedings pending. Mr. Franco's story sparked a class action lawsuit that seeks to establish: (a) a system for identifying and evaluating detained immigrants who may not be competent to represent themselves in immigration proceedings due to a serious mental disorder, (b) appointment of counsel for individuals who are in fact incompetent to represent themselves, and (c) bond hearings for those held longer than 6 months. Forensic psychiatrists have been crucial to the development of this case. If successful, this lawsuit will play an important

role in evaluating competency and working with appointed attorneys to develop claims for relief (including asylum) and release on bond.

**NO 6
IMMIGRATION AND ITS ADVERSITIES: CONCLUDING REMARKS**

Speaker: Nevine D. Ali, M.D., M.P.H.

SUMMARY:

This presentation draws upon the previous presentations to develop conclusions, initiate discussion, and consider next steps. Psychiatrists have a unique and critical opportunity to serve as educators and advocates for this vulnerable and marginalized population (immigrants involved in the asylum and detention process). By volunteering with the Physicians for Human Rights Asylum Program, psychiatrists can provide expert affidavits for immigrants facing deportation. By working collaboratively with lawyers, psychiatrists can provide meaningful education regarding trauma and culture and how these factors impact immigrants' narratives and testimonies. Efforts within the American Psychiatric Association (APA) are also critical. A recent APA position statement, "Detained Immigrants with Mental Illness," expresses deep concern about the lack of adequate attention to the mental health needs of detainees." Other potential next steps within the APA will also be described.

**SYMPOSIUM 133
FAMILY TREATMENT IN BIPOLAR DISORDER: BENEFITS AND BARRIERS**

Chair(s): Allison M. R. Lee, M.D., Igor Galynker, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the rationale for the inclusion of family members and other informal caregivers in the treatment of bipolar disorder; 2) Demonstrate familiarity with the different models of family-oriented bipolar treatment and how they are conducted; and 3) Identify barriers and risk factors that may lead to diminished effectiveness of these treatment models or diminished adherence, and understand ways to mitigate these factors;

SUMMARY:

Although most patients with bipolar disorder respond to pharmacotherapy, residual symptoms and relapse rates remain considerable, and inter-episode functioning in work and family life can be significantly impaired. Psychosocial treatments have been shown to confer added benefit in bipolar disorder, including those which involve a family member or other informal caregiver. There is persuasive evidence that making willing families an integral part of treatment improves outcome and that family characteristics influence treatment outcome. Yet, as compared to treatment protocols for chronic illnesses like diabetes, family members have seldom been part of the usual treatment process for bipolar disorder due to barriers such as tradition, stigma of mental illness, and medico-legal

issues. To address this gap, models of family-involved treatment have been developed, including intensive family-focused therapy (FFT; Miklowitz et al., 2003), family psychoeducation (Reinares et al., 2004), caregiver health promotion therapy (Family Focused Therapy-Health Promoting Intervention; FFT-HPI; Perlick et al., 2010), family-inclusive treatment using a family psychiatrist (FIT; Galynker et al., 2011) and others. In this symposium, new findings will be presented on how family-oriented treatment benefits patients and families, as well as about what barriers exist to delivering this form of treatment and how they might be overcome. Implications for the clinical treatment of bipolar disorder will be discussed, along with specific recommendations for clinicians.

NO 1 PATIENT PERCEPTION OF FAMILY RELATIONSHIPS AND TREATMENT ADHERENCE IN FAMILY TREATMENT OF BIPOLAR DISORDER

Speaker: Allison M. R. Lee, M.D.

SUMMARY:

In light of research support for models of bipolar treatment involving a family member, the Family Center for Bipolar at Beth Israel Medical Center practices family-inclusive treatment (FIT), in which the patient consents to sharing of illness-related information with an informal caregiver, as its standard of care. In this study we examined how patient perceptions of family relationships differed in families that remained in treatment in our center vs. those who did not, in an effort to shed light on which families might stand to benefit the most from a family approach and elucidate barriers to family treatment. We compared adherent to non-adherent patients on ratings of perceived criticism and social support at intake. Initial analysis on 21 patients showed that adherent patients had higher ratings of social support, as well as lower ratings of family criticism. These data suggest that patients' negative perceptions of family relationships can create barriers to family treatment.

NO 2 DEVELOPMENTAL CORRELATES OF CAREGIVER ADHERENCE IN FAMILY TREATMENT OF BIPOLAR DISORDER

Speaker: Lisa Cohen, Ph.D.

SUMMARY:

Bipolar disorder is among the most debilitating psychiatric conditions and frequently remains resistant to treatment. Inclusion of family members, particularly primary caregivers, has been shown to benefit both patients and their caregivers. However, treatment adherence remains a challenge for both patients and their families. Identification of caregivers' barriers to treatment is therefore of great import although there is currently little research on this topic. We compare caregivers who return to family treatment with those who do not on several developmental features: history of childhood trauma (CTQ), descriptors of parental relationship (PBI), and attachment status in adulthood (RSQ). Initial analysis on 22 caregivers showed that non-adherent caregivers reported higher levels of physical abuse, marginally higher levels of emotional abuse, and lower levels of paternal care. This data suggests

that caregivers' own childhood history can create barriers to family treatment.

NO 3 THE PROGNOSTIC ROLE OF PERCEIVED CRITICISM IN BIPOLAR DISORDERS

Speaker: Jan Scott, M.B.B.S., Ph.D.

SUMMARY:

We explored whether subjective levels of sensitivity criticism, medication adherence and/or family knowledge about illness are associated with relapse in bipolar disorders in 81 patient-family dyads. Perceived sensitivity was significantly correlated with symptom levels. At 12 months, the odds ratio (OR) for admission was 3.3 (95% confidence intervals 1.3–8.6) in individuals with poor medication adherence, high perceived criticism, and a family member with poor understanding. These findings were significant at 5 years. Perceived criticism may be a simple, robust clinical predictor of relapse. Perceived criticism, poor understanding of bipolar disorder and sub-optimal treatment adherence are risk factors for hospitalization that are potentially modifiable through strategic interventions such as family therapy.

NO 4 THE ROLE OF MEDICATIONS IN ADOLESCENT BIPOLAR DISORDER: TREATING THE PATIENT, TREATING THE FAMILY

Speaker: Christopher Schneck, M.D.

SUMMARY:

Pharmacotherapy is a mainstay in the treatment of bipolar disorder, though diagnostic uncertainty of the illness in children and adolescents, coupled with limited data supporting its efficacy create barriers to acceptance and adherence. The problem is magnified when treating adolescents with bipolar spectrum disorders, where evidence for medication efficacy is even more limited. We review pharmacological algorithms used in our Family Focused Therapy studies for adolescents and present early findings from our studies, including common pitfalls in pharmacological management, issues around adherence, the role of the family in helping/hindering pharmacotherapy, and characteristics of illness and treatment variables. Strategies for optimizing pharmacotherapy will be emphasized.

NO 5 FAMILY-FOCUSED TREATMENT FOR BIPOLAR DISORDER: OVERCOMING BARRIERS TO IMPLEMENTATION

Speaker: David J. Miklowitz, Ph.D.

SUMMARY:

Family-Focused Treatment (FFT) is an evidence-based therapy for bipolar adults or adolescents who are recovering from an acute mood episode. After a description of the three-phase FFT protocol (psychoeducation, communication enhancement training, and problem solving skills training), the speaker will present evidence for the effectiveness of FFT as an adjunct

to pharmacotherapy in bipolar disorder. The majority of the presentation will concern overcoming barriers to implementation of FFT in community practice. Variables that may affect ease of implementation include characteristics of the practice context, the treatment providers, the flexibility of the model, training and supervision procedures, and characteristics of the patient population. Early findings from an implementation study of FFT will be presented, and strategies for removing barriers to implementation will be emphasized.

SYMPOSIUM 134 PSYCHIATRY IN MULTICULTURAL SETTINGS: TRAINING AND PRACTICE

Chair: Richard L. Merkel Jr., M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the role of migration-globalization on psychiatric training and practice. This requires an increased understanding on how cross-cultural interactions affect identity and psychiatric care; 2) Describe various psychiatry training models and strategies in cultural psychiatry from the perspective of the psychiatry resident; 3) Describe the value of global health experiences in the training of psychiatrists at many levels and how these experiences enhance clinical practice in multicultural settings; 4) Describe the new DSM-5 Cultural Formulation as operationalized in a 16-item questionnaire and how its use can enhance psychiatric training and clinical work; and 5) Understand the impact of ethnocultural differences on psychiatric treatment and delineate strategies for overcoming the ethnocultural gaps occurring in multicultural settings.

SUMMARY:

This symposium will address the increasing need in psychiatry training and practice for effectiveness in multicultural settings, which are increasing due to migration and globalization. Practical and effective strategies will be examined in both training and clinical practice. In psychiatric training didactic and experiential methods will be reviewed from the perspective of both the academic supervisor and the resident. An emphasis will be placed on global health experiences as a way to gain comfort and efficacy in multicultural settings. The DSM-5 16 question Cultural Formulation will be described and its utility in both psychiatry teaching and clinical practice. In light of the ethnocultural gaps that may occur between the clinician and the patient in a multicultural setting, the importance of appreciating their potentially adverse impact on clinical care will be examined and practical means for addressing them will be delineated.

NO 1 CROSS-CULTURAL TRAINING: A RESIDENT'S PERSPECTIVE

Speaker: Karen Mu, M.D., Ph.D.

SUMMARY:

While formal training in cross-cultural psychiatry is an integral and required component of residency education, trainee

engagement varies between individuals. Nonetheless, it is increasingly essential that residents receive first class training in this area despite the numerous difficulties of shortages of time, expertise, and resources presently facing training programs in fulfilling this mandate. Residents enter training with diverse experiences and interests in cross-cultural issues and have differing degrees of familiarity with their own cultural identity and spirituality. This variability adds to the challenge of addressing cross-cultural and spirituality education across the levels of training. We will discuss different curricular models, including novel teaching and training methods, in order to explore and identify effective and ineffective approaches from a trainee perspective. We will also consider ways to further engage residents in cross-cultural psychiatry.

NO 2 CULTURE AND CULTURAL COMPONENTS IN PSYCHIATRIC RESIDENCY TRAINING: WHY AND HOW?

Speaker: Renato D. Alarcon, M.D., M.P.H.

SUMMARY:

The Migration-Globalization-Technology equation is discussed as one of the main factors in the consideration of Culture and cultural concepts in medical training programs. Their inclusion in psychiatric residency training is justified by a set of variables that include identity (patient's and clinician's), help-seeking patterns, explanatory models, diagnostic approaches, treatment strategies, clinical outcomes and Quality of Life. The "how to teach" cultural concepts to students at different levels of training is examined within a context of flexible didactic syllabi, and emphasis on practical and experiential activities. A comprehensive series of interactions with patients and their families, health care settings and social organizations, and the use of appropriate teaching tools are discussed. Whether Cultural Psychiatry should or should not be considered a subspecialty is briefly examined.

NO 3 THE DOCTOR-PATIENT RELATIONSHIP: NAVI- GATING ETHNOCULTURAL DIFFERENCES WITH PATIENTS AND FAMILIES DURING PSYCHIATRIC TREATMENT

Speaker: James L. Griffith, M.D.

SUMMARY:

Treatment relationships can be strained because of ethnocultural gaps between psychiatrist and patient in ethnicity, religion, or other cultural identities. Ethnocultural differences can impact a therapeutic alliance with adverse effects upon accurate disclosure of information, treatment adherence, or assessment of risks for suicide or violence. Navigating ethnocultural differences requires that a clinician shift to a posture of authentic curiosity and interest in the patient's cultural appraisal of the problem. For example, "the four C's" is a simple mnemonic for learning about a patient's cultural appraisal: What do you call the problem? What do you think is the cause of the problem? What do you expect the problem's course to be? What needs to change in order for the prob-

lem to resolve? Organizing treatment within the metaphors, worldview, and categories of the patient's culture can ensure a robust therapeutic alliance and effective implementation of treatment.

NO 4 THE USE OF THE CULTURAL FORMULATION IN TRAINING AND PRACTICE

Speaker: Roberto Lewis-Fernandez, M.D.

SUMMARY:

The DSM-5 Cultural Formulation Interview (CFI) is a 16-item questionnaire that provides a standardized, patient-centered template for a cultural assessment during a mental health evaluation. It can be used in routine clinical practice with any patient in any clinical setting. Evaluation of cases requiring in-depth cultural assessment are guided by 12 supplementary modules, which expand on each domain of the CFI and provide additional questions to assess youth, older adults, and immigrants and refugees. This talk will present an approach to teaching cultural psychiatry to second-year (PGY-2) adult psychiatry residents based on their use of these questionnaires with patients from their routine caseloads. Residents' impressions of this more structured approach will be compared to the impressions of the PGY-2 cohort from the previous academic year, who were trained in cultural psychiatry using the DSM-IV Outline for Cultural Formulation, a narrative-based assessment approach.

NO 5 THE VALUE OF GLOBAL HEALTH EXPERIENCES IN PSYCHIATRY TRAINING AND PRACTICE

Speaker: Lawrence G. Wilson, M.D.

SUMMARY:

This presentation will: 1) Review the range of settings on the global scene that can help supplement a psychiatrist's skills to work with multicultural populations. 2) Focus on some remarkable cultural influences on the manifestation of psychoses and mood disorders that can be observed in different cultural settings, and the interesting Explanatory Models that can be communicated. 3) Assert that psychiatrists can play an important role by collaborating with other fields of medicine in foreign settings, as consultant, teacher of primary care providers and other health care workers, or by assuming evaluation and treatment responsibilities for mild or severe psychiatric disorders in settings where other providers are either absent or scarce. 4) Conclude that global health experiences can be a fascinating personal and professional adventure as well as sensitizing the psychiatrist to cultural and ethnic influences on the functioning of both ill and healthy persons in all settings.

SYMPOSIUM 135 TREATMENT OF PERSONALITY DISORDERS

Discussant: John M. Oldham, M.D.

Chair: John Gunderson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To update and summarize knowledge about the treatment of major personality disorders; 2) Highlight new perspectives on treatment of personality disorders; and 3) Evaluate the relative strength of different therapeutic modalities.;4) Identify areas requiring research and their priorities.

SUMMARY:

Reviews on treatment of personality disorders to be published in the Treatment of Psychiatric Disorders: Edition V (G. Gabbard, Editor) will be presented by the experts who are writing them. The symposium will include updated reviews of Obsessive-Compulsive Personality Disorder (Glen Gabbard), Schizotypal (including paranoid) Personality Disorder (Mike Stone), Avoidant Personality Disorder (Chris Perry), Narcissistic Personality Disorder (Elsa Ronningstam) and Borderline Personality Disorder (John Gunderson). Each talk will examine the role of different therapeutic modalities (e.g., psychotherapy, group, medications). Presenters will then highlight recent advances in clinical practice, the current status of empirical validation, and the areas where research attention is most needed.

NO 1 TREATMENT OF OBSESSIVE-COMPULSIVE PERSONALITY DISORDER

Speaker: Glen O. Gabbard, M.D.

SUMMARY:

This presentation summarizes research data on treatments for obsessive-compulsive personality disorders. It also provides a way of thinking about the patient's psychological conflicts and defenses to assist clinicians in formulating interventions. Transference and countertransference themes are illustrated and discussed.

NO 2 CURRENT TREATMENT OF BORDERLINE PERSONALITY DISORDER

Speaker: John Gunderson, M.D.

SUMMARY:

Since the APA's Guidelines for Treatment of BPD was prepared in 2001, treatment of this condition has continued to evolve. Empirically validated treatments (EVT's) that existed then, i.e., Dialectical Behavior Therapy (DBT), Mentalization Based Treatment (MBT), and Transference Focused Psychotherapy (TFP) have received additional empirical support, sometimes extending their reach to different clinical settings and diagnostic groups. Each can boast a gradually growing cadre of loyal and skilled practitioners. In practice, however, BPD's treatment remains intermittent crisis-oriented treatment episodes provided by clinicians who are neither well-trained nor enthusiastic. Two changes in BPD's treatment may help address this. One is that new EVT's that are more case-management oriented, e.g., Systems Training for Emotional Predictability and Problem Solving (STEPPES), Cognitive Analytic Therapy (CAT), and Good Psychiatric Management (GPM).

NO 3 PSYCHIATRIC TREATMENT OF AVOIDANT PERSONALITY DISORDER

Speaker: J. Christopher Perry, M.D., M.P.H.

SUMMARY:

Avoidant personality disorder (AVPD) was first defined in DSM-IV and is to be included in DSM-V. Despite some controversy about the overlap between AVPD and the symptom disorder of Social Phobia (Social Anxiety Disorder), a research and clinical literature has evolved on its treatment and course. This presentation reviews this literature including both naturalistic studies, clinical reports and treatment trials. The author will present a summary of the treatment literature including psychotherapy, medication, partial hospitalization and biological approaches. It will also focus on particular problems that may arise in the therapeutic relationship affecting treatment response. While AVPD generally improves with treatment short or long-term treatments, in some treatment settings the rate of improvement in AVPD may be slower than for some other personality disorder types. Recovery is a possible outcome that requires time frames longer than most short term treatments allow.

NO 4**NARCISSISTIC PERSONALITY DISORDER**

Speaker: Elsa Ronningstam, Ph.D.

SUMMARY:**NARCISSISTIC PERSONALITY DISORDER**

The notion of narcissistic patients as untreatable has especially over the past years been further challenged. The introduction of a self-regulatory model for pathological narcissism that embraces both self-enhancement, inferiority and vulnerability has opened new perspectives on narcissistic personality functioning that promotes alternative strategies for alliance building and treatment. The dimensional diagnostic approach as proposed in DSM 5, can potentially guide the clinician at an early stage in treatment to focus on narcissistic patients' sense of identity and agency, fragility in self-regulation, self-protective reactivity and the range of self-enhancing and self-serving behaviors and attitudes. The aim of this presentation is to provide an overview of the up-to-date knowledge and development in the treatment of patients with pathological narcissism and NPD.

NO 5**SCHIZOTYPAL PERSONALITY DISORDER**

Speaker: Michael Stone, M.D.

SUMMARY:

Schizotypal personality [STPD] is discussed from a number of vantage points. The interplay of genetic and post-natal factors contributing to the development of STPD is highlighted, with an emphasis on its proximity in the majority of cases, via genetic loading, to the more serious variety of schizophrenic-spectrum disorders; namely, schizophrenia. Eccentricity or "oddity" of personality may be considered the prototypic trait of STPD. Various therapeutic approaches are described, including individual psychotherapy, focusing on psychoanalytically-oriented, cognitive-behavioral, and supportive – with suggestions as to which approach may be indicated, according to the particularities of the patient. Indications for other techniques are also described, including group therapy, family

therapy, and pharmacotherapy. Several illustrative clinical examples are provided, along with a comment on cultural factors affecting the diagnosis of STPD. Thus far, there have been no evidence based studie

SYMPOSIUM 136**REPORT FROM THE DSM-5 SEXUAL AND GENDER IDENTITY DISORDERS WORK GROUP**

Chair: Kenneth J. Zucker, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the substantive changes in the DSM-5 for female sexual dysfunctions; 2) Identify the substantive changes in the DSM-5 for male sexual dysfunctions; 3) Recognize the points of debate surrounding the DSM-5 revisions to the diagnosis of Pedophilic Disorder and to identify changes to the definition of a paraphilic disorder; and 4) Recognize the points of debate regarding the decision to not include Hypersexual Disorder in Section III.

SUMMARY:

This symposium will review some of the diagnostic changes (or lack thereof) of several diagnostic categories that were under the purview of the DSM-5 Sexual and Gender Identity Disorders Work Group. We will focus on changes to that were recommended by the Sexual Dysfunctions subworkgroup and on the changes that were made (and not made) to the diagnosis of Pedophilic Disorder that were recommended by the Paraphilias subworkgroup and the decision to not include Hypersexual Disorder in Section III. This symposium will review some of the diagnostic changes (or lack thereof) of several diagnostic categories that were under the purview of the DSM-5 Sexual and Gender Identity Disorders Work Group. We will focus on changes to that were recommended by the Sexual Dysfunctions subworkgroup and on the changes that were made (and not made) to the diagnosis of Pedophilic Disorder that were recommended by the Paraphilias subworkgroup and the decision to not include Hypersexual Disorder in Section III.

NO 1**RECONCEPTUALIZING FEMALE SEXUAL DYSFUNCTION: NEW DIRECTIONS FOR CLINICIANS AND RESEARCHERS**

Speaker: Cynthia Graham, Ph.D.

SUMMARY:

There have been significant changes in the DSM-5 classification of female sexual dysfunction, with two new disorders (Female Sexual Interest/Arousal Disorder and Genito-Pelvic Pain/Penetration Disorder) replacing the DSM-IV female diagnoses of Hypoactive Sexual Desire Disorder, Female Sexual Arousal Disorder, Dyspareunia, and Vaginismus. Other changes, across all of the female dysfunctions, include the addition of specific symptom duration and severity criteria and the move to polythetic diagnostic criteria. Factors that may be relevant to etiology and treatment and that should be considered dur-

ing the assessment of sexual dysfunction (e.g., relationship and partner factors) are highlighted. I will discuss the rationale for these changes, as well as the likely implications for both clinical practice and for research.

NO 2 A SCANDINAVIAN PERSPECTIVE ON DSM-5 PEDOPHILIC DISORDER CRITERIA

Speaker: Niklas Langstrom, M.D., Ph.D.

SUMMARY:

DSM-IV-TR diagnostic criteria for Pedophilic Disorder are retained in DSM-5. I will reflect on arguments presented for and against this decision, from the perspective of being a Scandinavian (Swedish) psychiatrist and researcher involved in the DSM-5 effort. For example, the dismissal of our work group's suggestion to include as a Pedophilic Disorder subtype individuals with an erotic preference for children in early puberty (Tanner stages 2-3, usually age 13 years or younger) might illustrate that divergent public discourses and legislation between Northern Europe and North America affected the decision process quite strongly compared to available empirical evidence.

NO 3 MALE SEXUAL DYSFUNCTIONS: NEW DIRECTIONS FOR CLINICIANS AND RESEARCHERS

Speaker: Robert t Segraves, M.D., Ph.D.

SUMMARY:

In DSM-5, the male sexual dysfunctions, including Male Hypoactive Sexual Desire Disorder, Premature (Early) Ejaculation, Erectile Disorder, and Delayed Ejaculation, have been modified. This presentation will review these modifications, provide the rationale for the changes, and consider implications for clinical practice and research.

NO 4 HAS THE DSM-5 (PARTIALLY) DEPATHOLOGIZED PEDOPHILIC DISORDER?

Speaker: Kenneth J. Zucker, Ph.D.

SUMMARY:

The DSM-5 has preserved the DSM-IV-TR diagnostic criteria for Pedophilic Disorder. I will discuss some of the potential problems in this decision, including the central issue of the diagnostic status of men who have an erotic preference for children 13 years of age or younger who are in early puberty (Tanner stages 2-3). I will consider whether or not this decision, in effect, has partially depathologized, from a psychiatric point of view, an erotic preference for children.

NO 5 WHAT HAPPENED TO HYPERSEXUAL DISORDER?

Speaker: Martin Kafka, M.D.

SUMMARY:

From its conception, Hypersexual Disorder (HD) was a controversial and newly synthesized diagnosis proposed for the Appendix (Section 3) of the DSM-5. The diagnostic criteria of Hypersexual Disorder were derived from common behavioral descriptors evident in multiple ratings scales whose reliability and validity had been tested in thousands of subjects-male and female, gay and heterosexual, including community controls. Despite field testing in over 200 subjects demonstrating reliability and validity of the specific polythetic criteria, the diagnosis was rejected for the Appendix. The trials, tribulations, and possible future for HD will be discussed.

SYMPOSIUM 137 ANTIDEPRESSANTS IN MAJOR DEPRESSIVE DISORDER: THE EFFICACY DEBATE

Chair: S. Nassir Ghaemi, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand and evaluate critiques of antidepressant efficacy based on the FDA randomized clinical trial database; 2) Appreciate the evidence for and against antidepressant efficacy in the FDA randomized clinical trial database and in the larger scientific literature; and 3) Demonstrate familiarity with differing interpretations of the above evidence and apply that evidence to clinical practice.

SUMMARY:

The popular media has brought much attention to the question of antidepressant efficacy, much of it based on analyses of the FDA database of randomized clinical trials (RCTs) in major depressive disorder (MDD). In this symposium, prominent psychiatrists who have been part of this debate, publishing some of those analyses, and representing views across the spectrum on this topic, will discuss that evidence. The limitations of many of those critiques, and how they have been interpreted in the public media, will be addressed scientifically. The evidence for and against antidepressant efficacy will be examined statistically and empirically, and the consequences of those interpretations for clinical practice will be discussed. The symposium represents all perspectives on this topic, and should provide a full analysis of this matter.

NO 1 REANALYZING A META-ANALYSIS: WHEN ANTI-DEPRESSANTS WORK

Speaker: Paul A. Vöhringer, M.D., M.P.H., M.Sc.

SUMMARY:

In a prominent meta-analysis of the FDA database of randomized clinical trials (RCTs) of antidepressants in major depressive disorder (MDD), it was claimed that antidepressants are not substantially more effective than placebo. A small difference was found, deemed to be clinically unimportant. While a larger benefit in severe depression was seen, antidepressants were minimally better than placebo for mild to moderate depression. In this reanalysis of the same database,

instead of absolute change in Hamilton Depression Rating Scale (HDRS) scores, we assessed relative improvement (% change), thus correcting for initial severity, and found clinically notable benefit with antidepressants over placebo in moderate depression. Thus, the conclusion from the FDA database is reversed: Instead of concluding that antidepressants are ineffective except in all but the most severe depressive episodes, as initially argued, antidepressants seem effective in all but the mildest depressive episodes.

**NO 2
TO BE OR NOT TO BE (EFFECTIVE), THAT IS NOT
THE QUESTION: BEYOND AN ALL-OR-NONE
VIEW OF ANTIDEPRESSANT EFFICACY**

Speaker: Erick Turner, M.D.

SUMMARY:

For decades psychiatrists read reassuring news of antidepressant efficacy. In published clinical trials, antidepressants always seemed to beat placebo. But all was not as it seemed. In a 2008 NEJM paper, our group showed these trials had been selectively published. FDA data revealed that only half the trials were positive, while negative trials remained unpublished. Nevertheless, combining FDA data from both positive and negative trials using meta-analysis, we found an overall effect size of 0.31, with a lower 95% confidence limit of 0.27, far above zero, the point of equivalence to placebo. The beauty of effect size is that we can view drug efficacy along a continuum. By contrast, if a threshold value is used as an arbitrary litmus test for drug efficacy, we are led to engage in primitive all-or-none thinking. But this is exactly the basis for recent declarations that antidepressants are categorically ineffective. This and related fallacies will be discussed.

**NO 3
ANTIDEPRESSANTS: IT DEPENDS WHAT YOU
MEAN BY EFFICACY**

Speaker: David Healy, M.D.

SUMMARY:

There is a great deal of evidence about agents we call antidepressants generated as part of a drug licensing process, none of which is designed to inform clinical practice. As a result, there is no evidence that antidepressants save lives or make people more functional. There is a considerable amount of evidence that recent antidepressants are inefficacious for melancholia and as such are close to misbranded as antidepressants. We could put alcohol or opiates through the same testing procedures and come out with results comparable to those we have for "antidepressants". But antidepressants do work in the sense that alcohol and opiates work. The issue then is what is their clinical role and who defines that role - physicians or pharmaceutical companies.

**NO 4
THE ANTIDEPRESSANT EFFICACY DEBATE: BE-
YOND THE ACUTE PHASE**

Speaker: S. Nassir Ghaemi, M.D., M.P.H.

SUMMARY:

Much of the debate about antidepressants has focused on whether or not they are effective based on the FDA database of pharmaceutically-sponsored randomized clinical trials (RCTs), almost all of which were in the acute phase of treatment of a major depressive episode. Discussions tend to ignore the question of maintenance efficacy, or long-term prevention of new depressive episodes. In this review, I will examine that question from two sources: published pharmaceutically-sponsored RCTs, and data from the NIMH-sponsored STAR*D study. In the pharmaceutically sponsored maintenance studies, I will examine how preselection of patients as drug responders (the enriched design) may impair the validity of long-term efficacy results. In the STAR*D data, I will describe and interpret results indicating that about 40% of acute responders did not stay well in relapse prevention despite staying on the same agent. Conclusions relevant to clinical practice will be considered.

**SYMPOSIUM 138
MAINTENANCE TREATMENTS IN BIPOLAR DIS-
ORDER: THE PURSUIT OF FULL RECOVERY**

Discussant: Michael Gitlin, M.D.

Chair(s): Eric D. Peselow, M.D., Waguih Ishak, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the importance of biopsychosocial interventions in maintenance treatment of bipolar disorder; 2) Identify classic and emerging pharmacological agents as well as the collaborative model used in maintenance treatment of bipolar disorder; and 3) Appreciate the definition and measurement of full recovery beyond symptomatic improvement and relapse prevention.

SUMMARY:

Bipolar disorder affects nearly 50 million people worldwide. The highest risk is early adulthood with half of the patients experiencing bipolar symptoms before age 25 (Kessler et al., 2005). In a WHO worldwide survey, bipolar spectrum patients showed that they experienced more symptom severity in depressive than manic episodes, with severe role impairment reported by 74.0% in bipolar depressed patients vs. 50.9% in bipolar manic patients (Merikangas et al., 2011). Bipolar disorder was reported to be the most expensive psychiatric diagnosis, due to direct costs of treatment and relapses and indirect costs due to loss of productivity (Peele et al., 2003). Relapse rates in Bipolar disorder are as high as 49% within 2 years (Perlis et al., 2006) of remission. Maintenance treatments have traditionally targeted relapse prevention, primarily by keeping patients on their medication regimens that were successful at remission. Compared to placebo, mood stabilizers and atypical antipsychotics showed different relapse prevention profiles especially in preventing manic vs. depressive episodes (Popovic et al., 2011). Moreover, the data remains scarce about psychosocial interventions. The goal of this symposium is to present original and comparative

data about maintenance treatments in Bipolar disorder using lithium, valproate, atypical antipsychotics, novel agents, and psychosocial interventions especially the collaborative chronic care model, with the purpose of orienting clinicians to innovative methods of defining and measuring recovery beyond symptomatic improvement and relapse prevention. In addition to symptom severity reduction, improvement of functioning and quality of life (QOL) enhancement in bipolar disorders need to take more of a priority in long-term maintenance in order to effect health restoration in Bipolar disorder. Models of measurement of functioning and QOL using patient-reported outcomes as recovery parameters will be presented. The participants will engage the audience in a lively debate about future treatment of Bipolar disorder that aim at helping patients achieve a state of wellness.

NO 1 MAINTENANCE WITH CLASSIC MOOD STABILIZERS: LITHIUM, VALPROATE, AND CARBAMAZEPINE

Speaker: Eric D. Peselow, M.D.

SUMMARY:

Most of the treatments recommended for bipolar disorder (BD) were initially studied in acute mania and were subsequently used for maintenance. We evaluated the long-term outcome of BD in a naturalistic clinical setting. 225 patients were included in this analysis: 98 patients were on lithium (LI) (43.6%), 77 were on valproate (VAL) (34.2%), and 50 were on carbamazepine (CA) (22.2%). Patients were followed for up to 124 months, until they relapsed to a manic/hypomanic or depressive episode, or until they dropped out of the study well. 103 relapsed to a manic or depressive episode (46%), 52 dropped out/well (23%), and 70 remained in the study well (31%). The data showed that patients taking lithium were significantly less likely to relapse to a depressive or manic/hypomanic episode than patients taking either VAL/CA ($\chi^2=5.97^*$, $p=0.05$) with relapse rates of 38%, 55%, and 50% on LI, VAL, and CA respectively. More studies are needed to evaluate the long-term efficacy of mood stabilizers.

NO 2 EMERGING ISSUES IN THE MAINTENANCE TREATMENT OF BIPOLAR DISORDER

Speaker: Alexander Fan, M.D.

SUMMARY:

Maintenance treatment in bipolar disorder often involves treating residual mood symptoms between episodes of mood instability. This treatment goal is difficult while using a medication regimen that is tolerable to the patient. New psychopharmacological strategies have been tested to achieve this goal. The maintenance treatment of bipolar disorder also requires that the clinician optimize the social and vocational functioning of the patient. A number of recent studies have addressed this issue, focusing particularly on cognitive impairment and impulsivity in stable bipolar patients. Several treatment studies have tested various strategies to improve cognitive function in bipolar patients.

NO 3 RECOVERY-ORIENTED COLLABORATIVE CARE TO IMPROVE MEDICAL AND PSYCHIATRIC OUTCOMES IN BIPOLAR DISORDER

Speaker: Amy Kilbourne, M.P.H., Ph.D.

SUMMARY:

Persons with bipolar disorder are more likely to suffer from cardiovascular disease (CVD) than the general population, leading to substantial functional impairment and premature mortality. This study sought to determine whether a recovery-oriented chronic care model (Life Goals Collaborative Care-LGCC) compared to enhanced usual care (UC), reduced CVD risk factors and improved mental health outcomes (QOL) in VA patients with bipolar disorder. LGCC included a self-management program focused on health behavior change in the context of symptom management, medical care management, and provider guideline dissemination. Of the 118 enrolled (mean age=53, 17% female), those randomized to LGCC had reduced systolic (Beta=-3.1, $P=.04$) and diastolic blood pressure (Beta=-2.1, $P=.04$) as well as reduced manic symptoms (Beta=-23.9, $P=.01$). LGCC is a potentially effective and scalable maintenance treatment that integrates physical and mental health treatments for persons with bipolar disorder.

NO 4 DEFINING AND MEASURING FULL RECOVERY IN BIPOLAR DISORDER

Speaker: Waguih Ishak, M.D.

SUMMARY:

The literature shows that recovery in Bipolar disorder has been generally defined as remission of symptoms or achieving sustained remission with or without medications. The schizophrenia literature showed that recovery could be described as remission over long duration (outcome) or as life satisfaction, hope, and empowerment (orientation) (Resnick et al., 2004). These two descriptions could define a complete and permanent recovery (Insel and Scolnick, 2006). Recovery could be defined as a tri-partite alleviation of the burden of illness comprising: no or few symptoms, i.e., remission + functioning at within-normal levels + quality of life within-normal levels. New methodology using principal component analysis, enabled measurement of The Individual Burden of Illness Index for Depression (IBI-D) (IsHak et al., 2011) using the above three dimensions. The presenter will highlight the application of the of the concept of burden of illness measurement in Bipolar disorder.

SYMPOSIUM 139 BULLYING AND SUICIDE: THE MENTAL HEALTH CRISIS OF LGBT YOUTH, WHAT IS BEING DONE ABOUT IT, AND HOW YOU CAN HELP

Chair: Amir Ahuja, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Better understand the link between anti-LGBT bullying and mental illness, and identify ways to help their patients who are victims; 2) Identify the work being done to both gather data on anti-LGBT bullying, and the various tactics being employed to combat this; 3) Identify areas of weakness in the approach to combat bullying and mental illness among LGBT youth and areas of future growth; and 4) Identify ways that they can be involved in furthering the awareness of bullying of all kinds and improving research & prevention.

SUMMARY:

Asher Brown, 13, Texas, shot himself in the head. Seth Walsh, 13, California, hung himself from a tree in the backyard. Jamey Rodmeyer, 14, New York, hung himself from his bedroom ceiling. Tyler Clementi, 18, New Jersey, jumped off of a bridge. What these teenagers all have in common is that they are Lesbian, Gay, Bisexual, Transgender and/or Questioning (LGBTQ) youth, and they were bullied incessantly until each one of them committed suicide. The tragic part of this is that they represent just a small portion of the many LGBTQ youth who are repeatedly harassed at home, in school, and by society at large. Many of these young people attempt suicide, and many of those are successful attempts. The Suicide Prevention Resource Center estimates that 20-30% of all lesbian, gay, or bisexual youth have attempted suicide. The Trevor Project has found that 90% of LGBTQ teens have been harassed or assaulted in the last year, vs. 62% of their heterosexual counterparts. Overall, it is estimated that LGBTQ teens attempt suicide 3-4 times more often than their heterosexual peers. These are alarming statistics, and are very relevant to Psychiatry, and to all Mental Health practitioners. What can we as a profession do about this problem? How can we stop young LGBTQ youth from feeling ostracized and depressed and seeing no way out? What is being done already to stop this problem, and where do we fit in? In this symposium, we assemble experts from across the country to examine this devastating mental health issue. First, Stephen Russell PhD and Cecil Webster, MD, with many publications in this area, will look at the problem from a mental health perspective and frame the issue at hand. Then a representative of the American Foundation for Suicide Prevention will discuss their work in preventing suicides in this population, and they will touch on the way that we talk about this issue, which in many ways is exacerbating the problem. Then, The Trevor Project, a national organization dedicated to LGBT suicide prevention, will discuss their many efforts to combat this problem and research it further (including LGBTQ-specific social networking and their national suicide hotline). After this, the Gay, Lesbian, and Straight Education Network, a national organization dedicated to safety and fairness for LGBTQ youth in schools, will discuss their attempts to research and tackle this issue (including setting up Gay-Straight Alliances in schools and giving school-based diversity training). Next, Ilan Meyer, PhD, a lawyer from UCLA who specializes in LGBTQ legislation discuss the legal implications of some of the interventions used with LGBTQ youth, and the ongoing legal battle to fight discrimination and bullying. Finally, we will have a discussion as a whole panel about the limitations of the current approach

to the bullying of LGBTQ youth, what the future opportunities for growth are, and where Psychiatrists and other mental health professionals fit in.

NO 1**ADOLESCENT LGBT SEXUALITY MATTERS: A MENTAL HEALTH PERSPECTIVE**

Speaker: Stephen T. Russell, Ph.D.

SUMMARY:

Sexual minority youth and adolescent sexuality are areas that remain poorly understood in adolescent mental health. While well-established research on the impact of non-heterosexual identity in adolescence exists (e.g., increased suicide risk, substance abuse, risky sexual behaviors, anxiety, and depression), there exist notable areas of deficit. Here there is an exploration of LGBT identity and how that impacts bullying and discrimination faced throughout adolescence and beyond. One major consequence of this victimization is depression, and ultimately suicide in many cases. The mental health community has tried various methods to combat this growing problem, from patient and parent education to more research into vulnerability and predictive factors. We discuss these efforts, and ways to increase involvement in the future.

NO 2**ADOLESCENT LGBT SEXUALITY MATTERS: A MENTAL HEALTH PERSPECTIVE**

Speaker: Cecil R. Webster Jr, M.D.

SUMMARY:

Sexual minority youth and adolescent sexuality are areas that remain poorly understood in adolescent mental health. While well-established research on the impact of non-heterosexual identity in adolescence exists (e.g., increased suicide risk, substance abuse, risky sexual behaviors, anxiety, and depression), there exist notable areas of deficit. Here there is an exploration of LGBT identity and how that impacts bullying and discrimination faced throughout adolescence and beyond. One major consequence of this victimization is depression, and ultimately suicide in many cases. The mental health community has tried various methods to combat this growing problem, from patient and parent education to more research into vulnerability and predictive factors. We discuss these efforts, and ways to increase involvement in the future.

NO 3**BULLYING AND SUICIDE AMONG LGBTQ YOUTH: UNRAVELING THE LINK**

Speaker: Nicole Cardarelli, M.S.W.

SUMMARY:

Unprecedented attention on bullying and suicide by the media, advocacy groups, politicians, and entertainers has resulted in positive and problematic outcomes. While we now have a wider recognition of the serious harm that bullying inflicts, we've also seen a dangerous "death by bullying"

narrative evolve which can unintentionally normalize suicide as a reaction to being bullied. This presentation will: 1) Discuss the complex relationship between bullying, mental illness, and suicide, including risk factors that contribute to vulnerability among LGBTQ youth and protective factors that increase resilience; 2) Provide guidance to clinicians and other stakeholders on how to help change public dialogue around and safely discuss bullying and suicide with clients, especially with young LGBTQ people who may be at-risk; and 3) Present recommendations for closing knowledge gaps about suicidal behavior in LGBTQ youth and for making LGBTQ suicide prevention a national priority.

NO 4

CONNECT, ACCEPT, RESPOND, EMPOWER: HOW TO SUPPORT LGBTQ YOUTH

Speaker: Phoenix Schneider, M.S.W.

SUMMARY:

This presentation will provide an overview of suicide among lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth and the different environmental stressors that contribute to their heightened risk for suicide. The first half of the presentation will focus on what research states regarding reducing the risk of suicide and promoting resiliency for all youth with a special emphasis on LGBTQ youth. After reviewing current research, there will be an emphasis on best practices and practical steps that health care providers can take to keep LGBTQ youth safe and assure they have appropriate resources that promote resiliency and decrease their risk for suicide.

NO 5

SAFE SCHOOLS AND THEIR CONTRIBUTION TO HEALTH AND WELL-BEING FOR LGBT YOUTH

Speaker: Steven A. Toledo, M.P.A.

SUMMARY:

GLSEN research demonstrates the connection between hostile school environments for lesbian, gay, bisexual and transgender (LGBT) students with these students having decreased attendance, reduced academic achievement, sense of school belonging and education aspiration, and increased anxiety and depression. GLSEN promotes four LGBT-related school resources to ensure safe and affirming school environments, including supportive school staff, inclusive curriculum, effective school safety policies and student groups such as gay-straight alliances. These resources have been established via GLSEN research to result in decreased levels of victimization, which in turn are related to higher self-esteem, increased mental health, and improved educational outcomes among LGBT students.

NO 6

SCHOOL-BASED INTERVENTIONS TO REDUCE HOMOPHOBIA: FIRST AMENDMENT AND ETHICAL CONCERNS

Speaker: Ilan H. Meyer, Ph.D.

SUMMARY:

Public health writers and educators are unified in their belief that reducing stigma and discrimination are important steps toward improving health and well-being, and reducing suicide, among lesbian, gay, bisexual, and transgender youth. However, few researchers or interventionists have considered conservative critics of such interventions, who have warned that by aiming to monitor stigma, such interventions attempt to control speech and religious beliefs, protected by the First Amendment to the U.S. Constitution and, thus, harm youth and community members who oppose homosexuality. We review conceptual approaches to interventions to reduce homophobia and assess how interventions address First Amendment concerns. We then review legal arguments, court decisions, and ethical principles related to the free speech critique. We conclude that good clinical practice demands that interventionists use community based approaches that have been shown effective in other public health areas.

SYMPOSIUM 140

RETURN TO WORK: THE MOST UNDERUTILIZED “PILL” IN THE PSYCHIATRIST’S FORMULARY

Discussant: John M. Oldham, M.D.

Chair(s): Alan Axelson, M.D., William L. Bruning, J.D., M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Reduce the time it takes for your patients to return to work following disability leave; 2) Recognize employers as partners in patient care; and 3) Be able to use the resources of the American Psychiatric Foundation’s Partnership for Workplace Mental Health to support connections with local businesses.

SUMMARY:

Today’s workplace confronts people with increasingly high levels of uncertainty and stress. More workers are absent from work because of stress and anxiety than because of physical illness or injury.¹ Effective psychiatric treatment requires understanding the impact of stress on the entire person, both physiologically and psychologically. Who is the champion for the employed psychiatric patient? Is it the psychiatrist? Is it the employer? Or can it be both? APA leaders, along with employers Dupont, JPMorgan Chase and the Department of Defense will present innovative employer mental health strategies and explore how psychiatry can be a partner in efforts to reduce employee stress and the amount of time away from work. The panel will discuss strategies aimed at the entire employee population and targeted initiatives such as executive training for sustaining leadership in difficult times and programs that address the needs of returning veterans. Employers increasingly recognize that untreated mental illness increases absenteeism, saps productivity, and drives up healthcare and disability costs. The panel will explore how employers collaborate through business coalitions to make a positive impact on mental healthcare delivery and financing.

Discover how the goals of business and psychiatry are aligned and how to engage your local business coalition.

NO 1 UNDERSTANDING THE PHYSIOLOGICAL AND PSYCHOLOGICAL IMPACTS OF WORKPLACE STRESS

Speaker: Josh Gibson, M.D.

SUMMARY:

Today's workplace confronts people with increasingly high levels of uncertainty and stress. Effective psychiatric treatment requires understanding the impact of stress on the entire person, both physiologically and psychologically. This talk reviews the autonomic, neuroendocrine, metabolic and immune responses to stress as well as their implications through the lifespan. High psychological job demands (e.g., excessive workload or job pressure) evoke stress responses that significantly increase the risk of Major Depressive Disorder and Generalized Anxiety Disorder. The stress protective effect of value affirmation and its implementation in the workplace are discussed. In addition, behavioral and psychoeducational groups demonstrate positive effects in stress reduction.

NO 2 DEVELOPING AND SUSTAINING AN INTERDE- PENDENT WORKFORCE

Speaker: Paul Heck, M.Ed.

SUMMARY:

Hear the story of DuPont, a multinational company so concerned about stress and emotional health that they have launched a global effort to send a simple yet powerful message to all of their employees. They have empowered employees to show caring and concern whenever they observe a colleague in distress and, conversely, to recognize the value of asking for help when needed. The focus of the "ICU" program is to normalize the concept of mental health as another element of general health while also reminding employees that it's always ok to express compassion and concern for another person. This presentation will review the development of the award winning "ICU" program as well as describe the organizational recognition that minimizing the stigma associated with psychiatric illness and emotional distress really is good business.

NO 3 MAKING A VAGUE CONCEPT ACTIONABLE

Speaker: Paul Hammer, M.D.

SUMMARY:

The burden of recognizing and addressing psychological health concerns is often placed solely on the individual in need. This presentation will address how a stress continuum model developed by the U.S. Marine Corps and widely adopted by the Department of Defense can be adapted to assist one's self, patients, employers, colleagues, individuals, family members and friends alike to identify and monitor four cas-

ading levels of stress. The session explores the relationship between the model and functionality at work and at home, how to promote healthy lifestyle behaviors to ensure physical, psychological and spiritual well-being. A widespread culture of stigma continues to surround "mental health" and those quietly suffering from mental health conditions, often preventing individuals from reaching out for help they need when they need it most. This lecture will provide examples of how an employer can enable help-seeking behavior in a non-clinical setting and help dispel stigma.

NO 4 I THINK I'M DISABLED, THEREFORE I AM: HOW TO PARTNER EFFECTIVELY WITH EMPLOYERS WHEN A PATIENT IS TOO ILL TO WORK

Speaker: Paul Pendler, Psy.D.

SUMMARY:

Mental health treatment and patient work functioning has recently been highlighted for psychiatrists to understand that symptomatic improvement does not always improve job functioning (Adler, Oslin, Valtenstein, Avery, Dixon, Nossel, Berlant, Goldman, Hackman, Koh & Siris, 2012). Working with patients off work on mental health medical leave requires additional partnering and symptom exploration. The idea of "functional impairments" will be highlighted in conjunction with DSM-IV diagnoses to present a model of how psychiatry can better partner with workplaces to restore patient functioning. The session will present a pathway to understand disability and identify various roles mental health professionals can play to enhance return to work planning. As Adler, et.al indicated, symptom reduction while essential is not sufficient for successful return to work. Defining how psychiatry can partner with Employee Assistance Program professionals to establish collaborative care strategies.

NO 5 THE INFLUENCE OF EMPLOYERS ON CARE DE- LIVERY, FINANCING, AND MENTAL HEALTH

Speaker: Laurel A. Pickering, M.P.H.

SUMMARY:

Employers are coming together in groups known as business coalitions, in order to have a greater impact on health plans and the delivery system. They have also identified a high prevalence of depression and mental health issues in their employee populations. This has an impact on health care costs and employee productivity. Learn about the project one group of employers, working with other stakeholders, has taken on to address depression working with both primary care and psychiatry; the challenges regarding health plan reimbursement, even when the plans are supportive; and the necessity to involve multiple payers when working with physicians. Additionally, the presentation will cover how employers use benefit design to engage employees in better self-care and how new payment models are being used to incentivize physicians and hospitals to provide higher value care. Discover how the goals of business and psychiatry are aligned and how to engage your local business coalition.

SYMPOSIUM 141 DEATH-HASTENING DECISIONS AND PSYCHIATRIC CONSULTATIONS

Discussant: Benjamin Liptzin, M.D.
Chair: Lewis M. Cohen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the need to reconceptualize suicide to reflect new options that are available to terminally ill people; 2) Appreciate the practical requirements in conducting psychiatric evaluations of people who make death-accelerating requests; 3) Assist with consultation requests from physicians and patients concerning end-of-life issues of dying people; and 4) Become familiarized with the laws and ethics pertaining to death-hastening interventions.

SUMMARY:

Widespread acceptance of the new specialty of Hospice and Palliative Medicine has underscored the reality that not only will everyone die but also that modern medicine allows people some control as to the timing and manner of death. This is underscored by the Death with Dignity movement that has led to legalization of assisted dying (physician-assisted suicide) in several states. The symposium examines these new developments from a psychiatric perspective. Presenters will offer a review of the changing ethical and legal landscape, a theoretical reconceptualization of suicide, and a description of practical issues that arise in conducting consultations related to death-accelerating requests. The anticipated far-ranging discussion will be conducted with emphasis on lessons learned from geriatric psychiatry.

NO 1 DEATH-HASTENING DECISIONS AND PSYCHIATRIC CONSULTATIONS

Speaker: J. Michael Bostwick, M.D.

SUMMARY:

In the general hospital psychosomatic services are frequently asked to evaluate "suicidal" patients. A significant proportion of these patients turn out to have failed to comply with medical recommendations or to have requested treatment withdrawal or other means of hastening death. The term "suicide" becomes at best ambiguous, at worst meaningless, when used to describe everything from one man's unilateral choice to end his life to a carefully considered decision a woman makes in consultation with her medical providers and loved ones to suspend life-extending treatment that has become burdensome, painful, hopeless, or all three. A conceptual model will be presented that differentiates "suicidal" phenomena based on whether they are unilateral versus collaborative and whether or not their intent is to hasten death.

NO 2 THE RIGHT TO DIE: A PSYCHIATRIST'S ROLE IN

AN ACCOMPANIED SUICIDE

Speaker: Zamir Nestelbaum, M.D.

SUMMARY:

A longstanding patient in my psychiatric practice suffering from amyotrophic lateral sclerosis (ALS) requested "psychiatric clearance" for an accompanied suicide in Switzerland as required by the program Dignitas, given his history of depression. My patient had been in clinical remission for many years with a regimen of medication and supportive therapy. This triggered for me much personal and professional deliberation regarding ethics, effects on therapeutic alliance, transference and countertransference along with legal and licensing exposure in my state. After consultations with his neurologist, his family and experts in right to die issues, I was convinced that he had no acute psychiatric disorder that would diminish his capacity to make health care decisions including the right to control the manner and timing of his inexorably approaching death in a jurisdiction that allowed it. This presentation will review this process.

NO 3 AN UPDATE ON THE ETHICAL AND LEGAL ASPECTS OF DEATH-HASTENING DECISIONS

Speaker: Lewis M. Cohen, M.D.

SUMMARY:

Death-hastening practices can be divided into two types: those associated with hospice and palliative medicine, and those related to death with dignity (physician-assisted suicide). The former include withholding and withdrawal of life-support, the use of palliative sedation, and aggressive reliance on opiate medications for symptom management. All of these practices are legal throughout the United States, but on rare occasions may still result in murder accusations. Some of the practices, e.g. withdrawal of feeding tubes, are more ethically controversial. There is an active death with dignity movement that has led to legalization of assisted dying in three states and recent campaigns in a number of others, including Massachusetts and Vermont. Ethicists and theologians are divided as to the practices being employed. Psychiatrists are being increasingly involved in these determinations.

SYMPOSIUM 142 UPDATE ON DELIRIUM: NOVEL PERSPECTIVES ON ETIOLOGY, DIAGNOSIS, PREVENTION, TREATMENT, AND LONG-TERM OUTCOMES

Chair: Jose Maldonado, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the latest theories on the neurobiology of delirium and identify the strengths and weaknesses of various screening and diagnostic instruments used for the detection of delirium; 2) Understand the clinical and evidence-based, effective treatment options for delirium, including non-conventional treatment approaches; and 3) Understand the most significant short and long term outcomes associated

with delirium.

SUMMARY:

This symposium will provide an analysis on the cutting-edge data on the neurobiology, diagnosis, prevention, treatment and sequelae of delirium, the most common psychiatric disorder in the medically ill patient. Dr. Maldonado will start with discussion of neuropathology of delirium. Delirium is a neurobehavioral syndrome caused by the transient disruption of normal neuronal activity secondary to systemic disturbances. This presentation will review the published literature and summarize the top six proposed theories and their interrelation. The syndromes of delirium represent the common end product of one or various interdependent neurochemical pathway derangements. Dr. Sher will then talk about clinical presentation and detection of the delirium. She will review the epidemiology of delirium in various healthcare setting including the risk factors that predispose to its development and the precipitating exposures that can be modified. Psychometrics of current screening tools and diagnostic measures will be examined. Dr. Sher will also discuss the novel pharmacological approaches. Deliriogenic effects of medications and toxins represent a major portion of the differential diagnostic considerations for confusion and agitation in the acute medical setting. She will discuss the available antidotes to treat psychosomatic toxidromes, including physostigmine, flumazenil, and naloxone in the treatment of states of altered con will discuss the available antidotes to treat psychosomatic toxidromes, including physostigmine, flumazenil, and naloxone in the treatment of states of altered consciousness, cognition, and behavior. Dr. Maldonado will then review the evidence-based prophylaxis and treatment of the delirium. Clinicians have three potential approaches when it comes to the management of delirium: (1) symptomatic management of delirium; (2) treatment of the underlying neurochemical derangement that causes delirium; or (3) prevention of delirium (i.e., use of techniques or methods, either pharmacologic or behavioral, with the purpose of avoiding the development of delirium). This presentation will review evidence-based approaches to prevention and treatment of delirious states. Dr. Lolak will concentrate on special considerations of QTc when treating patient with delirium with anti-psychotics. He will discuss significance of QTc, its relation to torsades de points and death and risk factors for torsades and sudden cardiac death. He will then review differential risk of QTc prolongation with various antipsychotics and strategies to deal with this important clinical issue. Dr. Kilbane will discuss short- and long-term sequelae of delirium. He will review the long-term outcomes of delirium, including a comprehensive review of the cognitive outcomes of delirium, post-traumatic stress disorder, as well as depression and anxiety related to delirium. He will also review the most recent data on delirium-associated mortality.

NO 1

NEUROPATHOLOGY OF DELIRIUM AND EVIDENCE-BASED PROPHYLAXIS AND TREATMENT

Speaker: Jose Maldonado, M.D.

SUMMARY:

Dr. Maldonado will start with discussion of neuropathology of delirium. Delirium is a neurobehavioral syndrome caused by the transient disruption of normal neuronal activity secondary to systemic disturbances. This presentation will review the published literature and summarize the top six proposed theories and their interrelation. The syndromes of delirium represent the common end product of one or various interdependent neurochemical pathway derangements.

NO 2

CLINICAL PRESENTATION AND DETECTION OF DELIRIUM AND NOVEL PHARMACOLOGICAL TREATMENTS

Speaker: Yelizaveta Sher, M.D.

SUMMARY:

Dr. Sher will discuss clinical presentation and detection of the delirium. She will review the epidemiology of delirium in various healthcare setting including the risk factors that predispose to its development and the precipitating exposures that can be modified. Psychometrics of current screening tools and diagnostic measures will be examined. Dr. Sher will also discuss the novel pharmacological approaches. Deliriogenic effects of medications and toxins represent a major portion of the differential diagnostic considerations for confusion and agitation in the acute medical setting. She will discuss the available antidotes to treat psychosomatic toxidromes, including physostigmine, flumazenil, and naloxone in the treatment of states of altered con will discuss the available antidotes to treat psychosomatic toxidromes, including physostigmine, flumazenil, and naloxone in the treatment of states of altered consciousness, cognition, and behavior.

NO 3

QTC AND ANTIPSYCHOTICS

Speaker: Sermsak Lolak, M.D.

SUMMARY:

Dr. Lolak will concentrate on special considerations of QTc when treating patient with delirium with antipsychotics. He will discuss significance of QTc, its relation to and risk factors for torsades de points and sudden cardiac death. He will then review differential risk of QTc prolongation with various antipsychotics and also other relevant medications and offer strategies to deal with this important clinical issue.

NO 4

SHORT- AND LONG-TERM SEQUELAE OF DELIRIUM

Speaker: Edward J. Kilbane, M.A., M.D.

SUMMARY:

Dr. Kilbane will discuss short- and long-term sequelae of delirium. He will review the long-term outcomes of delirium, including a comprehensive review of the cognitive outcomes of delirium, post-traumatic stress disorder, as well as depression and anxiety related to delirium. He will also review the most recent data on delirium-associated mortality.

ing with such populations.

SYMPOSIUM 143 ASYLUM SEEKERS AND REFUGEES: MENTAL HEALTH CHALLENGES AND NEEDS

Discussant: Judy Eidelson, Ph.D.

Chair(s): Ariel Shidlo, Ph.D., Joanne Ahola, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Assess the mental health needs of asylum seekers and refugees who flee persecution; 2) Identify the unique impact of complex trauma on LGBT asylum seekers and refugees; and 3) Recognize the mental health challenges of unaccompanied and undocumented immigrant children.

SUMMARY:

The United States is home to a growing population of asylum seekers and refugees. These individuals flee persecution and torture. They often present with complex PTSD and have specialized mental health needs and challenges. Asylum seekers and refugees experience repeated and cumulative trauma in their country of origin, during their flight from persecution, and post arrival in the U.S. In addition to providing assessment and treatment to this population, mental health clinicians' assistance in the asylum application process can be life saving: rates of approval of asylum applications double when a clinician provides expert testimony in immigration court. This multi-disciplinary symposium presents state of the art clinical guidelines and empirical research on the mental health needs of this vulnerable and underserved population. Papers include: (1) Guidelines for the mental health and forensic assessment of LGBT asylum seekers; (2) Mental health assessment and treatment of refugees who escape war torn countries; (3) Assessment and treatment of unaccompanied children refugees; and (4) Empirical data from a pioneering study of the mental health impact of immigration detention on LGBT asylum seekers. Video clips of interviews with asylum seekers will be used to humanize members of this population and allow them to speak directly about their mental health challenges.

NO 1 REFUGEES: MENTAL HEALTH CHALLENGES AND NEEDS

Speaker: Hossam M. Mahmoud, M.D., M.P.H.

SUMMARY:

War around the world has resulted in and continues to cause significant death, disability and displacement. The number of refugees has been steadily increasing. The survivors of such mass violence often suffer from complex and multiple traumas. A significant number of these civilians are, therefore, left with considerable post traumatic symptoms. In addition to their traumatic experiences in their country of origin, refugees face new challenges in their host countries, which makes them a unique population, with significant mental health needs and limited resources. The aim of this presentation is to describe the mental health needs of refugee populations and to discuss challenges that mental health care providers face when work-

NO 2 GUIDELINES FOR THE MENTAL HEALTH AS- SESSMENT OF LGBT ASYLUM SEEKERS AND REFUGEES

Speaker: Joanne Ahola, M.D.

SUMMARY:

Joanne Ahola and Ariel Shidlo provide guidelines for clinical and forensic assessment. LGBT asylum seekers and refugees present with unique mental health challenges. The pattern of multiple traumas that they experience is distinctive from other asylum seekers and refugees. This LGBT population experiences relentless persecution at the hands of paramilitaries and governments, but also at the hands of their family of origin and peers. Most LGBT asylum seekers and refugees present with complex PTSD, as well as depressive and anxiety disorders. Video clips of interviews with LGBT asylees will be used to demonstrate the mental health challenges of this population.

NO 3 MENTAL HEALTH NEEDS OF UNACCOMPANIED AND UNDOCUMENTED IMMIGRANT CHILDREN

Speaker: Kelsey Lebrun Keswani, M.A.

SUMMARY:

Over the past several years growing waves of unaccompanied and undocumented children are immigrating to the United States. This vulnerable population arrives in the United States after experiencing multiple traumas: in their country of origin, during their travel to the U.S., during their apprehension by U.S. border and immigration services, and during the period in immigration detention. These children present with complex PTSD, and depressive and anxiety disorders. A comprehensive program that provides post immigration detention mental health services to this population is described. Participants will learn guidelines for assessment and intervention with unaccompanied immigrant children.

NO 4 ADVOCATING FOR LGBT ASYLUM SEEKERS: HOW ATTORNEYS AND CLINICIANS CAN COL- LABORATE

Speaker: Christopher McNary, J.D.

SUMMARY:

Mental health clinicians have a critical role in assisting LGBT persons who flee persecution to obtain asylum. From the perspective of an immigration attorney, this presentation examines how attorneys and clinicians can collaborate in advocating for LGBT asylum seekers. An LGBT asylum seeker who has an otherwise valid claim for asylum is barred from obtaining asylum if he applied for asylum more than one year after he entered the U.S., unless he can show an "extraordinary circumstance" which excuses his delayed filing. An "extraordinary circumstance" includes a diagnosable mental disorder

and ongoing effects of trauma. Clinicians provide invaluable evidence when they explain how the symptoms that the asylum seeker has been experiencing in the U.S. prevented the applicant from seeking asylum help within the one year period. This discussion will address how to present psychological testimony and how Immigration Authorities interpret psychological evidence when adjudicating asylum claims.

NO 5 IMMIGRATION DETENTION OF LGBT ASYLUM SEEKERS: THE MENTAL HEALTH IMPACT

Speaker: Ariel Shidlo, Ph.D.

SUMMARY:

Ariel Shidlo, Mike Corradini, and Joanne Ahola report preliminary results from a pioneering study on the mental health impact of immigration detention on LGBT asylum seekers. Growing numbers of LGBT persons who flee persecution and seek asylum in the United States are jailed in immigration detention for extended periods. This population escapes anti LGBT persecution and arrives in the U.S. with a history of complex trauma. During immigration detention they often experience multiple verbal, physical, and sexual traumatic events.

SYMPOSIUM 144 PERSONALITY DISORDERS OVER THE LIFESPAN

Discussant: John Gunderson, M.D.

Chair: Joel Paris, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of recent data on changes in personality disorders over the life span; 2) Describe how these disorders present in childhood and adolescence; and 3) Compare the adult outcome of borderline and antisocial personality disorders.

SUMMARY:

Personality disorders develop over the life course but present differently at different developmental stages. These conditions can be identified early in life, typically in adolescence or childhood. While temperament is a crucial factor, biological maturation and social learning moderates psychopathology over time. Disorders can be diagnosed during adolescence, and can be distinguished from normative or temporary problems during this phase. Symptoms peak in the young adult period, and a decline in psychopathology by middle age is common, remission is often incomplete.

NO 1 CHILDHOOD PRECURSORS OF BORDERLINE PERSONALITY DISORDER

Speaker: Joel Paris, M.D.

SUMMARY:

The childhood precursors of antisocial personality disorder are well established (an early onset of severe conduct disorder), but less clear in borderline personality disorder (BPD). Current evidence points to an externalizing-internalizing pattern of symptoms in childhood that precedes the development of overt psychopathology. These are the same features, affective instability and impulsivity, that characterize BPD later in life. There are several unanswered questions concerning the precursors of BPD. First, why do children who later develop serious psychopathology rarely come to clinical attention? Second, what roles do temperament and psychosocial adversity play in the development of early symptoms? Third, can cohorts at risk be identified and followed over time?

NO 2 PERSONALITY DISORDER IN ADOLESCENCE: NO LONGER CONTROVERSIAL?

Speaker: Andrew M. Chanen, M.B.B.S., Ph.D.

SUMMARY:

Personality disorders are increasingly seen as lifespan developmental disorders that are just as reliable and valid in adolescence as they are in adulthood, are not reducible to Axis I diagnoses, and can be identified in day-to-day clinical practice. Personality disorders rise in prevalence from puberty, peak in young adulthood and steadily thereafter. Personality disorder (or dimensional representations of personality disorder) in young people demarcates a group with high current and future morbidity. Data also suggest considerable flexibility and malleability of personality disorder traits in youth, making this a key developmental period during which to intervene.

NO 3 PREDICTION OF TIME-TO-ATTAINMENT OF RECOVERY FOR PATIENTS WITH BORDERLINE PERSONALITY DISORDER FOLLOWED PRO- SPECTIVELY FOR 16 YEARS

Speaker: Mary Zanarini, Ed.D.

SUMMARY:

Objective: The purpose of this study was to determine the most clinically relevant baseline predictors of time-to-attainment of recovery from BPD. Method: Borderline patients were assessed during their index admission using a series of semistructured interviews and self-report measures. Recovery, which was defined as concurrent remission from BPD and good social and vocational functioning, was assessed at eight contiguous two-year time periods. Results: Seven variables were found to be significant multivariate predictors of this outcome, which was attained by 60% of those with BPD: younger age, no history of prior hospitalizations, a higher IQ, good premorbid vocational history, no anxious cluster person-

ality disorder, and higher trait extraversion and agreeableness. Conclusion: A temperament devoid of excessive avoidance and dependence as well as marked by positive emotions and a cooperative style seems to be the best predictor of time-to-attainment of recovery from BPD.

NO 4 LONG-TERM COURSE OF ANTISOCIAL PERSON- ALITY DISORDER

Speaker: Donald Black, M.D.

SUMMARY:

Antisocial personality disorder (ASPD) consists of socially irresponsible, exploitative, and guiltless behavior that affects family relations, schooling, work, military service, and marriage. ASPD has an onset in childhood or early adolescence, and is fully expressed by the late 20's or early 30's. The disorder is chronic but worse early in its course. People with ASPD improve with advancing age, and though improved many have ongoing irritability, social isolation, marital and family discord, work-related problems, and substance abuse. Those with childhood-onset (rather than adolescent-onset) tend to have a worse course. ASPD is associated with comorbid mood and anxiety disorders, ADHD, and substance use disorders. Antisocial persons often die prematurely. Better outcome is associated with lower levels of baseline severity, older age, and lack of ongoing substance abuse. Early brief incarceration may act as a deterrent to further antisocial behavior.

MAY 18, 2013

WORKSHOP 1**WOMEN AT WAR: PERSPECTIVES FROM MILITARY PSYCHIATRY**

Speakers: Elizabeth Brent, M.B.A., M.D., Amy Canuso, D.O., Sarah L. Martin, M.D., Christina Rumayor, M.D., Paulette Tucciarone, M.D., M.P.H., Elspeth C. Ritchie, M.D., M.P.H.

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Evelyn Vento, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand issues associated with being a female in a war zone.;2) Know particular complexities posed by physical health and hygiene issues;3) Recognize unique psychological stressors of female service members;

SUMMARY:

2.4 million service members have deployed in the 11 years since 9/11/2001. Approximately 15% of the military is female. More women have been exposed to combat in the wars in Afghanistan and Iraq than in any other conflict in our history. This workshop will highlight both personal experiences of female psychiatrists and the available data on female Soldiers and other service members. The presenters have served as female psychiatrists in war zones and will describe their experiences. There are a number of emerging sources of data about Post-Traumatic Stress Disorder (PTSD) in female Army Soldiers who have served in the conflicts in Iraq and Afghanistan. These data, gathered on both sexes, include: 1) self-report anonymous surveys completed during and after combat deployments; 2) Post-Deployment Health Assessment (PDHA) and Re-Assessment (PDHRA) screening data; 3) medical utilization data collected for all medical encounters; 4) evacuations from theater for Behavioral Health reasons and 5) self-report surveys by medical personnel. Generally, these recent data show very little difference in the rates of PTSD among male and female Army Soldiers. It is unclear why this differs from the civilian rates of PTSD, where several studies have estimated the female lifetime prevalence for PTSD being approximately twice as high as among men. Further study is required to understand the observed similarity in PTSD symptom prevalence and healthcare utilization among male and female Soldiers who have served in the wars in Iraq and Afghanistan.

WORKSHOP 2**MAKING PARITY PRACTICAL: NONQUANTITATIVE TREATMENT LIMITS AND THE MENTAL HEALTH PARITY AND ADDICTIONS EQUITY ACT OF 2008**

Speakers: Henry Harbin, M.D., Irvin L. Muszynski, J.D., Paul S. Appelbaum, M.D.

Chair: Patricia R. Recupero, J.D., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the process for analyzing health plans' nonquantitative treatment limits (NQTLs) in the context of the Mental Health Parity and Addictions Equity Act (MHPAEA) of 2008;2) Demonstrate knowledge of what constitutes a nonquantitative treatment limit under the interim final regulations of the MHPAEA recently released by the HHS and other federal agencies;3) Demonstrate knowledge of the APA's involvement in advocacy for patients through consultation in cases of alleged violations of the MHPAEA;

SUMMARY:

The interim final rules issued by federal agencies for the implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) require group health plans offering behavioral health coverage to provide reimbursement and benefits for mental health and addictions treatment equal to those offered for general medical and surgical benefits under the plan. Under the new rules, employers and providers must consider potentially discriminatory "nonquantitative" treatment limitations (NQTLs), i.e., limitations that are not expressed numerically but which otherwise limit "the scope or duration of benefits for treatment." Examples of NQTLs include discriminatory utilization review activities, such as different requirements for pre-admission certification or continued stay authorization for mental health services, or requiring employees to exhaust Employee Assistance Plan (EAP) counseling benefits before reimbursement of outpatient psychotherapy by a non-EAP provider. In a recent case filed in Vermont's federal district court, (*C.M. v. Fletcher Allen Health Care*), the plaintiff brought allegations that a health plan violated the MHPAEA "by imposing treatment limitations on mental health benefits that are not applicable to, not comparable to, and are applied more stringently than, those applied to medical and surgical benefits." This case will provide the basis for a discussion of the practical application of NQTLs in determinations of whether managed care organizations are in compliance with the final rule interpreting the MHPAEA. This workshop will feature a brief overview of relevant background and case law by Dr. Recupero, an analysis of the *C.M. v. Fletcher Allen* case and related cases by Dr. Appelbaum, a review by Mr. Muszynski of past successes and strategies for negotiating with insurance carriers to protect mental health parity, and a discussion by Dr. Harbin about the interface between clinical experience and needs and the interim final rules, with particular focus on NQTLs. Participants will gain a more thorough understanding of what constitutes a NQTL in the context of the MHPAEA.

WORKSHOP 3**MEDICAL CONDITIONS MIMICKING PSYCHIATRIC DISORDERS VERSUS PSYCHIATRIC DISORDERS MIMICKING MEDICAL CONDITIONS: DIAGNOSTIC AND TREATMENT CHALLENGES**

Speakers: Amanda J. Crosier, M.D., Yu Dong, M.D., Ph.D., Kathryn Walseman, M.D.

Chairs: Catherine C. Crone, M.D., Lorenzo Norris, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To better understand medical conditions that can result in secondary or organic psychiatric disorders that may lead to misdiagnosis, treatment nonresponse, or worsening of the patient's presentation; 2) To better understand psychiatric disorders that can appear more like primary medical conditions and result in misdiagnosis and mistreatment; 3) To better understand how to approach conditions with comorbid medical and psychiatric diagnoses to optimize diagnosis and treatment;

SUMMARY:

During the course of psychiatry training, significant efforts are made to instruct trainees about the recognition and treatment of primary psychiatric disorders such as major depression, bipolar disorder, post-traumatic stress disorder, panic disorder, and schizophrenia. However, exposure to cases that initially appear to be primary psychiatric disorders but are actually due to underlying medical conditions is often lacking, despite their common occurrence. Infections, hypoxia, electrolyte imbalances, endocrine disorders, autoimmune disorders (e.g. lupus, sarcoidosis) neurologic conditions (e.g. epilepsy, multiple sclerosis, delirium/encephalopathy) and medications are just some of the causes of patient presentations that mimic primary psychiatric disorders. Awareness of these "mimics" is needed as patients may otherwise appear to have "treatment-resistant" psychiatric disorders or, of greater concern, actually worsen when given psychotropic medications. An additional area of clinical knowledge that would benefit trainees and attending psychiatrists is the better recognition and management of psychiatric disorders that mimic medical conditions. Limited exposure to psychosomatic medicine during training may result in lack of experience with conversion disorders, somatization disorders, and factitious disorders. These are patient populations that are often responsible for excessive utilization of medical resources and healthcare dollars as well as being sources of mounting frustration and misunderstanding for medical colleagues. Requests for psychiatric involvement are not unusual, especially when medical work-ups are negative yet patients persist in their requests for medical/surgical intervention. The following workshop aims to provide attendees with an opportunity to learn more about secondary psychiatric disorders (psychiatric mimics) as well as somatoform disorders (medical mimics) in a case-based format with opportunities for questions and discussion with residents,

fellows, and attending physicians with experience and/or expertise in psychosomatic medicine patient populations.

Workshop Structure:

Introduction (5-10 minutes): presentation about the concept and causes of medical mimics of psychiatric disorders as well as psychiatric disorders mimicking medical conditions

Case 1 (10 minutes/ 10 minutes discussion)

Case 2 (10 minutes / 10 minutes discussion)

Case 3 (10 minutes / 10 minutes discussion)

Overall Questions/ Discussion (25 minutes): provides an opportunity for attendees and discussants to interact and address further questions about the case material presented as well as to bring up additional issues pertaining to the diagnosis and treatment of these patients.

WORKSHOP 4**DSM-5 FOR THE MEMBER-IN-TRAINING**

Chairs: Erik Vanderlip, M.D., Alik Widge, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Familiarize themselves with major revisions in DSM nomenclature and diagnoses; 2) Understand the applicability of revisions to clinical work; 3) Discuss revisions with faculty and other MIT's at home training institutions; 4) Stay apprised of future directions in DSM; 5) Understand current debates in diagnosis and epidemiology of mental disorders through specific case studies of DSM diagnoses;

SUMMARY:

Psychiatry residents and fellows are poised to enter an evolving field of psychiatry, with healthcare reform, mental health parity, and the medical home taking shape to significantly alter psychiatric practice. American Psychiatry has long been regarded as the experts in the diagnosis of mental disorders, and it is clear that psychiatrists will be essential to the future of complex psychiatric diagnosis and management. The DSM 5 incorporates significant changes to the classification system and the criteria used to define mental disorders, and will be the foundation upon which psychiatric expertise is constructed. As current Members-In-Training face a lifetime of practicing under DSM 5 nomenclature and beyond, they are most in need of critical updates. Additionally, they should be informed of how these changes may affect their clinical practice, and the underlying epidemiologic and validity debates that framed these new criteria. This workshop, presented by the current Member-In-Training Trustee and Trustee-Elect will orient residents and fellows to the DSM scientific process, and then familiarize them with significant updates across the disorders. It will be oriented specifically towards residents and fellows, with an understanding of how this may affect their current training or certification. Through some specific case

examples, the chairs will organize a discussion around validity and epidemiologic principles which guided several changes to disorders. The chairs will equip fellow Members-In-Training to bring these concepts to their home institutions and other Members-In-Training for further discussion. Finally, attendees will be apprised of future directions in DSM development, and ways in which they can become involved.

WORKSHOP 5 WITHDRAWN

NEW DEVELOPMENTS IN APA PRACTICE GUIDELINES ****WITHDRAWN****

Speakers: Lorrin Koran, M.D., Lon Schneider, Joel Yager, M.D.

Chairs: Joel Yager, M.D., Laura Fochtman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the development process and goals for APA guideline watches; 2) Identify changes in the evidence base supporting current APA guidelines for the treatment of eating disorders, obsessive-compulsive disorder (OCD), and Alzheimer's disease; 3) Recognize how APA guidelines and watches may help clinicians provide up-to-date care for patients with eating disorders, OCD, and Alzheimer's disease;

SUMMARY:

APA practice guidelines for the treatment of patients with eating disorders, OCD, and Alzheimer's disease were published in 2006 and 2007. The guidelines are used to aid clinical decision-making and for medical education and quality improvement activities. APA guideline watches are brief updates summarizing new scientific evidence and are intended to help psychiatrists in their consideration of treatment recommendations in the guidelines. In this workshop, authors of new watches on eating disorders, OCD, and Alzheimer's disease and other dementias will review changes in the evidence base since publication of these guidelines that clinicians should be aware of to provide up-to-date care to their patients with these conditions.

WORKSHOP 6

SUBSTANCE USE DISORDERS IN DSM-5

Speakers: Wilson M. Compton, M.D., Marc Auria-combe, M.D.

Chairs: Charles P. O'Brien, M.D., Ph.D., Deborah Hasin, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize and identify new criteria for DSM-5 Substance Use Disorders; 2) Recognize and identify the rationale for changes from DSM-IV; 3) Recognize and identify the implications of the changes for clinical practice and research;

SUMMARY:

The DSM-5 Substance-Related Disorders Workgroup recommended several important changes to the existing DSM-IV criteria for substance use disorders, resulting from an iterative process involving a considerable amount of research, and considerable input from the field. The DSM-5 workgroup made over 30 presentations at APA meetings and other professional meetings and conferences, which served as opportunities to explain the work that had been done and receive feedback. The changes in the substance use disorders recommended by the DSM-5 workgroup were also listed for public comment on the APA website, where several hundred responses were received. The DSM-5 recommendations and their rationale will be presented in detail at a separate symposium at the 2013 APA meeting. The purpose of this workshop is to provide additional opportunity for exchange between workgroup members and conference attendees. Topics to be presented include the combination of abuse and dependence into one disorder, the addition of the craving criterion and the measurement of craving, moving Gambling Disorder from the DSM-IV Impulse Control Disorder chapter to the DSM-5 Substance Use and Addiction chapter, changes in nicotine disorder criteria, the status of non-substance behavioral addictions, and other subjects as requested by the audience.

WORKSHOP 7

DISRUPTIVE BEHAVIOR IN THE WORKPLACE: DEALING WITH THE DISTRESSED AND DISRUPTIVE PHYSICIAN

Speakers: Martha E. Brown, M.D., William Swiggart, M.S.

Chairs: Martha E. Brown, M.D., William Swiggart, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize different types of behavior in the workplace that may be disruptive and harmful to patient care; 2) Identify the etiologies of distressed and disruptive behavior in physicians and other healthcare professionals; 3) Identify referral and treatment options that can appropriately and effectively address distressed and disruptive behavior; 4) Recognize potential risk factors in themselves and learn preventive strategies through audience participation in several mindfulness exercises and case discussions;

SUMMARY:

Only a small number of physicians and other healthcare professionals (3-5%) exhibit disruptive behavior in the workplace. However, 97% of physicians and nurses report they have experienced disruptive behavior in the workplace. The Joint Commission in 2008 published a Sentinel Alert on disruptive behavior defining it as "behaviors that undermine a culture of safety." It is known that disruptive behavior can result in increased workplace stress and poor workplace environments, which ultimately results in reduced quality of

patient care and an increased risk of litigation. There has also been recognition that disruptive behavior can foster medical errors, contribute to preventable adverse outcomes, and lead to loss of qualified medical staff. Communication breakdowns as a result of disruptive behavior has been directly correlated in studies to 91% of adverse events involving residents and 50% of OR errors. The spectrum of disruptive behaviors that affect the workplace range from aggressive behaviors (such as profane language, throwing objects, sexual comments, or demeaning behavior), to passive-aggressive behaviors (refusing to do tasks or derogatory comments about the hospital), to passive behaviors (not responding to calls or pages, inappropriate chart notes, or being chronically late). Barriers to dealing with the problems vary. Many times the behaviors are not extensively documented, there is a lack of policies or training regarding approaches to this type of situation, and there is reluctance to supposedly “harm” careers by addressing the issues.

This interactive workshop will cover the above issues, as well as discuss where to refer, types of treatment options from CME activities to inpatient evaluation, monitoring of behavior, use of 360 surveys, and prevention techniques. Audience participation will be strongly encouraged with exercises for the audience to determine personal risk factors themselves, mindfulness exercises, demonstration of assertive communication guidelines, and role play scenarios. The audience is encouraged to bring case scenarios to the workshop they wish to discuss.

WORKSHOP 8

PSYCHOTHERAPEUTIC STRATEGIES TO ENHANCE MEDICATION ADHERENCE

Speakers: Rama Rao Gogineni, M.D., Donna Sudak, M.D., Shridhar Sharma, M.B.B.S., M.D., Amir Ahuja, M.D.

Chairs: Salman Majeed, M.D., Muhammad H. Majeed, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify sources of poor adherence to medications in specific disorders and individual patients; 2) Address noncompliance to medications by supplanting cognitive-behavioral, Psychodynamic, educational, supportive, and family therapy techniques; 3) Enhance training of residents and clinicians to make use of psychotherapy strategies to improve compliance;

SUMMARY:

Purpose and background information: Several studies in adult and child psychiatric disorders have shown compliance rate of 20-70%, depending on the specific disorder. Outpatient antidepressant compliance is approximately 40%. Noncompliance in schizophrenics is 74%. Three months after initiation only 50% of the patients take ADHD medications. Medica-

tion noncompliance leads to recurrence of symptoms and re-hospitalizations. Poor understanding and misconceptions about illness and the need for medications, and comorbidity contribute noncompliance. Family dynamics, cultural and economic factors, cognitive distortions, psychodynamic factors and unrealistic expectations are cited as causative factors. Content: Psychoeducation is essential, but often insufficient to enhance compliance to medications. Cognitive skill training and cognitive-behavioral interventions focusing on patients' beliefs and attitudes about illness and medications are very useful in enhancing medication compliance, and have a substantial evidence-base. Psychodynamic aspects of resistance (denial of illness or pathological investment in symptom maintenance), or transference (medication as a threat to counterdependent stance in life) often impacts compliance. Psychodynamic etiologies can also involve projective identification from patients and countertransference in psychiatrists (narcissistic injury, guilt, anxiety, feelings of helplessness, and rage) can contribute to either over prescription or discontinuation of medications by treating psychiatrists. Family interventions and self-help groups are very helpful interventions in enhancing adherence. Recognition and management of non-adherence to psychopharmacological interventions is an essential skill for psychiatry residents and physician extenders to learn. Methodology: Case based learning and small group discussion encouraging active participation by attendees in addition to presentation of EBM in this area. Results and Importance: Psychoeducation, enhancing strategies to improve physician-patient treatment alliance, effective use of CBT techniques, teaching trainees and allied professionals to enhance medication adherence, and decrease recidivism and treatment failure.

WORKSHOP 9

CARE OF COMPLEX TRAUMATIC BRAIN INJURY PATIENTS IN THE UNITED STATES MILITARY

Speakers: Robert L. Koffman, M.D., M.P.H., David Williamson, M.D.

Chairs: Scott Moran, M.D., Brett Schneider, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify various etiologies that can potentially combine to impede the recovery of wounded warriors from combat injuries; 2) Assess two novel programs developed at Walter Reed National Military Medical Center, one inpatient and one outpatient, that are designed to assess complex patients with TBI; 3) Discuss these models of care and use case vignettes to illustrate the utility of these novel programs in complex cases;

SUMMARY:

Traumatic Brain Injury is the signature injury of the Global War on Terror. Wounded service members are also commonly afflicted with Post Traumatic Stress Disorder and other psychological sequelae of combat including mood disorders, adjustment disorders, addictions, and relational challenges.

Combined with severe physical injuries producing disability and chronic pain there are multiple etiologies that can potentially combine to impede the recovery of wounded warriors from combat injuries. This workshop will discuss two novel programs developed at the Walter Reed national Military Medical Center Bethesda, one inpatient and one outpatient, that are designed to assess complex patients with TBI and other disorders. The presentations will discuss models of care and use case vignettes to illustrate the utility of these novel programs in complex cases.

WORKSHOP 10

RESILIENCE AND RISK: HOW WOMEN PSYCHIATRISTS BALANCE LIFE-WORK ISSUES ACROSS THE LIFESPAN

Speakers: Felicia Akingbala, M.D., Alice Raymay Mao, M.D., Leah J. Dickstein, M.A., M.D., Silvia W. Olarte, M.D.

Chair: Toi B. Harris, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify innovative ways to cope with balancing multiple roles within and external to work environment across the life span of a female psychiatrist; 2) Delineate unique stressors that female physicians encounter related to their vocation within the context of phases of life; 3) Discuss possible strategies to enhance professional performance at specific career phases and within varying clinical contexts;

SUMMARY:

Over the last thirty years, the percentages of women medical students and women residents have continued to increase. According to the American Medical Association, in 1970, only 7.6% of U.S. physicians were female. By 2006, 27.8% of the physicians in the United States were women. (1) In 2010, females comprised 48.3% of the U.S. medical school graduates. (2) The percentage of female physicians will undoubtedly rise as the numbers of females matriculating into U.S. medical schools has approximated almost 50% since 2002. (3) At the same time the number of dual earner couples also is on the rise. Consequently the need to balance multiple roles is a reality that continues to challenge young professionals across the careers spectrum and life cycle. In 1995, the Association of Women Psychiatrists surveyed its membership to try to understand the impact of having to balance multiple roles had in the professional life of women psychiatrists. (4) At the time, most of the burden of the multiple roles still rested with women professionals. Women psychiatrists who demonstrated the ability to combine family life, intimate relationships, and academic involvement were the most satisfied. The price they reportedly paid was decreased availability for personal time. A more recent systematic review conducted highlighted persistent challenges with work-life balance and career satisfaction among female physicians as a group in comparison to

male colleagues. (5) This workshop will address some of the innovative solutions currently implemented by women psychiatrists across the life cycle who have encountered the stress of balancing personal life, family and career irrespective of marital status or practice type. References: 1. Physician Characteristics and Distribution in the U.S., 2008 Edition and prior editions. American Medical Association. Accessed on 9/8/11 at <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/women-physicians-congress/statistics-history/table-1-physicians-gender-excludes-students.page> 2. AAMC, Table 1: Medical Students, Selected Years, 1965-2010 https://www.aamc.org/download/170248/data/2010_table1.pdf 3. AAMC, Table 1: Medical Students, Selected Years, 1965-2010 https://www.aamc.org/download/170248/data/2010_table1.pdf 4. Olarte SW: Women psychiatrists: personal and professional choices--a survey. *Acad Psychiatry*; 2004;28(4):321-5. Rizvi, R, Raymer, L., Kunik, M., Fisher, J.: Facets of career satisfaction for women physicians in the United States: a systematic review. *Women Health*. 2012; 52(4): 403-21.

WORKSHOP 11

SUBSTANCE ABUSE AND SCHIZOPHRENIA

Speakers: Rohit Madan, M.D., Vishal Maheshwar, M.D., Srinivas Dannaram, M.B.B.S.

Chair: Saurabh Jauhari, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the epidemiology of substance abuse in schizophrenia; 2) Recognize the effect of substance abuse on longitudinal course of schizophrenia and associated risks; 3) Understand the biological basis of substance abuse in schizophrenia; 4) Diagnose and manage dual diagnosis (Schizophrenia and Substance abuse);

SUMMARY:

Substance abuse co-morbidity is common with psychiatric conditions; it is particularly prevalent with schizophrenia(1). Nearly 50% people with schizophrenia, including those with first episode have substance abuse problems. Substance abuse is three times more common in people with schizophrenia compared to general population(2). Numbers of theories have been proposed to explain the association of substance abuse with schizophrenia. According to self-medication hypothesis patients with schizophrenia use substances to overcome distress of symptoms(3) and side effects of anti-psychotic medications(4). However, studies conducted on this basis have failed to confirm this hypothesis(5). Neurobiological hypothesis suggests that the dysregulated dopamine-mediated mesocorticolimbic brain pathways cause symptoms and reward circuit deficits in schizophrenia(6). Use of substances temporarily improve reward deficits but worsen the course of schizophrenia(7). Substance abuse in schizophrenia worsens the symptom severity(8), increase the frequency and length of relapse(9), reduces the medication response

and adherence. Substance abuse problems in schizophrenia increase risk of violence(10), suicide(11), victimization and homelessness. Depending on the route of substances used they also increase risk of acquiring HIV, hepatitis C and hepatitis B infections(12). Theories explaining effect of substance abuse on long-term course of schizophrenia suggest that substance abuse can trigger early onset of schizophrenia in vulnerable individuals. Some reports suggest that substances like cannabis trigger psychosis only in adolescents with high output Q variant of the gene for catechol-o-methyl transferase suggesting an important gene-environment interaction as a risk. Management of schizophrenia with substance abuse co-morbidity is a major challenge for psychiatrists. Effective management needs multidisciplinary team approach combining medications, psychotherapy and psychosocial interventions. Recent studies have updated the role of psychosocial interventions, antipsychotics and anti-craving agents in the management of schizophrenia with co-morbid substance abuse. REFERENCES 1.Selzer and Lieberman 1993.

2.Regier et al.1990. 3.Khantzian, 1985, 1997. 4.Potvin, Pampoulova, et al., 2006; Siris, 1990. 5.Blanchard, Brown, Horan, & Sherwood, 2000; Brunette, Mueser, Xie, & Drake, 1997; Buckley, 1998; Kirkpatrick et al., 1996; Lysaker, Bell, Beam-Goulet, & Milstein, 1994; Mueser et al., 1990; Scheller-Gilkey, Thomas, Woolwine, & Miller, 2002. 6.Green, Zimmet, Strous, and Schildkraut 1999. 7.Green et al., 1999; Roth, Brunette, and Green, 2005.

8.Swartz et al., 2006. 9.Linszen, Dingemans, & Lenior, 1994. 10.Abram & Teplin, 1991; Swanson, Holzer, Ganju, & Jono, 1990. 11.Green, Salomon, Brenner, & Rawlins, 2002; Potvin, Stip, & Roy, 2003. 12.Cournos & McKinnon, 1997; Rosenberg, Goodman, et al., 2001.

WORKSHOP 12

IMPROVING QUALITY: THE KEY TO HIGH-PERFORMING MENTAL HEALTH CARE SYSTEMS

Chair: Nick Kates, M.B.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the dimensions of high quality care;2) Understand the reasons why mental health care systems underperform;3) Learn simple QI tools and approaches that can be applied in any mental health care service or system;

SUMMARY:

Quality Improvement is increasingly seen as a goal for all health care services. This workshop provides practical tools and models that can be used in any mental health care system to improve the quality of the work being performed, increase the efficiency of the way a system of care operates, and reduce the likelihood of errors occurring. It begins by defining quality and the key attributes as defined by the institute of medicine, framing these within the IHIs Triple Aim of better care, better health, and better value. It then provides

a framework for examining a system of care and 5 key tools for identifying and measuring what is working and where a system is under performing, analyzing why that is happening, and introducing changes using the model for improvement and PDSA rapid change cycles.

WORKSHOP 13

COMPLEMENTARY AND ALTERNATIVE THERAPY IN U.S. MILITARY SETTINGS

Speakers: Joseph M. Helms, M.D., Paul Sargent, M.D., Robert Neil McLay, M.D., Ph.D., Robert L. Koffman, M.D., M.P.H., Elspeth C. Ritchie, M.D., M.P.H., Gary H. Wynn, M.D.

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Gary H. Wynn, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the ever changing definition of Complementary and Alternative Medicine (CAM).;2) Learn which uses of CAM fit best in a military setting.;;3) Know when and the use of animals may be beneficial in therapy.;

SUMMARY:

The military is using CAM in a variety of different ways and programs. The simplest definition of CAM is medical treatments that fall outside the tradition of Western medicine and scientific mechanisms of action. In some instances traditional physicians may accept that certain CAM practices work, and even apply them, but reject the historical or spiritual basis for the treatment. Other forms of CAM may have been developed using the reasoning of science, but are outside traditional practice because there is not enough evidence to properly evaluate the technique. This symposium will discuss: 1) acupuncture; 2) research on CAM in the military; 3) use of CAM in military programs; and 4) animal-assisted therapy.

WORKSHOP 14

THE NEXT GENERATION: TRENDS, FACTORS, AND SUCCESS STORIES IN RECRUITING MEDICAL STUDENTS INTO PSYCHIATRY

Speakers: Sandra M. DeJong, M.D., M.Sc., Francis Lu, M.D., Vilma McCarthy, M.D., Robert M. Rohrbaugh, M.D.

Chairs: Deborah J. Hales, M.D., John Spollen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List some factors known to be associated with higher recruitment rates of medical students into psychiatry;2) Identify attributes of consistently high recruiting LCME-accredited medical schools that might influence student career

choice;3) Describe potential benefits of psychiatry student mentoring programs and student interest groups and how to develop them;

SUMMARY:

Psychiatry is a shortage specialty, with critical shortages in child and adolescent psychiatry, geriatric psychiatry and addiction psychiatry. According to the resident census data from the American Psychiatric Association (APA), the percentage of students entering psychiatry residencies upon graduation from US allopathic medical schools since 2005 ranges from 1.7% to over 10%, indicating substantial differences in recruitment rates among allopathic medical schools. Knowledge of which factors are associated with higher recruitment rates may assist in developing strategies to increase recruitment of medical students into psychiatry. Previous reports have listed potentially relevant factors, including graduating student debt, annual tuition for in-state students, percentage of international medical graduates in the school's psychiatry residency program, perceived strength of the department compared with other departments in the school and whether the behavioral science or clerkship director was the recipient of a teaching award. A collaborative effort between the Division of Education at APA and the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) has begun to further evaluate potentially important factors. Education leaders in medical student education in psychiatry were recently surveyed concerning various factors that could be important such as curriculum, educational leadership, presence of anti-psychiatry stigma, and existence of a student interest group and related organized recruitment. The relationship between survey response data and psychiatry recruitment rates will be evaluated and results presented. Despite year-to-year variability in recruitment rates, there are number of medical schools that consistently are among the top recruiting LCME-accredited medical schools. Learning from their successful efforts may provide valuable information for improving curricula as well as educational leadership, culture and climate factors that may influence recruiting rates. Some schools have undertaken specific recruitment efforts such as mentoring programs that may bridge the gap between initial interest and career choice. Development of an active student interest group affiliated with the Psychiatry Student Interest Group Network (PsychSIGN) may provide additional venues for incubating early psychiatry interest. This workshop will provide participants with an overview of factors that may be important in recruiting medical students into psychiatry and provide some examples of efforts that may have positively influenced recruitment rates at successful medical schools.

WORKSHOP 15

AUTISM AND LEARNING INTERVENTIONS: FROM EARLY DAYS TO THE NEXT FRONTIER

Speakers: Alice Raymay Mao, M.D., Jennifer Yen, M.D., Mikel Matto, M.D.

Chair: Mikel Matto, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the history and application of early therapeutic interventions for autism;2) Describe in detail the different modalities of autism treatment currently used and their effect;3) Discuss how the latest technology and software applications are being leveraged by educators, clinicians, parents and patients;

SUMMARY:

In the 100 years since the term "autism" was first coined, psychiatry's perception of the condition has changed dramatically. This workshop serves as a helpful tool for understanding the rich history of the disease and how those lessons shape our treatment today and tomorrow. How was autism first characterized and managed by clinicians? Which early tools worked and how were they adapted into the many modalities that are available today? How is Applied Behavioral Analysis currently used, how effective is it, and what are its next applications? How is the sophistication and availability of new technology such as the iPad and virtual reality being used to improve functioning and quality of life for patients who use it? This workshop celebrates the efforts of generations of parents, educators, therapists, and clinicians by showing the evolution of autism treatment in context, demonstrating the most effective current tools, and highlighting what is on the horizon for learning interventions.

WORKSHOP 16

THE RISKS AND RESPONSIBLE ROLES FOR PSYCHIATRISTS WHO INTERACT WITH THE MEDIA

Speakers: Brian Cooke, M.D., Tonia L. Werner, M.D., Ezra Griffith, M.D.

Chair: Brian Cooke, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the clinical, ethical, and legal considerations of psychiatrists' interactions with the media;2) Understand the events that led to the development of the Goldwater Rule;3) Apply an ethics-based method to guide one's own interactions with the media;

SUMMARY:

Journalists often turn to psychiatrists to analyze acts of violence as well as other social, political, and cultural events that involve human behavior. Once journalists seek our expertise, we often rush to be helpful and are not mindful of our ethics obligations. Found within the Principles of Medical Ethics with Special Annotations Especially Applicable to Psychiatry, the Goldwater Rule prohibits certain behaviors when psychiatrists share professional opinions with the public. In this workshop, we will first discuss the Goldwater Rule, highlighting the

events that led to its development and the professional response to its enactment. We shall then review other bases on which the professionalism of psychiatrists may be impugned when they commit errors in their media presentations such as breaching confidentiality or defaming people's character. After discussing the risks that may attend the psychiatrist's performance when interacting with the media, we then present a method illustrated by video clips to guide psychiatrists in their interaction with the media that will help them avoid violating ethics principles or the law. The workshop will invite participants to discuss their own experiences with the media and to apply our proposed framework of ethics principles to guide their behavior and thinking as they contemplate accepting to participate in interactions with the media.

WORKSHOP 17

PSYCHIATRISTS WHO HAVE SURVIVED THE SUICIDE DEATH OF A LOVED ONE: THEIR INSIGHTS

Speakers: Akshay Lohitsa, M.D., Anna Halperin Rosen, M.D., David Greenspan, M.D., Morisa Schiff-Mayer, M.D., Edward Rynearson, M.D.

Chair: Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Become familiar with how the suicide death of a loved one affects individuals, including psychiatrists; 2) Know what bereaved psychiatrists can teach us about this very unique loss; 3) Learn how we can help grieving psychiatrists when they consult us;

SUMMARY:

According to the Centers for Disease Control and Prevention, there were 36,909 deaths by suicide in the United States in 2009 (the most recent year for which we have data). It is estimated that each suicide ultimately affects at least six people, many of whom are surviving family members. For some survivors, losing a loved member of one's family while growing up may inform their decision to study medicine and perhaps psychiatry. But others may not become a survivor until they are already studying or practicing psychiatry. In this workshop, five psychiatrists who have been bereaved by the suicide death of a family member will enlighten us with their personal and courageous stories. Dr Akshay Lohitsa is a resident who went to medical school with the intention of being a psychiatrist. His brother developed a severe mental illness during medical school and died by suicide during his first year of residency. He will discuss finding him in the world and the world in his story. Dr Anna Halperin Rosen, a psychiatry resident, lost her brother, Anthony Halperin, a fourth year medical student to suicide in April 2011. She will discuss the difficulty of identifying risk factors in highly functioning people and the impact that a family member's suicide can have on a survivor who works as a mental health professional. Dr David

Greenspan lost his father to suicide in 1988. He will discuss the terrible guilt and catastrophic loss of faith in his skill and profession as he, a fully trained psychiatrist, was not able to save his own father from dying by his own hand. Dr Morisa Schiff Mayer lost her mother to suicide. She will discuss the underground emotion of anger associated with surviving the suicide of a loved one, in particular its confusing aspects for the survivor and his/her family, friends and associates. Dr Ted Rynearson, psychiatrist and author of "Retelling Violent Death" lost his wife to suicide in 1974. He will recount his memories of meeting with his wife's psychiatrist after her death and discuss ways in which clinicians can best help patients trying to cope with traumatic loss. Audience members are invited to engage with the speakers in their quest to understand this very difficult and painful loss.

WORKSHOP 18

SEXUALITY IN LONG-TERM CARE: THE PATIENT, POLICY, AND PATERNALISM

Speaker: Amita R. Patel, M.D., M.H.A.

Chair: Sanjay Vaswani, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize best practice strategies to address sexuality in the elderly, its implications in public policy making, the legal ramifications and recent updates in management of abnormal sexual behaviors; 2) Identify the differences between normal sexual behaviors and sexual aggression and to recognize the effects of such behaviors on safety and quality of life of peers and providers in Long Term Care; 3) Explore best practice guidelines to assess and manage abnormal sexual behaviors and aggression in the elderly with and without dementia in long term care setting; 4) Discuss the need for training and identify the training opportunities of long term care facility staff and health care providers to improve the sexual quality of life in the elderly; 5) Learn to manage sexual behaviors within the construct of various federal, state and other regulatory mandates alongside facility policies as they influence the care of the sexual issues;

SUMMARY:

Sexuality in long-term care (LTC) settings is not a well-understood and managed area of health. Concept of intimacy, sexuality, and sexual behavior among LTC residents is uncomfortable for many. Quality studies on late life sexuality & those focusing on the elderly in long term care settings are scant. There is also a lack of incorporation of the views of all the stakeholders including the elderly residents, families and staff in these studies. Sexual behaviors in the elderly in LTC setting are common. These behaviors are influenced by the elder's preferences and health and cognitive status affecting consent; family factors including values and level of comfort; and staff perceptions, biases, level of education etc. When combined these influence the outcomes in health care of the elderly.

To complicate this further, there is an inconsistent societal regulatory mandate for policies regarding sexuality in LTC. More often than not a paternalistic response to sexual behaviors and only minimal consideration for the elderly patient's needs and desires is evident. Legal system often dictates capacity & consent. There is considerable variability in the statutory definitions of "capacity to consent to sexual activity". Also, there are no universally accepted criteria for capacity to consent to sexual relations across states or institutions. Applicability of literature suggested guidelines or ethical and legal criteria is based on a case-by-case basis. It is also necessary to balance Resident's Rights vs. Agency Responsibilities involving sexual behaviors. Facilities, directors and managers should use formal means to decide whether a resident is safe to consent to sex to avoid legal implications in medical practice. This presentation will be divided in three components. First, a team approach to identify, assess and manage the various forms of sexual expression and the risks associated with it will be discussed. This will be followed by review of policies and procedures (essentials of documentation, safety, reporting to family and authorities etc.) and regulatory mandates that influence the overall sexual expression and its social and legal implications in LTC. Finally, a set of illustrative case studies will lead to a discussion of the best practice strategies in care of such behaviors to optimize the balance between the elder's sexual needs and the safety of others.

WORKSHOP 19

FIT FOR DUTY? EVALUATIONS IN HIGH-STAKES PROFESSIONS: LAWYERS, POLICE, AND PHYSICIANS

Speakers: Marilyn Price, C.M., M.D., Debra Pinals, M.D.

Chair: Patricia R. Recupero, J.D., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the impact of the recent amendments to the Americans with Disabilities Act and their implications for forensic evaluations of mental disability; 2) Demonstrate knowledge of the process for conducting a risk analysis for disabled professionals (in particular, lawyers, law enforcement officers, and physicians) in return-to-work evaluations; 3) Demonstrate knowledge of the process for determining and recommending reasonable accommodations to disabled professionals whose job performance may have public safety implications;

SUMMARY:

Psychiatrists are often called upon to evaluate professionals for determination of disability, accommodations under the American with Disabilities Act, return to service and other employment-related matters. For many occupations, the evaluator must consider not only the needs and abilities of the evaluatee, but also the impact of the return-to-work decision on the safety of the public. Although the recent ADA amendments support expanded protection for the rights of persons with

mental illness in the workplace, the evaluation of the professional's specific ability to perform the essential job functions remains a critical task for the examiner. This workshop will focus on the roles and responsibilities of the psychiatrist when performing hiring or return-to-work evaluations for attorneys, police officers and physicians. The presenters will review the recent amendments to the ADA and the new standards that evaluators might consider in assessing disability and reasonable accommodations. Some of the special job requirements of physicians, police officers and attorneys will be described along with suggestions as to how the forensic examiner might address such requirements. Presenters will offer strategies to help evaluators balance the rights of disabled persons in the workplace and the need to protect the public from impaired professionals.

WORKSHOP 20

STRATEGIES TO REDUCE UTILIZATION OF ANTI-PSYCHOTICS IN LONG-TERM CARE

Speakers: George T. Grossberg, M.D., Allan A. Anderson, M.D.

Chair: Abhilash Desai, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe research highlighting risks of antipsychotics to manage problem behaviors in persons with dementia; 2) Discuss common triggers for problem behaviors in long term care residents with dementia; 3) Discuss pharmacologic alternatives to the antipsychotics in managing problem behaviors; 4) Describe nonpharmacological interventions to manage problem behaviors;

SUMMARY:

In the last decade, there is growing research highlighting the serious and potentially fatal risks of antipsychotics when used to treat problem behaviors in persons with dementia. These risks include increased risk of stroke and mortality, risk of falls, hospitalizations, and accelerated functional and cognitive decline. The prevalence of dementia in long-term care facilities ranges from 60% to almost 100%. Antipsychotics use is highly prevalent in LTC population and ranges from 15-25%. Hence there is urgent need to focus on strategies to reduce utilization of antipsychotics in LTC population. These strategies begin with prompt identification of and treatment of common triggers to problem behaviors such as urinary tract infection, constipation, medication induced adverse effects, pain and dehydration. Research to date indicates that many pharmacological alternatives to antipsychotics (e.g., cholinesterase inhibitors, memantine, antidepressants) may have beneficial effects in treating depression, anxiety and other psychiatric symptoms underlying problem behaviors. Routine use of individualized, strength-based nonpharmacological interventions have also been found to reduce problem behaviors and improve quality of life of LTC residents with dementia.

WORKSHOP 21**UNITED KINGDOM CRITICAL PSYCHIATRY NETWORK: IMPLICATIONS FOR APA AND GLOBAL PSYCHIATRY**

Speakers: Hugh Middleton, M.D., Sami Timimi, , Pat Bracken, M.D., Ph.D.

Chairs: Helena Hansen, M.D., Ph.D., Bradley Lewis, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the history and function of the UK Critical Psychiatry Network (CPN) and the International Critical Psychiatry Network (ICPN);2) Recognize the relevance of these groups for the APA and further development of U.S. psychiatry;3) Understand the historical and philosophic importance of critical feedback for psychiatry;4) Learn about specific new developments in both theory and practice that offer new directions for psychiatric practice;

SUMMARY:

The CPN is a group of about 200 doctors, mostly based in the UK, but there is also an international network of critical psychiatrists (ICPN) from around the world. Members have a broad range of opinions about mental health and, although there is no unanimously held position, members share a concern about the dominant (narrow biomedical) models used in psychiatry. CPN members see psychiatry as a profession that helps people understand their distress, find better ways of coping, and that engages with efforts to ameliorate difficult social situations that contribute to mental distress. CPN members also advocate working closely with service user groups and advocacy organizations, and encourage adoption of a 'Recovery' agenda. CPN members are troubled by the distorting influence of the pharmaceutical profession and have campaigned for more stringent conflict of interest policies to be adopted by mental health services, with some success. The UK Royal College of Psychiatrists has reduced its reliance on sponsorship for its annual conferences. Other campaigns by members include campaigning for changes in Mental Health law, greater controls on use of ECT, a change in the way psychopharmacology is prescribed and diagnosis is used. Members are active in academia and service development, with many articles, including in high-ranking peer reviewed journals, and books written, and innovative services developed. The CPN organizes seminars, peer support groups (for practitioners), and conferences (including with service user organizations), and CPN members are regularly invited to be keynote speakers at conferences. This workshop will provide background on the CPN and its activities in the UK. We will review its relevance for the APA and international psychiatry. Specific contemporary topics covered include focusing on outcomes in service delivery, the use of alternative models for psychopharmacology, and the question of medicine's role in mental health care. In addition, we will review the purpose and importance for the continuing development of the profession of maintaining an open and self-critical stance.

WORKSHOP 22**TAMING THE BIG BAD WOLF: DIRECT SUPERVISION IN PSYCHOTHERAPY TRAINING**

Speakers: Ellen Haller, M.D., Jonathan Lichtmacher, M.D., Rick Steele, A.B., M.D., Ben Elitzur, M.D.

Chair: Tracy E. Foose, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Illuminate the pressures exerted on academic institutions by external regulatory bodies that impact psychotherapy training;2) Identify barriers to bringing supervision into the room;3) Examine the potential benefits of direct supervision to clinical care and education;4) Explore the challenges and negative impacts of direct supervision on training and patient experience;5) Develop tools with which to improvise customized solutions for participants' home institutions;

SUMMARY:

What happens when the psychotherapy supervisor enters the room with the patient and supervisee? Is it a new opportunity, or is it the end of the world as we know it? Or, is it both? Medical practice in academic settings is undergoing a dramatic change in response to evolving supervisory requirements from regulatory bodies (e.g. ACGME) and payors (e.g., Medicare). One change demonstrating marked impact on psychotherapy training over the past several years is the requirement that the attending observe, in real-time, some portion of each psychotherapy visit between trainee and patient. Using the illustration of the three little pigs who fortify their homes against the menacing wolf, this workshop will lead off with an interactive exploration of the genuine fears of patients, trainees, and academic faculty in response to this model of supervision. Examples include a patient's fear of being intruded upon, trainee's fear of lost autonomy, supervisor's fear of irreparably altering the therapeutic frame. Ideal design is able to identify, address, and utilize fears of change as a catalyst for innovation. We will briefly present our home institution's process to build a psychotherapy clinic structure that would utilize direct supervision toward an educational end. Then, working in breakout groups, participants will: 1) "Gather the Bricks," by identifying components of educational experience in psychotherapy clinic design – the "who, when, what, and how" of direct supervision, feedback, and psychotherapy education, 2) "Face the Wolf," by utilizing the fruits of the lead-off exercise to marshal anticipatory fears into outside-the-box, improvisational design solutions for educational and clinical challenges, 3) "Share the Blueprints," by re-convening as a large group to present breakout-group creations in an exchange of design solutions – fostering tangible, applicable possibilities for participants' home institutions. Workshop leaders will then wrap-up with a brief presentation of design solutions implemented in UCSF's psychotherapy training clinics. Participants will hear the experiences of patients, trainees, and faculty via a series of clinical vignettes gathered during

a year in a clinic model of psychotherapy training that utilizes real-time, in-room observation combined with a structured case conference to maximize the educational value of direct supervision.

WORKSHOP 23

CHANGES IN PSYCHIATRIC EDUCATION: THE PSYCHIATRY MILESTONES AND THE NEXT ACCREDITATION SYSTEM OF THE ACGME

Speakers: George Keepers, M.D., Donald Rosen, M.D., Alik Widge, M.D., Ph.D.

Chair: Christopher R. Thomas, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) describe the content and development process of the new Psychiatry Milestones for resident education and discuss how this affects the training of new psychiatrists.;2) Participants will be able to describe the with the Next Accreditation System and how it will affect residency programs.;3) Participants will be able to recognize the challenges and opportunities that these education reforms present in the training of psychiatrists.;

SUMMARY:

Graduate medical education is undergoing fundamental changes that include psychiatric residency training. There are a number of reasons for these reforms, including revisions in educational paradigms and public expectations for competency in physician training. Among the most important changes in residency training that are now occurring are the Psychiatry Milestones that lay out expectations in the development of skills and knowledge in psychiatry and the Next Accreditation System that alters the process of residency program review by the Accreditation Council of Graduate Medical Education (ACGME). It is essential that all members of the profession be aware of these basic reforms to resident training and how these might affect the profession through training of future psychiatrists. This workshop presents the new Milestones in Psychiatry, that will be implemented beginning in 2014 in the assessment of resident progress in training. In addition, the Next Accreditation System of the ACGME will also be reviewed as it is an integral part of how training programs will be reviewed in the future.

The presenters are all members of the working group that has developed the Psychiatry Milestones. Dr. Thomas will give an overview to the background and the reasons for these education reforms. Dr. Keepers will present the Psychiatry Milestones in the current draft form, their development and plan for implementation. Dr. Rosen will present the Next Accreditation System that will be used by the ACGME to measure the progress of and accredit all residency training programs. Dr. Widge will present a resident's perspective on the impact of these changes in psychiatric training. The development of these two projects and the implications for psychiatric

residency training will be discussed. Both will have a profound impact on expectations and assessment in residency training and the preparation of psychiatrists to meet the challenges of mental health care in coming decades. It is important for all psychiatrists to be aware of these changes as it relates to the profession.

WORKSHOP 24

INTEGRATED CARE AND THE PATIENT-CENTERED MEDICAL HOME IN THE VETERANS HEALTH ADMINISTRATION: WHAT HAS SIX YEARS OF NATIONAL IMPLEMENTATION TAUGHT US?

Speakers: Andrew S. Pomerantz, M.D., Edward Post, M.D., Ph.D., Patricia Gibson, M.D.

Chair: Andrew S. Pomerantz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the variety of approaches to successfully integrate mental health care into primary care;2) Apply the principles of advanced clinical access to assure the availability and utility of co-located mental health providers in the medical home;3) Describe the role of the psychiatrist as a critical member of the interdisciplinary medical home;4) List the advantages of adapting mental health care to the primary care setting;5) Use knowledge developed in the Veterans Health Administration's integrated care experience to help guide their own program development;

SUMMARY:

The Veterans Health Administration (VHA) is the largest single healthcare system in the United States, providing healthcare to over 7 million Veterans in 140 hospitals and over 800 community based outpatient clinics.. In 2007, VHA began to an ambitious effort to integrate mental health care into primary care, the Primary Care-Mental Health Integration (PC-MHI) program . PC-MHI combines disease specific care management (CM) with co-located collaborative care (CCC) to provide mental health care in primary care clinics. Although the care management program has been well described in numerous research studies and demonstration projects, co-located collaborative care has been less well studied. This component embeds mental health providers, including social workers, psychologists and psychiatrists in primary care to provide consultation, assessment and brief treatment for common mental disorders known to occur frequently but traditionally to be addressed less frequently within primary care. More recently, VHA has modified its primary care programs to the Patient Centered Medical Home model, known in VA as the Patient Aligned Care Team (PACT). These teams include social work, clinical pharmacy, clinical dietetics, health promotion disease prevention program managers and mental health providers, in addition to the core primary care providers. The mental health component includes both health behavior

specialists and the PC-MHI teams. Although the VA's financial model of prospective risk adjusted capitation to its facilities is not the norm in the United States, the underlying principles can be generalized to develop cost effective programs in any environment. Six years after its initial rollout the VA program has begun to generate increasing data at both the local and national level to support the important contribution made by the mental health providers working in the PACTs. The PC-MHI teams have become an established resource for identification and treatment of mental disorders in the primary care population. This workshop will be led by the national directors of Primary Care-Mental Health Integration and a VA Psychiatrist currently working as a member of the interdisciplinary primary care team. We will describe the makeup of the VA PACTs and these interdisciplinary teams, including the specific roles played by psychiatrists working in tandem with psychologists, social workers, care managers, nurses and other health professionals to provide comprehensive health-care to the VA population. We will also discuss the findings emerging from the national program evaluation center as well as findings from an increasing number of local program evaluation efforts and review clinical trials currently in progress. The national data will be complemented by a discussion of local level programming and the critical role that psychiatrists play in the VA interdisciplinary team providing integrated care in the medical home.

WORKSHOP 25

UNCONSCIOUS PROJECTIONS: THE PORTRAYAL OF PSYCHIATRY IN RECENT AMERICAN FILM

Chair: Steven Pflanz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the impact of the portrayal of psychiatry in film on the public perception of psychopathology and the profession of psychiatry;2) Assess the objectivity and accuracy of portrayals of psychiatrists in major motion pictures;3) Critically analyze films containing psychiatric themes and content;

SUMMARY:

The American film industry has long had a fascination with psychiatry. The history of film is replete with vivid images of psychiatrists and their patients. Like any art form, movies can be seen as literal projections of the unconscious minds of their Hollywood creators and screen writers regularly use psychiatry as a thematic device. Unlike any other force in America, major motion pictures have the power to enduringly influence the public perception of mental illness, its treatments, and the profession of psychiatry. In particular, the 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 two decades, including such films as *A Beautiful Mind*, *Antwone Fisher*, *As Good As It Gets*, *Good Will Hunting*, and *Girl Interrupted*. Each of these films achieved a certain degree of both critical acclaim and box office success and was seen by millions of Americans. The audience will view short film clips from each of these movies, discussing each in turn. The majority of the session will be devoted to audience discussion of how we understand contemporary film to influence the image of psychiatry and mental illness in America.

WORKSHOP 26

MAKING THE MOST OF YOUR CHIEF YEAR: CHIEF RESIDENTS' FORUM I

Speakers: Keith Hermanstyne, M.D., M.P.H., Esther Oh, M.D., Luke White, M.D., Neisha D'Souza, M.D., Suzanne Franki, M.D., Daniel Notzon, M.D.

Chairs: Lee A. Robinson, M.D., Alan J. Hsu, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Clearly define their role as Chief Resident;2) Identify effective strategies used in psychiatry residency programs to manage difficult issues and logistical problems;3) Share their learning experiences with other participants;4) Build a network with Chief Residents from other programs to provide ongoing support and consultation.;

SUMMARY:

Literature Reference #1 Ivany CG, Hurt PH: Enhancing the effectiveness of the psychiatric chief resident. *Academic Psychiatry* 2007; 31:277-280

Literature Reference #2 Warner CH et al: Current perspectives on chief residents in psychiatry. *Academic Psychiatry* 2007; 31:270-276

Literature Reference #3 Sherman RW: The psychiatric chief resident. *Journal of Medical Education* 1972; 47:277-280 This is Part I in a two-part workshop for incoming Chief Residents. Outgoing and former Chief Residents, residency directors and others interested in administrative psychiatry are encouraged to attend and share their experiences. In a 2007 study, most Psychiatric Chief Residents report having satisfying, positive experiences, with the majority (90.6%) saying they would choose to perform the Chief Resident's duties again. However, they also reported that they were less likely to have a clear description of their responsibilities. Literature dating back to 1980 discussed the several problems inherent in the role, including poor definitions of the role, lack of training for the job, divided loyalties and unrealistic expectations. The purpose of this workshop is to provide a forum to discuss these Chief Residency issues and to address the vague description of chief resident duties that often accompanies this role. This workshop will include presentations from outgoing Chief Residents at programs across the country. Since Chief

Residents often face similar tasks, time for an open group discussion will be designated to exchange ideas and strategies with Chief Residents and administrators from other programs. Issues to be addressed include (1) logistical issues - schedules, call coverage, retreats, (2) dealing with difficult residency issues - morale, supporting residents after patient suicide, supporting residents after violence, supporting residents with academic difficulties. As 88.7% of Chief Residents in a 2007 study said their Chief experience has inspired them to seek future leadership opportunities, this workshop will also provide administrative training and networking for future potential leaders in psychiatry.

WORKSHOP 27

EEG IN PSYCHIATRIC PRACTICE

Speakers: Oliver Pogarell, M.D., Nash N. Boutros, M.D.

Chairs: Oliver Pogarell, M.D., Nash N. Boutros, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the clinical EEG as auxiliary diagnostic tool in psychiatry; 2) Decide whether a clinical EEG is indicated for a particular patient; 3) Identify abnormalities and clinical consequences;

SUMMARY:

EEG remains an underutilized method for assessing organic factors influencing psychiatric presentations. Through this course clinicians will achieve an understanding of several clinical areas where EEG may provide valuable differential diagnostic information. Following a brief summary of historical developments, the psychiatrist will learn the basics of a normal EEG exam and understand both the limitations of EEG testing and the general classes of medical and organic variables that are reflected in abnormal EEG patterns. Specific clinical indicators ("red flags") for EEG assessment will be stressed. More detailed coverage of selected areas will include (1) EEG in psychiatric assessments in the emergency department (2) EEG in the assessment of panic and borderline patient (3) the value of EEG in clinical presentations where diagnostic blurring occurs (i.e. differential diagnosis of dementia, differential diagnosis of the agitated and disorganized psychotic patient, and psychiatric manifestations of non-convulsive status). Specific flow charts for EEG evaluations with neuropsychiatric patients in general and for EEG evaluations of repeated aggression will be provided. Numerous illustrated clinical vignettes will dramatize points being made. This course is intended for the practicing clinician. In conclusion, this course is designed to enable the practicing clinician to utilize EEG effectively (i.e., avoid over or under-utilization) to help with the differential diagnostic question and to be able to determine when an EEG test was adequately (technically) performed. At the conclusion of this workshop, the participant should be able to: understand the limitations of EEG and broad categories of pathophysiology that produce EEG abnormalities. The participants will also have a complete grasp of the general

indications and specific diagnostic uses of the clinical EEG. Attendees will also develop an understanding of how EEG can be useful in monitoring ECT and pharmacotherapy.

WORKSHOP 28

CHALLENGING CASES: MANAGEMENT OF PATIENTS WITH INTELLECTUAL DISABILITIES AND SEXUALLY OFFENSIVE BEHAVIORS

Chairs: Durga Prasad Bestha, M.B.B.S., Sunil K. Routhu, M.B.B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the evaluation of the challenging behaviors with focus on sexually offensive behavior seen in Intellectually disabled patient population; 2) Recognize the process of risk assessment and use of standardized instruments; 3) Understand the Multidisciplinary management in preventing sexual offenses in this population;

SUMMARY:

The risk of sexual offenses by patients with intellectual disabilities has been estimated to range anywhere from 4% to as high as 40%. It has been identified that a high proportion of these individuals have themselves been victims of inappropriate sexual behavior at an earlier stage in their lives. Defects in language and social cognition create a barrier for communication of needs and distress to caregivers. In the recent years, with the scaling down and restructuring of Mental health services at various levels, it is not uncommon to come across this patient population on an inpatient general psychiatry unit. This has necessitated the need for practitioners to become aware of the wide array of challenging behaviors that can be seen in intellectually disabled patient population. Early identification of behavioral signs that can be a precursor of sexual offenses along with initiation of safety precautions can prevent the patient from offending and protect other patients and staff from becoming victims. In the first part of this interactive workshop using clinical vignettes, the speakers will explore the challenging, problematic behaviors seen in patients with intellectual disabilities with special focus on sexually offensive behaviors. This will lead into the next section where the speakers will look at the role of standardized scales in assessing risk and aid in organizing and implementing multidisciplinary steps of risk management. In the next section, there will be a presentation of the review of current available evidence, based on literature review of the psychosocial and pharmacological interventions for the management of sexual offenders with intellectual disabilities. Throughout the workshop with active participation from audience, there will be emphasis on learning from experiences in different healthcare systems across various countries in managing these challenging clinical scenarios.

WORKSHOP 29**SPORTS PSYCHIATRY: SUPPORTING LIFE BALANCE AND PEAK PERFORMANCE FOR ATHLETES ACROSS THE LIFESPAN**

Chair: David R. McDuff, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify recent unhealthy trends in youth sports and intervene with young athletes and their families to minimize the negative impact of these trends;2) Recognize the most common substances misused by athletes at all competitive levels and intervene with them to reduced substance related events and the development of substance use disorders;3) Identify the most common injuries in athletic competition and manage the common barriers to injury recovery and return to play;

SUMMARY:

Athletic participation rates have risen significantly in youth, high school, and college sports over the past 20 years. Therefore, psychiatrist and other mental health professionals are likely to encounter stressed, injured, burned-out or underperforming athletes in their practices. The unhealthy trends in youth sports like early one-sport specialization, year round training, and winning at all cost are resulting in early failure, reduced self-esteem, performance anxiety, and overuse injuries. College and professional sports are so popular and receive such intense public and media scrutiny that intense performance pressure and unreasonable expectations develop. This creates a competitive environment that is so stress-filled and unhealthy that stress reactions, substance misuse, partner violence, performance failure, and serious injury result. This workshop will use an interactive discussion format of cases and experiences of an active sports psychiatrist to explore the common problems of athletes across the lifespan. Practical solutions and interventions will be identified that have applicability to work with non-athletes.

WORKSHOP 30**EMERGENCY PRESENTATIONS TO AN INNER-CITY PSYCHIATRIC SERVICE FOR CHILDREN AND ADOLESCENTS**

Speakers: Jurgen Cornelis, M.D., Flip-Jan van Oenen, M.D.

Chair: Linda M. Dil, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the most prevalent problems and diagnostics seen in emergency psychiatry in children and adolescents;2) Identify the related circumstances;3) Employ adequate therapeutic interventions;4) Balance both a psychiatric and a systemic approach;

SUMMARY:

A crisis in child-and adolescent psychiatry ensues when the surrounding support system (caretakers, judicial system, school, mental health care workers) is overwhelmed in its capacity to deal with the situation. Psychiatric emergency services for children and adolescents vary in process, structure and outcome. There are few systematic studies on the type and prevalence of psychiatric problems encountered, related circumstances or resulting interventions. In this workshop some introductory data are presented from a cohort study that took place in the Amsterdam Child Psychiatric Emergency Service in 2008, regarding data on clinical, demographic and consultation-related characteristics. A majority of the consultations (51.5%) was related to behavioral problems in the context of heavily strained relationships. The main Diagnostic and Statistical Manual of Mental Disorders classification was a relational problem (70%). A comparison is made with data from the international literature, followed by an invitation to the participants of the workshop to share some of their experiences. Then two clinical cases are discussed in depth, identifying characteristic difficulties and offering possible interventions to manage an emergency situation. REFERENCE

L. M. Dil & P. J. Vuijk (2012): Emergency Presentations to an Inner-city

Psychiatric Service for Children and Adolescents, Child Care in Practice, 18:3, 255-269

MAY 19, 2013

WORKSHOP 31**LEGAL AND RISK MANAGEMENT ISSUES IN PSYCHOSOMATIC MEDICINE: A PRACTICAL APPROACH**

Speakers: James Levenson, M.D., Rebecca Brendel, J.D., M.D.

Chairs: Rebecca Brendel, J.D., M.D., James Levenson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the central legal principles governing key aspects of psychosomatic medicine practice including in the areas of capacity, confidentiality, risk assessment, and risk management;2) Acquire practical skills for identifying and managing risk through provision of carefully constructed clinical care plans;3) Recognize the key underpinnings of malpractice liability;

SUMMARY:

In the practice of psychosomatic medicine, legal issues may arise for many reasons. For example, treating patients with psychiatric illness often focuses specific attention on sensitive issues such as confidentiality and the limits thereof. In addi-

tion, non-psychiatric (medical and surgical) colleagues often consult psychiatrists for legal and quasi-legal questions such as a patient's decision-making capacity and treatment refusal as these issues involve assessment of mental reasoning and abnormal behavior. Lastly, medicine is practiced in the context of an increasingly complex society with competing values and interests, and these tensions often emerge at the level of the individual. Examples include risk of harm to third parties and malpractice liability. The law provides a framework, often invisible, for how medicine is practiced in medical and surgical settings.

This workshop will provide an overview of the relevant central legal concepts that inform psychosomatic medicine (and general psychiatry) practice with an emphasis on the practical application of these principles to frequently encountered clinical scenarios. Specific topics will include an overview of legal framework, capacity determinations, confidentiality, risk assessment, and risk management (including malpractice risk). Given the variation in practice from jurisdiction to jurisdiction, methods for obtaining consultation and clarity will be reviewed. Significant time will be allotted for questions from participants about cases and application of the material to clinical practice.

WORKSHOP 32

PTSD CLINICAL PATHWAY DEVELOPMENT WITH- IN THE DEPARTMENT OF DEFENSE

Speakers: Kate McGraw, Ph.D., Meena Vythilingam, M.B.B.S., M.D., Paul Hammer, M.D., Charles Engel, M.D.

Chair: Paul Hammer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define the construct "clinical pathways", and distinguish between clinical practice guidelines and clinical pathways.;2) Recognize the strengths and challenges of pathway development and implementation within mental health settings.;3) Discuss the Department of Defense's current efforts to develop a clinical pathway for PTSD.;

SUMMARY:

The Department of Defense (DoD) Military Health System (MHS) requires continuous quality improvement (CQI) mechanisms for psychological health conditions in order to deliver high quality care in a cost effective manner. CQI mechanisms can be used to improve clinical processes, reduce variability in clinical practice, and improve treatment outcomes within the MHS. Clinical pathways, also known as critical paths or care paths, are management tools that provide the sequence and timing of actions necessary to achieve these goals. The Defense Center of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury is developing a Posttraumatic Stress Disorder (PTSD) Clinical Pathway for the MHS. The PTSD Pathway will address each point along the continuum

of care to include Screening, Diagnosis, Treatment, and Reintegration. Once developed, the MHS will have a roadmap to implement written care processes and analyze outcomes data for each point of care, to include cost and quality measures. Furthermore, this framework can serve as a mechanism to continuously improve psychological health clinical practice, education, and training within the DoD. While limitations exist when clinical pathways are applied to behavioral health-care practice, the potential benefits (to include reduction of variability in service delivery and improvement of treatment outcomes, as well as potential cost savings) outweigh these limitations. This presentation will review DoD advances in the development of a clinical pathway for the treatment of PTSD.

WORKSHOP 33

MAKING THE MOST OF YOUR CHIEF YEAR: CHIEF RESIDENTS' FORUM II

Speakers: Neisha D'Souza, M.D., Suzanne Franki, M.D., Keith Hermanstyne, M.D., M.P.H., Esther Oh, M.D.

Chairs: Alan J. Hsu, M.D., Lee A. Robinson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Clearly define the Chief Resident role;2) Identify effective strategies used in psychiatry residency programs to manage difficult issues and logistical problems;3) Share their learning experiences with other participants;4) Build a network with Chief Residents from other programs to provide ongoing support and consultation;

SUMMARY:

Literature Reference #1 Ivany CG, Hurt PH: Enhancing the effectiveness of the psychiatric chief resident. *Academic Psychiatry* 2007; 31:277-280

Literature Reference #2 Warner CH et al: Current perspectives on chief residents in psychiatry. *Academic Psychiatry* 2007; 31:270-276

Literature Reference #3 Sherman RW: The Psychiatric Chief Resident. *Journal of Medical Education* 1972; 47:277-280 This is Part II in a two-part workshop for incoming Chief Residents. Outgoing and former Chief Residents, residency directors and others interested in administrative psychiatry are encouraged to attend and share their experiences. In a 2007 study, most Psychiatric Chief Residents report having satisfying, positive experiences, with the majority (90.6%) saying they would choose to perform the Chief Resident's duties again. However, they also reported that they were less likely to have a clear description of their responsibilities. Literature dating back to 1980 discussed the several problems inherent in the role, including poor definitions of the role, lack of training for the job, divided loyalties and unrealistic expectations. The purpose of this workshop is to provide a forum to discuss these Chief Residency issues and to address the vague de-

scription of chief resident duties that often accompanies this role. This workshop will include presentations from outgoing Chief Residents at programs across the country. Since Chief Residents often face similar tasks, time for an open group discussion will be designated to exchange ideas and strategies with Chief Residents and administrators from other programs. Issues to be addressed include (1) logistical issues - schedules, call coverage, retreats, (2) dealing with difficult residency issues - morale, supporting residents after patient suicide, supporting residents after violence, supporting residents with academic difficulties. As 88.7% of Chief Residents in a 2007 study said their Chief experience has inspired them to seek future leadership opportunities, this workshop will also provide administrative training and networking for future potential leaders in psychiatry.

WORKSHOP 34

EAST MEETS WEST: LESSONS IN PSYCHOTHERAPY FROM THE BHAGAVAD GITA

Speakers: Venkata B. Kolli, M.B.B.S., Jayakrishna Madabushi, M.D.

Chairs: Subhash Bhatia, M.D., Vishal Madaan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the psychotherapeutic content and context of the Bhagavad Gita (the Gita);2) Understand the application of the Gita to contemporary psychotherapies to augment the therapeutic impact;3) Harness the secular content of the Gita for healthy mental health promotion;

SUMMARY:

There have been several instances of successful integration of eastern philosophies with western psychotherapies. For example, dialectical behavioral therapy is a successful amalgamation of the Zen principles with cognitive behavioral therapy. In most cultures, different philosophies and approaches have been used to promote wellbeing and thereby treat mental illnesses. The Bhagavad Gita is perhaps the most well known Indian spiritual text and is thought to encapsulate the Indian philosophy. The Bhagavad Gita is part of the ancient epic, the Mahabharata, whose story line revolves around the war between the two groups of virtuous and vicious royal cousins. In the prelude to the Gita, the mighty archer Arjuna, who carries the burden of the Pandava hopes of victory, becomes overwhelmed with emotion and anxiety prior to the war, and contemplates withdrawing from the battle. Lord Krishna, his charioteer during the war helps Arjuna overcome the dilemmas and guides him towards action and destiny, and this discourse is the Gita. Arjuna's internal conflict is analogous to what most of our patients face anxieties and dilemmas and this 700 verse long philosophical Sanskrit text is a commentary on how to address the inner conflict and move towards action, akin to the goal of psychotherapy. In this interactive workshop we discuss the background of the Gita, the conflicts and dilemmas faced by Arjuna and analogies with mental states

of our patients. We then discuss parallels between the Gita and contemporary psychotherapies. We start with applying the philosophy of the Gita to psychodynamic understanding of Arjuna's conflicts and the Gita's solutions in resolving these. We then discuss how the Gita can be used to address autonomic symptoms and cognitive distortions and follow with a review of mindfulness concepts in the text, and applying these to Cognitive Behavioral therapy approaches. We will then review how the Gita can be helpful to motivational enhancement therapy, grief emancipation therapies, interpersonal psychotherapy, health improvement and supportive psychotherapy. The final part of the workshop will have a speaker led discussion and review of literature about the role of adjunctive use of eastern philosophies, and barriers to their application in the treatment of mental health conditions. 1. Bateman A, Brown D.(2010) Introduction to Psychotherapy: An Outline of Psychodynamic Principles and Practice (4th Ed.) Hove: Routledge. 2. Easwaran E. (1975) The Bhagavad Gita for Daily Living (Vols 1-3). Berkeley, California: The Blue Mountain Center of Meditation.

WORKSHOP 35

PERSONAL EXPERIENCES IN THE COMBAT ZONE

Speakers: Robert Neil McLay, M.D., Ph.D., Christopher H. Warner, M.D., Christine L. Wolfe, M.D., Elspeth C. Ritchie, M.D., M.P.H., Christopher Ivany, M.D.

Chair: Elspeth C. Ritchie, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn basic principles of military psychiatry.;2) Identify common psychological problems of war.;3) Know the challenges of being a psychiatrist in combat.;

SUMMARY:

After 11 years of war, there are approximately 2.5 million veterans who have served overseas in wars in Iraq and Afghanistan. Side by side with the troops have been military psychiatrists. Many psychiatrists have deployed several times. This unique workshop will draw upon their personal experiences in Iraq, Afghanistan and elsewhere. Military doctors treat not just the American military, but also local nationals, and detainees. Basic principles of combat stress control will be demonstrated and updated. Complexities of balancing the needs of command and the troops will be highlighted. Finally some of the issues around treating detainees and supporting the local psychiatric systems of care will be discussed.

WORKSHOP 36**OVERVIEW OF CONSCIENTIOUS OBJECTION WITH SPECIAL ATTENTION TO QUAKER CONSCIENTIOUS OBJECTORS IN WORLD WAR II: UNLIKELY HEROES OF PSYCHIATRIC REFORM**

Chair: David Roby, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Provide a historical overview of conscientious objection with attention to the historic peace churches, and Quakers in particular; 2) Summarize Quaker conscientious objection in American history; 3) Scrutinize Quaker conscientious objection in World War II emphasizing service in psychiatric institutions;

SUMMARY:

It is estimated that 3,000 Quakers who chose to be conscientious objectors to military service in World War II were assigned to work in 60 psychiatric hospitals in the United States. Some Quakers were distressed by the living conditions in these hospitals, and made an expose with written comments, and photographs. One such story was based on experiences in Byberry Hospital in Philadelphia, and was published in Life Magazine in 1946. Eleanor Roosevelt was moved by the article, and met with the authors. She vowed to champion reform of conditions in state asylums. The workshop will delve into this somewhat obscure but nonetheless fascinating chapter in the history of Quaker mental healthcare reform.

WORKSHOP 37**TRANSITION TO PRACTICE AND TRANSITIONS IN PRACTICE: A WORKSHOP FOR MITS AND ECPS**

Speakers: Nina Kraguljac, M.D., Steve Koh, M.B.A., M.D., Anna Skiandos, D.O., Jose Vito, M.D., Deepika Sastry, M.B.A., M.D.

Chair: Paul OLeary, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Highlight the changes that occur when going from Residency to Career psychiatrist, including practice setting, population and focus of practice; 2) Provide first-hand accounts from Early Career Psychiatrists (ECPs), who will discuss their own areas of practice, including the rewards and challenges; 3) Inform psychiatrist about the 6 areas of work-life that will affect their job satisfaction; 4) Discuss what to look for in a job to decrease the chance of burnout and frequent job changes; 5) Discuss how the transition into practice differs for different psychiatrist, as the panel includes ECPs with an addiction, child and adolescent, forensic, geriatric, and research fellowship;

SUMMARY:

The transition from residency to practice can be a challenging time, as trainees leave behind the structure and support of the training program. In addition, early years of practice can frequently involve changes of various types, including practice setting, population and focus of practice. In this interactive workshop, several Early Career Psychiatrists (ECPs) will discuss their own areas of practice, including the rewards and challenges that they have faced as they have moved from training to early practice years and beyond. The panel will focus particularly on the 6 areas of work-life that will affect psychiatrists' job satisfaction, as well as, discussing how the transition into practice differs for different psychiatrist, as the panel includes ECPs with an addiction, child and adolescent, forensic, geriatric, and research fellowship. References: Whither hospital and academic psychiatry? Tesar GE - Psychiatr Clin North Am - 01-MAR-2008; 31(1): 27-42 Location, location, location: the role of place in career development. Freeman MP - J Clin Psychiatry - 01-JUL-2009; 70(7): 1024-5 Personal reflections on a career of transitions. Faulkner LR - J Am Acad Psychiatry Law - 01-JAN-2007; 35(2): 253-9 How should research productivity be assessed in early career psychiatric researchers? research funding versus scientific productivity. de Leon J - J Clin Psychiatry - 01-SEP-2009; 70(9): 1327-8; author reply 1328 Early career psychiatry. Freeman MP - J Clin Psychiatry - 01-NOV-2009; 70(11): 1571

WORKSHOP 38**THE CULTURAL FORMULATION INTERVIEW: APPLYING THE DSM-IV-TR OUTLINE FOR CULTURAL FORMULATION FOR DSM-5**

Speakers: Roberto Lewis-Fernandez, M.D., Ladson Hinton, M.D.

Chairs: Russell Lim, M.D., Francis Lu, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the 16 questions of the Cultural Formulation Interview, and informant module; 2) Name and describe the 12 supplementary modules; 3) Describe the application of the CFI to the diagnostic interview;

SUMMARY:

Beginning with DSM-IV in 1994 there has been increasing attention given to the impact of culture on psychiatric assessment and treatment by the APA, with the inclusion of the DSM-IV Outline for Cultural Formulation (OCF) and a glossary of culture bound syndromes in Appendix I. Also included are new culturally sensitive diagnostic categories such as an acculturation problem, or a spiritual crisis. DSM-V continues the trend with the inclusion of the Cultural Formulation Interview, consisting of sixteen questions, and supplemented by 12 modules, including Cultural Identity, Explanatory Models, Level of Functioning, Psychosocial Stressors, Social Network, Religious and Spirituality and Moral Tradition, Caregivers, Coping

and Help-Seeking, Patient–Clinician Relationship, Immigrants and Refugees, School Age Children and Adolescents, and Elderly. Participants will be able to discuss how the CFI and its modules will be helpful in completing a cultural assessment.

WORKSHOP 39

ESTABLISHING TELEPSYCHIATRY AND TELE-PSYCHOTHERAPY SERVICES FOR NURSING HOME RESIDENTS: A BEACON PROGRAM

Speakers: Christian Milaster, , Barbara Yawn, M.D., M.P.H., M.Sc.

Chair: Kathryn Lombardo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the opportunities and benefits of telemental health visits for nursing home residents;2) Describe the barriers to establishing telemental health visits for nursing home residents;3) Describe the reimbursement issues related to telemental health visits for nursing home residents;4) Describe and apply in their organization a pragmatic, patient-, provider- and care staff-centric approach to starting a telemental health program for nursing home residents;

SUMMARY:

Access to psychiatric care in nursing homes can be limited by the distance from the nursing home to the psychiatrist and the ability of the patient to be transported to the psychiatrist's office. Tele or distance visits may provide an opportunity to provide psychiatry care to those current unable to access such care and to increase the frequency of assessment and evaluation for those for whom transport to the psychiatrist's office is difficult and may change patient affect or cognitive function. Olmsted Medical Center, located in southeastern Minnesota, operates a geographically distributed integrated health care network including two multi-specialty outpatient clinics, physical and occupational therapy facilities, a weight loss & wellness center, two walk-in FastCare retail clinics, a 61-bed hospital with a 24-hour emergency department and BirthCenter in Rochester, MN as well as primary care clinics with 2 to 5 clinicians in nine Southeastern Minnesota municipalities. The medical staff serves as medical director of 12 nursing homes within this region including 4 within Rochester and another 8 located 15 to 48 miles from the main office where the mental health professionals are based. In 2012, Olmsted Medical Center received funding from the Beacon grant, funded through the Office of the National Coordinator (ONC), to launch demonstration projects in the area of geriatric psychiatric and psychotherapy care. We selected nursing homes as the initial sites in which to provide mental health telecare. Several barriers and facilitators of this work ranged from Medicare reimbursement policies, technical limitation to high speed communication in several of the rural sites, patient privacy concerns, issues with EHR documentation, training for onsite staff to facilitate telehealth visits, clinician reluctance, patient and family reluctance to impatience of early adopter

clinicians. In this session the presenters will share the lessons learned--what worked well and what didn't--from launching and conducting telepsychiatry and telepsychotherapy visits in four rural nursing homes from 25 to 60 miles distant from the psychiatrists' offices. The presentation will be based on a discussion of the underlying principles of systems thinking, design thinking, metrics-driven performance improvement, and formal project management along with building support across the organization's leadership and proactively managing the organizational change that laid the foundation for the success of this initiative. Presented solutions will be practical and transferrable to other organizations or health care systems considering moving into similar types of distance-based mental health care.

WORKSHOP 40

VIOLENCE AND THE AMERICAN SOLDIER

Speakers: Elspeth C. Ritchie, M.D., M.P.H., Christopher H. Warner, M.D., Remington L. Nevin, M.D., M.P.H., Michelle Hornbaker-Park, M.D.

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Marvin Ole-shansky, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about how the eleven years of war has intersected with violence for the American Soldier.;2) Understand the potential impact of mefloquine on suicide and violence.;3) Cover basic strategies to keep a clinic safe.;

SUMMARY:

The murders and murder/suicides at Ft Bragg in 1992 highlighted the perils of rapid return from the battlefields in Afghanistan to civilian life. Investigations showed continuing problems with access to care, as well as the reluctance of career minded Soldiers to seek treatment. While the rising suicide rate has been a major concern for all in the Army, episodes of violence, to include homicide, in general have not been as well studied. However epidemiological consultation teams were done on the homicides at Ft. Bragg in 2003 and Ft Carson in 2009. This lecture will outline some of the trends in both self-directed and externally directed violence, to include homicide and suicide-homicide. Domestic violence and the murder of a spouse/partner share many of the dynamics seen in suicide. The combination of unit and individual risk factors include: exposure to combat, the high operations tempo, feelings of disconnectedness on return home, problems at work or home, pain and disability, alcohol, and easy access to weapons. The use of mefloquine (Lariam) has also been associated with suicide and violence. The prolonged effects of exposure to violence and death are not easy to change but there are strategies for mitigation. Both psychiatrists and psychiatric patients were shooters and victims in 2009. Mental health and medical clinics need to ensure that they are prepared to react and protect their personnel in the event of an active shooter. Basic strategies to survive those events will be outlined.

WORKSHOP 41**BRAIN IMAGING AND PSYCHIATRIC DIAGNOSIS: SCIENTIFIC AND SOCIETAL ISSUES**

Speaker: Helen Mayberg, M.D.

Chair: Martha Farah, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify several ways that brain imaging has been used in basic and translational research, including specific examples of successful uses;2) Be able to enumerate and describe the limitations of imaging methods and research that impede its usefulness for diagnosis of primary psychiatric disorders;3) Know the reasons that patients, families and healthcare providers may nevertheless desire diagnostic brain imaging for psychiatric disorders;

SUMMARY:

Brain imaging permeates the media, with colorful scans showing the brain as it falls in love, craves drugs or makes economic decisions. Laypersons are aware that brain imaging can reveal the normal activity of the human brain and abnormal patterns of activity associated with psychiatric illness. The idea of diagnostic brain imaging in psychiatry is therefore plausible to non-experts and may increase patient confidence in the diagnostic process and subsequent clinical care. Yet brain imaging currently plays no accepted role in psychiatric diagnosis, beyond ruling out medical factors such as tumors or traumatic brain injuries. The goal of this session is to address the following questions concerning the role of brain imaging in psychiatry: How has brain imaging been used in basic and translational research? How do these uses differ from diagnosis? Why is brain imaging not used in diagnosing primary psychiatric disorders (e.g., depression, bipolar disease, schizophrenia, and ADHD)? What in the nature of brain imaging accounts for this? What in the nature of our diagnostic categories accounts for this? Why might patients and families nevertheless seek brain imaging for diagnosis? Why might some physicians nevertheless use imaging for diagnosis? The answers to these questions involve limitations of current science, technology and nosology, as well as the appeal of pictures, the promise of high technology, and the desire to ground psychiatry in neuroscience.

WORKSHOP 42**CHILDREN OF PSYCHIATRISTS**

Chairs: Leah J. Dickstein, M.A., M.D., Michelle Riba, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize and understand how as psychiatrist-

parents, their children think and feel about their psychiatrist-parents;2) Learn from other children about problems and opportunities;3) Share stories and situations that might be useful to understand;4) Present information regarding developmental stages that might have been impacted by being a child of a psychiatrist;5) Be better able to reflect about what it means to be a child of a psychiatrist.;

SUMMARY:

This 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 Dr. Dickstein to set the tone for the audience, and she and Dr. Riba will lead the discussion.

WORKSHOP 43**REJUVENATING EMPATHY THROUGH REFLECTIVE WRITING: A WORKSHOP FOR CLINICIANS**

Speakers: Shaili Jain, M.D., Suzan Song, M.D., M.P.H., Magdalena Romanowicz, M.D., Randall Weingarten, M.D.

Chair: Shaili Jain, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe how reflective writing can be used as a tool to trigger clinical reflection, self-awareness, and empathy;2) Demonstrate how reflective writing can be used to enhance one's skills as a clinician by allowing reflection on clinical experience and what gives meaning to work and life;3) Participant will be able to practice how reflective writing can be used as a creative outlet from the rigors of providing care to those living with mental illness;

SUMMARY:

Clinicians who care for the mentally ill can experience work related stress and signs of burnout. Programs focused on reflection and self-awareness are associated with restoring the therapeutic relationship between clinicians and patients. Writing narratives, related to our clinical experiences, is one such method for triggering reflection, self-awareness, and empathy. In this interactive workshop, presenters will engage the audience and demonstrate how to use reflective writing as a creative outlet from the rigors of providing clinical care. Audience members will: 1) read and discuss selected readings; 2) engage in a simple writing exercise, and; 3) share their writing in the group. The workshop will also highlight the humanistic dimensions of clinical practice and aims to celebrate the lives

of our patients through this act of writing. Dr. Jain serves as a staff psychiatrist at the VA Palo Alto Healthcare System. She teaches a reflective writing course to Stanford psychiatry residents, is a mentor for medical students in their medical humanities concentration and serves on the steering committee for medical humanities at the Stanford University School of Medicine. She also blogs about PTSD and psychological resilience on PLOS blogs. Dr. Song is a child and adolescent psychiatrist and frequently blogs for the Huffington Post about her work with child soldiers in Africa. Dr. Romanowicz is a child and adolescent psychiatry fellow at the Stanford School of Medicine. Dr. Randall Weingarten is an adjunct clinical professor with the department of Psychiatry and Behavioral Sciences at the Stanford University School of Medicine. Drs. Jain, Song, Romanowicz and Weingarten are members of the Pegasus Physicians at Stanford writing group. References: Charon R. Narrative medicine. *N Engl J Med.* 2004;350:862-4. Reisman AB, Hansen H, Rastegar A. The craft of writing: a physician-writer's workshop for resident physicians. *J Gen Intern Med.* October, 2006. Improving empathy of physicians through guided reflective writing. Misra-Heber, AD, et al. *Int J of Med Educ,* 2012,3:71-77

WORKSHOP 44

ACCULTURATIVE FAMILY DISTANCING: DEVELOPMENTAL AND CLINICAL PHENOMENA FOR CHILDREN OF IMMIGRANTS

Speaker: Shashank V. Joshi, M.D.

Chairs: Dawn Sung, M.D., Andres J. Pumariega, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the background behind the identification of Acculturative Family Distancing (AFD) and the development of Brief Strategic Family Therapy (BSFT) and Bicultural Family Effectiveness Training (BFET) in relation to Hispanic and Chinese families;2) Define the concept of AFD and how it affects the parent-child relationship;3) Describe the basic principles of BSFT and Bicultural Family Effectiveness Training;4) Identify how the concept of AFD and principles of BSFT could be applied to various clinical scenarios in diverse cultural populations;

SUMMARY:

As the U.S. population grows more diverse with a rapidly expanding immigrant and second generation population, there is a need to better understand the process of acculturation and how it affects families. By understanding inter-generational adaptation and conflict and its impact on the mental health of immigrant children, we can identify approaches to improve family functioning and either prevent or improve adverse clinical outcomes. Dr. Andres Pumariega will review the background and concepts behind Acculturative Family Distancing (AFD), and Dr. Shashank V. Joshi will discuss the concepts of Brief Strategic Family Therapy (BSFT) and Bicultural Family Effectiveness Training. Drs. Dawn Sung and Pumariega will

present three case studies (two of them personal developmental examples and one an actual treatment case). Workshop participants will be encouraged to apply these concepts and share other clinical considerations. Participants will also be asked to discuss their own clinical experiences and ask questions from the panel.

WORKSHOP 45

WHAT ARE PEOPLE SAYING ABOUT YOU ONLINE? YOUR E-REPUTATION AND WHAT YOU CAN DO ABOUT IT

Speakers: Paul S. Appelbaum, M.D., John Luo, M.D., Robert C. Hsiung, M.D.

Chair: Robert C. Hsiung, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define "e-reputation";2) Give examples of online information that would enhance and detract from one's e-reputation;3) Describe ways to manage one's e-reputation;

SUMMARY:

Your e-reputation reflects your e-professionalism and affects the vitality of your practice. Prospective patients don't just ask others for referrals; Google empowers them to find their own psychiatrists. What are people saying about you online? Is that what you want prospective patients -- and colleagues -- to see? In this workshop, we define "e-reputation" and "e-professionalism" and explore, with illustrative vignettes, the myriad complications presented by the Internet in general and social media in particular. In small groups, participants have the opportunity to receive feedback on their own e-reputations. Group members who volunteer are Googled by other members of their groups. Each group presents its findings and recommendations to the workshop as a whole. We conclude by discussing ways to manage one's e-reputation. APA will provide wireless Internet access for this workshop. Participants should bring a laptop or at least a smartphone to participate fully. Being Googled in the small groups is entirely voluntary. Participants cannot, however, prevent prospective patients from Googling them, and this workshop is designed to prepare them for that eventuality.

WORKSHOP 46**CHOOSING MEDICATIONS FOR PATIENTS WITH OPIOID DEPENDENCE, WHO GETS WHAT AND WHY: A CASE-BASED WORKSHOP**

Speakers: John J. Mariani, M.D., Timothy W. Fong, M.D., Eric D. Collins, M.D.

Chairs: Margaret Haglund, M.D., Meredith Kelly, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify available options for maintenance treatment in opioid dependence; 2) Understand aspects of the clinical assessment that guide treatment selection; 3) Recognize the barriers to pharmacotherapy, despite the strong evidence-base to support their use; 4) Develop an approach to the management of opioid dependence in patients who also have chronic pain;

SUMMARY:

Opioid dependence is a significant public health problem in the United States, with increasing prevalence and associated morbidity and mortality. In 2008 there were approximately 213,000 current (past-month) heroin users in the United States, representing an increase of 60,000 users from the previous year, while the point prevalence estimate in 2005 for Americans with opioid analgesic abuse or dependence was a staggering 1.5 million. The Center for Disease Control reports a marked increase in unintentional drug overdose death rates in recent years, largely driven by deaths involving opioid analgesics. Patients with opioid dependence routinely present in a general psychiatry setting, yet many psychiatrists have minimal training or experience in this area. As a result, many patients receive short-term abstinence-based psychotherapy treatments following detoxification. Meanwhile, opioid dependence is associated with high risk for relapse if treatment is not ongoing. Despite the evidence supporting the use of medications in recovery, there remain significant barriers to their use, including practitioner discomfort, fear of precipitating overdose, concern for diversion, and logistical impediments. We will address these barriers as well as the question of whether individuals on maintenance agonist therapy may be considered “abstinent”, allowing participation in organizations such as Narcotics Anonymous. Our workshop will help inform the general psychiatrist of existing medication based treatments of opioid dependence. We will also address the special case of treatment of opioid dependent patients with co-occurring chronic pain syndromes. National Institute on Drug Abuse website, [HTTP://WWW.DRUGABUSE.GOV/PUBLICATIONS/DRUGFACTS/HEROIN](http://www.drugabuse.gov/publications/drugfacts/heroin)

L.A. Ghandour,¹ S.S. Martins,¹ and H.D. Chilcoat. Understanding the patterns and distribution of opioid analgesic dependence symptoms using a latent empirical approach *Int J Methods Psychiatr Res.* 2008; 17(2): 89–103.

Leonard Paulozzi, MD, et al. CDC Grand Rounds: Prescription Drug Overdoses - a U.S. Epidemic. *Morbidity and Mortality Weekly Report.* 2012; 61(01);10-13. Sigmon SC, Bisaga A, Nunes EV, O'Connor PG, Kosten T, Woody G. Opioid detoxification and naltrexone induction strategies: recommendations for clinical practice. *Am J Drug Alcohol Abuse.* 2012;38(3):187-99. Epub 2012 Mar 12. Bart, G. Maintenance medication for opiate addiction: the foundation of recovery. *J Addict Dis.* 2012; 31(3): 207-225.

Sigmon SC, Bisaga A, Nunes EV, O'Connor PG, Kosten T, Woody G. Opioid detoxification and naltrexone induction strategies: recommendations for clinical practice. *Am J Drug Alcohol Abuse.* 2012;38(3):187-99. Epub 2012 Mar 12.

WORKSHOP 48**WHEN THE PURSUIT OF WELLNESS IN ONE DOMAIN LEADS TO DISABILITY IN ANOTHER DOMAIN: IMPLICATIONS OF EVIDENCE FOR HEALTH CARE AND HEALTH POLICY**

Speakers: Barbara Collins, Ph.D., Farooq Mohyuddin, M.D., Sharon A. West, M.D.

Chairs: Sheila Hafter-Gray, M.D., Paul Wick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Critically review the evidence regarding the effects of somatic therapies, such as adjuvant chemotherapy for cancer, on cognition; 2) Take the multi-factorial nature of so-called “chemo fog” into account when assessing the mental state of cancer patients; and apply similar considerations when evaluating outcomes of other treatments; 3) Regularly balance the possible improvement in one domain of functioning against potential disability in another domain when developing treatment plans; and inform patients of these considerations; 4) Help patients weigh the relative risks and benefits of a specific treatment to their overall wellbeing; 5) Apply the practical and ethical implications of these findings to health care and health policy;

SUMMARY:

Clinicians are aware that effective somatic treatments for physical and mental disorders may be associated with significant disability in another domain of functioning, leading to an overall diminution in the quality of life. Deterioration of mental or physical status following cancer chemotherapy, anesthesia and long term psycho-pharmacology are often attributed to the treatment triggering a patient-specific vulnerability, not to the agent itself. New research by Barbara Collins and colleagues (Cognitive effects of chemotherapy in breast cancer patients: a dose–response study. *Psycho-Oncology*: Online publication 30 August 2012.) demonstrates a clear dose-response relationship between chemotherapy for breast cancer and cognitive decline. There is a growing body of evidence for similar effects on physical or mental well-being by general anesthesia and medication for psychiatric disorders. These

findings require us to reevaluate the way we view somatic treatments and discuss them with patients. How may we help an individual choose between the benefit of an elective surgical operation and the very real risk of diminished working memory? Is living a year longer in a 'chemo fog' better or worse than a year less in full possession of one's cognitive skills? What is the implication for the treatment alliance when a prescribed medicine alleviates depression but causes anomia? Does the focus on the most rapid relief of symptoms with the least expenditure of clinician time – supported in part by the economics of contemporary health care – limit our implementing safer psychosocial interventions? Participants will be asked to consider the ethical and practical implications of these findings for health care and health care policy, including the funding of future research.

WORKSHOP 49

SUPPORTING HEALTHY TRANSITIONS FROM ADOLESCENCE TO ADULTHOOD IN SPECIAL POPULATIONS

Speakers: Cynthia Moran, M.A., M.D., Patrick Tyler, M.A., Niranjan Karnik, M.D., Ph.D., Pilar Bernal, M.D.

Chairs: Cynthia Moran, M.A., M.D., Tara Chandrasekhar, B.Sc., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the common and unique needs of youth from special populations in transitioning from adolescence to adulthood; 2) Recognize the challenges youth in foster care face as they transition from care and into adulthood, and factors that can assist with healthy transition; 3) Understand the unique factors influencing risk behaviors and service needs among homeless youth transitioning to adulthood; 4) Identify some of the unique challenges youth with autism and their families face as they transition from adolescence to adulthood;

SUMMARY:

"Emerging adulthood" is a time of increased independence and responsibility, and exploration of romantic relationships, careers, and identity. It is also the average age of onset for many psychiatric disorders, and a time when youth with mental illness are forced to leave the children's mental health system and find their way into the adult system. Youth in the foster care system, homeless youth, and youth with autism face the challenges typical to all youth who are transitioning to adulthood, as well as some unique challenges that this workshop seeks to explore. Dr. Cynthia Moran, along with co-chairs Dr. Nicole Kozloff and Dr. Tiona Praylow, will provide an overview of the transition from adolescence to adulthood and its implications on functioning and use of mental health services and other resources. Mr. Patrick Tyler will draw on his experience as Clinical Director of Boys Town, a village dedicated to the care, treatment, and education of at-risk children

in Nebraska, to present some of the challenges youth face as they concurrently age out of the foster care system and transition from adolescence to adulthood. He will also present findings from a 16-year follow-up study and preliminary findings from a randomized-controlled trial studying youth reintegration. Dr. Niranjan Karnik will present results from his ongoing research with homeless youth in Chicago that examines the effects of various chronological factors (total time homeless, number of episodes of homelessness, and age at first homeless episode) as well as contextual factors (family history, educational experience) on risk behaviors and substance use patterns. He will also discuss new interventions and strategies for addressing the needs of homeless youth, including the use of mobile technologies as a method for reaching out to vulnerable and hidden populations. Dr. Pilar Bernal will discuss experiences from her practice working with children and adolescents with autism and their families and helping them transition to adulthood. Using these special populations as examples, the co-chairs and presenters will facilitate a discussion with the audience on vulnerabilities and strengths of youth as they transition from adolescence and adulthood, and how mental health practitioners and the health care system can support this process.

WORKSHOP 50

RESPONDING TO THE IMPACT OF SUICIDE ON CLINICIANS

Speaker: Jane G. Tillman, Ph.D.

Chair: Eric Plakun, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Enumerate clinician responses to patient suicide; 2) List practical recommendations for responding to patient suicide from the personal, collegial, clinical, educational, administrative and medico-legal perspectives; 3) Design a curriculum to educate and support trainees around their unique vulnerabilities to the experience of patient suicide; 4) List recommendations for responding to the family of a patient who suicides;

SUMMARY:

It has been said that there are two kinds of psychiatrists—those who have had a patient commit suicide and those who will. 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 anticipates and avoids professional isolation and disillusionment, maximizes learning, addresses the needs of bereaved family, and may reduce the risk of litigation. The workshop will include ample time for interactive discussion with participants about their own experiences with patient suicide.

WORKSHOP 52

WRITING FOR THE LAY PUBLIC: A JOURNALIST SHARES POINTERS AND PITFALLS FOR PSYCHIATRISTS IN PRACTICE TRAINING

Speakers: Stephen Fried, B.A., David J. Hellerstein, M.D.

Chair: Stephen Fried, B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the importance of psychiatrists and other mental health professionals writing well, responsibly and engagingly for the lay public; 2) Identify potential pitfalls in translating scientific studies and clinical practice observations for lay public; 3) Understand the writing and research demands for several different standard types of articles for the lay public;

SUMMARY:

More than ever, psychiatrists want to be able to write well and powerfully for both a professional and lay audience. While mental health professionals are taught to be excellent one-on-one communicators, they are not taught how to communicate with the broader public. In this age where information is so readily accessible from both credible and non-credible sources, it is increasingly important that trained professionals have their voices heard in the media, and learn how to do so in responsible accurate and engagingly readable fashion. It is also important that they learn how to read and digest lay media coverage of mental health related issues in a new more informed way.

In 2010, Stephen Fried, a well-known magazine writer and author with a specialty in mental health and adjunct professor at Columbia University Graduate School of Journalism, was asked by APA President-elect Dr. Jeffrey Lieberman to mentor a fourth-year Columbia Psychiatry resident who wanted to learn to write for the lay public, and better understand lay media coverage of mental health. He was also asked to develop a Grand Rounds on the subject and a curriculum that could be used by other trainees and faculty.

This workshop is an outgrowth of those projects, as well as his years of covering mental health care and doing private

editorial consulting work with mental health professionals. The session will include a lecture and power point, remarks from Fried's former trainee at Columbia Psychiatry, Dr. Serina Deen, and his faculty colleague, Dr. David Hellerman, and then a practical exercise for all audience members, who will be broken up into groups and brainstorm story ideas for lay publications, which will then be discussed in group setting.

WORKSHOP 53

DIFFERENTIAL DIAGNOSIS IN DEMENTIA AND WHAT'S NEW IN DSM-5

Speaker: Rita Hargrave, M.D.

Chairs: Maria Llorente, M.D., Mohit P. Chopra, M.B.B.S., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the more common causes of dementia among older adults; 2) Complete a medical work up for dementia, including indications for neuropsychological testing; 3) Identify upcoming diagnostic classification changes in DSM V relative to the dementias; 4) Diagnose etiology of dementia based on case histories;

SUMMARY:

The population of the United States is aging and with adults aged 65 and older expected to grow to 72 million by 2030. A recent meta-analysis indicated that the incidence of dementia rises exponentially to age 90, such that by 2050, 100 million people will be affected worldwide. At this same time of pending growth in demand for evaluation and management recommendations, the geriatric workforce is in very short supply. As a result, these patients will likely be seen in general psychiatrist offices. This workshop will review the presentation and etiology of dementia and provide the generalist psychiatrist with a review of the medical work up to clarify the diagnostic etiology. The workshop will additionally provide an update on the new diagnostic nomenclature for cognitive disorders in the DSM-V. An update on future trends in diagnostic work ups will also be offered and will include promising biomarkers, and functional neuroimaging, as well as recent updates on the genetics of the dementias, including Alzheimer's disease, Diffuse Lewy Body Dementia, Huntington's Disease and Parkinson's Disease. Lastly, this workshop will include an interactive component in which actual cases will be provided to participants who will then be asked to provide the diagnosis.

WORKSHOP 54**PRESCRIPTION BRAIN FOOD: FROM BENCH TO TABLE**

Speakers: Roger S. McIntyre, M.D., Mala Nimalasuriya, M.S., Emily Deans, M.D.

Chairs: Drew Ramsey, M.D., Philip R. Muskin, M.A., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review the recent evidence connecting food choices to brain health. Understand the clinical implications of nutritional epidemiological studies regarding dietary patterns and psychopathology;2) Learn the proposed molecular pathways involving inflammation and neurogenesis that relate to nutrition;3) Recognize high-yield clinical encounters that merit dietary intervention. Appreciate recent trends in dietary patterns and the potential psychiatric implications of consuming a "Western" diet;

SUMMARY:

A growing national interest in food and nutrition provides psychiatrists with clinical opportunity. Mood and dietary patterns are increasingly linked in epidemiological studies and clinical experience. But what is the evidence that connects our forks to our feelings? And what are the proposed underlying mechanisms of mealtime choices in regards to brain health?

This workshop updates clinicians on recent evidence connecting dietary patterns with psychiatric pathology along with proposed underlying pathways and clinical applications. As food choices affect states of inflammation and neurogenesis, the proposed molecular pathways involving brain derived neurotrophic factor (BDNF), omega-3 fats, flavonoid phytonutrients, B-vitamins/methylation, and traditional diets will be presented. Implications for psychiatrists of new dietary trends such as paleo, vegan, and raw diets will be reviewed. Participants will take a trip from bench to table and gain knowledge of high yield clinical encounters, specific recommendations for psychiatric patients, and clinical pearls providing clinicians with additional (and delicious) tools to aid patients.

WORKSHOP 55**TREATING CANNABIS USERS WITH MOOD DISORDERS: AN OPEN DISCUSSION**

Speakers: Amanda Reiman, Ph.D., John J. Mariani, M.D.

Chairs: Zimri Yaseen, M.D., Igor Galynker, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe approaches to prioritizing treatment ob-

jectives for cannabis users with mood disorders;2) Describe approaches to managing cannabis use and stopping cannabis abuse;3) Recognize cases where cannabis use may be harmless or even beneficial for the patient's overall mental health;4) Understand potential implications of medical marijuana laws on practice in treating mood disordered patients with comorbid marijuana use;

SUMMARY:

Marijuana use has been linked to increased morbidity in psychotic disorders, however its effects in mood disorders remain poorly understood. To date a single published study (Jones, et al., Clin. Psychol. Psychother. 18, 426–437 (2011)) has examined a combined CBT and motivational interviewing approach to treating bipolar patients with comorbid cannabis use, reporting on a series of three cases. In this workshop we present a series of brief case reports and preliminary psychometric and outcome data based on our experience in Beth Israel's CUBSS and Columbia's STARS programs treating mood disordered cannabis users using a similar agnostic motivational interviewing informed framework. Cases will cover a spectrum ranging from marijuana use as a biological cause, psychosocial causal factor in, symptom of, and treatment of mood disorder. Psychometric and outcome data report on a series of 20 subjects, presenting rates of comorbid personality disorders measured by MCMI (>80%), levels of marijuana use based on clinical interview, and relationships between level of marijuana use and change in level of marijuana use and treatment outcome, measured by the global assessment of function, and level of perceived marijuana associated problems as measured by the cannabis problems questionnaire ($r=-0.68$, $p<0.001$ for MJ at intake vs. level of perceived problems with MJ).A brief discussion on the psychopharmacology of cannabinoids and treatment approaches will follow. Finally, we will discuss the policy landscape for medical marijuana and the role of psychiatrists in shaping medical marijuana policies and programs, followed by an anonymous interactive poll of workshop participants on their experiences with cannabis use in mood disorder patients with live presentation of poll results as a seed for an active audience participatory discussion.

WORKSHOP 56**DEVELOPING A CAREER IN CHILD AND ADOLESCENT PSYCHIATRY**

Speakers: William Arroyo, M.D., Eric R. Williams, M.D., Marcy Forgey, M.D., M.P.H., Ledro Justice, M.D.

Chair: Ara Anspikian, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the nature and extent of the shortage and need for child psychiatrists;2) Identify the different career paths and opportunities available to a child psychiatrist;3) Identify challenges and opportunities within the field of child psychiatry;4) Be familiar with the general aspects of a career

in private practice, community leadership, advocacy, fellowship and academia for a child psychiatrist;

SUMMARY:

A career in child and adolescent psychiatry presents as a very rewarding endeavor, especially considering the wide array of career trajectories starting from fellowship training and spanning academic settings, private practice, community leadership, advocacy and a variety of consultative and collaborative roles. The literature demonstrates a continuing and significant shortage of Child and Adolescent Psychiatrists, a wide breadth and depth of career paths and high ratings of career satisfaction compared to other medical specialties. A recent physician satisfaction survey indicates that child psychiatry finds itself in the top ten in regards to overall satisfaction from a total of 42 specialties surveyed. Despite high satisfaction rates the shortages in child psychiatrists especially in certain states is staggering. Ranging from 3.1 child and adolescent psychiatrists per 100,000 youth for Alaska up to 21.3 for Massachusetts. The United States as a whole was noted to have 8.67 child psychiatrists per 100,00 in 2001 as compared to 6.73 in 1990. This workshop is geared for medical students, general psychiatry residents, child psychiatry fellows and early career child psychiatrist who have an interest in child psychiatry training and career opportunities. The purpose of the workshop is to outline the types and benefits of training in child psychiatry and opportunities within the field. This talk will also describe what the range of available careers are in child psychiatry, including discussions of careers in academia, the community, government, leadership and private practice. The workshop aims to provide an interactive avenue to bring together leaders from the field of child psychiatry with those interested child psychiatry as a career and to discuss issues of relevance in regards to developing and pursuing a career in child psychiatry. After brief presentations by the speakers, the workshop will proceed to a small group and interactive format. If you have any interest in child psychiatry come join us for more information, new ideas, answers to questions and an opportunity for discussion, mentoring and networking.

WORKSHOP 51

HOW TO USE FEDERAL DISABILITY LAW TO HELP CLIENTS WITH PROBLEMS AT WORK

Chair: Aaron Konopasky, J.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Determine whether a client has legal rights under the Americans with Disabilities Act because of a mental disorder; 2) Recognize when a client is able to use federal disability discrimination law to address problems at work, such as absenteeism, decreased performance, impaired social functioning, harassment, and bias; 3) Perform assessments that establish whether a client is legally entitled to a change at work, such as an altered schedule or permission to telework, that is needed because of a psychiatric condition; 4) Understand the risks and benefits to clients of asserting the right to

a reasonable accommodation on the basis of a mood, anxiety, personality, or other mental disorder; 5) Understand the confidentiality requirements of the ADA, and how information about a client may and may not be used by employers;

SUMMARY:

The Americans with Disabilities Act (ADA) prohibits employment discrimination against individuals with disabilities, and provides them the right to a reasonable accommodation at work. Many people with common mental disorders qualify for these rights and protections; major depressive disorder, bipolar disorder, PTSD, OCD, and schizophrenia should all easily be found to be disabilities, and many other conditions may qualify as well. The presenter will provide an overview of the ADA, and explain how clinicians may help to protect the rights it provides. A reasonable accommodation is a change in the way things are normally done at work that the individual needs because of a physical or mental impairment. For example, someone who has experienced panic attacks at work might be entitled to telework as a reasonable accommodation, and someone who has had difficulty concentrating due to depression may be entitled to receive instructions in writing or other changes in supervisory methods. Without a reasonable accommodation in place, these same individuals could be subject to discipline or even termination for absenteeism or inadequate performance. A clinician may help a client obtain needed accommodations by performing an assessment of his or her functional limitations, which will be used to establish that she has a right to a reasonable accommodation. The presenter will explain what a clinician needs to know to perform an adequate assessment, and what the clinician should and should not disclose in a report. Clinicians may also help clients to decide which reasonable accommodations to request or accept. Common accommodations include altered work schedules for therapy appointments, time off for treatment, changes in supervisory methods, telework, and reassignment to a vacant position. These are just examples; employees are free to request other modifications or changes. However, requestors should know that employers are not required to provide accommodations that lower production standards, fundamentally alter the nature of the job, or cause significant difficulty or expense. As with any release of medical information, a request for reasonable accommodation may sometimes have unintended negative consequences. To help clinicians evaluate these risks, the presenter will review the ADA's confidentiality rules, its prohibitions on harassment and disability discrimination, the EEOC's role in protecting individuals who make ADA claims, and the potential relevance of substance abuse. The presenter will also discuss the risks and possible legal consequences of failing to request a reasonable accommodation before a related performance or conduct problem occurs.

MAY 20, 2013

WORKSHOP 57

MEFLOQUINE NEUROTOXICITY PLAUSIBLY CONTRIBUTES TO THE BURDEN OF PTSD, TBI, SUICIDE, AND VIOLENCE WITHIN THE U.S. MILITARY*Speaker: Remington L. Nevin, M.D., M.P.H.**Chair: Elspeth C. Ritchie, M.D., M.P.H.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Describe the clinical presentation of mefloquine intoxication and neurotoxicity.;2) Recognize how mefloquine neurotoxicity may confound the diagnosis and management of PTSD and TBI .;3) Understand the epidemiology of mefloquine exposure within the U.S. military.;

SUMMARY:

The antimalarial drug mefloquine developed by the U.S. military nearly 40 years ago has been used widely for the prophylaxis and treatment of malaria despite a known risk of serious neuropsychiatric side effects that include acute psychosis and chronic vertigo. Subsequent experimental findings and clinical insights and have characterized mefloquine as a potent neurotoxicant. Acute neuropsychiatric side effects attributable to mefloquine may now be best understood as an idiosyncratic intoxication syndrome of limbic encephalopathy, while subacute and chronic side effects are consistent with a multifocal brain and brainstem neurotoxic injury. According to the Centers for Disease Control and Prevention, the neuropsychiatric side effects of mefloquine may confound the diagnosis and management of PTSD and TBI. Mefloquine potently disrupts electrical synaptic transmission within the amygdala, hippocampus, and other limbic structures, and also plausibly disrupts gap junction communication within the supporting glial network, potentially contributing to apoptosis. Recent case series and case report evidence also link mefloquine intoxication to impulsive suicide and acts of violence. In this lecture, the neurotoxicity of mefloquine is reviewed, and the putative biological mechanisms linking mefloquine to the pathogenesis of PTSD, TBI, suicidality and violence are reviewed. The epidemiology of mefloquine exposure within the U.S. military is presented, and the relevance of these insights to the management of neuropsychiatric disorders within military populations are discussed.

WORKSHOP 58

“CRISIS JUNKIES”: STEREOTYPES AFFECTING THE TREATMENT OF PATIENTS WITH BORDERLINE PERSONALITY DISORDER*Chair: John Maher, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Appreciate how negative stereotypes and transference issues affect the care of patients with Borderline Personality Disorder.;2) Develop a deeper understanding of the subjective illness experience of persons living with Borderline Personality Disorder.;3) Share with colleagues an appreciation and understanding of how negative medical cultures produce harmful outcomes for patients with Borderline Personality Disorder.;

SUMMARY:

Denigrating labels create or reinforce a negative clinical culture bias and hurt people with BPD. As a result, the core pathology of BPD illness may be misunderstood or downplayed. The prejudice and myths become reinforced by clinical responses that set a patient up for failure through ignorance, insensitivity, or overt provocation. Proper treatment or referral may not happen, unnecessary suffering perdures, and some patients die. By understanding the illness better we may respond with greater kindness, respect and empathy, we may teach others wisely, and we may work to correct the wounding stereotypes that are carelessly or intentionally perpetuated.

WORKSHOP 59

FEELING BURNOUT? THERE'S AN APP FOR THAT!*Chair: Sermsak Lolak, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Recognize the issues and impact of imbalanced work-life, burnout, compassion fatigue and ways to improve it.;2) Understand the concepts and techniques of mindfulness and compassion cultivation practices and how these practices can help with above issues.;3) Identify and be familiar with technological resources, especially mobile device applications, to improve work-life balance.;4) Apply the knowledge and skills from this workshop into real life both in and outside of work;

SUMMARY:

Physician wellness, work-life balance, and burnout are among the top challenges affecting quality of life of the physician, regardless of level of training or practice setting. These issues are now more important than ever given growing distractions,

responsibilities, and demands both from professional and family areas. Up to one-third of physicians are affected by burnout, which has negative impacts on health, well-being, job satisfaction, productivity, in addition to patient care. This interactive workshop will explore practical tools and tips to help decrease burnout and improve work-life balance with the emphasis on scientifically-proven contemplative practices such as mindfulness and compassion cultivation techniques adapted from Buddhist traditions, although can be used regardless of practitioners' religious orientation. The first part of the workshop will offer a summary of the literature regarding issues of burnout and work-life balance, as well as possible interventions especially on the area of contemplative practices. During the second part of workshop, we will focus on practical solutions to the problem, with the emphasis on utilizing contemplative practices in a secular context. There will be an experiential component of guided meditation using mindfulness and compassion cultivation techniques, followed by suggestions of adapting these concepts and practices to everyday life. The last part of this workshop will be an interactive discussion and sharing. Participants are encouraged to share personal tips, practices, including using smart phone technology or "applications" to help improve their work-life balance and to decrease feeling burnout. This workshop is open to participants from all health-related disciplines, regardless of their level of training. Speakers Dr. Lolak is a Clinical Associate Professor of Psychiatry at Stanford University. He is currently a Rathmann Family Foundation faculty fellow in Medical Education and Patient-Centered Care at Stanford University School of Medicine. He is interested in the subject of work-life balance, physician burnout, and contemplative practices. Dr. Lolak participates in the teacher training program at Stanford Center of Compassion and Altruism Research and Education. Growing up in Thailand, he has been practicing mindfulness meditation from Theravada Buddhist tradition. References : 1.Thomas NK. Resident burnout. *Jama* Dec 2004;292(23):2880-2889. 2. Shanafelt TD et al. Career fit and burnout among academic faculty. *Arch Intern Med.* May 25 2009;169(10):990-995. 3. Huggard P. Compassion fatigue: how much can I give ? *Medical Education* 2003 ;37: 163-164 4. Krasner MS et al. Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *Jama.* Sep 23 2009;302(12):1284-1293. 5. Jazaieri H, Jinpa GT, McGonigal K, et al. A Randomized Controlled Trial of a ComCompassion Cultivation Training Program. *J Happ Study* 201

WORKSHOP 60

CONFLICT REVISITED: PSYCHOTHERAPY JOINS NEUROSCIENCE

Speakers: Regina Pally, M.D., Barton J. Blinder, M.D.

Chair: Andrei Novac, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand conflict in terms of a neuro-scientific framework of defense mechanisms;2) Model a new, scientific mode of discussing conflict in the practice of psychotherapy;3) Discuss the role of metacognition and mindfulness in addressing conflict in psychotherapy;

SUMMARY:

Over the past decade, the study of psychotherapy and psychoanalysis has incorporated neuroscientific findings. However, the study of psychological conflict and defense mechanisms and their neurological relationship to specific clinical manifestations has been less emphasized. There is a significant emergent literature on a variety of aspects of memory, including consolidation (Alberini, 2010), reconsolidation (Nader, et al., 2004), traumatic memories (Pitman, et al., 2001; Hull, 2002), associative memories (Park, et al., 2012), autobiographical memory testing (van Vreeswijk & de Wilde, 2004), and the transformation of experience into memories (Suthana & Fried, 2012). Yet, little is covered in the current neuroscience literature on consolidation of memories related to psychological conflict. Conflict memories are reluctant to change. Clinically, they seem to be governed by a specific gradient of consolidation, possibly linked to a mechanism of defensive mood regulation. The presenters, experienced psychiatrists and psychoanalysts, who are students of psychological trauma, will examine a variety of candidate mechanisms in which antagonistic mental states are consolidated early in life and constitute a baseline model for different aspects of the autobiographical self. A review of pertinent information regarding autobiographical memory and its relations to the formation of episodic and implicit memories will be presented. The presentations will include an updated expansion on conflict as it relates to the autobiographical self, attachment, uploaded narratives, language integration, and the concept of shared circuits as one adaptive mechanism of interpersonal healing activated during psychotherapy (Blinder, 2004; Hesse, et al., 2003; Novac, 2012; Pally, 2010). In addition, reference to a proposed ventral and a dorsal neural system of emotional regulation (Viamontes & Beitman, 2006) will be discussed. The authors will present an integration of current data into a comprehensive model of early encoding of psychological conflict and proposed mechanisms of decoding and processing of such conflict during long term dynamic psychotherapy. Promotion of change in psychotherapy and its reworking of personal narratives into a new autobiographical self will be emphasized. Clinical vignettes will be included to support some of the proposed concepts.

WORKSHOP 61

COMPREHENSIVE TREATMENT OF GERIATRIC DEPRESSION

Speakers: Craig Nelson, M.D., Alice X. Huang, M.D., M.S.

Chairs: Craig Nelson, M.D., Uyen-Khanh Quang-Dang, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Cite the evidence for antidepressant efficacy in depressed older adults;2) Recognize predictors of response

and non-response to antidepressants in depressed older adults;3) Describe the evidence for the efficacy of psychotherapy in depressed older adults;4) Identify types of psychotherapy that are effective in depressed older adults;5) Make informed choices about appropriate treatment in depressed older adults;

SUMMARY:

Antidepressants are often used in the treatment of older adults with MDD, yet a meta-analysis of 10 controlled trials of antidepressants (Nelson et al 2008) revealed drug effects were modest (NNT = 11). Thus, patient characteristics have been examined to find predictors of drug response. Open label studies in mixed-age patients found anxious patients less likely to respond, thus we performed a trial level meta-analysis of response in anxious and non-anxious older depressed patients from 8 placebo controlled studies of antidepressants (Nelson et al 2009). Early studies found differing results of outcome for antidepressants in depressed elders with dementia, thus we performed a meta-analysis of 7 antidepressant trials in older depressed patients with concurrent dementia (Nelson and Devanand 2011). Sneed and colleagues (2010), in a retrospective analysis of an outpatient study of citalopram in patients over 75 years of age, examined outcome in patients with executive dysfunction. Recently we performed an individual patient-level meta-analysis of data from the 10 placebo-controlled conducted in outpatients \geq 60 years of age. Potential moderators of response including age, age of onset, sex, course (single episode vs. recurrent) and baseline depression severity were examined. Moderators of response were identified. In this presentation results of the previous studies and results of the recent meta-analysis will be presented.

Psychotherapy is an effective treatment in older adults with depression (Mackin and Arean 2005). Limitations of the prior reviews include inclusion of non-MDD depression and variable control conditions including wait list or no treatment controls. Few trials controlled for the non-specific supportive effects of frequent visits that occur in psychotherapy and in the conduct of drug trials. The current review and meta-analysis update previous reviews and focus on differences in the control groups used. A search of Medline, Psycinfo, and the Cochrane Clinical Trials Database was conducted through May 2012. Trial selection was limited to trials 1) with subjects 60 years or older, 2) with depression, 3) that randomized subjects to a control condition, and 4) that monitored depression severity throughout the trial using an objective scale. Meta-analysis was performed to determine standardized mean differences for change scores and risk ratios for response and remission rates if reported. The search found 2706 reports after duplicates removed. Results of the meta-analysis will be presented. Sensitivity analyses will include examination of differences in outcome between all depression trials and the MDD only trials and possible effects of baseline depression severity on outcome. The analysis will tell us which depression-focused psychotherapies are evidence-based.

WORKSHOP 62

ETHICAL ISSUES IN GERIATRIC PSYCHIATRY

Speakers: Philip Whang, Deena Williamson, M.B.A., M.S.N.

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define the four ethical principles in healthcare;2) Describe the decisional capacity in older adults with psychiatric illness;3) Discuss surrogate decision making in older adults with psychiatric illness;4) Enumerate end of life care in older adults with psychiatric illness;5) Highlight legal issues in the care of older adults with psychiatric illness;

SUMMARY:

As the population of the United States ages, the number of older adults with psychiatric illness is bound to grow. Ethical issues and conflicts are often seen in the care of these older individuals. Major ethical issues include the maintenance of autonomy while ensuring the safety of the individual and those others around them. Family dynamics further complicate the care needs of these individuals. In this workshop we will discuss two cases that highlight common ethical issues seen in the care of older adults with psychiatric illness. We will also review various ethical issues seen during the care of these individuals. We will conclude the workshop with an overview of important legal aspects of caring for older adults with psychiatric illness.

WORKSHOP 63

PSYCHOTHERAPY OF THE MEDICALLY ILL: OVERLAPPING DYNAMIC, CBT, AND INTERPERSONAL APPROACHES

Speakers: James J. Strain, M.D., Stuart J. Eisendrath, M.D., Audrey Walker, B.A., M.D., Harold Bronheim, M.D.

Chair: Harold Bronheim, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the rationales, application, and comparative benefits of Dynamic, CBT, & IPT approaches in the treatment of patients with a variety of psychopathology;2) Understand the depth to the complexity of psychological management of comorbidities; mental & physical in the acute and chronic medically ill;3) Discuss the benefits of the use of particular psychotherapy vs. an alternative approach, or/and an amalgam of approaches at different stages of the psychotherapeutic endeavor;

SUMMARY:

Patients with medical illness clinically benefit from psychotherapeutic intervention in settings where psychopharmacology may be quite limited. During acute exacerbation and hospitalization the ability to recognize psychological distress, regressed behaviors and defensive structures is necessary to facilitate adherence to complex and critical medical interventions. Patients with chronic illness often become depressed and manifest distorted cognitive ideations which surface with surprising regularity. Interpersonal relations are commonly altered with a loss of normal role function and abnormal social withdrawal which impacts recovery. This workshop will discuss the relevant Psychodynamic stressors and defenses encountered in the medical setting and Dynamic treatment; Cognitive Behavioral Therapy (CBT) approach to depression in chronic illness and the critical role of Interpersonal Psychotherapy (IPT) in the psychotherapy of adolescents. Although conceived as separate therapeutic paradigms the needs of the medically ill require all psychiatrists to be familiar with all three approaches in an overlapping melody of psychotherapy intervention as they become manifest at different stages of psychotherapy.

WORKSHOP 64**CHECKLISTS, TOOLKITS, AND EVIDENCE-BASED POLICY: NEW YORK OFFICE OF MENTAL HEALTH STRATEGUES TO IMPROVE EVIDENCE-BASED ANTIPSYCHOTIC PRESCRIBING**

Speakers: Gregory Miller, M.B.A., M.D., Thomas Stroup, M.D., M.P.H., Enrico Castillo, M.D., Cassis Henry, M.A., M.D., Jay Carruthers, M.D.

Chairs: Matthew D. Erlich, M.D., Sharat Parameswaran, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the impetus for the New York State Office of Mental Health's antipsychotic prescribing best practice initiatives, including the SHAPEMEDs checklist and the Clozapine Campaign; 2) Assess how a checklist can be implemented in a statewide public mental health care system and its use to generate a clinical database specific to antipsychotic medication prescribing; 3) Describe the processes that can be used by a public mental health care system to assist and increase the prescribing of clozapine; 4) Evaluate the data generated by a prescribing checklist, including how it can develop and inform policy to improve current prescribing practices;

SUMMARY:

Prescribing antipsychotic medications for the treatment of persons with severe mental illness is a highly challenging and complex practice. Clinicians and consumers need to weigh the benefits of these medications against multiple risks and potential side effects with the primary goal of realizing recovery and wellness.

Assisting clinicians in their efforts to guide shared decision-making with consumers is a priority of the New York State Office of Mental Health. Using a public-academic partnership, the Office of Mental Health continues to improve statewide clinical best practices initiatives for providers prescribing antipsychotic medications. These include an electronic checklist, SHAPEMEDs, to foster evidence-based prescribing practices and encourage shared decision-making; monitoring of physical health indicators to prevent and lower mortality from concurrent physical illness; and a new outreach to promote recovery with the increased utilization of clozapine for eligible consumers. Success of these evidence based policies rely upon a systematized dissemination and continuous quality improvement process, including learning collaborative sessions, tool-kits, clinical web-based modules, and other evidence-based implementation strategies. Likewise, the lessons learned from one initiative can be the impetus for development of additional best practices. The SHAPEMEDs electronic checklist has generated a unique clinical database capable of characterizing antipsychotic prescribing practices in a public mental health system, including antipsychotic prescribing patterns, polypharmacy, and use of high metabolic risk antipsychotic medications. Data from this checklist was presented to OMH policymakers and has led to a new statewide policy and implementation strategy to improve prescribing of clozapine. The Best Practice Initiative on Clozapine Task Force was launched in 2012 to increase clozapine utilization statewide via training manuals, videos, community engagement, and provider consultation support. This workshop will seek to stimulate discussion about the use of electronic checklists and web-based decision making tools in behavioral health care, including implementation of checklists and databases in public mental health systems. The workshop will also include discussion of some of the policy implications of having a generated data set, including its potential to inform the process of quality improvement initiatives (as SHAPEMEDs did not necessarily inform the content of the clozapine initiative, but it informs the initiative's monitoring). It also will seek to examine implementation strategies that can be used to impact antipsychotic prescribing on a statewide level.

WORKSHOP 65**CROSS-CULTURAL COMMON DENOMINATORS: RESILIENCY IN TRAUMATIZED CHILDREN AND ADOLESCENTS**

Speakers: Myron L. Belfer, M.D., M.P.A., David Henderson, M.D., Mardoche Sidor, M.D., Christina T. Khan, M.D., Ph.D.

Chairs: Gabrielle L. Shapiro, M.D., Mardoche Sidor, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the different types of trauma and how each is viewed cross-culturally; 2) Explore the effects of world disaster and other forms of trauma on children and adoles-

cents from a cross-cultural perspective;3) Identify child and adolescent resiliency factors across cultures, including commonalities and differences;4) Identify means to adopt resiliency factors cross culturally, including challenges, implementation and rewards;5) Identify areas for further research and exploration;

SUMMARY:

According to the Centers for Disease Control and Prevention, "child—hood abuse or maltreatment includes any act of commission or omission by a parent or another caregiver that results in harm, potential of harm or threat of harm to a child."¹

The effects of trauma can manifest in different ways^{2, 3,4} and can affect different aspects of development⁵, including relationship with caregivers, family members, friends⁶, and authority figures. It can also disturb children's academic performance, their ability to work, to form relationships, and can even impact their sense of a future. When issues in these areas emerge, at times they are either not dealt with, or not dealt with properly, ⁷ as the effect of trauma, which is often at the root of the problem, may not be recognized⁸.

In developed countries, including the United States and Europe, estimates of pediatric physical abuse ranges from 5-35%, sexual abuse 15-30% in girls and 5-15% in boys, and psychological abuse and neglect approximately 10%. Between 10% and 80% of all physical abuse is perpetrated by the caregiver. ⁹ Estimates in developing countries are less widely available but are comparable to these estimates. The effect of trauma on children or adolescents is not uniform cross-culturally and can be colored by cultural factors and considerations.¹⁰ There is a growing literature on community resilience centered on flexibility and adaptability among pediatric populations in the midst of hardship or in situations where there is an unexpected necessity to adjust. These cultural perspectives can inform clinicians on resiliency, protective and preventive factors that can be implemented and integrated when working with pediatric populations, both in mental health and general pediatrics.

This workshop will explore lessons learned from work with child and adolescent populations around the world and identify common denominators that may be considered when working with children affected by trauma.

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WORKSHOP 66

MAKING YOUR PRESENTATION MORE INTERACTIVE: THE BETTER WAY

Chair: Jon S. Davine, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the superiority of interactive group teaching versus the traditional didactic model in changing physician behaviour;2) Use and participate in different group activities that enhance interactive group teaching;3) Maximize the use of "Hollywood" film clips and audiovisual patient encounters to enhance group teaching;

SUMMARY:

Educational literature has shown that traditional didactic presentations usually are not effective in ultimately changing physician performance. Conversely, interactive learning techniques, particularly in smaller group settings, have been shown to be much more effective. In this workshop, we review the literature behind these conclusions. We discuss factors that can enhance interactive learning techniques, including room arrangements, proper needs assessment, and methods to facilitate interactive discussions. The workshop will then have an interactive component, which involves participants in different group activities, such as "Buzz Groups", "Think-Pair-Share", and "Stand Up and Be Counted", which enhance small group interaction. The use of commercial film to enhance educational presentations has been coined "cinem-education". We will discuss techniques to help use film as a teaching tool, along with having an experiential component which will involve the direct viewing and discussion of a film clip to demonstrate principles of using films as a teaching tool.

Audiovisual tapes of patient encounters have been used as interactive teaching tools. In this workshop, we will discuss the literature describing how to maximize the use of audiovisual patient encounters as a teaching tool. We will then have another experiential component which will involve direct viewing of an audiovisual tape encounter of a patient where the group will directly participate in an interactive session using the audiovisual tape as a teaching tool.

WORKSHOP 67**MEASUREMENT-BASED CARE IN PRIVATE PRACTICE**

Chairs: David Lischner, M.D., Peter Roy-Byrne, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the rationale and evidence for employing measurement based care;2) Identify the advantages and limitations of using measurements and distinguish the different types of measurements;3) Treat using specific scales for specific disorders in order to improve judgment of severity of illness and responsiveness to treatment;

SUMMARY:

Measurement-based care has been shown in multiple studies to facilitate identification of clinically important psychiatric syndromes as well as their treatment. While the routine use of psychiatric measures has been adopted by some primary care as well as community mental health settings, they are infrequently used in office based psychiatric practices. This workshop will be divided into two sections; each section will heavily emphasize audience participation and include a final Q&A wrap-up. The first section will review the rationale and evidence for measurement-based care, the tradition of measurement in medicine, the evolution from observer to self-rated scales, how measurement based care compliments “evidence based care”, how measurement based care provides a way to individualize and “personalize” treatment, and how clinical acumen is crucial in complementing the use of measurements (i.e. a person with a “normal” score could still require treatment and a person not yet in the “normal” range might be “better” and not require treatment). During this section, a discussion of the most common psychiatric syndromes, the availability of useful measures, and syndromes for which useful measures are still not standardized will be discussed. The second section will provide a specific review of individual disorders and specific measures in the public domain that can be easily employed by practicing clinicians, along with cut-off points to interpret levels of clinical severity and change score values that indicate clinically significant improvement. Both Presenters have over 30 years combined experience using measures within their respective practices and will provide clinical anecdotes to illustrate the promises and pitfalls of their use. The workshop will conclude with a discussion about how to incorporate measures, including the use of pencil and paper approach, and the possibility of incorporating technology to facilitate obtaining measurements and tracking over time, resulting in substantial clinical documentation time savings.

WORKSHOP 68**APPLICATION OF YOGIC TECHNIQUES IN MENTAL HEALTH AND ILLNESS**

Speakers: Madhusmita Sahoo, M.D., Anup Sharma, M.D., Ph.D., Andres J. Pumariega, M.D.

Chairs: Barry Sarvet, M.D., Basant K. Pradhan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the basic concepts of yoga-meditation as they were originally proposed in ancient India as expositions explaining how mind works;2) Understand the psychotherapeutic implications of the various yogic concepts about mind and its operations;3) Appreciate use of yogic techniques in daily life in healthy people for a better quality of life, peace and increased productivity;4) Appreciate use of yogic techniques in management of common psychiatric conditions, including but not limited to anxiety and stress problems, substance abuse and attentional disorders;

SUMMARY:

Yoga can be conceptualized as a self-management strategy to gain insight into the principles that explain the nature of one's thoughts and experiences and re-access a natural, positive state of mind, which in turn leads to experiencing sustained day-to-day calm, insight, and well-being, regardless of the circumstances¹. Despite more than 2,500 years of track record on its use, much of the yogic concepts have not been examined systematically in a scientific evidence-based format, and thus still remain mystified to the public. Hence, there is a great need to examine the utility of yogic techniques in an evidence-based-medicine format.

We have designed a Standardized Yoga-Meditation Program for Stress Reduction (SYMPro-SR)² for use in clinical as well as research settings. As the name suggests, the SYMPro-SR program is a standardized yoga –meditation protocol which has been adapted from the Yoga Sutras of Patanjali¹ and intended for use in healthcare both clinically and research wise. This protocol was developed by Dr. Basant Pradhan, a child psychiatrist at Cooper University Hospital, Camden, New Jersey, integrating the insights he gained from his monastic training as well as practice and research on yoga. SYMPro-SR has 15, 30, and 45 minute formats, designed based on ‘preparedness and make up’ of the clients. Beginners can start with 15-minutes protocol and can progress later to the 30 and 45 minutes ones if they want. The 15-minute time frame is based on a previous Mayo Clinic feasibility study³. This protocol is intended to be practiced twice daily every other day.

We will present preliminary data about the utility of this program in psychiatric cohorts (adults and children⁴) as well as in healthy volunteers. We propose an integrative model explaining how some yogic techniques can be used in mental health wellness and mental illness treatment settings, and not only in clinical practice but also in mental health research. This

workshop will present a synthesis integrating insights from the yogic traditions of ancient India with the knowledge from evidence based medicine. Obstacles in carrying out this kind of research, particularly measurement challenges and cultural acceptability, will also be discussed.

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WORKSHOP 69

ABPN AND APA PERSPECTIVES ON MAINTENANCE OF CERTIFICATION

Speakers: Robert J. Ronis, M.D., M.P.H., Mark Rapaport, M.D., George Keepers, M.D., Kailie Shaw, M.D., Barbara Schneidman, M.D., M.P.H., Paramjit Joshi, M.D.

Chairs: Larry R. Faulkner, M.D., Deborah J. Hales, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the ABPN's maintenance of certification program, including its rationale and requirements; 2) Describe the APA's programs and products that have been developed for meeting maintenance of certification requirements; 3) Describe the rationale for recertification for physicians;

SUMMARY:

The purpose of this workshop is to present information on the ABPN's evolving maintenance of certification (MOC) program and on the APA's related efforts on behalf of its members. As mandated by the American Board of Medical Specialties, the ABPN has developed an MOC program for specialists and subspecialists that has four components: professional standing (licensure); self-assessment and lifelong learning; cognitive expertise (computerized multiple-choice examination); and assessment of performance in practice, including peer and patient ratings. The phase-in schedule for the components and the options that are available for meeting the requirements will be presented. The computerized multiple-choice

examinations will be described, as will examination results. Representatives of the APA will outline the programs and services the organization has developed to meet the needs of psychiatrists participating in MOC. Related issues such as research on the development and maintenance of professional expertise and maintenance of licensure will also be discussed.

WORKSHOP 70

DECIDING WHO DECIDES: SURROGATE DECISION-MAKING POLICIES ACROSS THE UNITED STATES

Speakers: Susan Rushing, J.D., M.D., Andrew M Siegel, M.A., M.D.

Chairs: Susan Rushing, J.D., M.D., Andrew M Siegel, M.A., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize accepted frameworks guiding evaluation and documentation of patient medical decision-making capacity.; 2) Identify the implications and limitations of state laws governing the hierarchy of surrogate decision makers.; 3) Apply the 4-Criteria Model of Capacity developed by Grisso and Appelbaum when performing assessments of medical decision-making capacity.;

SUMMARY:

Part 1: Hospital-based consultation psychiatrists are often faced with complicated, high-risk clinical scenarios in which making accurate, evidence-based assessments and recommendations will protect the patient from harm. These scenarios include complicated biological, legal and ethical questions the consultation psychiatrist must efficiently work through to knowledgeably advise the consulting medical team. Within the last decade, many states have enacted legislation guiding the clinician on assigning Surrogate Decision Makers when patients lose the ability to make their own medical decisions. This workshop will review the ethical framework of informed consent, of which decision-making capacity is one element. We will review accepted frameworks for discussing and documenting a patient's medical decision making capacity abilities. We will then delve into the nuances of the state laws governing the assignment of surrogate decision makers. We will look at the hierarchy of decision makers in various states and discuss the ethical and policy implications behind the selected hierarchy. We will discuss specific limitations regarding when surrogates can consent on behalf of an incapacitated person. In some states, this is limited to termination of life support if the patient is permanently unconsciousness; whereas in other states, surrogates may give consent for standard medical care, disposition, or participation in research protocols. We will discuss whether states allow physicians or members of the ethics committee to serve as surrogates. We will also review decision-making standards (substituted judgment vs. best interest). Participants will be invited to discuss

their experiences with their state law and how the implementation of the law has changed their practice.

Part 2: Medical decision-making capacity is an essential capability of the fully autonomous patient. Assessing patient capacity, however, engenders broad conceptual and practical questions, which have been the subject of much scholarship over the past few decades. There is currently no single professional standard for assessing capacity and prior studies have demonstrated poor inter-rater reliability when no standardized approach is used. Consequently, hospitals have begun developing their own policies to guide capacity assessments. This workshop will first review some of the relevant philosophical, legal, and ethical conceptions of medical decision making capacity. I will then present initial data from a study our group is conducting in which we evaluate the degree to which current hospital policy conforms to the four-criteria model of medical decision making capacity developed by Appelbaum.

WORKSHOP 71

MANAGEMENT OF THE DIFFICULT SERVICE MEMBER OR VETERAN

Speakers: Sebastian R. Schnellbacher, D.O., Judy Kovell, M.D., Rachel Sullivan, M.D.

Chair: Wendi M. Waits, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Participants will be able to recognize at least three unique and challenging patient populations they are likely to encounter in a military or VA setting.;2) Participants will gain practical tips on how to manage these patient populations while maintaining a therapeutic alliance.;3) Participants will acquire an understanding of how to adapt supportive, motivational, and cognitive-behavioral psychotherapeutic techniques in the management of these patient populations.;

SUMMARY:

Many behavioral health providers experience anxiety and frustration when dealing with certain populations of military service members and combat veterans. While caring for most veterans can be extremely rewarding, some can present as “difficult patients,” bringing with them a challenging array of values and behaviors. This workshop will provide practical tips for managing three of the most challenging military and veteran populations: the “angry” service member, the “historically inconsistent” service member, and the “poorly resilient” service member. Participants will be oriented to contextual clues to suggest that they may be dealing with one of these patient types, will learn about specific interventions to address problematic behaviors while maintaining a therapeutic alliance, and will learn how to incorporate military and VA-specific community resources into their treatment plans.

WORKSHOP 72

MENTAL HEALTH, INVOLUNTARY TREATMENT, AND DUE PROCESS OF LAW

Speaker: Alexander A. Guerrero, J.D., Ph.D.

Chair: Alexander A. Guerrero, J.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) understand the existing legal framework for dealing with indigent individuals who face involuntary commitment or involuntary treatment for mental health issues;2) identify and evaluate some of the deficiencies of the existing legal framework with respect to involuntary commitment or involuntary treatment;3) understand and evaluate some of the proposed changes to the legal framework that might be possible in light of recent developments at the Supreme Court and with the Civil Right to Counsel movement;

SUMMARY:

In the United States, indigent litigants have a federal constitutional right to counsel in criminal cases, but not in civil cases. In a significant number of states, however, indigent individuals who are facing involuntary commitment to a mental health facility or involuntary treatment within a mental health facility have a state-level right to various elements of legal process, including, in some states, a right to state-provided counsel. Unfortunately, what this means in practice is that the quality of legal process for indigent individuals with mental health issues varies widely from jurisdiction to jurisdiction and from state to state. Additionally, even in states with substantial legal entitlements, there are real issues as to how and whether those entitlements are actually provided. This workshop will address a number of issues that arise at the intersection of mental health, poverty, and law, including the following questions: (1) what are the current “best practices” with respect to procedural due process in the mental health context; (2) what are the most significant problems relating to procedural due process in the mental health context; and (3) what, if anything, does the recent Supreme Court decision in *Turner v. Rogers* (in which the Court found that procedural due process required “alternative procedural safeguards,” but not necessarily a right to counsel, in a civil contempt proceeding in which the individual faced loss of liberty as a potential consequence) mean for due process in the mental health context? Finally, the workshop will consider whether mental health advocates should embrace recent significant efforts made to secure a Federal civil right to counsel in cases implicating basic human needs, efforts including the formation of a National Coalition for a Civil Right to Counsel and a 2006 American Bar Association resolution calling for a civil right to counsel.

WORKSHOP 73**CONTROVERSIES AROUND POSTTRAUMATIC STRESS DISORDER**

Speakers: Elspeth C. Ritchie, M.D., M.P.H., Harold Kudler, M.D., Michael Colston, M.D., Remington L. Nevin, M.D., M.P.H., Gail H. Manos, M.D.

Chairs: Gail H. Manos, M.D., Elspeth C. Ritchie, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the issues around whether it should be called an injury or disorder; 2) Understand the complexity of diagnosis in relationship to disability; 3) Know the issues around treatment of complex PTSD;

SUMMARY:

Post Traumatic Stress Disorder has always been a controversial diagnosis. Currently there are major controversies about: 1) the name (should it be a disorder or an injury); 2) diagnostic criteria and the relationship to disability; 3) complex treatment guidelines. With 2.5 million veterans returning from the theater of war, these are not esoteric issues. Psychiatrists are often in the hot seat, blamed for either under-diagnosing or over-diagnosing. An unresolved question is whether the use of medications like mefloquine may exacerbate symptoms in some service members. This workshop will focus on some of the controversial issues.

WORKSHOP 74**THE USE OF ACT, CBASP, AND DBT FOR TREATMENT REFRACTORY PSYCHIATRIC ILLNESS**

Speakers: Lynn McFarr, Ph.D., Robyn Walser, Ph.D.

Chair: Eric Levander, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize when to utilize ACT, CBASP, and DBT in the treatment of complex psychiatric illness; 2) Learn the basic theories behind ACT, CBASP, and DBT; 3) Develop an understanding of the basic techniques utilized in ACT, CBASP, and DBT;

SUMMARY:

Cognitive behavioral therapy (CBT) has long been used in the treatment of affective illness, anxiety disorders, and other psychiatric disorders. Unfortunately, not all psychiatric conditions respond as well to standard courses of CBT and many patients remain symptomatic. Acceptance and commitment therapy (ACT), the cognitive behavioral analysis system of psychotherapy (CBASP), and dialectical behavioral therapy

(DBT) are other therapies that fall under the umbrella of CBT have shown efficacy in the treatment of refractory psychiatric disorders in evidence based trials. These three evidence based therapies have been found to be effective in trials of treatment refractory anxiety disorders, depression, obsessive compulsive disorder, psychosis, substance abuse disorders, eating disorders and borderline personality disorder. Yet few clinicians are familiar with these novel psychotherapies. ACT utilizes mindfulness and acceptance strategies to decrease avoidance, attachment to difficult thoughts, and increase a focus on the present. ACT teaches patients to live a valued life utilizing more effective behavioral strategies. CBASP utilizes structured tools to teach chronically depressed patients, with global and defeatist perspectives, adaptive and effective interpersonal problem solving skills. Therapists utilize the technique of disciplined therapist personal involvement to target problematic interpersonal behaviors. DBT combines both individual therapy and group behavioral skills training for patients along with a consultation team for the therapist. In DBT, therapists and patients focus on hierarchical behavioral targets to decrease self-injurious behaviors and behaviors that would interfere with the therapeutic process and learn strategies both tolerate emotional distress and make changes to create a more effective environment. This workshop will provide an overview to the clinician on ACT, CBASP, and DBT.

WORKSHOP 75**WHAT HAPPENS NOW THAT I'VE GRADUATED? PEARLS, PITFALLS, AND STRATEGIES FOR NEGOTIATING YOUR FIRST JOB AND OTHER TRANSITIONS AFTER RESIDENCY**

Speakers: Molly McVoy, M.D., Claudia L. Reardon, M.D., Kayla M. Pope, J.D., M.D.

Chair: Sarah B. Johnson, M.D., M.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand strategies necessary to negotiate a job in the psychiatric field including types of jobs available, what questions to ask during job interviews and what today's employers want; 2) Recognize and troubleshoot challenges facing early-career psychiatrists, including navigation of the complex healthcare system, maintenance of certification and work-life balance; 3) Identify potential knowledge gaps (business, medico-legal issues, etc.) in current medical education that participants may benefit from self-directed learning prior to beginning their first job; 4) Understand the importance of networking and maintaining professional relationships after residency, including discussion of opportunities for professional development within the APA;

SUMMARY:

The completion of residency training is an exciting and dynamic time. As trainees transition into the "real world" they are faced with many challenges. While current psychiatric educa-

tion standards and current board certification processes ensure a certain level of proficiency in the practice of psychiatry and patient care, many residents and early career psychiatrists feel under-prepared to deal with other challenges and transitions following graduation. The first challenge that emerging psychiatrists face is negotiating their first job. This workshop will include an overview of types of jobs available, pros and cons of different work settings and negotiating strategies to aid in the process. Once entering the workforce, early career psychiatrists frequently feel overwhelmed by business aspects of medicine as well as medico-legal. A discussion of these issues and resources available for self-guided learning in these areas will allow residents to better prepare for these challenges during training and potentially lessen the learning curve as they transition into their careers. The parallel process of life transitions including married life or partnership, parenthood, and/or caring for aging parents as one transitions into their career is common, and this workshop will include discussion of these issues and strategies for achieving balance. Finally, mentorship and having a supportive professional network in place can be a valuable asset in successfully navigating these changes. We will discuss the importance of having these resources, and how the APA can be a valuable resource for young psychiatrists. The presenters for this workshop include early career psychiatrists who work in a variety of psychiatric settings and have been involved with the APA in leadership roles. All consider themselves "survivors" of the transition from residency into early careers and hope that attendees will benefit from both evidence based overview of issues facing early career psychiatrists and lively discussion during this presentation.

WORKSHOP 76

UNIVERSAL BEHAVIORAL PRECAUTIONS: A WORKSHOP FOR DEVELOPMENT OF A HOSPITAL CRISIS RESPONSE TEAM, A SMARTER TEAM, AND A SAFER HOSPITAL

Speakers: Peter K. Sangra, M.D., Ritesh Amin, M.D.

Chair: Cheryl A. Kennedy, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of early indicators and signs of risk for the loss of behavioral control; 2) Demonstrate knowledge of early recognition of increased risk of violence through body language, verbal threats, etc.; 3) Demonstrate knowledge of de-escalation techniques; 4) Demonstrate knowledge of basic components of hands on interventions and principles for the indications for and the safe use of restraints; 5) Demonstrate knowledge of the components of an effective Behavioral Crisis Response Team;

SUMMARY:

Hospital and patient safety includes violence prevention. Behavioral crises are among the most difficult and sensitive situations that occur in the hospital setting and can be violent.

It is well understood that some patients with Psychiatric disorders may have the potential for violence or self harm. But, delirium affects 15-60% of hospitalized patients (drug interactions, infections, alcohol or other drug intoxication or withdrawal, head trauma, etc.)(1). Patients with delirium or dementia, and others may also act in ways that are dangerous to themselves and to those around them. Lack of training may lead responders like security personnel to intervene using only physical restraint when in fact a verbal, environmental or even, pharmacological intervention may have been successful. Alternatively, doctors or nurses may lack sufficient training in safe physical restraint when necessary, leading to dangerous interventions for the healthcare staff and patients alike. If employees feel threatened or are unable to respond effectively to patients with an altered mental state (regardless of the cause), then patient outcomes could potentially be adversely impacted.

Crisis Response Teams, often found in Psychiatric and Residential care settings (2) offer an intervention model of care that can prevent violence, ensure patient safety and support staff. A heightened awareness of ensuring patient and employee safety lead our University Hospital Psychiatric Team to develop a Behavioral Crisis Response Team to support the medical-surgical units in dealing with behavioral crises. Our trained team approach provides skills and expertise used in Psychiatric inpatient units along with a Consultation Liaison Psychiatrist who has special expertise in working with medically ill patients. We offer this workshop to provide a framework for others to adapt for their health care settings. At the end of the workshop the participants will demonstrate knowledge of the options for dealing with behavioral crisis in the health care setting, including the intervention model. 1. Ely EW, Seigel MD, Inouye SK: Delirium in the intensive care unit: an under recognized syndrome of organ dysfunction. *Semin Resp Crit Care Med* 2001;22:115-126. 2. Zook, R. Developing a Crisis Response Team, *Journal for Nurses in Staff Development* 2001; 17:125-130

WORKSHOP 77

EMOTIONAL AND SEXUAL INTIMACY AMONG GAY MEN: MENTAL HEALTH ISSUES AND TREATMENT APPROACHES TO RELATIONSHIP PROBLEMS

Speaker: Stewart Adelson, M.D.

Chairs: Robert Kertzner, M.D., Marshall Forstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify common psychological issues related to difficulties starting or sustaining relationship intimacy among gay men; 2) Recognize the impact of social context on the pursuit of relationship intimacy among gay men; 3) Identify psychotherapeutic interventions to help gay male patients experience greater relationship intimacy;

SUMMARY:

Gay men may seek psychotherapy for help in starting or sustaining intimate relationships. A variety of mental health issues underlie difficulties in establishing intimate relationships including depression, internalized homophobia, discomfort with emotional dependency needs, and developmental dynamics in some gay men that lead to separate pathways for the pursuit of emotional and sexual intimacy. In addition, certain aspects of contemporary gay social life such as the ready availability of partners via technology or the ubiquity of pornography can contribute to patients' difficulties. This workshop will center on a case presentation with discussion of clinical, psychological, and social perspectives and will explore mental health approaches to helping gay male patients achieve greater emotional and sexual intimacy in their relationships.

WORKSHOP 78**CPT CODING AND DOCUMENTATION UPDATE: 2013 CPT CHANGES**

Speakers: Allan A. Anderson, M.D., Chester Schmidt, M.D., David Nace, Jeremy S. Musher, M.D.

Chair: Ronald Burd, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify recent CPT coding changes; 2) Recognize Up-to-date Medicare reimbursement concern; 3) Better understand CPT coding, documentation and reimbursement.;

SUMMARY:

The goals of the workshop are to inform practitioners about changes to the CPT Coding and current issues associated with documentation guidelines including the major changes for 2013. This year's workshop will focus on 1) a review of the new CPT codes for 2013, including the major changes for 2013; 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.

AMERICAN MEDICAL ASSOCIATION: CURRENT PROCEDURAL TERMINOLOGY, 2013, CHICAGO, IL, AMA PRESS, 2013

AMERICAN MEDICAL ASSOCIATION: MEDICARE RBRVS: THE PHYSICIANS GUIDE, 2012, CHICAGO, IL, AMA PRESS 2012

WORKSHOP 79**UNDERSTANDING AND OPERATIONALIZING THE SOMATIC SYMPTOM DISORDERS**

Speakers: Arthur Barsky, M.D., Francis Creed, M.D., Javier Escobar, M.D., M.S., Michael Irwin, M.D., Michael Sharpe, M.A., M.D., Lawson Wulsin, M.D.

Chairs: Joel E. Dimsdale, M.D., James Levenson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To understand the problems with the status quo somatoform disorders; 2) To understand the criteria proposed for factitious disorder, conversion disorder, psychological factors affecting medical care, somatic symptom disorder and illness anxiety disorder; 3) To discuss how these criteria may be used in routine clinical practice; 4) To discuss how these criteria may be used in psychiatric epidemiology; 5) To discuss how to convey this information to non-psychiatric colleagues;

SUMMARY:

This workshop will discuss the rationale for making changes in the somatoform disorders section of DSM. It will discuss the precise criteria wording selected for factitious disorder, conversion disorder, psychological factors affecting medical condition, somatic symptom disorder, and illness anxiety disorder.

The workshop will then discuss how to recognize the features of these disorders in clinical practice and how they lend themselves to organizing effective treatment. The workshop will also discuss how to operationalize these disorders in future psychiatric epidemiology studies and how to convey this information to non-psychiatric colleagues, particularly those in primary care

WORKSHOP 80**SOCIAL MEDIA AND THE INTERNET: NEW CHALLENGES TO BOUNDARIES IN PSYCHIATRY**

Chair: Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To provide a brief overview of social media; 2) To consider some of the characteristics of psychiatric practice that make dealing with social media particularly challenging; 3) To stimulate discussion among the participants of the practical and ethical issues that arise when psychiatrists consume and produce social media content;

SUMMARY:

The evolution of the Internet to include user-generated content, often referred to as Web 2.0, has altered our society's

basic notions of privacy, connectivity, and communication. As more people are blogging, posting on social media websites, and uploading personal videos onto the Internet, one notable consequence has been the blurring of the boundary between social and professional spheres. Psychiatrists have not been immune from these trends. Whether as users of data posted by others or creators of information that others can access, psychiatrists are full participants in the social media revolution—creating a complex set of practical and ethical challenges for psychiatric practice. After a brief introduction to these issues, this workshop will consider a series of case examples of psychiatric involvement with social media that will be presented to the audience for discussion. Questions to be addressed will include: What principles should guide professional involvement in social media? What are the pitfalls of which psychiatrists and other mental health professionals should beware? How can positive use be made of the Internet and social media in one's professional and personal life? The focus will be on helping participants identify approaches to these issues that will be useful in their own lives and practices.

WORKSHOP 81

TO SLEEP OR NOT TO SLEEP: PSYCHOTROPICS AND SLEEP ARCHITECTURE

Speakers: Venkata B. Kolli, M.B.B.S., Alexandra E. Schuck, M.D.

Chairs: Durga Prasad Bestha, M.B.B.S., Vishal Madaan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the basic physiology and neurobiological aspects of sleep; 2) Recognize the effects of psychotropic medications on sleep architecture; 3) Identify the potential benefits and adverse clinical outcomes arising from the effects of psychotropics on sleep architecture, leading to better and safer prescribing patterns;

SUMMARY:

Sleep disruption is an important concern for patients with a variety of psychiatric disorders. In addition, primary sleep disorders are also more prevalent in this population. Disturbance in sleep patterns may increase not only the morbidity of psychotic, affective and anxiety disorders, but also have been commonly shown to have a detrimental impact on the functioning of cardiovascular and immune systems. Different classes of psychotropic medications such as sedative-hypnotics, anti-depressants and anti-histamines have been used to promote sleep and these can have a wide array of differential effects on the sleep architecture. This can be beneficial in certain aspects but can also interfere with the role of sleep in learning and cognition, lead to emergence of nightmares and sleep-related behavioral disorders. This interactive workshop will begin with an overview of the essentials of physiology and neurobiology of sleep. Using this as the core foundation, speakers will then explore the effects of sedative-hypnotics,

followed by an engaging discussion on non-sedative-hypnotic psychotropic medications used for sleep disorders. An understanding of the medication-induced changes in the sleep architecture will help the audience become familiar with the potential positive and negative clinical outcomes, so that we can better educate and monitor patients. Following this, an overview of the unintended effects of commonly used psychotropic medications (such as anti-depressants, mood stabilizers, anti-psychotics and stimulants) on sleep wave patterns will be discussed. Throughout the workshop, there will be an emphasis on especially promoting behavioral interventions as an essential adjunct to help patients and practitioners have a more realistic understanding of the complexities faced in managing the morbidity arising from poor sleeping patterns.

WORKSHOP 82

THE GOOD, THE BAD AND THE UGLY: PRACTICAL ISSUES IN ADDRESSING THE EPIDEMIC OF PRESCRIPTION DRUG ABUSE

Speakers: Kelly J. Clark, M.B.A., M.D., Mary Helen Davis, M.D., Michelle Lofwall, M.D.

Chair: Kelly J. Clark, M.B.A., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Better advocate funding by understanding the total costs and consequences of prescription drug abuse on medical care, total stakeholder burden, and the treatment costs of prescription drug abuse; 2) Learn to support and defend quality medical practice by working with state regulatory and legislative bodies seeking greater control of physician prescribing; 3) Improve practice skills by using the research data and clinical pearls to reduce the potential for your patient's abuse, misuse, and diversion of controlled substances;

SUMMARY:

The United States Centers for Disease Control has declared prescription drug abuse a national epidemic, and the White House has declared this a public health crisis. Psychiatrists have a vital role to play in managing this crisis by providing direct addiction psychiatry treatment services. In addition, the leadership and guidance of psychiatrists is increasingly sought by non-psychiatric physicians, lawmakers, community activists, members of the judicial and correctional systems, school systems, and other stakeholders in our communities. This workshop is presented by psychiatrists practicing in the Kentucky, the epicenter of the epidemic with over 1000 Kentuckians lost annually due to unintentional overdose. Practical Issues discussed represent The Good, The Bad, and The Ugly of combating prescription drug abuse. Dr. Michelle Lofwall is an addiction psychiatrist at the University of Kentucky researching prescription drug abusing population in Appalachia. Her clinical practice is informed by this and other data. Dr. Lofwall will present not only evidence-based treatment approaches, such as Galanter's Network Therapy, but also clinical pearls regarding use of pharmacist resources, drug

screens, as well as the continuum of treatment intensity and other contingency management techniques used in her clinical practice. This represents the practical clinical issues of addressing the epidemic of prescription drug abuse – directly helping our patients is “The Good”. Dr. Kelly Clark practiced addiction psychiatry in a variety of a settings before becoming the medical director of behavioral health for a health plan. There she made the business case for funding of addiction psychiatric services by understanding the total cost of care of patients with untreated prescription abuse. This includes emergency department, lab, imaging, primary and specialty providers, and pharmacy costs. Data regarding often overlooked costs related to drugged driving injuries and addicted neonates will be presented. The significant cost savings gained by investing in addiction services will be described in the context of large stakeholder groups, including savings of crime-related costs, jail and prison costs, and improved work hours with related tax base improvements. The tremendous societal cost and consequences of the prescription drug epidemic represents “The Bad”. Mary Helen Davis is a psychiatrist appointed by the Governor of Kentucky to head the task force on the use of the state’s Prescription Drug Monitoring Program. In reaction to the community devastation brought by the epidemic, the state legislature passed laws criminalizing many aspects of what had been standard medical and psychiatric practice. Presenting tips from her leadership experience in the ongoing work between the regulators and physicians, the gritty but vital work of defining, supporting and defending medical practice in the new wave of state regulations represents “The Ugly” .

WORKSHOP 83

STEROID USE AND CONSEQUENCES IN THE MILITARY

Speakers: Christopher S. Nelson, M.D., Sebastian R. Schnellbacher, D.O.

Chairs: Remington L. Nevin, M.D., M.P.H., Elspeth C. Ritchie, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand rise of steroid use in the military.;2) Recognize signs and symptoms of steroid abuse.;3) Treat psychiatric side effects of steroid abuse.;

SUMMARY:

A survey conducted by the Department of Defense in 2008 (the last year for which figures were available), showed that 2.5 percent of Army personnel had illegally used steroids within the past 12 months. This was up from 1.5 % three years prior. Anecdotally the numbers are still rising. SSG Bales was charged with steroid use, among many other crimes, after he allegedly gunned down 16 Afghan villagers in March 2012. Military officials do not routinely test for steroids unless abuse is suspected. The disparity between the cost of a steroid analysis, from \$240 to \$365, to what a marijuana analysis

cost, about \$8, is huge. Clinicians who are working with military service members should be alert for steroid use, as well as the use of other licit and illicit substances. Steroids can be injected or taken orally. Effects of steroids include irritability, insomnia, mood swings and angry outbursts. These symptoms are often confused with similar symptoms of Post-traumatic Stress Disorder and traumatic brain injury.

WORKSHOP 84

YOU CAN'T CALL MY MOM: BALANCING PRIVACY VERSUS POTENTIAL NEGLIGENCE IN EMERGENCY PSYCHIATRIC ASSESSMENT

Speakers: Kathleen Dougherty, M.D., Jonathan D. Small, M.A., M.D., Bahar Hadjesmaailoo, M.D.

Chair: Kenneth M. Certa, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the value of collateral information in emergency psychiatric assessment;2) Describe the limits of confidentiality when assessing an individual's potential for suicide or homicide;3) Appropriately weight concern for patient privacy against need for information for accurate assessment of risk;4) Identify legal principles which guide confidentiality provision in emergency psychiatric assessment;

SUMMARY:

Psychiatric assessment in emergency settings are frequently limited by a patient's distress, disorganization, or dishonesty (usually for secondary gain.) Often accurate diagnosis and appropriate treatment are best served by obtaining information from other sources; generally family, sometimes other providers of care, and insurers. Many times patients are not willing to have such information made available, and expressly forbid the treatment team from contacting anyone else. Often this prohibition is accompanied by references to HIPAA and lawsuits. Physicians differ in their interest and/or willingness to make such calls to family over a patient's objection. In cases of clearly impaired capacity, when further medical history or substitute decision making is needed, most ER doctors will get on the phone. In assessing suicide attempts or threats, there is sometimes reluctance to do this, since mental health treatment is considered even more sacrosanct.

The risk of making diagnosis or treatment decisions based on incomplete or inaccurate history must also be considered, however. The potential for missing a truly suicidal patient who will die if released, requires that all sources of information be accessed, if known. Clearly psychiatrists cannot place calls to individuals without being provided phone numbers, but charts often contain next of kin listings. Deciding not to call a patient's mother while assessing her twenty-something son who has raised a concern of suicide, risks missing vital information such as the presence and wording of a suicide note, or that the patient had just exchanged the mother's flat-screen TV for heroin, and that she had notified the police. Recommended

intervention might be very different in these cases. This workshop will present some of the legal and ethical underpinnings of the decision to act counter to a patient's expressed wishes that no one else be contacted for information. Cases which illustrate these points will be presented, and workshop participants will be encouraged to give their opinions concerning how these cases were managed, as well as their own inner guideposts and experience with making such calls.

WORKSHOP 85

PROFESSIONALISM IN SOCIAL NETWORKING: WHAT SHOULDN'T BE TWEETED, BLOGGED, OR POSTED

Speakers: Michelle Chaney, M.D., M.Sc., Almari Ginory, D.O., Molly Ryan, D.O., M.P.H.

Chairs: Almari Ginory, D.O., Molly Ryan, D.O., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize inappropriate and unprofessional uses of social networking;2) Maintain appropriate boundaries in online patient interactions;3) Knowledge of how to proceed if inappropriate content is posted by colleagues;4) Discuss real case examples of unprofessional content in social networking;

SUMMARY:

Social Networking has rapidly become part of our daily vernacular. One can post birthday messages on Facebook, Tweet about daily life on Twitter, pin favorite websites on Pinterest, and post vacation pictures instantly with Instagram. While these platforms are good ways to maintain contact with friends, they can also create visible venues for HIPAA and boundary violations. Residents and medical students are commonly using social networking sites. A study conducted of Psychiatry residents subscribed to the American Psychiatric Association list serve by this author, found that 85.9% of respondents had an active Facebook profile. Of those respondents less than 3% had received any education on appropriate uses of social networking. Both the American Medical Association and Federation of State Medical Boards have recommended guidelines, which include separation of personal and private information online, maintaining privacy standards on online interactions, and reporting of inappropriate content. In February 2011, the American Association for Directors of Psychiatric Residency Training developed a task force that completed a curriculum on professionalism and the Internet. In addition, the British Medical Association specifically recommends that physicians refuse friend requests from patients. The purpose of this workshop will be to provide education to residents and medical students about the specific guidelines as they relate to social networking. Potential boundary and HIPAA violations will be presented using real life examples. Discussion will be fostered among attendees on ways to handle situations such as a friend request from a patient, an inappropriate post from a colleague and how to monitor your Internet presence. We will also encourage

attendees to return to their programs and foster education on these topics.

WORKSHOP 86

NONCOMMUNICABLE DISEASES, COLLABORATIVE AND INTEGRATED CARE: ESSENTIALS FOR THE PRACTICING PHYSICIAN AND THE HEALTH TEAM

Speakers: Jurgen Unutzer, M.D., M.P.H., Lori Raney, M.D., Eliot Sorel, M.D.

Chairs: Mary Anne Badaracco, M.D., Eliot Sorel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize that non-communicable diseases lead in the global burden of disease and of disability and that mental disorders lead among them. Recognize also the high levels of comorbidity among them;2) Identify the merits of collaborative and integrated care to diagnose and treat non-communicable diseases, including mental disorders in the context of medical home and accountable care organizations;3) Acquire new knowledge, skills and attitudes to be effective members and leaders of the newly emerging models of collaborative and integrated care health systems;4) Learn the language of collaborative and integrated care in order to enhance clinical and management communication, effectiveness, efficiency, outcomes and satisfaction;

SUMMARY:

Non-communicable diseases, collaborative and integrated care:

Essentials for the practicing physician and the health team

Invited workshop

Council on Health Care Systems and Financing

American Psychiatric Association Annual Meeting

San Francisco, California, May 2013

Eliot Sorel, MD, Chairman, Jurgen Unutzer, MD, Co-Chair

Presenters: Jurgen Unutzer, MD, Lori Raney, MD, Eliot Sorel, MD

Abstract

Physicians, health teams and health systems, in the United States and around the world are challenged by the rising global burden of diseases and of disability caused by non-communicable diseases (NCDs), including mental disorders.

Mental disorders, lead in both the global burden of disease (14%), and of disability (30-45%). Additionally, health systems' fragmentation, challenge clinicians, educators, research-

ers and policy makers to develop innovative models and responses that would enhance access, quality and outcomes.

In response to the above stated challenges, our workshop defines the opportunities for clinical and scientific development of collaborative and integrated care in the context of medical homes and accountable care organizations; the new knowledge, skills and attitudes essentials for physicians and the health team; their impact on access, quality, outcomes; and the implications for health systems services, training, education, research and policy, inclusive of financing. A brief lexicon relevant to collaborative and integrated care will also be provided to workshop participants.

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Sorel, E., Everett, A., Psychiatry and primary care integration: Challenges and opportunities, *International Review of Psychiatry*, Feb 2011, 23(1); 28-30

Frenk, J., Reinventing primary health care: the need for systems integration, *The Lancet*, Vol. 374, Issue 9684, 11 July 2009; 170-173

WORKSHOP 87

AMPLIFYING THE VOICE OF YOUR PROFESSION AND YOUR PATIENTS: ADVOCATING FOR YOUR PATIENTS IN AN ERA OF HEALTH CARE REFORM

Speakers: Nicholas M. Meyers, B.Sc., Robert Cabaj, M.D., Ara Anspikian, M.D., Jerry Halverson, M.D.

Chair: Jerry Halverson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify APA's national advocacy goals and how APA advocacy works to attain those goals;2) Learn to set up an advocacy plan to advance and execute advocacy goals at local and state level;3) Learn how to identify and approach allied health groups, patient advocacy groups and other partners that can help advance your advocacy goals;

SUMMARY:

Our workshop will give attendees concrete direction on how to successfully advocate for psychiatry and our patients at the local, state and national levels. The speakers are members of the APA Council on Advocacy and Government Relations (Ara Anspikian MD, Jerry Halverson, MD, and

Chair Robert Cabaj, MD) and Department of Government Relations Director Nick Meyers. Mr. Meyers will discuss the APA's national advocacy goals and how the APA works to achieve them. Dr. Anspikian, an early career psychiatrist will discuss setting achievable advocacy goals and planning successful advocacy. Dr. Halverson will discuss working with key constituencies such as patient advocacy groups and working within the house of medicine in order to further our advocacy goals as well as giving concrete examples of successful legislation. Dr. Cabaj will introduce the panel and serve as the discussant to pull the above talks together and discuss concretely how participants can be more active advocates

in their local communities. 30 minutes of discussion will follow

WORKSHOP 88

GUESS WHO'S COMING TO DINNER? CHALLENGES AND STRENGTHS OF INTERCULTURAL INTIMATE RELATIONSHIPS

Speakers: Walter E. Brackelmanns, M.D., Esther Oh, M.D., Sonia Krishna, M.D., Anna Xiao, M.D., M.H.A., Russell Lim, M.D.

Chair: Ye Du, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the need for training on cultural factors within intimate relationships;2) Highlight key challenges and strengths of various inter-cultural intimate relationships;3) Discuss approaches to working with cultural issues in intimate relationships;4) Be more comfortable addressing cultural issues in practice;

SUMMARY:

Since the 1967 landmark civil rights case of Loving vs. Virginia, race-based limitations on marriage were deemed unconstitutional(1). Over the past two decades, interracial marriages have nearly tripled in the US. Currently, one in eight new married couples and one in five of unmarried couples are of different races or ethnicities(2). The ACGME and ABPN require that psychiatrists be trained in cultural competency and psychiatrists are witnessing more and more cross-cultural issues in the lives of our patients(3,4). However, training in the appreciation and management of these cross-cultural issues in intimate relationships remains minimal, even in model cultural psychiatry curricula. As a result, discussion of cultural conflicts in intimate relationships related to racial/

ethnic, religious, and other differences is often overlooked, uncomfortable, or even taboo, for both clinicians and patients. This workshop seeks to help clinicians grapple with the challenges and strengths of intercultural intimate relationships. We begin by emphasizing the need for better understanding of cross-cultural issues in relationships. We then present three different case studies based on the real-life experiences of individuals that highlight these issues. Two experts on couples therapy will then provide insights on the inter-analytic framework and practical methods in approaching cultural issues in intimate relationships. Finally, we will lead the audience in a discussion of barriers and innovative solutions in clinical practice and in the future training of clinicians in addressing culture in the setting of intimate relationships.

References: 1.Loving vs. Virginia, 388 US 1 (1967). FindLaw. <http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=US&vol=388&invol=1>

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4.American Board of Psychiatry & Neurology. Psychiatry and Neurology Core Competencies Version 4.1.

WORKSHOP 89

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY UPDATE: CERTIFICATION IN PSYCHIATRY AND ITS SUBSPECIALTIES

Speakers: Barbara Schneidman, M.D., M.P.H., Kailie Shaw, M.D., Robert J. Ronis, M.D., M.P.H., George Keepers, M.D., Paramjit Joshi, M.D.

Chair: Larry R. Faulkner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the ABPN's requirements for certification in psychiatry;2) Describe the new format for certification in psychiatry and in child and adolescent psychiatry, including the clinical skills requirements;3) Describe the ABPN's requirements for certification in the psychiatry subspecialties and in the multi-disciplinary subspecialties;

SUMMARY:

The purpose of this workshop is to present information on the ABPN's requirements for certification in psychiatry and the subspecialties of addiction psychiatry, child and adolescent psychiatry, forensic psychiatry, geriatric psychiatry, and psychosomatic medicine, as well as in the multi-disciplinary subspecialties of clinical neurophysiology, pain medicine, sleep medicine, and hospice and palliative medicine. Training and licensure requirements will be outlined, and the requirements for the assessment of clinical skills during residency

training (and post-residency if needed) in psychiatry and in child and adolescent psychiatry will be delineated. The on-line application system will be described, as will payment options. The schedule for phasing out the Part II (oral) examinations in general psychiatry and in child and adolescent psychiatry and the content and format of the new certification examinations in general psychiatry and in child and adolescent psychiatry will be presented. The content of the extant Part I (computer-administered multiple choice), Part II (oral), and subspecialty examinations will be reviewed, as well as examination results. A substantial amount of time will be available for the panelists to respond to queries from the audience.

WORKSHOP 90

PSYCHIATRY IN THE COURTS: HOT TOPICS

Speakers: Howard Zonana, M.D., Paul S. Appelbaum, M.D., Daniel Hackman, M.D.

Chairs: Paul S. Appelbaum, M.D., Howard Zonana, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the process and criteria by which APA decides to become involved as a friend of the court in major cases;2) Appreciate the issues involved in constitutional litigation over the insanity defense;3) Recognize how recent case law may change the dominant approach to punishment of juvenile offenders;4) Grasp why regulations limiting the application of unequal utilization review are essential to protecting parity for mental health treatment, and the role of the courts in protecting them;

SUMMARY:

The Committee on Judicial Action reviews on-going court cases of importance to psychiatrists and our patients, and makes recommendations regarding APA participation as amicus curiae (friend of the court). This workshop offers APA members the opportunity to hear about several major issues with which the Committee has been involved over the past year, and to provide their input concerning APA role in these cases. Three cases will be summarized and the issues they raise will be addressed: 1) Delling v. Idaho – Delling is a psychotic man who was convicted of murder in Idaho, one of four states in the U.S. that lacks an insanity defense. His attorneys have asked the U.S. Supreme Court to review his claim that the option of pleading not guilty by reason of insanity is required as a matter of constitutional law, under the doctrine of substantive due process. APA filed an amicus brief supporting Delling's request that the Court hear his case and arguing that recognition of severe mental illness as potentially negating culpability is an essential component of American criminal law. Delling also raises the important question of whether there are constitutionally required components to an insanity standard; 2) Miller v. Alabama - In its last term, the US Supreme Court issued an opinion striking down the constitutionality of mandatory sentences of life without parole for defendants who commit-

ted homicides while juveniles. The opinion may open the door to a reconsideration of the role of rehabilitation in juvenile- and perhaps adult-corrections. APA filed a brief supporting Miller's claim, and providing background information about the ways in which the mental capacities of juveniles differs from adults; 3) *C.M. v. Fletcher Allen Health Care* – This Vermont case challenges a health plan's alleged violation of the federal mental health parity law by applying different standards for the review of psychiatric vs. non-psychiatric treatment. Although this case is still at the trial level, APA is following it closely and will consider subsequent participation on the question of how the legitimacy of non-quantitative treatment limitations, such as utilization review practices, should be determined. Since new cases are likely to arise before the annual meeting, the Committee may substitute a current issue on its agenda for one of these cases. Feedback from the participants in the workshop will be encouraged.

MAY 21, 2013

WORKSHOP 91

HOW TO ESTABLISH AN ECT SERVICE IN A GENERAL HOSPITAL SETTING

Speakers: C. Edward Coffey, M.D., William M. McDonald, M.D.

Chair: Dawn-Christi M. Bruijnzeel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify patient populations that may benefit from ECT; 2) Discuss the initial evaluation of a patient who is an ECT candidate; 3) Identify the essential elements necessary to establish a clinical ECT service; 4) Understand the obstacles and opportunities in establishing and running an ECT service;

SUMMARY:

Electroconvulsive therapy (ECT) is a treatment modality that has been available since the 1930s. The use of ECT has gone through periods of decline as well as resurgence. It has been established as the gold standard treatment for treatment refractory depression, acute suicidality, psychotic depression and catatonia (1). Despite the preponderance of evidence demonstrating the efficacy of ECT, many psychiatrists do not have an ECT program within a reasonable distance from their practice to which they can refer their patients. Currently, less than 6% of psychiatric institutions in the United States have ECT programs (2). Many medical centers within the Veterans Affairs Healthcare System offer ECT, with an estimated 73,000 treatments performed over a recent 11 year period (3). This workshop will review the patient selection criteria and efficacy data for ECT in comparison to other therapies. By effectively treating severely and chronically ill patients, ECT can save a significant amount of health care expenditures that would otherwise be spent on inpatient hospitalizations and frequent outpatient care, as well as medical hospitalizations following potential suicide attempts. We will discuss the need

for ECT programs in treatment settings and the essential elements for establishing, maintaining and growing an ECT program-including cost, space, staffing and time commitment. Data from the Malcom Randall VA Medical Center will be presented reflecting the increase in referrals and treatment success over the past 12 years as the ECT program has grown. Guest presenters will share data and experience with establishing and running ECT programs in their facilities. Questions will be welcomed and discussion will follow.

1. American Psychiatric Association, Committee on Electroconvulsive Therapy, Richard D. Weiner et al (2001). *The practice of electroconvulsive therapy: recommendations for treatment, training, and privileging* (2nd ed.). Washington, DC: American Psychiatric Publishing. ISBN 978-0-89042-206-9.

2. Leiknes et al. 2012. Contemporary use and practice of electroconvulsive therapy worldwide. *Brain and Behavior*. 2(3): 283-345.

3. Watts BV et al. 2011. An examination of mortality and other adverse events related to electroconvulsive therapy using a national adverse event report system. *Journal of ECT*. Jun;27(2):105-8.

WORKSHOP 92

CONFIDENTIALITY AND RELEASE OF INFORMATION: OVERCOMING THE MORAL AND LEGAL OBSTACLES TO FAMILY INCLUSION

Speakers: Jonathan M. Lukens, Ph.D., Phyllis Solomon, Ph.D.

Chairs: Jonathan M. Lukens, Ph.D., Phyllis Solomon, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the importance of family inclusion in treatment planning, and its place in current treatment standards; 2) Understand the obstacles to family inclusion including practitioner attitudes and beliefs and Federal and State confidentiality laws; 3) Increase knowledge of confidentiality standards and the circumstances under which patient information may be shared with family members; 4) Increase knowledge of differential treatment of confidentiality between the states and between state and the federal government and between the U.S. and other countries.;

SUMMARY:

There is a growing body of evidence that supports greater family inclusion in the planning and implementation of treatments for persons with severe mental illness. Current practice standards as well as government care standards dictate family involvement. Psychiatric advance directives--an important tool in recovery oriented services--require the involvement caregivers (often family members) to ensure they are implemented in time of crisis. But while many practitioners

and policy makers have come to regard family inclusion as a treatment imperative, there are significant obstacles to implementing services that include greater family involvement.

Confidentiality laws as well as outmoded attitudes toward family involvement impede progress in family inclusion. Firstly, some practitioners may hold negative attitudes toward family inclusion; these attitudes are often rooted in beliefs regarding the family as a contributor to psychiatric distress, or a lack of proper training in how to effectively collaborate with family members. The persistence of such negative attitudes has clear and negative implications for treatment outcomes. Secondly, inadequate knowledge of confidentiality policies results in black and white decision making regarding release of information to family members, with many practitioners believing that confidentiality must be understood as almost absolute. Fear or legal penalties for breaking confidentiality exacerbate this problem.

This presentation will explore the current clinical evidence supporting family inclusion. The presenters will then illuminate the legal and moral issues related to release of information to family members, and provide attendees with an increased understanding of the importance of family involvement in treatment planning and implementation, how to navigate the legal and ethical standards of confidentiality, the kinds of information that may be shared with family members, and the circumstances under which such sharing may take place.

WORKSHOP 93

SUPERVISORY, CONSULTATIVE, COLLABORATIVE RELATIONSHIPS: LIABILITY ISSUES WITH SPLIT TREATMENT

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

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the types of roles in split treatment: supervisory, consultative and collaborative relationships and the liability issues involved; 2) Recognize the importance of supervision of trainees, office staff and related malpractice issues; and; 3) Discuss case examples and discussions to have when working with mid-level providers and non-psychiatrist mental health providers.;

SUMMARY:

Demand for psychiatric services is on the rise, however, there may be fewer resources available to patients seeking treatment. As such, other mental health providers are often involved in the overall care and treatment of the patient. The managed care model of medication management being provided by the psychiatrists and psychotherapy being provided by the psychiatrists and psychotherapy being provided by a non-physician clinician is typical and increasing. In addition,

with the emerging integrated medicine practice, psychiatrists are working with other non-psychiatrist clinicians. This 1.5 hour risk management seminar will examine the three types of relationships as well as the relationships in the integrated practice setting. This program will provide real life case examples, will examine the benefits of split treatment, and explore the potential risk and liability concerns for the psychiatrist. Additionally, risk reduction strategies will be identified.

WORKSHOP 94

RESEARCH LITERACY IN PSYCHIATRY: PART 1

Speakers: Diana E. Clarke, Ph.D., S. Janet Kuramoto, M.H.S., Ph.D., William Narrow, M.D., M.P.H.

Chairs: Diana E. Clarke, Ph.D., William Narrow, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand basic study designs, concepts and statistics used in psychiatric research; 2) Discuss and understand scientific literature; 3) Identify why it is important to the individual psychiatrist be able to understand scientific literature and interpret study concepts, design and statistics.;

SUMMARY:

The overall goal of the research literacy workshops is to educate students on what it means to critically appraise the scientific literature. In Part 1 of this workshop the participant is introduced to the basic concepts, study designs and statistics in psychiatric research. That will enable the individual to read and understand scientific literature and appreciate why it is important for them to do so. After a thirty minute break in which a study article is read by participants they are invited to attend part two of the workshops and discuss the article, view it with a critical eye and analyze and apply concepts learned in part one.

WORKSHOP 95

DEPICTIONS OF MENTAL ILLNESS IN THE HISTORY OF ART

Speakers: Susan Hatters-Friedman, M.D., Karam Radwan, M.D.

Chairs: Fernando Espi Forcen, M.D., Carlos Espi Forcen, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe familiarize with the way mental illness have been represented throughout the history of art; 2) Discuss what various artwork pieces demonstrate about the artist's thoughts about mental illness and discussion will be held on this topic; 3) Through some of the most representative art pieces, the audience will be able to explain importance of mental illness in the history of art;

SUMMARY:

In this workshop a multimedia presentation with the objective of discussing the iconography of madness in different artistic periods in the history of art will be given. By selecting and analyzing some particular images we will overview the history of psychiatry since ancient times until our days. Even if mental disorders are as old as the human being, the artworks of a historical moment allow us only to hint some of them. Thus, the concept of suicide and examples of megalomania are already present in Ancient Rome. With the emergence of Christianity over the Middle Ages and the Modern period, demonic possession and exorcism came to be the key mechanisms to justify and treat mental pathologies. However, they were not the only ones, there were other cultural explanations for mental illness, such as the myth of the extraction of the stone of madness and the ship of fools, a common topic in Flemish Renaissance art. During the Baroque and the Enlightenment, madhouses became for the first time subject of artistic representation with a very accurate approach. Contemporary art suffered a severe transformation that has permitted to certain individuals to become artists not only for their talent, but also for their artistic persona. Madness has widely helped to configure an enticing persona of some prominent artists such as Van Gogh, a practice that has been maintained until today. Psychoanalysis played a key role in the development of avant-garde art, above all in Surrealism (Miró, Dalí) and American Expressionism (Pollock, De Kooning). Late 20th century and 21st century art has been influenced by a wide variety of topics and psychiatric issues have sometimes been the source of artistic inspiration.

WORKSHOP 96**AMERICANS ABROAD: THE PSYCHIATRIC EPIDEMIOLOGY OF AMERICAN DIPLOMATS AND FAMILY MEMBERS SERVING OVERSEAS WITH THE DEPARTMENT OF STATE**

Speaker: Kenneth Dekleva, M.D.

Chairs: Mark Vanelli, M.D., M.H.S., Joshua McDavid, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify common mental health conditions experienced by American diplomats and families members overseas; 2) Know how rates of selected mental disorders compare among military, civilian and State Department populations; 3) Understand the organizational processes and personnel used to support the mental health of US diplomats and family members overseas;

SUMMARY:

US diplomats and their family members serve around the globe where their mental health needs are cared for by regional psychiatrists and their medical colleagues in the US State Department's Office of Medical Services. The emotional

challenges of assignments abroad include prolonged time away from family and friends in the US, frequent changes in residence, adaptation to new cultures and languages and life under often unpredictable and difficult environmental and political conditions. In this workshop we will discuss the psychiatric epidemiology of US diplomats and their family members who live and work overseas. We will discuss how rates of psychiatric illness in this population differ from those of comparison civilian and military populations. The discussion will include information on the organizational processes and personnel that the US State Department uses to promote the mental health and resilience of its diplomats and their family members. This workshop is likely to be relevant to United Nations agencies, the US military, nongovernmental organizations and multinational corporations who all face the challenge of supporting the mental health and wellbeing of employees overseas.

WORKSHOP 97**MILITARY/VETERAN-FRIENDLY PRACTICES AND HEALTH SYSTEMS**

Speakers: A. Kathryn Power, M.Ed., Eileen Zeller, M.P.H., Harold Kudler, M.D., Elspeth C. Ritchie, M.D., M.P.H., Richard McKeon, M.P.H., Ph.D.

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Christopher H. Warner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the military and veterans' health administrations medical structure.; 2) Identify how to do a needs assessment for your region or state, in a team based approach; 3) Recognize the specifics of military experience which may impact willingness to seek services.;

SUMMARY:

After 11 years of war, there are approximately 2.5 million veterans who have served overseas in wars in Iraq and Afghanistan and at least as many military dependents who have served on the home front. Military and civilian medical systems are stretched thin and lack essential coordination and public health perspectives needed to address the health burden of being a nation at war. In addition, many veterans cannot or will not seek the steadily growing array of health services and benefits available through the Department of Veterans Affairs. Civilians are stepping up to help, both formally and informally, and the White House Joining Forces initiative has begun efforts to orchestrate these with federal efforts but fully coordinated national response remains elusive. The SAMHSA Policy Academy is a state-by-state effort to define needs and promote resources for military members, veterans, their families and their communities. North Carolina, a mentor state in SAMHSA's program, has worked in this arena for six years and has a mature plan. Responses in Washington DC prioritize health care, economic security, ending homelessness,

education for veterans, and criminal justice. This session will review best practices at federal, state and community levels and define a vision and practical steps in service to our newest veterans and in preparation for veterans of future wars.

WORKSHOP 98

THE MAKING AND UNMAKING OF ALZHEIMERS DISEASE AND ITS ETHICAL IMPLICATIONS

Chair: Jason Karlawish, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To understand the proposed revisions to the definition of Alzheimer's disease.;2) The examine how the concept of biomarkers and risk are changing how define disease.;3) To understand the ethical and social implications of changes in the definition of Alzheimer's disease.;

SUMMARY:

Alzheimer's disease is changing. What was once a disease defined by a clinical category-being demented-is becoming a disease defined along dimensions. These changes are unfolding in two notably different ways, one proposed by the field of Alzheimer's disease researchers and the other proposed by the American Psychiatric Association. The first group seeks to redefine Alzheimer's disease according to biological measures, commonly called "biomarkers." The second is proposing a novel category called "neurocognitive disorder" that is subcategorized into "major" and "minor" neurocognitive disorder and emphasizes the need to measure and scale cognition to then fit it within degrees of severity. This talk will review the ethical and social implications of these events. How we talk about what is Alzheimer's disease, and therefore what is and is not a healthy brain, has notable ethical implications because losses in brain function affect the capacity to act autonomously which, in turn, resonate with the heart of contemporary ethics. Even more compelling is labeling persons who are abnormal because they are at risk of the loss of brain function.

WORKSHOP 99

ETHICAL DILEMMAS IN PSYCHIATRIC PRACTICE

Speakers: Burton Reifler, M.D., Mark Komrad, M.D., Elissa P. Benedek, M.D., Stephen C. Scheiber, M.D., Claire Zilber, M.D., Wade Myers, M.D.

Chairs: Richard D. Milone, M.D., William Arroyo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize ethical dilemmas and common situations which may signal professional risk;2) The participant should understand what resources are available to them;3) Identify boundary issues and conflicts of interest;4) Identify practical resolutions to ethical dilemmas;

SUMMARY:

This workshop will be entirely devoted to the APA Ethics Committee members taking questions from the audience on ethical dilemmas they have encountered, participated in, or read about. Audience participation and interaction will be encouraged, and ensuing discussions will be mutually driven by audience members and Ethics Committee members. All questions related to ethics in psychiatric practice will be welcomed. Possible topics might include boundary issues, conflicts of interest, confidentiality, child and adolescent issues, multiple roles (dual agency), gifts, emergency situations, trainee issues, impaired colleagues, and forensic matters.

WORKSHOP 100

TO BE OR NOT TO BE OUT: GAY AND TRANSGENDER PSYCHIATRISTS DISCUSS IMPLICATIONS FOR FACULTY, TRAINEES, AND PATIENTS

Speakers: Larry Ozowara, M.A., M.D., Francesco Ferrari, M.D., M.S., Jack Pula, M.D., Marshall Forstein, M.D.

Chair: Jack Pula, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Illustrate how gay and transgender psychiatrists navigate identity within the context of clinical care, including but not limited to consideration of countertransference and transference;2) Demonstrate gaps in institutional support for LGBT psychiatrists and how this impacts professional development and patient care;3) Learn about the needs of lesbian, gay, bisexual, and transgender patients through the lens of clinicians who live and work on this spectrum;

SUMMARY:

The treatment of Lesbian, Gay, Bisexual, and Transgender (LGBT) people in the fields of medicine and psychiatry has received increased attention, as the Institute of Medicine, the Joint Commission, and now the APA have published statements and policies geared to advancing our understanding and treatment of LGBT patients. While this indicates welcomed progress in our profession, there continues to be a lack of education and support in the field of psychiatry related to both the care of LGBT patients and the realities of being an LGBT clinician. While there may be a growing number of LGBT physicians training and teaching in psychiatric residency programs, the dilemmas and clinical pearls they experience have received little attention. A range of possibilities may account for this discrepancy, including institutional bias, stigma, and clinician discomfort with revealing delicate personal information. We assert and seek to illustrate in this workshop that the recognition and exploration of the experiences of LGBT faculty and trainees working with psychiatrically ill patients can have interesting and profound clinical implications. In this workshop the experiences of two resident psychiatrists and one attending psychiatrist at Ivy League psychiatric residency training programs will be explored, with particular attention to

the role that their sexual orientation and gender identity play in the treatment of their patients, relationships with colleagues, professional development, and knowledge of system fault-lines on both a policy and clinical level. The unique viewpoints, experiences, and resultant ideas of these clinicians and others like them carry great potential for creative solutions at multiple levels of psychiatric care and training, ranging from the consultation room where individual treatment occurs, to large systems of care, to university and medical center policy, and to classroom education. Our discussant, Dr. Marshall Forstein, will bring in his experience as a training director at Harvard to help us reflect on the significance of the panelists' work to the field of psychiatry, and to facilitate discussion with the audience.

WORKSHOP 101

RESEARCH LITERACY IN PSYCHIATRY: PART 2

Speakers: Diana E. Clarke, Ph.D., William Narrow, M.D., M.P.H., S. Janet Kuramoto, M.H.S., Ph.D.

Chairs: Diana E. Clarke, Ph.D., William Narrow, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss and critically appraise scientific literature.;2) Recognize the importance of staying abreast of scientific data and changes in occurring in the field of psychiatry;3) Identify gaps in literature in a practical sense, to have greater access to evidence-based care and informed clinical decisions.;

SUMMARY:

The overall goal of the research literacy workshops is to educate students on what it means to critically appraise the scientific literature. In this follow up to part 1 the participant will learn how to appraise scientific literature in a critical, thorough, and systematic manner. Not only will this course help students stay abreast of changes in the field and identify gaps in the literature, in a practical sense, it will enable greater access to evidence-based care and inform clinical decisions. A scientific article will be reviewed and analyzed offering practical application of concepts learned in part one and two of the Research Literacy workshops.

WORKSHOP 102

IMPROVING THE HEALTH OF CLIENTS IN ASSERTIVE COMMUNITY TREATMENT

Speakers: Steve Harker, M.D., Walter Rush, M.D., Lara C. Weinstein, M.D., M.P.H.

Chairs: Nancy Williams, M.D., Erik Vanderlip, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Comprehend the challenges and opportunities inherent in improving physical health of ACT clients;2) Employ strategies utilized in ACT teams to address the physical health needs of ACT clients;3) Acknowledge client outcomes presented as a result of ACT team interventions;4) Understand the role of the ACT psychiatrist in initiating and sustaining interventions to improve physical health of ACT clients;

SUMMARY:

The difficulties the seriously mentally ill experience in terms of poor access to healthcare and early mortality are well acknowledged. Many attempts are currently underway to reconcile these disparities in medical care. As it currently exists, ACT is one of the few evidence-based treatments for those with persistent mental illness. ACT has been widely disseminated, and efforts to shutter long-standing state institutions have further incentivized the adoption of ACT networks nationally. ACT teams are in a unique position to improve physical health outcomes by virtue of having medically trained staff and frequent, close interpersonal relationships with their clientele. This workshop will discuss pioneering strategies employed by four ACT teams across the country to improve the physical health outcomes of clients. Presenters will describe the process and outcome of interventions designed to improve both individual and population health. Particular emphasis will be placed on the role of the ACT psychiatrist in orchestrating the provision and coordination of medical care. The participants will share their learned experiences, and demonstrate novel techniques in which ACT teams engage their clients in physical health promotion.

WORKSHOP 103

CLINICALLY CHALLENGING CASES WITH ETHICAL DIMENSIONS, OR HOW TO KEEP YOUR MORAL COMPASS POINTED IN THE RIGHT DIRECTION

Speakers: Shannon Robinson, M.D., Marie Tobin, M.D., Maria Tiamson-Kassab, M.D.

Chair: Kristin Beizai, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize ethical dimensions of challenging clinical cases;2) Learn an approach to bioethical analysis that can be utilized in managing complex clinical cases;3) Identify, diagnose and treat challenging clinical cases;

SUMMARY:

Clinical cases can be made more challenging by ethical dilemmas, whether they be on the consultation liaison service, the emergency room, the outpatient substance use treatment program, or the inpatient psychiatric unit. This workshop will

include a basic review of approaches to bioethical analysis, as well as a brief discussion of the “APA Principles of Medical Ethics, with annotations especially applicable to psychiatry”. These principles will provide an outline for the following discussion of a variety of challenging clinical cases. Examples of some of the cases to be discussed include: a refractory, non-compliant patient with alcohol dependence, which brought up issues of the physicians right to decline treatment, resource allocation as well as consideration of countertransference; a suicidal patient refusing removal of the insulin pump (which was the identified plan), with resulting concerns about safety, capacity, preserving autonomy and nonmaleficence; a patient with a diagnosis of cancer, with denial and the issue of informed consent; a patient with a left ventricular assist device requesting it be turned off, with the resulting assessment and issues amongst staff. The discussants will present their assessment, treatment and management in the cases, including involvement of a bioethics committee where relevant. Current literature will be discussed where relevant as well. The goal of this workshop is to discuss a framework to manage challenging clinical issues with ethical dimensions, with a focus on utilizing the 4 basic ethical principles (autonomy, beneficence, nonmaleficence, and justice), as well as a discussion of the 4 box method of ethical analysis.

WORKSHOP 104

SAFETY MEASURES FOR VICTIMS OF STALKING

Speakers: Gail E. Robinson, M.D., Karen Abrams, M.D.

Chair: Gail E. Robinson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the consequences to the victim of being stalked;2) Recommend measures to increase the safety of stalking victims;3) Understand the risk of health care professionals being stalked;4) Minimize the risk of being stalked as a health care professional;

SUMMARY:

Stalking is a serious offence perpetrated by disturbed offenders. It can cause major mental health consequences that are often poorly understood by society. The majority of victims are female. Up to 1 in 20 women will be stalked during her lifetime. Victims may develop anxiety, depression, guilt, helplessness and symptoms of post-traumatic stress disorder. They may also experience vandalism and personal violence. Victims also suffer from a lack of understanding by family, friends, society, police and the legal system, all of which may minimize the behavior or not enforce laws. As well as engaging in psychotherapy, therapists must know about practical ways in which victims can reduce their risk. They need to be informed about routine and emergency safety measures at home, in the community and at work. Issues re communication with the stalker and documentation will also be discussed. Health care professionals have an elevated risk of being stalked but often are unaware of this possibility. They usually have no education

about how to prevent stalking or address it when it occurs. They may ignore or tolerate behavior that can put them in emotional, physical or professional danger. This workshop will focus on practical measures to reduce stalking risk and prevent harm to the victim.

WORKSHOP 105

TRAINING PSYCHIATRY RESIDENTS IN COLLEGE MENTAL HEALTH

Speaker: Thomas Kramer, M.D.

Chairs: Valerie E. Houseknecht, M.D., Leigh A. White, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review the unique characteristics of college mental health practice;2) Discuss why these unique characteristics provide a valuable training environment for general and child psychiatry residents;3) Describe models for both elective and required resident rotations;4) Describe a program for a PGY 5 year in college mental health;

SUMMARY:

College Mental Health is an emerging subspecialty in Psychiatry and one which provides a rich training ground for resident education. This workshop will identify the unique aspects of the practice of psychiatry in the campus setting which offers residents an integrative experience that will benefit their future practice on and off campus. Resident training in college mental health offers the range of clinical experience, supplemented with a focus on public health, opportunities to partner with wider university and community resources, as well as to build skills in advocacy and policy development. It also offers opportunities to work closely with multidisciplinary integrated health teams addressing issues such as eating disorders, ADHD, and alcohol abuse. Discussion will include various current models for resident education in College Mental Health as well as presentation of a program for a PGY 5 year for graduating residents who are committed to a career in the university setting and want to learn comprehensive expertise within that setting.

WORKSHOP 106 (WITHDRAWN)

DSM-5: DO VALUES REALLY UNDERMINE OBJECTIVITY IN DISEASE CLASSIFICATION?

Speaker: Arthur Caplan, Ph.D.

Chairs: Arthur Caplan, Ph.D., Mark Komrad, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explain how and why values permeate psychiatric nosology; and that this fact does not necessarily invalidate

psychiatry classifications;2) Explore the role of values in helping to form the DSM;3) Engage with participants about the philosophical and ethical dimensions of controversies related to proposed shifts in the DSM;

SUMMARY:

Objectivity and replicability are key features of any classification system and psychiatric nosology is no exception. Finding sufficient evidence to bolster the use of a particular diagnosis in terms of reliability and utility is a key measure for assessing the work done in revising DSM5. However in the effort to secure objectivity it is sometimes argued that ethical values and norms cannot play any role in DSM5. This view of disease is overly narrow as well as inconsistent with the social and normative role that shapes the practice of mental health. The role of values and norms in helping to form DSM5 will be explored with special attention to new diagnostic and disease states.

WORKSHOP 107**MILD TRAUMATIC BRAIN INJURY: ASSESSMENT AND INITIAL MANAGEMENT WITH NEUROPHARMACOLOGY**

Speaker: David B. FitzGerald, M.D.

Chairs: Josepha A. Cheong, M.D., David B. FitzGerald, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand multiple areas of impairment/symptoms brought about by mild TBI;2) Identify pharmacological interventions which are appropriate for treating mild TBI;3) identify non-pharmacological interventions for treating mild TBI;

SUMMARY:

Loss of consciousness or alteration of consciousness for a short duration (less than 30 minutes) is thought to be a relatively benign experience, either in military settings or in civilian settings. The strengths and weaknesses of the current classification system of TBI are reviewed, with examples. A proportion of those experiencing brief loss of consciousness or alteration of consciousness (or mild TBI) have chronic adverse symptoms, which are only now being characterized.

The magnitude of the problem in both military and civilian areas is discussed. Recent imaging data using conventional anatomical imaging as well as a review of diffusion weighted imaging after mild TBI is also presented to provide better insight as to mechanisms of damage.

Current therapeutic approaches, both pharmacologic and non-pharmacologic approaches are discussed.

WORKSHOP 108**TRAUMATIC BRAIN INJURY AND PTSD: EASING THE PAIN**

Speakers: Venkata B. Kolli, M.B.B.S., Durga Prasad Bestha, M.B.B.S., Jayakrishna Madabushi, M.D.

Chair: Sriram Ramaswamy, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the epidemiological link and clinical symptom overlap of Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI);2) Become aware of the treatment challenges seen in patients with TBI and co-morbid PTSD;3) Become familiar with the effective pharmacological and non-pharmacological interventions in this patient population;

SUMMARY:

In the United States around 1.7 million individuals suffer Traumatic brain injury each year. Around 20% of the veterans returning from the recent wars in Iraq and Afghanistan at least meet the criteria for mild TBI. TBI doubles the risk of PTSD, and has been linked with increasing the risk of suicide. Patients with TBI often have suffered from other physical injuries and medical conditions like epilepsy, pain syndromes and are on multiple medications which further complicate the management. In patients with TBI, PTSD tends to have a chronic course and the management of this is hindered by absence of guidelines for this patient population. In the initial part of the interactive workshop we will discuss the relationship between TBI and PTSD. We focus on the role of specific brain region afflictions with a review of recent neuroimaging research findings, physical health problems including chronic pain conditions and psychosocial adversities, in precipitating and perpetuating these two conditions. Next, we will appraise the role of psycho-pharmacological treatments including but not limited to antidepressants, mood stabilizers, antipsychotics, sedatives and stimulants with treating these co-morbid disorders. We will emphasize the necessary precautions that need to be taken to ensure that treatment of one condition does not exacerbate the other. In the next section, a review of psychological therapies, combination treatment and psychosocial interventions that aid improving these conditions will be presented. The workshop will conclude with the discussion on common problems encountered in treating PTSD when present in conjunction with TBI with an active participation by the audience. References: Morgan M, Lockwood A, Steinke D, Schleenbaker R, Botts S. Pharmacotherapy regimens among patients with posttraumatic stress disorder and mild traumatic brain injury. *Psychiatr Serv.* 2012 ;1;63(2):182-5. McAllister TW. Psychopharmacological issues in the treatment of TBI and PTSD. *Clin Neuropsychol.* 2009;23(8):1338-67. Lowenstein DH. Epilepsy after head injury: An overview. *Epilepsia,* 2009;50: 4-9.

WORKSHOP 109**ON THE SEARCH FOR PEOPLE IN THE CLINIC: CREATIVE APPROACHES TO RECLAIMING SUBJECTIVE DATA IN PSYCHIATRY**

Speakers: John S. Strauss, M.D., Jeffrey Katzman, M.D., Sarah Mourra, M.D.

Chair: Sarah K. Fineberg, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the ways that psychiatric documentation highlights and can actually create distances between clinician and patient; 2) Consider subjectivity as a theoretical approach to re-frame our thinking about both clinicians and patients that might increase the richness and effectiveness of clinical engagement; 3) Open discussion of novel approaches to engaging subjectivity derived from the creative arts;

SUMMARY:

In this workshop we use our clinical experiences together with our writing in the medical record and in the creative realm to describe problems and possibilities in clinical engagement. We explore the consequences in our writing and in our patient encounters of the heavy weight we place on "objective" data. The ways we write about patients describe, and perhaps even construct, a distance between psychiatrist and patient which is often alienating. This feeling can generate major impediments to adequate evaluation and treatment. We suggest that more focused attempts to understand and represent the subjective experience, both of the patient and the clinician, might inform these problems. We expect that along with symptom presentation, the experience of engagement in the clinic also differs for patients across their varied perspectives from disease to recovery and across stages of the lifespan, among other variables. We will use four brief reports (two from very early career psychiatrists, and two from senior faculty) to provide a framework in which to consider engagement with subjective data in the clinical encounter. We will focus on approaches derived from creative writing and theatrical role play that can help us to develop awareness of this problem and to work with subjective data, as so to promote more connected and collaborative work with patients. We will describe specific examples of how these approaches can impact on writing for official documentation and in the clinical encounter. The workshop will conclude with time for attendees to share their own ideas and to develop further possibilities for creative interventions that can better engage subjectivity in our individual practices.

WORKSHOP 110**THE CLINICAL UTILITY OF VIOLENCE RISK ASSESSMENT TOOLS IN AN ACUTE CIVIL INPATIENT PSYCHIATRIC POPULATION**

Speakers: Debbie Green, Ph.D., Lizica C. Troneci, M.D.

Chairs: Katya Frischer, M.D., Ali Khadivi, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Evaluate the practical utility of violence risk assessment tools in a civil inpatient population; 2) Critically review all existing studies of risk assessment tools available for the civil psychiatric population; 3) Compare the advantage and disadvantage of using clinical judgment versus risk assessment tools in assessing and managing risk of violence in a civil psychiatric population;

SUMMARY:

Despite major developments in violence risk assessment tools, their application to everyday clinical use in civil inpatient psychiatric settings remains limited. Furthermore, clinicians and experts disagree on the usefulness of these instruments with civil psychiatric inpatients. The use of these instruments is seen as time consuming and a process requiring extensive training and resources. Furthermore, a recent study that examined the predictive power of the violence risk instruments in 24,827 people showed only low to moderate ability to predict violence in the community. The study also demonstrated that risk assessment that incorporates clinical judgment was as effective as actuarial instruments. The aim of this symposium is to critically examine the clinical utility of violence risk assessment measures in civil inpatient psychiatric settings. The focus of the symposium will be on the assessment of non-sexual violence by psychiatric inpatients discharged to the community. Both actuarial and structured professional judgment instruments will be critically reviewed as to the ease of their use, empirical support and their clinical usefulness in predicting and managing violence risk. The first presenter will introduce the instruments with a focus on their clinical utility. The second presenter will critically review all existing studies of the measures that sampled from civil psychiatric populations. The third presenter, using an inpatient psychiatric case, will compare the advantage and disadvantage of using clinical judgment vs. risk assessment tools in assessing and managing violence risk. The fourth presenter will integrate all the presentations, discuss the clinical implications, and offer recommendations as to how to implement clinically useful violence risk assessment into an acute civil psychiatric unit.

WORKSHOP 111**CHILD CUSTODY EVALUATIONS: NEW ISSUES AND NEW METHODS**

Speakers: Bradley W. Freeman, M.D., James S. Walker, M.Sc.

Chair: William Bernet, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the eleven critical factors that should be considered in determining “the best interests of the child” as part of a child custody evaluation; 2) Demonstrate knowledge of interview techniques and psychological tests that can be used to assess each of the eleven critical factors; 3) Demonstrate knowledge of the differential diagnosis of contact refusal, including estrangement, parental alienation, and other possible causes;

SUMMARY:

Child custody evaluations are perhaps the most common and also the least well defined task of forensic child psychiatrists and psychologists. There is no uniformly accepted procedure for conducting custody evaluations. In the past, opinions were frequently based on “expert opinion” rather than on standardized tests and well developed differential diagnoses. In this workshop, the presenters discuss ways to apply recent research in child development, psychological testing, and family dynamics in conducting these complex evaluations. First Presenter. Custody evaluators strive to identify “the best interests of the child,” although the criteria for the best-interests test have seemed arbitrary and subjective. Recent research has identified specific factors that constitute the best interests of the child as applied in custody disputes. There are 6 positive factors: positive parenting skills; parental school involvement; promotion of interpersonal development, such as encouraging the child’s relationships with appropriate peers; promotion of mental health; promotion of extracurricular activities; and effective co-parenting. There are 5 negative factors: poor parent-child attachment; poor parenting skills; emotional instability or mental disorder of the parent; environmental instability; and excessive conflict between the parents. (This part of the workshop is based on *Improving the Quality of Child Custody Evaluations: A Systematic Model*, by L. W. Tolle and W. T. O’Donohue, 2012.) Second Presenter. The 11 critical factors should be investigated in a systematic manner. Interview techniques and specific psychological tests may be used to assess each of the 11 factors, and the results can be tallied up in a way that indicates the strengths and weaknesses of both parents. Ideally, of course, the goal of a custody evaluation is not simply to identify which parent will raise the children and which parent will be marginalized; ideally, the goal should be to identify the best way for the parents to raise the children together, based on their individual strengths and weaknesses. The presenter will explain interview techniques and psychological tests that can be used to assess the 11

critical factors. (This part of the workshop is based partly on *The Art and Science of Child Custody Evaluation*, by J. Gould and D. Martindale, 2007; and *Conducting Child Custody Evaluations*, by P. Stahl, 2011).

Third Presenter. “Contact refusal” is a general term that refers to a child’s persistent attempts to avoid spending time and maintaining a relationship with one of the parents. When that symptom occurs, it is important to consider the differential diagnosis, which includes anxiety, oppositionality, estrangement, and parental alienation. The presenter will discuss evaluation techniques for sorting out the possibilities and arriving at a diagnosis. (This part of the workshop is based on *Parental Alienation*, DSM-5, and ICD-11, by W. Bernet.)

WORKSHOP 112**ARE YOU MY DOCTOR? DEFINING DUTY IN MALPRACTICE CASES**

Speakers: Brian Cooke, M.D., Reena Kapoor, M.D., Ezra Griffith, M.D.

Chair: Brian Cooke, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss how emerging areas of controversy in the doctor-patient relationship arise in malpractice cases; 2) Understand the case law and medical scholarship related to several “gray areas” in the doctor-patient relationship: independent medical exams, research trials, psychotherapy supervision, former patients, and technology-based relationships; 3) Learn how to navigate these murky doctor-patient relationships when serving the role of the clinician;

SUMMARY:

The practice of psychiatry has changed along with technology, and the use of websites, email communications, and telepsychiatry has become commonplace in many parts of the United States. In this workshop, we examine the impact of these changes upon malpractice litigation in recent years. We review the case law and medical scholarship related to several “gray areas” in the doctor-patient relationship: independent medical exams, research trials, psychotherapy supervision, former patients, and cocktail party conversations. In addition, we focus on technology-based relationships, such as telepsychiatry, “suicide hotlines,” smartphone applications, and on-call psychiatrist phone calls. We invite the audience to examine whether the movement toward patients’ rights and consumer-driven practice has had an impact on the definition of the doctor-patient relationship in psychiatry. We then discuss whether the changing relationship between doctor and patient is reflected in the outcomes of malpractice litigation, as well as the role of professional organizations in advocacy around these issues. We will offer potential solutions for the psychiatrist involved in cases with unclear doctor-patient relationships.

WORKSHOP 113**THE UTILITY OF MOTIVATIONAL INTERVIEWING IN PSYCHIATRIC TRAINING**

Speakers: Steven Cole, M.D., Petros Levounis, M.D.

Chairs: Erica C. Lander, Psy.D., Michael S. Ascher, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the 4 basic elements of the Spirit of Motivational Interviewing (MI);2) Explain the 4 core processes of MI as elaborated in the new Miller and Rollnick book (October, 2013);3) Discuss ways that MI can contribute to contemporary psychiatric practice;4) Generate ideas on ways to initiate MI training into residency training programs;

SUMMARY:

Motivational interviewing (MI) is a collaborative conversation between a patient and clinician that addresses ambivalence about change through attention to the language of change. MI is designed to help patients to resolve ambivalence and mobilize strength, commitment and personal resources for change. Through the exploration of the person's own reasons for change, MI embodies an atmosphere of acceptance and compassion. MI has been described as a "way of being" with people that can break down barriers and establish open lines of communication with patients, colleagues, supervisors and subordinates in a profound way. In this presentation, we will first review the fundamental principles of MI. The audience will screen a video clip that demonstrates "the spirit of MI." The presenters will discuss the benefits of integrating training in MI into residents' curricula and will share personal examples of how they have provided MI training to physicians and students in various settings. We will make the case for the inclusion of training in MI as a competency required of all trainees.

WORKSHOP 114**PSYCHIATRIC CARE IN SEVERE OBESITY: PREPARING FOR BARIATRIC SURGERY AND BEYOND**

Speakers: Weronika Gondek, M.D., Sanjeev Sockalingam, M.D., Raed Hawa, M.D.

Chair: Sanjeev Sockalingam, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize predisposing psychosocial factors to obesity;2) Apply a psychiatric approach to managing bariatric surgery patients in the peri-operative phase;3) Identify specific psychosocial interventions for managing eating disorders, body image concerns and enhancing medical outcomes following massive weight loss;

SUMMARY:

With the obesity epidemic reaching epic proportions in North America and high prevalence of obesity in psychiatric patient populations, psychiatrists are now considered integral to the management of severe obesity in hospital and community based settings. Pathways to obesity often involve a myriad of factors including biological, environmental and psychological factors. Psychiatrists are in a unique position to provide much needed multi-modal psychosocial approach to individuals suffering from severe obesity during patients' weight loss journey. Weight loss surgery (bariatric surgery) is now a recommended treatment for severe obesity. Given the high rates of psychiatric co-morbidity in bariatric surgery candidates, a comprehensive psychiatric assessment is needed to determine risks, anticipate post-operative complications and to improve long-term surgical outcomes. Unfortunately, massive weight loss has also been associated with psychosocial complications, including body image disturbance and new onset disordered eating. These psychiatric complications associated with bariatric surgery highlights the need for greater attention to psychosocial interventions during the post-bariatric surgery phase. Moreover, the rapid expansion of bariatric surgery centers across North America has increased the need for effective psychosocial models of peri-operative care that can maximize weight loss surgery outcomes and can maintain resolution of co-morbid obesity-related diseases. The following symposium will explore the relationship between psychiatric illness across the continuum of the "massive weight loss" journey. Dr. Sockalingam will introduce the symposium and provide a brief overview of biopsychosocial factors linked to severe obesity. Dr. Micula-Gondek will provide a psychiatric approach to the assessment and management of bariatric surgery candidates in the peri-operative phase. Dr. Hawa will discuss the long-term psychiatric complications and psychopathology unique to massive weight loss, including de novo eating disorders and body image issues. An approach to managing post-bariatric surgery psychiatric issues will be discussed. Lastly, Dr. Sockalingam will summarize evidence on psychosocial interventions improving weight loss and psychosocial outcomes post-bariatric surgery. Data from the University of Toronto Bariatric Surgery Collaborative will be used to supplement the evidence for psychosocial interventions. The presenters will argue for a spectrum of psychosocial care during massive weight loss surgery. Cases and an illustrative patient video will be used to highlight the above concepts.

WORKSHOP 115**A COGNITIVE-BEHAVIORAL APPROACH TO WEIGHT LOSS AND MAINTENANCE**

Chair: Judith Beck, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Teach dieters specific "pre-dieting" cognitive and behavioral skills;2) Keep motivation high long-term;3) Facilitate permanent changes in eating;

SUMMARY:

A growing body of research demonstrates that cognitive behavioral techniques are an important part of a weight loss and maintenance program, in addition to exercise and changes in eating (see, for example, Stahre & Hallstrom, 2005; Shaw, 2005; Werrij et al, 2009, Spahn et al, 2010; Cooper et al, 2010). An important element that is often underemphasized in weight loss programs is the role of dysfunctional cognitions. While most people can change their eating behavior in the short-run, they generally revert back to old eating habits unless they make lasting changes in their thinking. This interactive workshop presents a step-by-step approach to teach dieters specific skills and help them respond to negative thoughts that interfere with implementing these skills every day. Participants will learn how to engage the client and how to solve common practical problems. They will learn how to teach clients to develop realistic expectations, motivate themselves daily, reduce their fear of (and tolerate) hunger, manage cravings, use alternate strategies to cope with negative emotion, and get back on track immediately when they make a mistake.

Techniques will be presented to help dieters respond to dysfunctional beliefs related to deprivation, unfairness, discouragement, and disappointment, and continually rehearse responses to key automatic thoughts that undermine their motivation and sense of self-efficacy. Acceptance techniques will also be emphasized as dieters come to grips with the necessity of making permanent changes and maintaining a realistic, not an "ideal" weight that they can sustain for their lifetime.

WORKSHOP 116**BATH SALTS, ZOMBIES, AND CROCODILES: BATTLING A NEW DESIGNER-DRUG EMERGENCY**

Speakers: Constantine Ioannou, M.D., Shabneet Hira-Brar, M.D., Amarpreet Singh, M.B.B.S., M.D., Majid Samad, M.D., Mukesh P. Sharoha, M.B.B.S., M.D.

Chair: Damir Huremovic, M.D., M.P.P.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the public health relevance of growing epidemics of abuse of cathinone derivatives (e.g. mephedrone) and other novelty drugs (desomorphine); 2) Understand clinical features, signs, and symptoms of novelty drug intoxication and abuse; 3) Recognize, diagnose, and treat cases of intoxication with and abuse of cathinone derivatives and other novelty drugs in emergency and office settings; 4) Understand the social, economic, and international context of this epidemic and the role of new social media in spreading novelty drugs; 5) Utilize newly acquired knowledge of cathinone derivatives abuse to advance their approach to treating substance abuse patients;

SUMMARY:

Mephedrone, together with similar cathinone derivatives, synthetic cannabinoids, and designer opioid analogues, has been rapidly gaining prominence among recreational drug abusers worldwide while achieving international notoriety through a few bizarre, well-publicized cases of so-called 'zombie-attacks' associated with use of these drugs, commonly known as 'bath salts'. Known as 'bath salts', 'spice drugs', 'meow-meow', 'Ivory Wave', 'herbs', or 'K2', these substances have been surreptitiously, but intensely discussed, advertised, and circulated through online communities. Veiled in the shroud of virtual obscurity and legal ambiguity, these substances have managed to quickly gain traction among stimulant-seeking club-hoppers and meditation-focused connoisseurs alike. Novelty drugs have continued to increase their market share without triggering some of the common societal alerts - they are not illegal in all jurisdictions, they can be manufactured and distributed locally, they are marketed online, their addiction-forming potential remains unknown, and they are not identified by most commercial toxicology screen tests. While their use has spread significantly over the past five years, true epidemiological and public health scope of this issue still remains a mystery. Limited data, however, indicate a tremendous increase (e.g. a number of 'bath salts' related calls to poison control centers in the US went from 304 in 2010 to 6,138 in 2011), prompting legal action (Synthetic Drug Abuse Prevention Act of 2012) at the national level in July this year. Our understanding of clinical effects of such drugs is slowly evolving, still largely based on individual case reports, scarce case series, and data from poison control centers. Long-term effects of use of such substances remain largely unknown. The fact that these substances sprout in a number of varieties or tend to differ from one batch to another makes our understanding of this problem and our treatment approach to it even more challenging. Our lack of evidence-based knowledge on these derivatives makes them a moving target when it comes to suspecting their use and recognizing their effects when approaching patients with altered behavior and mental status in emergency settings. The primary goal of this workshop is to educate participants about novelty drugs and increase clinicians' suspicions of abuse in appropriate cases. Participants will also be educated about establishing the diagnosis and treating cases of intoxication with novelty drugs, followed by longer term approach to substance abuse treatment and counseling. Special attention will be given to the international scope of the problem, the role of new social media in this issue, and on how to incorporate screening for novelty drugs into routine evaluations. Case examples will be provided by a panel of clinicians from different parts of the country. Ample time will be allowed for interactive discussions and exchange of experiences.

WORKSHOP117**MINIMIZING HARM IN FORENSIC PSYCHIATRIC EXAMINATIONS: VULNERABLE POPULATIONS**

Chair: Robert Sadoff, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the vulnerable individuals in forensic cases;2) Minimize harm to defendants and plaintiffs when conducting forensic examinations;3) Minimize harm to vulnerable individuals when writing forensic reports;4) Minimize harm to plaintiffs and defendants when giving expert testimony;

SUMMARY:

Unlike treatment psychiatry, forensic psychiatrists work in a potentially harmful system: the justice system, either criminal or civil courts. Forensic psychiatrists cannot adhere to the standard medical ethical doctrine of *Primum non Nocere*: First do no Harm. In fact, the forensic psychiatrist may harm defendants in criminal cases of plaintiffs (or defendants) in civil cases. The harm may come irrespective of which side the mental health professional is on. The harm may come during the examination, the report writing or when giving expert testimony. Some individuals are especially vulnerable: children and adolescents, the elderly, the mentally retarded, the severely mentally ill, victims and perpetrators of sexual violence, immigrant, prisoners and death row inmates and the forensic expert, among others. This presentation will highlight the areas of potential harm in conducting the examination, the report writing and during testimony, and discuss means of minimizing harm to various vulnerable individuals. Finally, the ethical principles of forensic psychiatry will be discussed: concepts of honesty and striving for objectivity and seeking truth and justice can lead the way to minimizing harm to those we evaluate in a forensic setting.

WORKSHOP118**YOU BE THE NEUROLOGIST: DIAGNOSIS AND TREATMENT OF MILD TBI IN A CASE STUDY FORMAT**

Speaker: David B. FitzGerald, M.D.

Chair: David B. FitzGerald, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand criteria for diagnosis of mild TBI;2) Identify diagnostic steps to be considered when evaluating a symptomatic patient with mild TBI;3) identify alternative diagnoses to be considered when elements of the patient's history and time course do not seem to fit with the diagnosis of mild TBI.;

SUMMARY:

Mild TBI is defined clinically. This clinical definition has an expected set of symptoms and an expected time course of recovery from these symptoms. However, not all patients presenting with a diagnosis of mild TBI have mild TBI. Some patients may have moderate to severe TBI based on imaging. Some patients may have additional diagnoses which confuse the diagnostic work-up and prevent resolution of symptoms or result in suboptimal diagnostic approaches.

Cases with a presenting diagnosis of "mild TBI" are reviewed with a brief history, imaging as appropriate, other diagnostic tests and test results as indicated, a final diagnosis, treatment and outcome. This session is intended to be interactive with "what should the next step be?" as part of the presentation.

Although presented by a neurologist, neurological jargon will be kept to a minimum.

WORKSHOP 119**IMPROVING CLINICAL EFFICIENCY WITH DO-IT-YOURSELF INTRANET WEB BROWSER APPLICATIONS**

Speakers: Kelly Driver, M.D., Shirley Pullan, B.A., David Gotlib, M.D.

Chair: David Gotlib, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the principles behind simple web browser-based applications;2) Be able to construct a simple application, and identify sources for additional design information as needed;3) Identify potential applications within their own workplace;

SUMMARY:

Web-based technologies are sufficiently advanced and user-friendly to permit those with little or no technical training to construct practical and useful browser-based intranet applications to improve clinical effectiveness and communication. This workshop will demonstrate the techniques and resources necessary to do this, through 3 recently implemented, zero-budget projects in a large community teaching hospital:

-an electronic whiteboard enabling staff across the hospital to view moment to moment changes in the roster of patients being assessed in the emergency department; -a suite of online appointment scheduling systems;

-a multidisciplinary care plan which guides and documents the current treatment episode, follows the patient through different levels of care, and provides a cumulative record of mental health interventions. Each participant will be given reference material, and the code to run the applications presented in their own workplace.

WORKSHOP 120**THE PHYSICIAN PAYMENTS SUNSHINE ACT: WHAT PSYCHIATRISTS NEED TO KNOW**

Speakers: Daniel Carlat, M.D., James H. Scully Jr., M.D.

Chair: Daniel Carlat, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the history of the Physician Payments Sunshine Act;2) Describe the rationale for the Physician Payments Sunshine Act;3) Describe how payments from the pharmaceutical industry to physicians and hospitals will be reported on a publically available website;4) Understand how to talk to patients about the reported payments.;

SUMMARY:

The Physician Payment Sunshine Act was passed in 2010 as part of the Affordable Care Act. The law requires that all payments and gifts from drug or device companies to physicians or hospitals be reported to the government and be posted on a public website. The passage and implementation of the law has been controversial, and psychiatry has played a large role in discussions surrounding the law. In this workshop, we will discuss the history of the law, and describe the various requirements. We will provide advice on how to ensure that your payments are reported accurately and how to educate your patients about the payments in order to avoid disruptions in the trust underlying the doctor/patient relationship.

WORKSHOP 121**TREATMENT OF ACUTE MANIA: ALGORITHM FROM THE PSYCHOPHARMACOLOGY ALGORITHM PROJECT AT THE HARVARD SOUTH SHORE PROGRAM**

Speaker: Othman Mohammad, M.D.

Chair: David Osser, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify medications with anti-manic properties that have the best overall efficacy for all phases of bipolar disorder;2) Participants will select anti-manic agents taking into consideration their short and long-term tolerability and safety;3) Participants will recognize those combinations of anti-manic agents that have the best evidence of effectiveness;

SUMMARY:

This workshop focuses on a new algorithm for the pharmacotherapy of acute mania developed by the Psychopharmacology Algorithm Project at the Harvard South Shore Program.

The authors conducted a literature search in PubMed pairing known anti-manic medications in Boolean "AND" searches with mania. They also reviewed other algorithms and guidelines and their references. Special attention was given to newer meta-analyses and studies that were not considered in previous reviews. Treatments were prioritized considering 3 main goals: 1) effectiveness in treating the current episode, 2) preventing relapses of mania and depression, and 3) minimizing side effects over the short and long term. After initial steps including accurate diagnosis, ruling out medical causes, discontinuing antidepressants, awareness of the patient's child-bearing potential, and treatment of substance abuse, the basic algorithm would first ask for a determination if this is a psychotic mania. Patients with very severe psychotic mania may be treated first with haloperidol. This preference is based on expert opinion rather than evidence, as patients this ill are rarely included in studies. For more moderately psychotic and non-psychotic mania, the first-line recommendation is lithium because of multiple advantages considering the priorities stated above. Lithium may also be added to the haloperidol for severe psychotic mania with a plan to eventually transition to lithium alone. When lithium is used first, and it is deemed necessary to add another anti-manic agent, quetiapine is favored because it is the only antipsychotic or anticonvulsant with broad spectrum efficacy in all phases of bipolar. If the response is still unsatisfactory, consider adding valproate while stopping any clearly ineffective medications that have been initiated to this point while ensuring that at least one medication remains with ability to prevent future depressions. Valproate's recent evidence base is fairly weak but it had good early studies and has broad experience in clinical practice. If none of these options has helped, the next set of options includes other atypical antipsychotics and carbamazepine. Risperidone, olanzapine, and carbamazepine are first-tier, with aripiprazole, ziprasidone, and asenapine second-tier. Clozapine is third-tier based on its weaker evidence base and greater side effects. The algorithm concludes with a review of a selection of less favored or less evidenced choices including oxcarbazepine, levetiracetam, tamoxifen, allopurinol, and repetitive transcutaneous magnetic stimulation. Electroconvulsive therapy may be considered at any point in the algorithm if there is a history of positive response or intolerance of medications. In this workshop, the authors will present the algorithm and the reasoning justifying the sequence of recommended treatments and there will be ample time for attendees to respond and interact with the presenters.

WORKSHOP 122**PSYCHIATRIC DISORDERS IN EPILEPSY**

Speakers: Madhuri Pulluri, M.B.B.S., Srinivas Dan-naram, M.B.B.S., Harmit Singh, M.D.

Chair: Ashish Sharma, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the epidemiology of psychiatric disorder

ders and associated risk's in patients with epilepsy;2) Understand the psychopathology of psychiatric disorders in patients with epilepsy;3) Manage psychiatric disorders in patients with epilepsy;4) Assess and manage risk's associated with psychiatric disorders in epilepsy;5) Identify temporal relationship between psychiatric disorders and seizures;

SUMMARY:

Epilepsy is the most common serious neurologic disorder, it affects >50 million people worldwide(1). Psychiatric events are more frequent in people with epilepsy than in general population(2). Influences of psychiatric events on social and occupational functioning of patients with epilepsy are more severe compared to general population 3. Psychiatric events in people with epilepsy differ in their presentation; longitudinal course and treatment response compared to general population4. Associated psychiatric risks, suicides in particular are high in people with epilepsy and comorbid psychiatric conditions(5). Depression impacts quality of life more than the impact of seizure frequency and severity in people with treatment resistance epilepsy. Psychiatric events tend have an atypical presentation (Inter ictal psychopathology) when associated with epilepsy, some psychiatric presentations like interictal dysphoric disorder(6), peri-ictal anxiety and postictal psychosis are seen more frequently in people with epilepsy. Psychiatric events also vary in presentation with age and type of epilepsy, indicating a possibility of shared pathophysiological process. Studies suggested that there is a mutual relationship between seizure frequency, severity and psychiatric events. Medication management of psychiatric events in patients with epilepsy is different from general population. This is due to various factors like mutual pharmacokinetic interactions of antiepileptic and psychotropic medications, effect of psychotropic medications on seizure threshold and influence of antiepileptic medications in inducing psychiatric events. The association between psychiatric events and epilepsy is complex. The variations in presentation with high mortality and morbidity demand a good understanding of this topic for both psychiatrists and neurologists. Effective management may need a corroborative approach involving neurologists and psychiatrists to understand temporal relationship between seizures and psychiatric events, assessment of risk and considering appropriate psychotropic medications and antiepileptic medications. REFERENCES 1. World Health Organization 2005; Ngugi et al. 2010. 2. Gaitatzis A, Trimble MR, Sander JW. The psychiatric comorbidity of epilepsy. *Acta Neurol Scand* 2004; 110:207-20. 3. Beyenburg S, Mitchell AJ, Schmidt D, Elger CE, Reuber M. ?Anxiety in patients with epilepsy: systematic review and suggestions for clinical management. *Epilepsy Behav* 2005; 7:161-71. 4. Christensen et al., 2007; Thapar et al., 2009. 5. Fukuchi T, Kanemoto K, Kato M, Ishida S, Yuasa S, Kawasaki J, et al. Death in epilepsy with special attention to suicide cases. *Epilepsy Res* 2002; 51:233-6. 6. Blumer D. Dysphoric disorders and paroxysmal affects: recognition and treatment of epilepsy-related psychiatric disorders. *Harv Rev Psychiatry* 2000.

WORKSHOP 123

ISSUES IN THE TREATMENT OF PAIN AND ADDICTION

Speakers: Roger Chou, M.D., John A. Renner Jr, M.D.

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify evidence-based practices associated with safe opioid prescribing and treatment of opioid dependence;2) Identify safe opioid prescribing practices: evaluation of pain, toxicology screening, prescription monitoring programs, use of treatment agreements, and opioid alternatives/ adjunctive treatments;3) Recognize and treat co-occurring psychiatric disorders in chronic pain patients;4) Recognize substance dependence co-occurring with chronic pain and learn about treatment options for opioid dependence;5) Use training and mentoring resources for safe use of opioids and treatment of opioid dependence, including the PCSS-B and PCSS-O;

SUMMARY:

The United States is currently experiencing an epidemic of abuse of prescription pain medications. There has been a 300% increase in the sales of powerful opioid pain medications in the U.S. since 1999. Coincident with the greater availability of these drugs, we have seen a surge in deaths from overdoses with 14,800 deaths in 2008-more than for heroin and cocaine combined and in 2009 we saw 475,000 emergency department visits for adverse events related to misuse of opioid pain medications. In 2010, more than 12 million Americans over the age of 12 reported nonmedical use of prescription pain medications. Treatment admissions for addiction to pain medicines increased fourfold between 1998 and 2008. Because of the high rates of co-occurring mental disorders in this population, psychiatrists will play an increasingly important role in participating in the evaluation of pain, safe and effective opioid prescribing, and when clinically indicated, in diagnosing and treating co-occurring mental and substance use disorders. This workshop will address issues in assessment and treatment of pain, mental illness, and substance use disorders treatment. National training and mentoring resources available to assist physicians through the Physicians' Clinical Support System-Buprenorphine and the Prescribers' Clinical Support System for Opioid Therapies will also be discussed.

WORKSHOP 124**USING EVIDENCE TO OPTIMIZE CARE: TREATING BEHAVIORAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA IN THE ERA OF BLACK BOX WARNINGS**

Speakers: Deena Williamson, M.B.A., M.S.N., Vikrant Mittal, M.D., M.H.S.

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define behavioral and psychological symptoms of dementia (BPSD);2) Enumerate the epidemiology, neurobiology and evidence-based assessment protocol for BPSD;3) Elaborate on the various treatment modalities for BPSD;4) Review recent controversies in the treatment of BPSD;5) Highlight the medicolegal issues in the treatment of BPSD;

SUMMARY:

Behavioral and Psychological Symptoms of Dementia (BPSD) refers to a group of non-cognitive symptoms and behaviors that occur commonly in patients with dementia. BPSD results from a complex interplay between various biological, psychological and social factors involved in the disease process. BPSD is associated with increased caregiver burden, institutionalization, a more rapid decline in cognition and function and overall poorer quality of life. It also adds to the direct and indirect costs of caring for patients with dementia. Available data indicate efficacy for some non-pharmacological and pharmacological treatment modalities for BPSD. However, recently the use of psychotropic medications for the treatment of BPSD has generated controversy due to increased recognition of their serious adverse effects. In this presentation we will discuss the epidemiology, neurobiology, diagnosis and evidence based treatments for BPSD. We will also elaborate on the recent controversies in the treatment of BPSD. Finally, we will provide an evidence based guideline to assess and treat patients with BPSD thereby helping clinicians optimize outcomes for their patients.

WORKSHOP 125**TOP 10 GERIATRIC PSYCHIATRY ISSUES FOR THE GENERAL PSYCHIATRIST**

Chairs: Josepha A. Cheong, M.D., Iqbal Ahmed, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the key issues in the geriatric patient presenting in a general clinic setting;2) Initiate appropriate treatment and medication of cognitive disorders;3) Manage behavioral disturbances in an elderly patient with cognitive disorders;

SUMMARY:

With the ever increasing population of older adults over the age of 65, the population of elderly patients in a general psychiatry practice is growing exponentially also. Within this patient population, diagnoses and clinical presentations are unique from those seen in the general adult population.

In particular, the general psychiatrist is likely to encounter a growing number of patients with cognitive disorders and behavioral disorders secondary to chronic medical illnesses. Given the usual multiple medical comorbidities as well as age-related metabolic changes, the geriatric patient with psychiatric illness may present unique challenges for the general psychiatrists. This interactive session will focus on the most common presentations of geriatric patients in a general setting. In addition to discussion of diagnostic elements, pharmacology and general management strategies will also be presented. This small interactive session will use

pertinent clinical cases to stimulate the active participation of the learners.

WORKSHOP 126**COGNITIVE BEHAVIOR THERAPY FOR PERSONALITY DISORDERS**

Chair: Judith Beck, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Conceptualize personality disorder patients according to the cognitive model;2) Improve and use the therapeutic alliance in treatment;3) Set goals and plan treatment for patients with characterological disturbance;4) Describe advanced cognitive and behavioral techniques;5) Manage low motivation and resistance.;

SUMMARY:

A growing body of literature supports the efficacy of Cognitive Behavior Therapy in the treatment of Axis II patients. The conceptualization and treatment for these patients is far more complex than for patients with Axis I disorders. Therapists need to understand the cognitive formulation for each of the personality disorders. They need to be able to take the data patients present to develop individualized conceptualizations, including the role of adverse childhood experiences in the development and maintenance of patients' core beliefs and compensatory strategies. This conceptualization guides the clinician in planning treatment within and across sessions and in effectively dealing with problems in the therapeutic alliance. Experiential strategies are often required for patients to change their core beliefs of themselves, their worlds, and other people not only at the intellectual level but also at the emotional level.

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WORKSHOP 127**MANAGEMENT OF ALCOHOL ABUSE, WITHDRAWAL, AND DEPENDENCE: A PRACTICAL GUIDE FOR GENERAL PSYCHIATRISTS***Chairs: Jose Maldonado, M.D., Yelizaveta Sher, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Neurobiology of alcohol dependence and neurochemical mechanisms of withdrawal; 2) Use of non-benzodiazepine treatment protocols as alternative management of alcohol withdrawal syndrome; 3) Use of pharmacological agents for the treatment of alcohol dependence;

SUMMARY:

Alcohol use disorder (AUD) is the most serious substance abuse problem in the United States (US) and worldwide. Alcoholism has been reported in 20% to 50% of hospitalized medical patients. Most of the alcohol dependent patients admitted to the general medical wards will develop alcohol withdrawal symptoms, significant enough to require pharmacological intervention regardless of the cause for admission. Alcohol abuse and withdrawal are associated with an increased risk for medical comorbidities (e.g., infections; cardiopulmonary insufficiency; cardiac arrhythmia; bleeding disorders; need for mechanical ventilation) and longer, more complicated hospital and ICU stays making it particularly important for Psychosomatic Medicine specialist to be adept in the recognition and management of alcohol dependence and withdrawal states. Alcohol renders its depressant central effects through its agonistic effect on GABAA receptors primarily in the cerebral cortex, medial septal neurons, and hippocampal neurons. But is through its disinhibition of GABA-mediated dopaminergic-projections to the ventral tegmental area, leading to increases in extracellular dopamine in the nucleus accumbens that it mediates the initially pleasurable effects of alcohol and thus the impulse to drink more. The development of alcohol tolerance is a neuroadaptive process directed at reducing the acute effects of alcohol and thereby providing homeostasis via an adaptive suppression of GABA activity, mediated by internalization and down regulation of GABAA-BZ receptor complexes; increased synaptic glutamate release; and overactivity of noradrenergic neurons in the CNS and the peripheral nervous system. The symptoms of alcohol withdrawal syndromes (AWS) are then associated with abnormalities in the levels of NE (i.e., symptoms of autonomic hyperactivity, DA (i.e., agitation & psychosis), and GLU (i.e., seizures). Certainly the use of benzodiazepines and other GABAergic agents (e.g., barbiturates, propofol) can lead to suppression of excess activity of all these neurotransmitters and associated receptors, but at a high cost: significant neurological (e.g., ataxia), medical (e.g., respiratory depression), and cognitive (e.g., amnesia, delirium) impairment; as well as possible development of iatrogenic benzodiazepine dependence. This workshop will review the

neurobiology of alcohol dependence and neurochemical mechanisms of withdrawal and address the state of the art regarding the use of benzodiazepine and explore the potential of non-benzodiazepine agents (i.e., anticonvulsants, antipsychotics and alpha-2 agonists) in the management and treatment of AWS. We will examine the available evidence for their effectiveness and compare these results to what benzodiazepines can do; highlighting advantages and pitfalls in treatment. We will also discuss the pharmacological and non-treatment of alcohol dependence and methods to manage cravings and prevent recidivism.

WORKSHOP 128**USING EMPIRICAL CLINICAL PRACTICE DATA TO INFORM POLICY AND IMPROVE CARE FOR SERVICE MEMBERS***Speakers: Joshua Wilk, Ph.D., Charles Hoge, M.D., Joyce C. West, M.P.P., Ph.D., Farifteh Duffy, Ph.D.**Chairs: Charles Hoge, M.D., Joshua Wilk, Ph.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session, the participant should be able to: 1) Recognize how the Army uses systematic clinical practice data collected from behavioral health clinicians to inform policy and improve care for service members, with regard to the treatment of PTSD; 2) Identify key factors affecting treatment access and quality for service members receiving behavioral health treatment in the army; 3) Understand current rates of use of evidence-based practices with respect to patient assessments and treatment for substance use disorders among service members.;

SUMMARY:

This workshop will highlight how systematic clinical practice data collected from behavioral health clinicians through the WRAIR Army Behavioral Health Practice and Treatment Study have been used by the Army to inform policy and improve care for service members. A major focus will be on describing how findings related to the assessment and quality of treatment for post-traumatic stress disorder were specifically used to inform the Department of the Army's Policy Guidance on the Assessment and Treatment of Post-Traumatic Stress Disorder. In addition, key findings focusing on clinicians' reports of factors affecting treatment access and quality for a systematically selected sample of service members receiving behavioral health treatment in the army will be presented, along with clinical practice findings related to quality of assessments and treatment for substance use disorders in Army behavioral healthcare settings. The implications of these findings for strengthening services delivery and clinical practice in the Army in order to improve care for service members will be discussed.

The format of the workshop will consist of an introduction and three brief presentations. After each presentation, the session co-chairs (Joshua E. Wilk, PhD and Charles W. Hoge, MD)

from the Walter Reed Army Institute of Research (WRAIR) will lead a discussion focusing on the implications of the findings presented for policy and clinical practice. There will be ample time allocated for questions and comments from attendees after each presentation.

WORKSHOP 129

HYBRID RESEARCH-ADVOCACY ORGANIZATIONS, DISEASE PARADIGMS, AND DSM: A CASE STUDY OF AUTISM

Speakers: Benjamin DiCicco-Bloom, M.A., Debra Dunn, J.D., Rebecca Johnson, M.A.

Chairs: Rebecca Johnson, M.A., Dominic Sisti, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To learn about the ethical implications of the intersection of the DSM's development and psychiatry's professional practices with disease-specific advocacy groups; 2) To learn about the dual impact that a DSM diagnosis may have upon patients: providing a diagnostic home and support community versus providing a label that can create social stigma; 3) To learn about the different ways of autism has been conceptualized by different stakeholders throughout history, and the impact of this conceptualization on the child to adult transition in autism;

SUMMARY:

This workshop uses autism as a case study to examine the role of patient and family advocacy and experience in shaping psychiatric research priorities and nosology. The DSM has come under scrutiny by patient and family advocates seeking to incorporate what some deem "non-clinical" concerns (i.e. insurance reimbursement, special education issues, etc.) into the manual, while simultaneously funding significant amounts of research into areas such as disease etiology and treatment more aligned with the DSM's clinical and research aims. What are the ethical implications of this research-advocacy model for DSM nosology and how can family advocates and patients have their voices incorporated in an equitable and judicious manner?

Highlighting the importance of patient and family incorporation into the process of constructing psychiatric nosology, the second part of the workshop will home in on the impact of proposed changes to the DSM-5 on families and caregivers. After facing difficulties obtaining a diagnosis, patients may find themselves without a diagnostic home; in this part of the workshop, the speaker will explore the dichotomy between the esteem many associate with the "Asperger" label compared with the "stigma" of "autism" and the implication the change may have on the willingness of some to seek and/or accept a diagnosis.

While the existence of the diagnostic tradeoff-autism as community-granting but also stigma-giving-has come into sharp re-

lief with the proposed changes to the DSM-5, the third part of this workshop will add nuance to the present debates through a historical and ethnographic analysis of three conceptual paradigms of autism: psychogenic, mainstream science, and biopolitical. Each of these models eschews research into autism's long-term prognosis, instead focusing on more youth-oriented concerns such as etiology and treatment. As a result, there remain important questions about and a lack of research on the child-to-adult transition for persons with autism, and questions surrounding social integration, planning for the future of an aging child, and caregiving outside the family. What is the relationship between the DSM as a form of currency for many of these social services and its uses as a research tool and clinical document? How can the DSM adapt to emerging issues in the study of the child-to-adult transition in autism and how does hybrid research-advocacy either facilitate or hinder the incorporation of these emerging issues?

WORKSHOP 130

PSYCHIATRIC SERVICES IN JAILS AND PRISONS: AN UPDATE ON THE APA GUIDELINES

Speakers: Lama Bazzi, M.D., Joseph V. Penn, M.D., Roberta Stellman, M.D.

Chairs: Michael Champion, M.D., Henry C. Weinstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify and describe critical issues and changes in the criminal justice /corrections environment that call for a revision of the APA Guidelines on Psychiatric Services in Jails and Prisons; 2) Describe and discuss the developing process of revising the APA Guidelines on Psychiatric Services in Jails and Prisons; 3) Provide an opportunity for APA members to give feedback and input on topics for potential inclusion in the revision of the APA Guidelines on Psychiatric Services in Jails and Prisons; 4) Update APA members on the work of the APA Workgroup on Persons with Mental Illness in the Criminal Justice System;

SUMMARY:

The publication in 1989 of the APA Guidelines on Psychiatric Services in Jails and Prisons was a landmark in correctional psychiatry - the first detailed guidelines specifically directed to the provision of adequate mental health services for mentally ill inmates. It was hailed as the finest as well as the first. The APA Guidelines uniquely set out the broad general principles of such care, such as the requirement for the provision and assessment of quality care, issues of the education and training of all mental health professionals, requirements of informed consent, confidentiality, treatment modalities to be available, issues relating to research in jails and prison, administration and administrative issues and interprofessional relationships. The second part of the APA Guidelines outlined the specific, required, mental health services to be provided in local lock-ups, jails and prisons. The Second Edition, published a

decade later added sections to the “Principles” on cultural awareness, suicide prevention, the provision of psychiatric services in court and other settings and as well as jail diversion and other alternatives to incarceration. Importantly, the Second Edition added a new section applying the principles and the guidelines to specific populations: women inmates, youth in adult correctional facilities inmates, patients with HIV/AIDS, patients with substance use disorders and/or co-occurring disorders, geriatric patients and patients with mental retardation/developmental disability.

Since the publication of the Second Edition, further dramatic changes have been taking place including an emphasis on evidence based practice, challenges to accessing care in segregation units, new models for the administration and management of correctional facilities, the rapid development of diversion programs and mental health courts, a major focus on reentry issues and, concomitantly, the need for close coordination with community mental health agencies.

Members of the Workgroup on Persons with Mental Illness in the Criminal Justice System will lead this interactive workshop which will describe and discuss these issues and the development of plans to revise the APA Guidelines on Psychiatric Services in Jails and Prisons. A substantial portion of time will be provided for audience members to give feedback and input on topics for potential inclusion in the revision of the APA Guidelines on Psychiatric Services in Jails and Prisons.

WORKSHOP 131

HIGH-YIELD CBT FOR BRIEF SESSIONS

Speakers: Jesse H. Wright, M.D., Ph.D., Judith Beck, Ph.D., David Casey, M.D.

Chair: Donna Sudak, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify CBT methods that can be delivered effectively in treatment sessions lasting less than 50 minutes;2) Recognize strategies for enhancing the efficiency of CBT in brief sessions;3) Describe key methods of integrating CBT with pharmacotherapy in brief sessions;

SUMMARY:

In modern clinical practice, most psychiatrists spend the majority of their time with patients in sessions that are shorter than the traditional “50-minute hour.” Yet, traditional psychotherapy training emphasizes full-length therapy sessions. In this workshop, methods are described and illustrated for drawing from the theories and strategies of CBT to enrich briefer sessions. Examples of specific interventions that are detailed include enhancing adherence to medication, using targeted behavioral strategies for anxiety disorders, cognitive restructuring in brief sessions, and CBT for insomnia. Participants will have the opportunity to discuss how they could implement CBT in brief sessions in their own practices.

Specific techniques that are needed to adapt CBT into briefer formats will be detailed and resources for further training and study discussed. Participants will have ample opportunity to watch role-play and video demonstrations of the techniques described.

WORKSHOP 132

TREATING MEDICAL STUDENTS AND PHYSICIANS

Chairs: Leah J. Dickstein, M.A., M.D., Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the more common difficulties in medical students and physicians that bring them for psychiatric treatment;2) Itemize the common underlying dynamics of resistance in physician-patients;3) Apply biopsychosocial principles in comprehensive assessment and treatment of medical students and physicians;4) Recognize common transference and countertransference dynamics when psychiatrists treat medical students and physicians;

SUMMARY:

It is well-known that medical students and physicians can pose unique challenges when they become ill. Some of these are: engaging the medical student or physician in a treatment alliance and overcoming stigma; advocacy issues when negotiating with deans of medical schools, training directors, licensing boards, and insurance carriers; treating substance-abusing medical students and physicians and working with physician health committees; addressing privacy and confidentiality of medical records; avoiding conflict-of-interest matters; treating physicians who have been sued or reported to their licensing board; treating medical students and physicians who are members of racial, ethnic or religious minority groups or physicians who are international medical graduates (IMGs); complexities when treating the suicidal physician; treating relationship strain in medical students and physicians; reaching out to family members and significant others of symptomatic medical students and physicians; understanding the many transference and countertransference issues when psychiatrists treat medical students, residents, and colleagues. The presenters have a combined experience of treating over 2000 medical students and physicians over their lengthy careers. This is a wholly interactive workshop; didactic presentations will be limited to 15 minutes each leaving one full hour for discussion with attendees.

WORKSHOP 133**COMPREHENSIVE CARE FOR PATIENTS WITH MEDICAL AND PSYCHIATRIC COMORBIDITY: A NEW MODEL OF CARE AND OPPORTUNITY FOR PSYCHIATRISTS**

Chairs: Steven Frankel, M.D., James A. Bourgeois, M.D., O.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define "case complexity." What are the characteristics associated with common definitions of "complex case" and "complex patient?"; 2) Understand what are the explanations for the commonly encountered separation of systemic medical and mental health care? What are the chief arguments, economic and medical, for the integration of the two?; 3) Understand the "Medical-Psychiatric Coordinating Physician" (MPCP) model of care delivery is offered as an antidote to fragmentation of care for complex patients. Describe the features of this model; 4) Describe in what ways is the MPCP model an extension of outpatient psychosomatic medicine? How does it potentially supplement primary care practice?;

SUMMARY:

Objective: We propose an innovative clinical role, the "Medical-Psychiatric Coordinating Physician (MPCP)," involving psychiatrist-led multispecialty teams for managing the most challenging segment of complex outpatients. "Complex patients" (Kathol et al.) present with significant comorbid systemic medical and psychiatric illnesses and challenging management requirements (de Jonge et al.). We developed the MPCP method for enhancing the efficiency and efficacy in care of these patients.

The goal of the MPCP's work is to achieve and sustain treatment focus. Specific roles include active involvement organizing workups; collaboration with patients and their families, and formal tracking of treatment progress. Regular liaison with the patient's PCP allows the MPCP to place psychiatric/systemic medical co-morbidity as central to the patient's management. Method: The authors pilot tested this model with 52 complex cases followed for 18 months. Patients were selected from office based patients according to the following criteria: at least two other professionals had been involved in their care; at least one other treatment had been attempted and failed; the patient required frequent extra contacts.

Results: Comprehensive clinical review indicated sustained improvement in at least two clinical dimensions (utilization of resources, treatment adherence, decrease in systemic medical and/or psychiatric symptoms, quality of life) in 44 patients following adoption of MPCP care.

Conclusions: Other models to manage complex outpatients include patient centered medical homes; care managers embedded in primary care offices; and collaborative or stepped

care models advocated, for example, by Katon et al. The MPCP led model differs from these models with the psychiatrist taking a more central and ongoing role. It is a preferred model for the "most complex of the complex", i.e., patients who fail other integrated care models, including those with severe cases of somatically expressed psychiatric illness (e.g. somatoform disorder, chronic pain). -- It represents a new role for psychiatrists who are interested in comprehensive management of complex patients. The following is an example of a case managed with this model Solomon was referred for psychiatric care after his wife left him, unable to tolerate his disfigurement from scleroderma. Associated with his scleroderma were esophageal fibrosis; festering, chronically neglected, skin lesions; and pulmonary fibrosis. Depressed and immobilized, he was unwilling to cooperate with his physicians or adhere to advice from family members. Workshop proposal: The authors will describe this model of care delivery, illustrated by case examples. Two discussants will be engaged, at least one of whom represents a care delivery model alternative to or that competes with the MPCP model. The development of an MPCP treatment program will be included as a topic. Ample time will be allocated for participant and audience discussion.

WORKSHOP 134**THE MENTALLY ILL AND GUNS: A PERFECT TARGET?**

Speakers: Susan Hatters-Friedman, M.D., Abhishek Jain, M.D., Ryan C.W. Hall, M.D.

Chair: Renee Sorrentino, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the federal and state laws prohibiting firearms possession by individuals identified as mentally ill; 2) Identify the ethical issues that arise in the prohibition of guns in the mentally ill; 3) Discuss the role of the psychiatrist in managing patients who have access to firearms;

SUMMARY:

The right to bear firearms in the United States is enumerated in the second amendment of the Constitution. However over 40 years ago the federal government barred individuals with a history of involuntary psychiatric hospitalization from purchasing or possessing firearms. Today all 50 states prohibit persons who have been civilly committed to treatment settings and those found not guilty by reason of insanity from owning and carrying firearms (Norris and Price, 2008). There have been several national cases of mentally ill individuals committing mass homicides with legally purchased firearm. Studies have corroborated a positive association between suicide and firearm ownership, as well as homicide and firearm ownership (Traylor et al, 2010). Together such cases and data have raised important questions for the target population of the mentally ill. How is mental illness defined in gun laws? How is this information conveyed to the distributors of firearms? Should gun prohibition be life long? What role do psychia-

trists have in these restrictions? How effective are the current restrictions?

This workshop will address these questions by a review of the federal and state laws prohibiting gun ownership in the mentally ill, an analysis of their efficacy and the clinical implications of such laws. The panel will debate the pros and cons of gun restriction in this population. In conclusion the panel will identify the role of psychiatrists in gun licensure and possession.

WORKSHOP 135

POSITIVE PSYCHIATRY: A STRENGTHS-BASED RECOVERY MODEL FOCUSED ON UNDERREPRESENTED MINORITIES IN MEDICAL SCHOOL AND RESIDENCY

Speakers: Courtney L. McMickens, M.D., M.P.H., Farah Rahiem, M.D., M.P.H., Sarah Bougary, M.D., Hasani Baharanyi, M.D., Nisha N. Shah, M.D.

Chairs: Miko Rose, M.D., Artha Gillis, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Participants will gain an understanding about the risks of untreated “burnout” in student and physician populations both from a biological and social perspective.;2) Participants will learn the basic tenets of Positive Psychology and the challenges of changing from a perceptual focus on pathology to a focus based on supporting strengths while healing pathology.;3) Participants will gain practical experience in a mindfulness practice and positive psychiatry.;4) Participants will also learn about how different meditative practices and positive psychiatry are being used in diverse settings.;

SUMMARY:

Rationale

- Medical student burnout is estimated at 49-51% throughout the course of medical education; suicidal ideation is estimated at 11.2%. (1)
- Burnout that continues into medical residency is directly correlated with higher incidence of medical errors and decreased compassion in patient care. (2)
- Mindfulness meditation has been demonstrated to decrease symptoms of anxiety, including when provided in training sessions for medical students. (3)
- Cognitive Behavioral Therapy and Positive Psychology exercises have proven effective in decreasing depression symptoms and improving positive attitude and happiness/outlook on life, for the clinically ill and for people without pathology. (4,5)

Last year, residents from the APA/SAMHSA Minority Fellow-

ship program presented a workshop on aspects of resiliency in minority medical residents. However, taking steps beyond endurance into a positive state of wellness and thriving amidst challenges, also known as “positive psychiatry,” has yet to be discussed.

This year during his inaugural address, APA President Dr. Dilip Jeste, discussed the importance of addressing positive psychiatry as an important and emerging area in psychiatry. In addition, cultural aspects of positive psychiatry may have implications for serving not just minority medical trainees-but potentially minority populations at large.

Our workshop will explore the unique role that positive psychiatry can play in medical training of under-represented minorities. We will present demographics and statistics on medical trainees, with a focus on minorities in training. We will define/outline models of positive psychiatry and introduce aspects of cultural psychiatry and the unique role that positive psychiatry poses to play in this context. Further, we will present a summary of current implementation of positive psychiatry programs in medical training, including the work of two of the presenters. Finally, we will outline recommendations for training programs interested in implementing positive psychiatry as a component of training. Schedule permitting, Dr. Dilip Jeste has also offered to speak on his experience with positive psychiatry.

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WORKSHOP 136**ADVANCEMENT IN ACADEMIC CAREER FOR WOMEN INTERNATIONAL MEDICAL GRADUATES**

Speakers: Joan Anzia, M.D., Vijayalakshmi Appareddy, M.D.

Chairs: Rashi Aggarwal, M.D., Nyapati R. Rao, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify common challenges in the career paths of female psychiatrists; 2) Evaluate the influence of being an IMG woman on professional success in psychiatry; 3) Discuss potential solutions to challenges faced by women IMG's of different cultural backgrounds;

SUMMARY:

Even as the overall percentage of women in medicine has been increasing over the years, the percentage of women in academic medicine has not kept up. In the last 15 years the percentage of women faculty members has only increased by 1% - from 10% to 11%. Psychiatry is a specialty that women favor as it requires skills such as empathy and the ability to listen. In psychiatry 43% of all full time faculty are women with a substantial representation by IMG's. Women in psychiatry are more likely to enter academic careers today than they were in the past, but are less likely than men to stay in it. They are also less likely than men to rise to the highest ranks in the field. Psychiatry does have some female leadership – a recent APA president being a woman – however, the total proportion of female leaders is still low. Women do not have many role models of successful women psychiatrists. IMG women face an even more daunting task!

Multiple reasons for the lack of women in academic and leadership roles have been proposed. They include societal expectations – being able to juggle a demanding academic or leadership role while being the primary caregiver for family. Further, there are not enough role models of women psychiatrists who successfully manage academic careers and family lives. The problem is further complicated by the fact that different cultures have different expectations of how women should balance being caregivers and professionals. These cultural influences can have a large impact on IMG women psychiatrists' professional success. For a woman of Asian Indian origin, for example, there is a strong cultural expectation that she will prioritize her family's needs over her work, her work being less important than that of her husband. Even the simple act of going out of town for a conference can be contentious. In this workshop we will discuss many of the challenges facing IMG female psychiatrists in academia. We will also discuss the roles culture and ethnicity play in the lives of professional women. We will share some personal experiences of IMG female psychiatrists. The audience will have an opportunity to engage in a discussion based on their own experiences. We will offer potential solutions that IMG woman psychiatrists can

use to face and resolve these challenges successfully. More than half of the psychiatry residents now are women. We hope that better understanding of the challenges faced by women in psychiatry generally and IMG women in particular, will help them and the field of psychiatry.

WORKSHOP 137**TO TREAT OR NOT TO TREAT, IS THAT THE QUESTION? THE EVALUATION AND TREATMENT OF MOOD DISORDERS IN CASE EXAMPLES OF PREGNANT WOMEN**

Speakers: Kara Driscoll, M.D., Katherine Wisner, M.D., M.S., Laura Miller, M.D.

Chair: Kara Driscoll, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the barriers to the identification and treatment of mood disorders during pregnancy; 2) Engage the patient in discussion and decision-making regarding her treatment; 3) Deliver evidence-based psychiatric care to this vulnerable and important population;

SUMMARY:

Women are particularly vulnerable to the occurrence of mood episodes during the childbearing years. In spite of this, identification of mood disturbance is often delayed and under-treated during pregnancy, particularly as compared to non-pregnant women. As a result, there is a risk of relapse of prior illness or unnecessary prolongation of the identification and treatment of new illness during pregnancy which impacts both mother and her child. Many mental health practitioners and patients feel overwhelmed by the decision-making involved in the care of a pregnant woman with mood disturbance. This workshop is designed to 1) highlight and address some of the barriers to identification and treatment of mood disorders during pregnancy and 2) facilitate better care of the pregnant patient. Attendees will participate in discussion of case examples of pregnant women with mood disorders, focusing on evaluation, treatment options, and common dilemmas. The workshop leaders and attendees will collaborate in creating an individual treatment plan for each patient. The workshop will highlight common screening tools, risks of treatment versus no treatment, possible exposures during pregnancy, and potential for relapse in those with a history of mood disorders. Workshop leaders and participants will also discuss issues of medication monitoring and dose adjustments secondary to pregnancy metabolism and as well as planning for the post-partum period. Finally, the participants will practice skills for engaging the patient in a discussion about treatment and fostering patient participation in the decision-making. Workshop presenters will incorporate current evidence available for the treatment of mood disorders during pregnancy. At the end of this workshop, the participants will have increased comfort with the individualized evaluation, identification, and treatment of mood disorders in pregnant women.

WORKSHOP 138**MENTORING 101: SECRETS FOR SUCCESS**

Speakers: John Luo, M.D., Robert Boland, M.D., Josepha A. Cheong, M.D.

Chair: Marcy Verduin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize characteristics of effective mentors and mentees;2) List techniques for identifying an appropriate mentor;3) Identify strategies for developing an effective mentoring relationship;

SUMMARY:

An effective mentoring relationship is critical in one's professional development. Many residents and junior faculty, however, have difficulty identifying appropriate mentors and cultivating a successful mentoring relationship. The workshop presenters have extensive experience with mentoring, both as the mentor and as the individual being mentored, and have discovered that finding and cultivating a successful relationship with a mentor is a skill that can be taught and must be practiced in order to be effective. In this workshop, the importance of mentoring and the characteristics of effective and ineffective mentors will be discussed. By the end of the workshop, participants will develop a step-by-step plan to identify appropriate mentors for various facets of their professional development and will develop a strategic plan for intentional mentorship.

WORKSHOP 139**WORKING AS A CIVILIAN PSYCHIATRIST ON A MILITARY BASE**

Speakers: Elizabeth Brent, M.B.A., M.D., Judy Kovell, M.D., Sawsan Ghurani, M.D., Christopher S. Nelson, M.D., Elizabeth C. Henderson, M.D., Wendi M. Waits, M.D.

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Sebastian R. Schnellbacher, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn how to find out where jobs are available for civilian providers on military bases.;2) Understand the basics of military culture.;3) Know what medical board and administrative separations entail.;

SUMMARY:

The military has expanded its' ranks of providers, by recruiting civilians as both government employees and as contractors. For the foreseeable future, the number of uniformed behavioral health providers will not be sufficient to meet the demands. Civilians who may be interested may also find the process of finding a position, getting hired, and learning the "system" confusing. There are issues both making the way through the hiring process and learning how to work with service members. Persistence is needed to be hired, despite the military's call for psychiatrists. Understanding the military culture is important. There are a number of resources available to assist. This workshop will feature psychiatrists who have joined the effort, both as government employees and contractors. Military psychiatrists will also share their perspectives. The goal is to share lessons learned, and make the process easier.

WORKSHOP 140**NO POSTER, NO PUBLICATION, NO PROBLEM: A STEP-BY-STEP GUIDE TO GET YOU STARTED IN THE SCHOLARLY ACTIVITY PROCESS**

Speakers: Nicole Guanci, M.D., Cristina Montalvo, , M. Pilar Trelles-Thorne, M.D.

Chair: Rashi Aggarwal, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify barriers to scholarly activity that hinder medical students, residents, practicing physicians, and faculty;2) Identify unique cases and learn how to convert an interesting case into a publication;3) Learn the process of converting a research idea into a research project that is attainable on a busy schedule;

SUMMARY:

Resident scholarly activity is encouraged for all psychiatry residents as per the 2007 ACGME program requirements. However, the ACGME does not delineate specific requirements regarding what type of scholarly work should be accomplished by residents. Studies show that fewer than 10% of psychiatry residents will choose research as a career, but publications such as abstracts are important for any psychiatrist interested in an academic career or in compiling a more competitive curriculum vitae. Regardless, many residents lack the experience necessary to approach choosing a topic and presenting an abstract for poster presentation, especially if this process entails preparing for publication. According to a study, only 30% of residents had national presentations with 54% having no publications. Further, many psychiatric training programs lack faculty members who are able to mentor residents in these activities. The goal of this workshop is to assist participants with scholarly activity at the beginner level –whether medical student, resident, fellow, or practicing physician. We aim to facilitate the scholarly activity process by identifying barriers to lack of productivity and delineating

specific techniques for tackling these barriers. We will provide concrete guidelines on how to identify novel and relevant cases, undertake a literature search, find the most appropriate format for conveying ideas (poster, case report, letter), and start the writing process. These guidelines are not only helpful for potential writers, but are also useful for residency program directors and clerkship coordinators wanting to create an academic environment that fosters scholarly activity. Ultimately, we will focus on scholarly activities most attainable for busy residents and departments without significant grant support, including poster presentations, research models that are survey or records-based, and publications such as letters and case reports. During this workshop, we will offer examples of scholarly activities by residents in our own program, which produced 15 posters and 5 publications in the past 2 years under the guidance of 1 mentoring faculty member, using our proposed tips. Our workshop will be highly interactive and the process of taking a rough idea and then narrowing it into a research question will be demonstrated by role-play. Participants will be able to discuss some of their own research ideas or ideal patients for case reports and will be guided through the process in order to be more prepared to tackle their first poster, first publication, or first research design. By the end of this workshop, participants will be better equipped with practical knowledge of progressing from the inception of an idea to completing a scholarly activity.

WORKSHOP 141

ETHICS AND IMG RESIDENTS: CHALLENGES AND OPPORTUNITIES FOR TEACHING

Speakers: Frederick A. Smith, M.D., Nyapati R. Rao, M.D., M.S., Jacob Sperber, M.D., Shabneet Hira-Brar, M.D., Madhavi Latha Nagalla, M.B.B.S.

Chair: Damir Huremovic, M.D., M.P.P.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the key differences between ethical values in American healthcare and healthcare from cultures that supply US with IMGs; 2) Identify challenges IMG trainees and graduates face in negotiating cultural differences while attending to ethically sensitive cases; 3) Demonstrate understanding of educational strategies that can be used to help IMG trainees to adjust to challenges arising from ethically complicated cases within the context of evolving US healthcare; 4) Understand the role IMG graduates' cultural background plays in dealing with ethically challenging cases and to operate with basic strategies to address and overcome those challenges;

SUMMARY:

Psychiatrists practicing in the US are routinely called to evaluate patients that are deemed ethically complex and challenging. Such ethical issues represent formidable challenges even for seasoned US educated psychiatrists, but for foreign-trained psychiatrists (International Medical Graduates – IMGs)

they may pose insurmountable obstacles for a number of reasons, such as: 1. Cultural paradigm that may greatly differ between psychiatrist's culture of origin and American culture, 2. Cultural, racial, and religious diversity thriving in the US that, quite likely, is not present in the IMG's culture of origin, and 3. Advanced state of American healthcare that expands the forefront of ethical issues (e.g. gene therapy, transplant issues, end-of-life care, etc.), that may be yet inexistent in the international graduate's culture and healthcare system of origin. When it comes to healthcare, American culture is unique with its emphasis on inalienable individual rights and patient autonomy. Physicians coming to practice in the US from other, more collectivistic, cultures often have to struggle with accepting patient autonomy as the prevalent ethical determinant as well as with functioning comfortably in the collaborative doctor-patient relationship, which limits physician authority. IMGs often tend to err on the side of undervaluing patient autonomy (e.g. 'feeling' that their duty lies in acting 'in patient's best interest') or overemphasizing it (e.g. respecting patient autonomy and privacy even when decisional capacity may be compromised) and these biases may lead to further complications and delays in treatment, adverse outcomes, and additional liability. As IMGs represent a significant proportion of past and current US Psychiatry residents, it is essential for training programs and IMGs to be aware of such challenges and be able to address them appropriately. From that perspective, this workshop is primarily aimed at Program Directors and IMG residents and alumni. From a broader perspective, this workshop is useful for all Psychiatrists who encounter ethically sensitive cases, for those who do liaison work with colleagues from other specialties who are themselves IMGs, and for consultants who work with patients and their families from other cultural backgrounds (i.e. immigrant communities). Most frequent ethical challenges identified by IMG residents and fellows will be identified and addressed. Working across cultural lines when both providers and their patients hail from different cultures will be examined. Additional attention will be given to ethical challenges within the evolving healthcare reform. Legal implications of ethically challenging cases and utilization of Bioethics resources at different institutions will be examined. In addition to examples from personal experiences of clinicians from different parts of the country, ample time will be allowed for an interactive discussion among presenters and participants.

WORKSHOP 142

WILD CHILD? ASSESSING RISK OF PEDIATRIC INPATIENT VIOLENCE

Speakers: Drew Barzman, M.D., Douglas Mossman, M.D.

Chair: Drew Barzman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Summarize principles of developing risk assessment tools; 2) State approximate rates of inpatient aggression

and list two chief risk factors for it;3) Describe procedures for using a risk assessment measure;4) Report improved ability to rapidly identify children and adolescents at elevated risk for violence during psychiatric hospitalization;

SUMMARY:

Violence by psychiatrically hospitalized minors is a common phenomenon that can cause emotional and physical injury to patients and staff members. This workshop will give attendees a hands-on demonstration of the Brief Rating of Aggression in Children and Adolescents (BRACHA), a 14-item instrument for quickly assessing short-term risk of aggression by minors admitted to psychiatric units. The workshop will feature video vignettes used in a study that evaluated the reliability of BRACHA assessments. The workshop will introduce participants to the BRACHA, describing steps in developing the instrument, contexts for its use, published validation and accuracy data, additional accuracy data, and analyses of reliability. Next, audience members will participate in interactive demonstrations that simulate recent reliability studies of the BRACHA. Participants will view teaching videos for learning about the instrument's scoring, followed by additional videos for which audience members will provide ratings for the risk of aggression of the "patients" (who are portrayed by actors). Presenters will elicit audience members' comments about and reactions to the instrument and presenters' research methods. Participants will also discuss the potential applicability of the risk assessment tool to diverse settings, possible future studies, and alternative areas of potential application.

WORKSHOP 143

DEMENTIA: WHAT KIND IS IT AND WHAT DO YOU DO ABOUT IT?

Chairs: Cynthia Murphy, M.B.A., Psy.D., Lisa K. Catapano-Friedman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review the presentation and diagnostic criteria of the most common dementias--although some are relatively uncommon;2) Using case demonstrations and audience participation, demonstrate the variety of ways uncommon presentations of common dementias can fool us;3) Discuss treatment and management of these dementias;

SUMMARY:

Although classical Alzheimer's disease is relatively easy to diagnose, it often doesn't present so classically. At times the problem can look like--and sometimes actually is--frontotemporal dementia, Lewy Body dementia, Creutzfeld-Jacob Disease, Primary Progressive Aphasia (the semantic variant of FTD), and other entities. Using cases from our clinic, in a clinical problem solving format, involving audience participation, we will examine and discuss presentation, diagnosis, and treatment of some cases of atypical Alzheimer's disease as well as of some of these other dementias. The discussion

of treatment will include discussion of management of some of the behavioral issues as well, since behavioral issues, and their treatments, may vary with the diagnosis.

WORKSHOP 144

DYNAMIC THERAPY WITH SELF-DESTRUCTIVE PATIENTS WITH BORDERLINE PERSONALITY DISORDER: AN ALLIANCE-BASED INTERVENTION FOR SUICIDE

Speaker: Eric Plakun, M.D.

Chairs: Eric Plakun, M.D., Donald Rosen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Utilize principles of an Alliance Based Intervention for Suicide as part of psychodynamic therapy of self-destructive borderline patients;2) Understand the symptom of suicide in borderline patients as an event with interpersonal meaning and as an aspect of negative transference;3) Understand common factors in treating self-destructive borderline patients derived from study of 6 behavioral and dynamic psychotherapies;

SUMMARY:

Psychotherapy with self-destructive borderline patients is recognized as a formidable clinical challenge. Although much has been written about metapsychological issues in psychodynamic psychotherapy, relatively little practical clinical guidance is available to help clinicians establish a viable therapeutic relationship with these patients. This workshop includes review of 9 practical principles helpful in establishing and maintaining a therapeutic alliance in the psychodynamic psychotherapy of self-destructive borderline patients. The approach is organized around engaging the patient's negative transference as an element of suicidal and self-destructive behavior. The principles are: (1) differentiate therapy from consultation, (2) differentiate lethal from non-lethal self-destructive behavior, (3) include the patient's responsibility to stay alive as part of the therapeutic alliance, (4) contain and metabolize the countertransference, (5) engage affect, (6) non-punitively interpret the patient's aggression in considering ending the therapy through suicide, (7) hold the patient responsible for preservation of the therapy, (8) search for the perceived injury from the therapist that may have precipitated the self-destructive behavior, and (9) provide an opportunity for repair. These principles are compared to a set of common factors derived from review of 6 evidence-based therapies for suicidal borderline patients. 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.

WORKSHOP 145**ETHICAL ISSUES IN PSYCHIATRY**

Speaker: Laura Roberts, M.D.

Chair: Dominic Sisti, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Participants will be able to articulate the definition of professionalism in medicine;2) Participants will be able to identify and apply core ethics principles to dilemmas commonly encountered in psychiatric practice;3) Participants will be able to identify the relationship between concerns about self care and impairment and professional practice in psychiatry;

SUMMARY:

The practice of psychiatry poses many complex ethical decisions. In this talk, the speaker offers definitions of professionalism and outlines the key ethics skills for physicians. The “Big C’s” of ethics in psychiatry are contact, confidentiality, consent, conflicts of roles / conflicts of interest, and colleagues. These ethical issues will be discussed and illustrated with real-life clinical scenarios. The tone of this session will be warm and collegial and questions related to the shared experiences of participants will be explored.

WORKSHOP 145**THE USE OF EXPOSURE AND RITUAL PREVENTION WITH OCD: KEY CONCEPTS AND NEW DIRECTIONS**

Chair: Bradley Riemann, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Participants will gain knowledge regarding the components of exposure and ritual prevention;2) Participants will gain knowledge regarding keys to making exposure therapy successful;3) Participants will gain knowledge regarding how exposure and ritual prevention hierarchies are developed and exposure exercises assigned;4) Participants will gain knowledge regarding empirical support for the use of exposure and ritual prevention in OCD;5) Participants will gain knowledge regarding new directions in OCD treatment;

SUMMARY:

This workshop will focus on the use of exposure and ritual prevention (ERP) with obsessive compulsive disorder (OCD). OCD is a common and debilitating psychiatric condition. ERP is considered the therapy of choice for OCD, however it is a complex and commonly misunderstood technique. Discussion will focus on the components of ERP as well as keys to making exposure therapy successful. In addition strategies for developing an exposure hierarchy and empirical support

for ERP in OCD will be reviewed. Finally, new directions in treatment for OCD will be discussed including the use of technology to enhance ERP outcomes.

WORKSHOP 146**BUILDING USER-FRIENDLY PRACTICE GUIDELINES: LESSONS LEARNED FROM PRACTICING PSYCHIATRISTS’ USE OF CLINICAL INFORMATION RESOURCES**

Speakers: Robert M. Plovnick, M.D., M.S., Farifteh Duffy, Ph.D., Laura Fochtman, M.D.

Chair: Robert M. Plovnick, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss their own experiences in using information resources in clinical practice as compared to the experiences reported by a broad sample of psychiatrists;2) Identify clinicians’ sources for gathering information and their current unmet information needs;3) Provide feedback to further inform the development of user-friendly practice guidelines and other clinical information resources;

SUMMARY:

Psychiatrists are faced with an ever-increasing body of clinical evidence and an ever-shrinking amount of time to digest and incorporate it into their practice. Clinical practice guidelines can serve as a valuable resource for clinicians by compiling and synthesizing recent scientific knowledge with expert consensus on best practice. However, when guidelines are developed using a traditional narrative structure, they can rapidly become outdated and are time-consuming to access and apply at the point of care within a busy clinical environment.

The APA Department of Quality Improvement and Psychiatric Services (QIPS) received funding support from the National Library of Medicine to develop a prototype, Web-based, clinical practice guideline for the treatment of patients with major depressive disorders. This prototype and future APA guidelines will be offered in a Web-based, modular format rather than as traditional narrative books. They will provide evidence-based recommendations for disorder-specific clinical questions as well as questions addressing clinical care issues that may cut across multiple disorders, such as sleep problems. This format is expected to better serve the needs of busy psychiatrists at the point of care. It will also allow the APA to provide timely updates of current supporting evidence to specific recommendations in a more efficient manner. Finally, this approach to guideline development will facilitate eventual integration of practice guidelines into electronic decision support, a component of many electronic health record (EHR) systems.

In this session, the APA Practice Guidelines team will describe work underway for making guidelines more user-friendly, relevant, and accessible at the point of care. Additionally,

APIRE and QIPS staff will present data from a recent study of psychiatrists' current practices, sources of clinical information, and clinical information needs of practicing psychiatrists. Session participants will be encouraged to share their own experiences using clinical information resources at the point of care, and provide feedback to further inform the development of APA practice guidelines and other information resources that are clinically useful and user-friendly.

WORKSHOP 147

THE FUTURE IS NOW: THE FUTURE OF PSYCHIATRY THROUGH THE EYES OF NEW PSYCHIATRISTS

Speakers: Sharat Parameswaran, M.D., Matthew D. Erlich, M.D., Andres Barkil-Oteo, M.D., M.Sc., Michael Yao, M.D., M.P.H., Jules Ranz, M.D.

Chairs: Sharat Parameswaran, M.D., Matthew D. Erlich, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify ongoing changes in psychiatry and different viewpoints of the newest psychiatrists entering the profession on the future role of psychiatrists; 2) Question the current "identity crisis" of psychiatry with the primacy of evidence-based prescribing and the declining role of psychiatrists on the frontlines of behavioral health care treatment; 3) Assess the impact of managed care and health reform upon behavioral health care and the implications to the delivery of mental and physical healthcare services; 4) Determine if the expanding role of paraprofessionals, the growing importance of recovery, and the increased emphasis on primary care integration will lead to the marginalization of psychiatry; 5) Consider the role of psychiatrists in "new media" and other mediums of interaction with the public beyond clinical practice, and how this can impact the public, policy, and the future of psychiatry;

SUMMARY:

The role of the psychiatrist is rapidly changing at a pace not seen since the 1960s, likely comprising a "fourth psychiatric revolution" that is reshaping the field, from practice to economics to policy. While many experts have opined about the potential impacts that these changes may have on the future of psychiatry, the viewpoint of the newly-minted psychiatrists entering the field amidst this change has not been a central focus. This workshop seeks to stimulate an interactive discussion on various viewpoints on the future of psychiatry of the newest psychiatrists at the forefront of these changes to the profession. Over the last two decades, ongoing advances in the neurobiological understanding of mental illness have helped to provide an evidence-based approach and greater scientific legitimacy to mental health treatment. However, the increased emphasis on evidence-based medicine may have led to an "identity crisis", with psychiatrists being defined by 15-minute med checks, rather than being recognized as

therapists or integral members of mental health care teams. Furthermore, new psychiatrists often find that the ground is moving beneath them, with emerging policies regarding health care reform and the expanding role of managed care. Increased accountability and quality standards are being shaped through economic drivers such as managed care, accountable care organizations, value-based purchasing, and pay-for-performance, all of which are shifting power and independence away from psychiatrists. The growing recognition of recovery and functioning as goals of treatment is also shifting responsibility of mental health services to other non-physician providers, with an emphasis on consumer-based models of care, peer-based services, and the increasing role of advocates as stakeholders in the mental healthcare system. In addition, the impact of physical co-morbidities of mental illness and the salient call for comprehensive approaches to health care are leading to an increased focus on integrated models of treatment, with mental health care centered around primary care providers and with psychiatrists relegated to being non-treating consultants. The role of psychiatrists in the public eye is also changing, with the ability to influence social discourse and policymakers through new media, a resource that has largely been untapped by the field. This workshop seeks to stimulate discussion about how the role of the psychiatrist will change in the face of these various issues from the perspective of the new psychiatrist, including determining what direction the field, our educators, policymakers, and the American Psychiatric Association should take to confront these changes. While the discussion will be led by a panel of the newest psychiatrists entering the profession, the goal will also be to incorporate the experience of psychiatrists at all stages to help guide the future of the field.

WORKSHOP 148

DON'T CALL ME BABY: SEXUAL HARASSMENT OF FEMALE PHYSICIANS

Speakers: Kimberly Sanders, M.D., Gauri Khatkhate, M.D.

Chair: Christina Girgis, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define sexual harassment and recognize the existence of sexual harassment by patients; 2) Identify the repercussions of sexual harassment of physicians on physicians themselves as well as patient care; 3) Develop strategies to address sexual harassment by patients when it occurs;

SUMMARY:

Sexual harassment in the workplace is a well-studied issue, and the damaging nature of harassment of subordinates by supervisors is widely acknowledged. Consequences can be significant, and include a hostile work environment, lowered job performance, and effects on physical and psychological wellbeing. Despite this knowledge, sexual harassment in the medical workplace has received far less attention. The

literature that is available regarding physicians focuses on harassment by coworkers and supervisors, with almost no information available regarding harassment of physicians by patients. The limited existing data suggests that up to 75% of female physicians have been sexually harassed by patients sometime during their career (NEJM 1993). The majority of physicians do not report the harassment, making this a prevalent yet under-recognized issue. Several reasons may explain why female physicians choose not to report sexual harassment by patients. These include minimizing the seriousness of the harassment, feeling embarrassment or shame, or worrying about being perceived as overly sensitive. Others may feel uncomfortable with being angry toward patients, especially those with cognitive or psychiatric issues which affect impulse control. This topic deserves more investigation. The presenters of this workshop are two early-career, female psychiatrists working at a Veterans Administration (VA) Hospital, and one female resident working at both a VA and a University Hospital. Each has experienced unwanted sexual attention from patients. In speaking with female colleagues, the presenters found that many have had similar experiences. However, most have had little guidance during training or in the workplace to help guide their response. In researching this topic, it was noted that there is little information that validates this as an important clinical issue, or explores its impact on either physicians or patient care. The workshop will begin by reviewing sexual harassment in the workplace as a general topic, including definitions, prevalence, and sequelae. The available research about sexual harassment of physicians, particularly by patients, will be summarized. The presenters are currently collecting data from physicians at their institution to better understand the scope of the problem and its effects. Specifically, they are examining the frequency of unwanted sexual attention, as well as responses to such attention, and the reporting of incidents. They are further attempting to discern whether such incidents occur at different frequencies in a VA as compared to a University Hospital setting, and whether different interventions are thus warranted. They will present the data collected during the workshop. Finally, they will present case examples and information gathered from colleagues and residents. The workshop will then open to the audience for discussion and consideration of future directions for research and education.

WORKSHOP 149

A PRAGMATIC FRAMEWORK FOR ETHICAL DECISION-MAKING

Chair: Marna Barrett, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe and thoughtfully argue key ethical issues often encountered in practice, teaching and research settings in order to better understand why these issues are often problematic.;2) Distinguish between "right vs. wrong" dilemmas and "right vs. right" dilemmas, highlighting the reasons why dilemmas often create interpersonal conflict.;3) Learn several

models for decision-making that can be used to resolve ethical dilemmas in practice, teaching, and research.;

SUMMARY:

Whether providing child, adolescent, or adult mental health care, psychiatrists are faced with ethical dilemmas in their daily work. Confidentiality, informed consent, involuntary treatment, and professional boundaries are but a few of the ethical issues we face whether in the clinical or research arena. Although the APA code of ethics acknowledges the occurrence of unique dilemmas, few guidelines exist to direct our decision in terms of appropriate action. The purpose of this workshop is to delve more deeply into the ethical dilemmas unique to mental health, address inherent ambiguities, and present strategies for resolving such problems. Participants will be challenged to move beyond traditional "right vs. wrong" decisions and consider ethical dilemmas as "right vs. right" conflicts. Several frameworks for decision-making will be presented and applied to case examples.

WORKSHOP 150

THE AMERICAN JOURNAL OF PSYCHIATRY RESIDENTS' JOURNAL: HOW TO BE INVOLVED

Speakers: Robert Freedman, M.D., Sarah M. Fayad, M.D., Arshya Vahabzadeh, M.D.

Chair: Monifa Seawell, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the purpose of the Residents' Journal;2) Identify ways to be involved in the Residents' Journal, such as authoring manuscripts, peer review and guest editing;3) Identify the different manuscript types which are accepted at the Residents' Journal and how to prepare such manuscripts;

SUMMARY:

The American Journal of Psychiatry Residents' Journal was founded in 2006 in an effort to get psychiatric residents, fellows and medical students involved in the manuscript writing, editing and publishing process. The Residents' Journal continues to make changes on an annual basis in an attempt to provide trainees with additional scholarly activities. This workshop will provide participants with knowledge about the Residents' Journal, demonstrate ways in which one can be involved with the Journal, and further strengthen academic writing, peer review and even editing skills.

WORKSHOP 151**EVALUATION AND TREATMENT OF ANXIETY AND MOOD DISORDERS IN INFERTILITY PATIENTS AT STANFORD UNIVERSITY: AN INTEGRATED APPROACH**

Speakers: Penny Donnelly, M.S.S.W., R.N., Natalie Rasgon, M.D., Ph.D.

Chair: Katherine E. Williams, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the risk factors for new onset and recurrence of mood and anxiety disorders in women undergoing infertility evaluation and treatment;2) Demonstrate knowledge regarding the central nervous system effects of the medications used in infertility treatments and their potential impact on mood and anxiety disorders in women;3) Demonstrate knowledge of the unique psychiatric issues in infertility patients with Polycystic Ovarian Syndrome (PCOS), subclinical hypothyroidism and Ovarian Insufficiency Syndrome;4) Demonstrate knowledge of current psychosocial treatments for infertility patients with mood and anxiety disorders, including support groups and individual psychotherapies;5) Discuss the current questions and controversies regarding antidepressants and reports of increased risk of miscarriage in order to prove informed consent to patients in need of antidepressants;

SUMMARY:

Women who are undergoing infertility evaluation and treatment have twice the rates of anxiety and depression as women in the general population, and the reason for this increased prevalence is multifactorial and, includes the unique biological, psychological and social stresses involved in, and in some cases underlying, the diagnosis of infertility. The purpose of this workshop is to explore causes for these increased rates of psychiatric symptoms, such as shared biological processes, as in women with subclinical hypothyroidism or polycystic ovarian syndrome, and review the recent research regarding the central nervous system effects of medications used in infertility treatment protocols, such as Clomiphene Citrate, Human Menopausal Gonadotropins, progesterone supplementation. The unique psychological stresses of the third party reproductive techniques ovum donation, sperm donation and surrogacy will be presented, as well as an overview of current knowledge regarding effective treatments for mood and anxiety disorders in women with infertility. Specific unique psychopharmacological treatment questions to be addressed will include informed consent regarding increased risk of spontaneous abortion in women on antidepressants. In this workshop, we will present the Stanford Center for Neuroscience in Women's Health and Stanford Reproductive Endocrinology and Infertility programs' interdisciplinary approach to the evaluation and treatment of mood and anxiety disorders in infertility patients.

WORKSHOP 152**A CAREER IN CHILD AND ADOLESCENT PSYCHIATRY: FROM A DEVELOPMENTAL PERSPECTIVE**

Speakers: Tami D. Benton, M.D., Clarice Kestenbaum, M.D., Christina T. Khan, M.D., Ph.D., Cathryn A. Galanter, M.D.

Chairs: Louis Kraus, M.D., Courtney L. McMickens, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the range of psychopathology, treatment modalities, and treatment settings child psychiatrists encounter in the lifespan of their careers.;2) Recognize the varied training and career pathways within the field of child and adolescent psychiatry.;3) Identify challenges and rewards associated with practicing as a child and adolescent psychiatry in various treatment settings.;4) Identify the needs of patients and providers within the field of child and adolescent psychiatry.;

SUMMARY:

While there are 7, 418 child and adolescent psychiatrists practicing in the United States (1), children's mental health is greatly underserved. In 1999, the NIMH and the Surgeon General reported that only 20 percent of children with mental illness received mental health care (2). Limited funding and recruitment challenges have been recognized as factors sustaining the shortage of child and adolescent psychiatrists (3). In a study examining factors affecting recruitment into child and adolescent psychiatry, 64 percent of general psychiatry residents surveyed reported that they had seriously considered child psychiatry as a career choice (4). Nineteen percent noted negative experiences on their child and adolescent psychiatry rotations as a barrier to choosing a career in child and adolescent psychiatry, specifically limited exposure to the diverse opportunities provided by a career in child psychiatry(4).

The goal of the workshop is to increase the exposure to careers in child psychiatry for medical students, general psychiatry residents, child psychiatry fellows, and early career child and adolescent psychiatrists (CAPS) through a panel discussion with CAPs in different stages of their careers. The panel discussion will be moderated by a resident and Chair of the APA Council on Children and Families. Our panel will include CAPs working in academic medicine, administration, infant psychiatry, juvenile justice, private practice, and community settings. The format will include a ten minute introduction, stating the goals and objectives of the workshop. This will be followed by ten minutes from the panelist stating the current stage of their career and describing their personal developmental journey to reach the current stage. Lastly, we will leave twenty minutes for questions and answers.

1. American Academy of Child and Adolescent Psychiatry.

(2009, April 5). "Shortage Of Child And Adolescent Psychiatrists Reaches Crisis Point, USA." Medical News Today. Retrieved from <http://www.medicalnewstoday.com/releases/144968.php>.

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WORKSHOP 153

E-PSYCHIATRY: HOW INNOVATIVE WEBSITES REACH DIVERSE POPULATIONS

Speakers: Ye Du, M.D., M.P.H., Andrea M. Brownridge, J.D., M.D., Sarah Vinson, M.D., Henry Acosta, M.A., M.S.W., John Luo, M.D., Robert Kennedy, M.A.

Chair: Enrico Castillo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how the Internet websites can impact diverse, underserved consumers and the work of providers; 2) Highlight model websites focused on outreach to diverse consumer populations and creating professional collaborations among providers; 3) Evaluate future directions in the use of websites to improve information access to underserved, culturally diverse populations; 4) Discuss potential challenges in creating future websites and brainstorming potential solutions;

SUMMARY:

For people from diverse backgrounds struggling with mental illness, the double stigmatization of race/ethnicity and mental illness may potentially decrease healthcare utilization and negatively impact the way services are used (1-3). By contrast, those with a stigmatizing illness including mental illness, have been found to be significantly more likely to use the Internet for health information, to communicate with their physicians via the Internet, and to have increased healthcare utilization due to health-related information found online, likely in some part due to the relative anonymity the Internet provides (4). Providers' and advocates' utilization of the Internet has the potential to substantially impact the knowledge, attitudes, and healthcare utilization among diverse underserved populations suffering from or at-risk for mental illness.

Mental health advocacy organizations, community clinics, and providers are pushing the envelope on how to use the internet to decrease stigma, promote local events, connect consum-

ers to resources for care, and further the work of professional organizations. This workshop highlights the work of three providers who have developed creative websites to meet the needs of key patient populations and their colleagues. The workshop will begin with a brief introduction of why and how websites will play a key role in the future of mental health in general and cultural psychiatry specifically. Each presenter will then provide the history behind their websites and detail the challenges and rewards they have faced, with a specific focus on how their sites have enhanced care for diverse populations and/or furthered a sense of community among providers. Group discussion, moderated by experts in medical informatics and web development, will allow participants to envision ideal future websites, how these sites could impact providers and consumers, and the practical challenges to developing their own community or personal mental health website.

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WORKSHOP 154

HEALTH REFORM AND BEHAVIORAL HEALTH-CARE: CLINICAL, POLICY, AND ETHICAL TRANSFORMATIONS

Speakers: Dominic Sisti, Ph.D., Stephanie Hales, J.D.

Chair: Dominic Sisti, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify key provisions in the Affordable Care Act that will enable psychiatrist to develop new models of patient-centered care.; 2) Recognize the opportunities afforded by the ACA to advance several of the goals of the New Freedom Commission.; 3) Describe how the ACA provides for insurance reform, integrated care incentives, innovation, and training and how these provisions reflect particular ethical values.;

SUMMARY:

Behavioral health care -- which includes treatment for substance abuse and mental illness -- in the U.S. is currently deeply fragmented, leading to poor access and bad outcomes. These structural and systemic flaws create com-

mon ethical dilemmas for clinicians who aim to do right by their patients. Issues include, among others, ineffective and disintegrated single-specialty treatment without appropriate wrap-around services; difficulties related to providing patient-centered (i.e., “recovery-based”) services; cultural incompetence in dealing with particular populations; a lack of clarity around evidence-based treatment options; disruptions, inadequacies, or absence of treatment and services due to uninsured or underinsured status; and uncertainties as to how best to implement and honor requirements for mental health parity. In this workshop, we will examine several specific provisions within the ACA that hold strong promise to enhance the way in which behavioral healthcare is delivered, and which we believe should help resolve several common ethical problems encountered by behavioral healthcare professionals. Though realization of this promise depends upon ongoing and future implementation efforts at the federal, state, and local levels, these ACA provisions lay the groundwork for achieving truly meaningful progress in transforming mental health care in America. These provisions can be clustered around three key areas - (1) insurance coverage reform; (2) integrated care incentives; and (3) innovation (including research and technology initiatives) and education programs - all of which dovetail with the five key goals explicated in the 2003 report of the President’s New Freedom Commission on Mental Health. We aim to complement the APA’s own primer on Health Reform (2012) by highlighting how these changes offer both challenges and opportunities to psychiatry.

WORKSHOP 155

MANAGEMENT OF TREATMENT REFRACTORY OBSESSIVE-COMPULSIVE DISORDER

Speakers: Lynne M. Drummond, M.B.B.S., Himanshu Tyagi, M.D., Rupal Patel, M.B.B.S.

Chair: Himanshu Tyagi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand and diagnose treatment refractory OCD based on previous three decades of research evidence;2) Learn main principles in the management of treatment refractory OCD and its potential complications;3) Learn to manage the co-morbidities with treatment refractory OCD and how they differ in presentation in this condition (with a special focus on comorbid depression);4) Update themselves with latest research evidence and future trends in management of treatment refractory OCD including brain stimulation therapies;

SUMMARY:

Up to 40% of OCD patients do not respond to convention treatment strategies. This figure highlights the importance of knowing the evidence based management for treatment non-responders. The course providers have been running an inpatient unit for profound treatment resistant OCD (YBOCS 30 and above) in United Kingdom for last few years and have

been very successful in terms of achieved outcomes with this cohort of patients. This workshop would focus on explaining and defining treatment resistance in OCD, discuss the main reasons for it, appreciate the research evidence from last 10 years, give practical advice on the management of such patients and talk about the current and emerging trends in its management. Both psychological and pharmacological approaches to treatment and augmentation strategies would be discussed in detail. The handouts included would be informative and evidence based.

WORKSHOP 156

WELLNESS THROUGH THE GENERATIONS

Speakers: Deirdre C. Johnston, M.B., M.B., Elizabeth Kastelic, M.D., Karen L. Swartz, M.D.

Chair: Bernadette Cullen, M.B.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss and manage aspects of wellness associated with various age groups;2) Discuss the challenges in recognizing and treating mood disorders in adolescents and comprehensive treatment;3) Discuss the challenges involved in serving urban-dwelling elders aging in place with psychiatric illness, and describe three examples of models of care;4) Identify service delivery methods of promoting wellness in the out-patient setting;5) Discuss the challenges in the identification, assessment and treatment of psychiatric conditions in young adults in college.;

SUMMARY:

The physical, mental and social wellbeing of all is important but can be particularly challenging to achieve for those who have psychiatric illnesses. The purpose of this workshop is to review aspects of wellness particular to specific age groups with psychiatric illnesses and to discuss ways that the out-patient psychiatric team can promote wellness amongst these groups.

Major Depression is a common medical illness experienced by at least 5% of American teenagers. A naturalistic cohort study of teenagers found an association between depression during adolescence and increased risks of substance abuse, unemployment, early pregnancy, and educational underachievement at follow-up as young adults. Each of these negative outcomes has its own consequences. Potential novel community-based interventions to address depression in adolescence such as school-based education about mood disorders, as well as parent and teacher training will be discussed. A national co-morbidity study indicates that 20 to 75% of major mental illness, has its onset between the ages of 14 and 24 years, which includes college-age youth. This results in an increasing number of youth with onset of psychiatric illness while in post-secondary school. We will focus on two groups of youth who may access mental health services during the college years: 1. Youth transitioning to college who

have a known psychiatric condition. 2. Youth with onset of psychiatric conditions while in college. As clinicians, we need to think about the needs of these patients at their respective stages and develop effective strategies to address their needs. Adults with chronic mental illness are faced with many challenges. Not only do they have to contend with the specific symptoms of their illnesses but in addition the illnesses themselves and their treatment can directly affect the physical and social wellbeing of the affected individual. Over the course of 2012 the Johns Hopkins Community Psychiatry Out-patient Program adopted a theme of Health and Wellness and has actively promoted 4 health objectives for patients – healthy eating, regular exercise, smoking cessation and attendance at a primary care physician appointment. Details of this initiative will be discussed. Older people with psychiatric illness are often socially isolated, particularly in urban areas and they tend to be poor users of mental health services. Several studies have shown that seniors living in public housing have an even higher rate of untreated mental illness. Social isolation in the presence of psychiatric illness can also limit access to appropriate medical care. For these particularly vulnerable adults, community based mental health outreach teams can ensure access to and effectiveness of primary care and preventive services, and connect mentally ill seniors with other necessary resources and supports. Three models of care will be discussed.

WORKSHOP 157

PSYCHOTHERAPY UPDATE FOR THE PRACTICING PSYCHIATRIST

Chair: Priyanthy Weerasekera, M.D., M.Ed.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Participant will learn to select specific evidence-based psychotherapies for patients with psychiatric disorders;2) Participant will be able to determine which patient variables predict differential response to treatment;3) Participants will identify new ways of learning psychotherapy;

SUMMARY:

The last few decades have witnessed significant advances in psychotherapy research. This research has demonstrated that there are evidence-based psychotherapies for patients with psychiatric disorders, that the therapeutic alliance is a key variable in outcome, and that individual variables help tailor treatments to patients. Of the evidence-based therapies studied to date, cognitive-behavioral, interpersonal, psychodynamic, experiential, couple, family and group, target specific psychiatric disorders or problems that commonly accompany these conditions. Level 1 evidence (that is meta-analyses or double-blind controlled trials) exists for most of these therapies across a variety of conditions. The therapeutic alliance has also been found to predict outcome early in treatment independent of therapy type, and is related to therapist skill and attributes, and to patient variables. Individual variables such as attachment styles and personality traits have also

been shown to differentially predict response to treatment, indicating that not all patients with the same disorder respond similarly to the same psychotherapy.

The purpose of this workshop is to provide a psychotherapy update for the practicing psychiatrist, who is not familiar with the extensive literature in this area. By reviewing this literature the clinician will become familiar with the current indications and contraindications of the various psychotherapies for patients with psychiatric disorders. How research informs practice will also be closely examined with clinical case examples. References will be provided as well as resources to assist the clinician to keep up with this challenging and exciting area.

WORKSHOP 158

PERINATAL PSYCHIATRY: NEW OPPORTUNITIES FOR PREVENTION, TREATMENT, AND EDUCATION

Speakers: Margaret M. Howard, Ph.D., Samantha Meltzer-Brody, M.D.

Chair: Julia B. Frank, A.B., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explain the purposes served by different forms of perinatal psychiatric care (mother baby inpatient unit, specialized partial hospital or specialty outpatient clinic);2) Conduct formal and informal assessments of an institution's need for perinatal psychiatric services;3) Use the EPDS and other assessment tools to identify and monitor women in need of services;4) Identify resources needed to successfully implement a perinatal psychiatric program;

SUMMARY:

Although perinatal psychiatry is not a recognized board certified sub-specialty, pregnant and post-partum women are at specially high risk for the development of serious mood and anxiety disorders. Women with established psychiatric disorders also need advice about pregnancy, along with careful monitoring during the perinatal period to ensure healthy outcomes for themselves and their infants. To identify and treat perinatal psychiatric disorders (PPDs), the mental health provider must have a broad understanding of the role of individual and family based interventions and detailed knowledge of the risk benefit profiles of psychotropic medications for mothers, fetuses and infants. Each presenter at this workshop has overcome many barriers that impede forming integrated, interdisciplinary services for PPDs along the continuum of care. Participants will learn about the first inpatient perinatal psychiatric mother baby unit in this country (UNC), a unique partial hospital for postpartum women and their babies (Brown University), and a specialized outpatient service, the Five Trimesters Clinic, that provides assessment, brief treatment and referral for problems related to conception, pregnancy and post-partum adjustment, while training residents and medical students (George Washington University). Brief

presentations will focus on how to assess the need for a specialized service, identify relevant resources, and implement a particular program in different academic and resource environments. Participants will leave with new ideas on how to design and implement perinatal psychiatric programs in their home institutions.